

Clinically Integrated Networks: A Cooperation Analysis

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Health care in the United States is in the midst of a major transformation. After decades of spiraling health care costs, rising numbers of uninsured and underinsured people, and increasingly poor health status indicators, the fee-for-service business model that has shaped health care in the U.S. for the past century is coming to an end. Rapid growth in health care costs is threatening the sustainability of the social compact and the competitiveness of American industry. More importantly, the fee-for-service model is increasingly recognized as failing American consumers in the pursuit of better health, contributing to overutilization, overprescribing, poor care coordination, and slow adoption of best practices.

Over the past ten years, a fundamentally new way of thinking about health care delivery has emerged. This new approach is usually referred to by the phrase “population health management” and takes the form either of “accountable care organizations” (which largely work with government payers) or “clinically integrated networks” (which work with both commercial and government payers and may include accountable care organizations). On the surface, this approach is similar to managed care initiatives launched in the 1990s, which focused on reducing costs by managing utilization. Clinically integrated networks, however, promise real improvements over

managed care. Under managed care, medical management and care coordination were located with the payers, setting up an adversarial relationship between payers and providers. Clinically integrated networks establish collaborative partnerships between payers and providers, as they work together to achieve common goals.

Therefore, health care as an industry, and Catholic health care as the largest not-for-profit sector within that industry, is now in a context where collaboration and integration are not simply strategies necessary for economic survival on an ad hoc basis (as was often the case in the past). Now collaboration, integration, and partnerships have become the fundamental values of a reshaped health care system. Such a reshaped health care system also transcends traditional boundaries. As Matthew Stiefel and Kevin Nolan, analysts at the Institute for Healthcare Improvement (IHI), note:

Because no single sector alone has the capability to successfully pursue improving the health of a population, the Triple Aim explicitly requires health care organizations, public health departments, social service entities, school systems, and employers to cooperate. Fostering this cooperation requires an integrator that accepts responsibility for achieving the Triple Aim for the population. Whether the integrator

is a new or existing structure or organization, some entity is needed to pull together the resources to support the pursuit of the Triple Aim. Once the integrator creates an appropriate governance structure, the integrator then needs to lead the establishment of a clear purpose for the pursuit of the Triple Aim, identification of a portfolio of projects and investments to support that pursuit, and creation of a cogent set of high-level measures to monitor progress. The set of measures should operationally define each dimension of the Triple Aim. A good set of population outcome measures can fuel a learning system to enable simultaneous improvement of population health, experience of care, and per capita cost of health care.¹

May a Catholic health system create such an ‘integrator’? May it take the lead and welcome the responsibility for achieving the Triple Aim for defined populations? If so, under what conditions?

To create a clinical integrator will require any Catholic health care organization to approach collaborative partnerships in a new way. Networks and alliances offer opportunities to create or build upon linkages with other non-Catholic providers without engaging in ownership/joint venture relationships. Alignment allows physicians the proper autonomy required to practice medicine while helping to create sufficient moral distance between the physician and the health system in case of conflicts. As always, new partners should, insofar as possible, share the values of the Catholic organization.

Before moving forward, Catholic health care must analyze the moral dimensions of Catholic participation in clinically integrated networks, especially in light of the fact that the United States Conference of Catholic Bishops has long recognized the necessity and value of forming new partnerships

with health care organizations and providers (*Ethical and Religious Directives for Catholic Health Care Services*, Part Six, Introduction). Yet all partnerships raise questions about the potential for issues of moral cooperation and scandal. The *Directives* have long assisted Catholic institutions in maintaining Catholic identity within the boundaries of a Catholic system. They can also help maintain fidelity to Catholic identity beyond those boundaries.

The following analysis outlines key aspects that may be included in the infrastructure of clinically integrated networks. The paper then provides a moral analysis of these aspects using the principle of moral cooperation. While CINs may differ from each other in the details of how they are organized, the analysis concludes that clinically integrated networks, as a model, should pose no new problems from the perspective of Catholic teaching and may, in fact, provide a new answer to the challenges of partnering with non-Catholic health care providers.

1. The Structure of Clinically Integrated Networks

At the most basic level, clinical integration involves collaboration among *independent* providers for the purpose of improving quality and containing costs. It is a way to align hospitals, employed medical groups, independent physicians, and other providers in order to improve the quality and efficiency of health delivery and to capture the value created through those improvements. A Clinically Integrated Network (hereafter referred to as a CIN or Network) does not establish a new type of relationship between these entities—Catholic hospitals and health systems have long contracted with independent physician groups in a variety of ways. Rather, it builds upon these previously established relationships in order to achieve the goals of the Triple Aim.

Clinical integration is necessary for accomplishing these goals for at least three reasons. First, in order to assess health outcomes and improve them, baseline data on the *health* of a defined population must be gathered. Secondly, baseline data on the *costs* of providing care among these providers for this population must be gathered before new performance targets can be set. Third, clinical integration provides a vehicle for physicians to share knowledge and determine *best practices* that simultaneously improve clinical and financial performance. All three activities require a concerted effort among providers caring for a particular population.

One of the most important things to recognize is that a CIN is not a health care provider. The hospital is a health care provider; the independent physicians are health care providers. But the CIN is an integrator, a network—essentially an *infrastructure*. It is a mechanism by which independent providers can share information about their patients' health status, about the care they provide to their patients, and about the costs of providing that care. Providers who wish to participate in this mechanism agree to share and adopt best practices for improving patient care and satisfaction and for reducing costs across the population defined by the payer. If, by sharing this information, the health status and satisfaction of the defined population improves and the costs go down, the providers receive a financial bonus, over and above the costs for which they have already been compensated by the payer; if care/satisfaction or cost outcomes are negative, they receive no bonus; by sharing the risk of higher cost/higher care patients across the Network, the CIN makes it more likely that these patients will receive care than under fee-for-service or managed care mechanisms. While what is described here is a typical payment structure, other models are also possible. In some, for example, the CIN may take on risk and assume a loss or a portion of the loss if costs are higher.

Thus, because it is a mechanism or an infrastructure, the relationships between participants are very different than in situations in which the hospital owns or employs the physicians.

1.1 Ownership

Ordinarily, to create a CIN, a local hospital or set of geographically proximate hospitals (along with their affiliated allied health facilities) must secure partnerships with local independent physicians who agree to align exclusively with that hospital/system. [For exceptions to exclusivity see section 2.3 below]. Like Catholic health systems, non-Catholic health systems have begun creating CINs. In each market, aligning physicians will be crucial for the ability of Catholic hospitals to transition to this new model of health care; if they do not, they will survive for a time as the payer system transitions from fee-for-service to population health, but eventually, their viability will be compromised.

Therefore, Catholic health systems will need to proactively initiate CINs. While ownership models may differ according to location and circumstance, in most cases but certainly not all, the Network itself will be initiated by a Catholic health care organization, with the local Catholic hospital potentially serving as the sole 'member' of a limited liability company (LLC).² Ordinarily, it will retain a number of reserved powers. Ownership of the CIN in these cases would be strictly civil ownership and it is ownership in a very different sense than the term is generally used because the "owner" does not really own anything. There are no bricks and mortar buildings, employment agreements, management authority and the like. Physicians who join the Network ordinarily would have no ownership interests in the Network; similarly, neither the Catholic health system nor the Network would have ownership interests in the independent physician practices.

1.2 Independent Physicians

A critical step in developing such Networks is to align independent physicians with hospitals. Catholic hospitals and health systems have always been in contractual relationships ('aligned' or 'affiliated') with independent physician groups. With CINs, the Catholic hospital/health system neither owns nor manages the independent physician groups. The Catholic hospital and aligned independent physicians both accrue benefits (financial, practical, professional) from these relationships.

CINs seek to build upon these pre-existing types of relationships in order to achieve the scale and scope of services required for achieving the goals of the Triple Aim. In these Networks, the independent physicians remain independent. Neither the Catholic health system nor the CIN own them; they have no control over the ways in which the independent physician practices do business or practice medicine. The physicians participate in the CIN but continue to manage their own practices and care for their own patients. Although the Network may remove an individual physician (or a practice) from the Network for failing to meet *Network* performance goals, the Network ordinarily would not have a direct governance or management role vis-a-vis individual physicians especially as they provide patient care.

1.3 Governance and Management

Critical to the success of CINs is physician leadership. Consequently, although a Catholic health system may initiate a Network, such Networks ordinarily will be governed by an independent and collaborative board of directors, most of whom are physicians. They will not be governed or managed by the local hospital or the Catholic health system, nor will the Network govern or manage the local Catholic hospital. The governing boards of these Networks will largely be

comprised of representatives from the local hospital, physicians employed by the hospital, and the independent physicians. Ordinarily, representatives from the independent physician practices will comprise a majority of the board members. While the local Catholic hospital and the independent physicians all participate together in the Network, the affiliation will not create a partnership or joint venture between or among participants in the Network or between the Network and participating members, in most cases.³

This approach to governance of a Network is consistent with this new approach to thinking about health care delivery. CINs are designed to be physician-led and patient-focused. These Networks create a new way for physicians to collaborate with each other and with local hospitals while giving them a greater voice regarding patient-care protocols, financial incentives, and risk sharing. They require the development of a culture of mutual collaboration and interdependence among previously competitive and adversarial providers.

Notably, the governance of these Networks is separate from the governance of the hospital and the provider practices. The Network governs only: the relationships with payers; the sharing of information among participants; the development of clinical performance initiatives, patient care protocols and clinical performance measures for the Network; the monitoring of clinical performance; and the distribution of performance incentives. Furthermore, it should be kept in mind that the Catholic providers (both hospitals and physicians) can influence decisions and recuse themselves if and when necessary.

1.4 Sponsorship and Catholic Identity

Although CINs will ordinarily be subsidiaries of a Catholic organization, they may not always be

recognized as ‘Catholic’ entities. Often, subsidiaries of Catholic health systems and facilities that are not directly involved in patient care—in other words, that are not providers—are not considered Catholic. Determination of whether a particular CIN will seek recognition as a Catholic entity will be made by the governing board, ideally in consultation with the local Ordinary.

Such determinations assist in minimizing the effect of the CINs on the Catholic identity of the local hospital and its relationships with its allied health facilities or employed physicians. As Catholic, the hospitals, employed physicians, and medical office buildings will continue to follow the *Ethical and Religious Directives* per current practice and employment agreements.

1.5 Financing

In order to launch a CIN, a Catholic health care entity will ordinarily provide the majority of the start-up costs for the Network. In most cases, participating physicians will pay a relatively nominal initial participation fee. Ideally, once the CIN has established its contracts with payers, the Network will become self-sustaining, its costs being paid through a portion of the incentive funds earned by and paid to the Network by health plans. Neither physicians nor the Catholic health care entity should have an ongoing direct payment to the Network. The cost of operations should be paid for through the incentive funds. Of course, as noted above, it might also be the case that the Catholic provider chooses not to have the role of “integrator” and instead leaves that to another party and it might also be the case that another reimbursement model is employed.

These incentive funds will be generated by the difference between the payments received from payers and the costs of care within the Network. Eventually, when the fee-for-service model has been eclipsed,

Networks will ordinarily receive a flat fee per member per month (PMPM) to provide care, whether that care is delivered at a physician’s office, the hospital, long-term care facility or other location. Since hospital-based, acute care is clearly more expensive than care at a physician’s office, there is an incentive to provide patients with earlier, upstream or preventative care to keep them out of the hospital. This requires knowing one’s patients better, spending more time with them, catching their illnesses earlier, and improving their health rather than just treating acute episodes. It also requires that hospitals, providers, and insurers overcome their previously adversarial relationships. In other words, financial incentives are tied to real improvements in patient health and care. And, importantly, risks of caring for chronically ill patients or patients with acute episode are not borne by individual providers or hospitals but are distributed broadly over the network. Network participants are compensated based not on ownership but on service and performance.

Generally, the finances shared between the Catholic hospital and the independent physicians will not be based on direct patient care. Ordinarily, both the Catholic hospital/system and the independent physicians will be directly reimbursed for the care they provide and then they will share the *difference* between the payments provided by the payer for all members of the defined population and the costs of caring for the persons in that population.⁴ Especially at the outset, payment models will differ depending on contracts. Under fee-for-service arrangements, unless a participating physician authorizes a Network to bill and collect for fees on her/his behalf, independent providers and the Catholic hospital will bill the payer directly and be compensated from the payer directly for the services each provides, following current practice. Alternatively, the Network might receive and pay independent physicians a PMPM fee that includes ‘bundles’ of care. In both cases, the

Catholic hospital and independent physicians will receive a bonus from the shared savings achieved by the Network; under such a structure, the Catholic hospital/system neither shares nor receives compensation for specific services performed by independent physicians.

In some instances, the Catholic health care organization or the CIN may provide management support services to some of the participating members to assist in achieving Network outcomes—such as IT support, case managers, other personnel, or funding for these services. Billing services may be made available to some of the participating members using a third party vendor. In such cases, arrangements will need to be made, following current practices, to separate management support services from any prohibited services and billing for such services should be carved out of the Network's finances.

1.6 Contracting with Payers

In the past, Catholic hospitals, Catholic health systems, and independent physician practices negotiated individually with insurance companies to be part of the insurance company network for each particular employer. Health systems negotiated for their employed physicians. This highly fragmented process required significant duplication of effort with associated high costs. The CIN infrastructure simplifies this process: the CIN negotiates with payers on behalf of the local hospital(s) and aligned physicians that are now configured as a geographically regional 'integrated network' to cover a particular population of persons. In exchange for responsibility for a fixed number of 'covered lives' from the payer, the Network as a whole assumes accountability for the cost, quality of service, and health status of defined populations, while sharing the utilization risks across the Network (thus minimizing the risk on any one provider). Covered populations may be defined in a

variety of ways, such as employee health plans, insurance plan membership, attributed network physician panels, or geographically defined populations.

1.7 Clinical Performance Management Systems

At the heart of a clinically integrated network is an infrastructure—an IT infrastructure—for sharing information. Integrated networks achieve the Triple Aim by measuring health outcomes (mortality measures, health and functional status, and healthy life expectancy); patient experience (safety, effectiveness, timely, patient-centered, equitable, and efficient); per capita cost data; and then sharing this information within the Network.

Therefore, critical to the establishment and the successful integration of a Network is the implementation of an IT infrastructure. Each local Network will need to establish a Clinical Performance Management System (CPMS). This system will provide the infrastructure necessary for collecting, organizing, analyzing and reporting data about the health care services provided by the participants, the costs of those services, and the needs and health outcomes of patients. It includes the information necessary to guide effective clinical intervention and care management for individuals as well as to manage the risk associated with providing services to populations. All providers and sites of care will be required to utilize the same CPMS in order to create a health database on the defined 'population.'

Ideally, the CPMS will enable any care provider at any location in the Network to access a patient's record, regardless of where in the Network the patient receives care, greatly enhancing continuity of care. These records will help effectively to coordinate episodes of illness (both acute and chronic) over time and across multiple care settings, including patients' homes.

As patients visit providers, providers (including the hospitals) will upload certain data regarding patient care from the EHR to the CPMS, such as radiology and imaging data for patients, prescription information, as well as physician orders (instructions for the treatment of patients by other medical personnel). Electronic physician orders reduce errors (from transcription or handwriting), decrease delays in communicating the orders to other medical personnel (e.g., radiology, pharmacy, laboratory), and can be accessed from any location by the departments responsible for fulfilling the orders.

Ordinarily, providers will be responsible for collecting their own fees, billing payers through the CPMS and will be paid directly by the payer for their services. This billing information, although stored in the CPMS, is the property of the individual providers. Pharmacy Benefits Management (PBM) data will also be uploaded from the EHR to the CPMS for sharing and analysis. Patients will be able to access their health information through their patient portal.

With all this data compiled in one place (on the CPMS), the Network can then analyze the aggregate information on patient care, satisfaction, and cost. Based on this information, it can develop recommendations for improving patient care (new clinical protocols) and reducing costs, and it will have information on the costs saved for the purposes of determining Network incentives. This data can be tracked in real time. Data for individual physicians or aggregate data for independent physician practices can also be analyzed.

1.8 Clinical Performance

A main function of the CPMS, in light of the Triple Aim, is the improvement of patient care. The information entered into the CPMS during the start up period of a Network's operation will generate a

baseline for the health status and costs of the covered population. The CPMS will identify variations in clinical protocols across the Network and areas where health and cost outcomes are less than ideal. Based on this data, the Network—via a physician-led committee—will be able to develop clinical protocols to be adopted across the Network. The goal of these protocols will be to coordinate and improve patient care while lowering the overall costs of care.

Achievement of these goals will result not only in the great good of improved patient health status, but will also be necessary to continue to be awarded contracts by payers. The CPMS will be essential to providing ongoing monitoring and assessment of improvement in patient outcomes and satisfaction, provider performance and cost information.

In most instances, a subcommittee of the board—named, perhaps, a "Clinical Performance Committee"—will oversee the Network's gathering and analysis of performance data and practices. It will use this data to set goals and take action, to identify high risk or complex patients, and to measure and analyze the results of performance measurement activities. It will recommend clinical performance initiatives for the Network, develop patient care protocols and clinical performance measures, monitor clinical performance, and develop and recommend incentive plans.

2. Clinically Integrated Networks and the Principle of Cooperation

As has always been the case in working with independent physicians, CINs present the possibility that a Catholic hospital or health system may find itself collaborating with physicians who share many, but not all, Catholic values. Catholic health care organizations prohibit abortion, euthanasia, assisted suicide, and reproductive technologies within their own institutions. As Catholic health care organizations establish CINs, they will need to craft

ways to prohibit abortion, euthanasia, assisted suicide or reproductive technologies involving human embryos from interfacing with the Network.

Yet as is currently the case, independent physicians may insist on providing certain contraceptive practices (prescriptions, vasectomies, Essure, laproscopic tubals) within the privacy of their own practice. They may wish to refer their patients for tubal ligations to locations not associated with the Catholic health care organization. The following section addresses how CINs can ensure that sufficient moral distance is in place between a Network and such actions.

2.1 The Principle of Moral Cooperation: An Overview

All Christians will cooperate with *wrongdoers* (sinners). This is an inevitable aspect of living and working in the world, especially of living and working for the Kingdom of God. In fact, orthodox Catholic theology recognizes that we are all *wrongdoers*—we all sin and fall short of the glory of God. The principle of moral cooperation does not seek to prevent Catholics from cooperating with *wrongdoers*, as that would be impossible.

It is a central tenet of the Second Vatican Council and of a significant volume of magisterial teaching that Catholics are to be in the world, to serve the world, and to cooperate with persons across the spectrum for the common good. In all instances, of course, the purpose of such collaboration must be to pursue the good.⁵ In doing so, Catholics must take care to minimize, to the extent possible, their cooperation with immoral *acts*. The principle of moral cooperation is a tool that helps Catholics and Catholic institutions create sufficient *moral* distance between themselves and the immoral *acts* committed by those with whom they find themselves in relationship.

Catholic health care institutions must take care to ensure that in their relationships with non-Catholic partners, sufficient moral distance exists with regard to governance, management, finances and performance of acts inconsistent with Catholic teaching.⁶ A cooperator is one who finds him or herself in a situation where his or her otherwise good actions are appropriated by another person (the principal agent) in the commission of a morally illicit action. For such cooperation to be justifiable, the cooperator's actions must not contribute 'substantially' to the wrongdoing. 'Substantial' is defined by one set of scholars as "indistinguishable, inseparable, and indispensable" to the wrongdoing. Absent any one of these elements, the cooperation is not substantial.⁷

2.2 Formal Cooperation

The first question is whether the Catholic health care organization, by establishing clinically integrated networks, will engage in formal cooperation with prohibited acts possibly performed by independent physicians in the Network.

With regard to formal cooperation, the Network structure distances the CIN—and therefore the Catholic health care organization—from institutional participation in prohibited procedures and activities in the following ways:

- No prohibited services will be provided within entities belonging to the Catholic health care organization or that are recognized as Catholic. Any contraceptive services provided by independent physicians will be conducted within their already established private practices. Any contraceptive services provided by physicians employed by the Catholic health care organization will be conducted within the moral space of their limited private

practice following already established guidelines.

- Although a Catholic health care system, via the local Catholic hospital, may legally and financially establish and own a Network, most Networks will not ordinarily seek recognition as a Catholic entity. Eventually, they will become self-financing.
- Most Networks will not be formally sponsored by a Catholic sponsor.
- Neither the Catholic system nor the local Catholic health care entity directly will govern or manage the Network. Each Network will have its own governance and management structure, including a self-perpetuating board.
- Neither the Catholic health care organization nor the Network has ownership, governance, or management authority over the independent physician practices where prohibited procedures may occur. Independent physician practices will continue to be separately incorporated and operated.
- At this time, the Networks do not secure the viability and survival of the independent physician practices. These practices are fully operational in the current market. The purpose for establishing a Network is entirely proactive. Therefore, these Networks do not indirectly ensure the continuation of procedures and activities that otherwise would not be occurring. [Even if a Network did secure the survival of these practices, the National Catholic Bioethics Center has determined that such an action would be licit mediate remote material cooperation].⁸
- A Network may offer management services to independent physician practices (to cover accounting, security, human resources, etc.) as long as for each service the agreement ensures a complete separation from any prohibited procedures.⁹
- Neither the Catholic health care organization nor the Networks, in writing agreements to initiate a Network or to accept independent physicians, will directly establish the governance, management, financing or segregation of prohibited procedures performed by independent physicians.^{10, 11}
- Independent physicians who provide services not covered or approved by the Network are free to negotiate and contract separately with payers for such services.

In these ways, CINs avoid both formal cooperation and implicit formal cooperation. In terms of formal cooperation, neither the CIN nor its affiliated Catholic entities participate in or approve of any prohibited procedures potentially carried out by aligned physicians. In terms of implicit formal cooperation, while the local Catholic hospital will in some cases be the sole member and possible owner of the CIN, neither the Catholic health care organization nor its hospitals sponsors, governs, or manages the Network; the Network does not govern, manage, or own the independent physician practices; nor does the Catholic health care organization or the Network establish the conditions under which prohibited services might be conducted nor provide governance, management or financing thereof. Any concerns due to ownership are mitigated by the proper proportionality between the goods protected and the gravity of any acts committed by independent physicians.¹²

2.3 Material Cooperation

If neither the Catholic health care organization nor the CINs are engaged in formal cooperation, might they be involved in material cooperation and, if so, would the cooperation be sufficiently remote? The key question is whether or not a Network provides “essential circumstances” for independent physicians who wish to prescribe contraception and/or conduct direct sterilizations within their practices. If it provides a circumstance essential to conducting the act itself, then the cooperation would be immediate. If it provides a “nonessential circumstance,” the cooperation would be mediate. To answer this question requires examination of different aspects of the Networks.

2.3a Contracting with Payers

One potential area for concern is the fact that the Network negotiates contracts with payers. Eventually, payers will ordinarily provide bundled payments—per patient per month—for the Network to cover the entirety of members’ health care needs. What if an employer negotiates with the payer to include coverage for practices that are at odds with Catholic teaching? Would accepting such a package from a payer involve the CIN in formal or material cooperation?

First, in negotiating with payers, Networks will need to make clear that at least one member of the Network—the local hospital belonging to the Catholic health care organization—is Catholic. It should therefore request that certain procedures not be covered, especially actions which imperil life—abortion, euthanasia, assisted suicide, in vitro fertilization and other reproductive technologies involving human embryos.

Especially in the current climate, questions of coverage of contraceptive services—both prescription and surgical interventions—have become highly contested. The federal government’s recent accommodation with regard to mandated contraceptive coverage greatly assists with this issue. When the Network contracts with payers, the payers may—as with other Catholic institutions—offer separate policies, at their own expense, for contraceptive services.

Even if this were not to happen, Peter Cataldo, former staff of the National Catholic Bioethics Center and ethicist for the Archdiocese of Boston, has argued that complying with insurance mandates does not necessarily entail illicit cooperation. As he notes:

Unlike the case of direct sterilizations being performed in a Catholic hospital in which the hospital contributes circumstances that are essential to the sterilizations, complying with a contraceptive insurance mandate does not entail an essential contribution to the act of contraception. The circumstances essential to this act are the contraceptive drug or device itself, the actions of the patient, the writing and filling of prescriptions for them, and certain other actions of a health-care provider in cases of contraceptive devices. How the contraceptives are paid for is not a circumstance essential to the act of contraception itself.¹³

Cataldo is clear that Catholic organizations must include in their contract and plan literature disclaimer language that does makes clear their opposition to practices not consistent with Church teachings. If they do, their role in negotiating these health plans constitutes licit mediate cooperation:

The circumstance to which the Catholic employer contributes is financial access to contraceptive support, procedures, drugs, and

devices through its general health plan, from which plan the employee otherwise receives many morally good benefits. Any contribution that this circumstance makes to contraceptive acts is unintended under the recommended disclaimer. The circumstance of providing financial access is, as has been pointed out, nonessential to the act of contraception. This mediate material cooperation by the Catholic employer is remote and not proximate. The Catholic employer's mediate material cooperation in contraceptive acts is remote because there are many intervening causes between offering a health insurance plan and the contraceptive acts themselves. Finally, the real threat to a Catholic employer of losing employees and the possible termination of the organization if health-care benefits are not offered is a proportionately grave reason for the mediate material cooperation.¹⁴

While Cataldo is analyzing the question from the perspective of a Catholic employer, the same argument would apply to a Catholic health care organization negotiating with the same insurance company regarding the same patient population. Thus, even in cases where the CIN elects to be recognized as Catholic, both the HHS mandate and the subsequent accommodation provide more than sufficient moral distance between the CIN and the accepting of coverage for contraceptive services by a payer. The CIN would here be engaging, at most, in remote mediate material cooperation, which would be justified by the real threat to the Catholic health system of being unable to secure payer contracts and losing aligned physicians. Moreover, if certain independent physicians in the Network wish to be able to provide certain services separate from the Network, they are free to negotiate separately with payers for these services.

2.3b Cooperating with Physicians

Independent physicians might, while participating in the Network, prescribe contraception for their patients or conduct a variety of in-office sterilization procedures. Does the CIN engage in material cooperation with the physicians who engage in such actions?

Many Catholic health systems currently employ the National Catholic Bioethics Center's (NCBC) notion of "limited private practice" to balance the necessary good of employing physicians with the insistence by some physicians that they be allowed to continue prescribing contraception in their offices.

In this regard, the NCBC makes two important observations. First, they recognize the legitimate autonomy of independent physician practices. Second, they make clear that location and independence are the deciding criteria. As they note:

Even though the Church considers vasectomies to be as immoral as tubal ligations, vasectomies seldom come into conflict with the policy of a Catholic hospital since they can be done on an outpatient basis in a physician's office. Similarly, the prescribing of oral contraceptives and diaphragms seldom causes problems because it is done in a physician's office and under the physician's auspices, not those of the Catholic medical center or hospital. It is undoubtedly true that most obstetrician-gynecologists who have privileges at Catholic institutions are prescribing contraceptives. As deplorable as that may be, it is not the Catholic institutions themselves that are sponsoring, promoting, or prescribing it.¹⁵

Thus, the NCBC makes clear that Catholic hospitals are free to cooperate with *wrongdoers*, even to enter

into contracts with such wrongdoers, as long as the *wrongdoing* is conducted at a non-Catholic location and under non-Catholic auspices. Even if they participate in a CIN, the independent physician practices remain independent—i.e., they are not, in any meaningful sense, under the auspices of a Catholic institution.¹⁶

Therefore, with regard to the prescribing of contraceptives, any cooperation by the Network would be secondary—or a further step removed—from the primary cooperation being performed by the independent physician. As Cataldo noted earlier, the prohibited acts in question are the patient’s contraceptive acts themselves. Physicians are cooperators with the patients when they write prescriptions (both formal and immediate material). The physicians are supported by their independent practices. The Network is yet another step removed from the use of contraceptives and the writing for prescriptions insofar as it is simply aligned with these physician practices. Further, these physician practices provide a wide variety of health care services that only occasionally includes the writing of prescriptions. Thus, insofar as they neither sponsor, promote nor prescribe the contraception, CINs, at most, engage in licit, remote, material cooperation in the writing of prescriptions for contraception.

Similarly, the Network is buffered from independent physicians who choose to conduct vasectomies or similar sorts of sterilization procedures in their offices. Here the physicians are the principal agent of the action; their own practice group is the primary cooperator; the Network is, again, one step removed from the practice itself. It is not involved at all in the governance or management of the practice, it neither sponsors nor promotes the procedures, nor does it provide any material support for the conduct of the procedures.

In short, within CINs, most physicians will remain independent of the Catholic institution. They will “participate” in the Network—similar to having admitting privileges at a Catholic hospital—but any prohibited procedures will be conducted on an outpatient basis at the independent physician’s office.

It might be argued that the Network moves independent physicians closer to the Catholic institution. If so, an analogy to the NCBC’s “Modified Clinical Practice Guidelines for Affiliated Health Professionals with Respect to Prescription of Contraceptives” would be applicable.¹⁷ These guidelines apply to physician practices owned by the Catholic hospital or health system, but they could be extended and modified for the purpose of Network analysis.

2.3c Electronic Billing

Most aspects of the CPMS present no problems with regard to the principle of moral cooperation. One question that might be raised concerns the use of the CPMS by independent physicians for electronic billing for prohibited services. Physicians affiliated with the CIN will potentially submit bills for these procedures through the CPMS. Will this entail material cooperation on the part of the CIN?

Information on all medical care conducted within independent physician practices—including prohibited procedures—will be entered into the patient’s electronic health record (EHR), which will ordinarily be owned by the independent physician practices. Certain information will be uploaded from the EHR to the CPMS for purposes of access across the Network and analysis.

Independent physicians will submit bills for all care provided to payers via the CPMS. Here, an otherwise good component of the CIN (the CPMS) may be appropriated by a principal agent in relation

to a prohibited procedure. However, billing occurs after the fact of the procedure—it is not essential for carrying out the act. Moreover, no profits from individual procedures return to the CIN. The physician bills the payer directly and is reimbursed directly. In cases where the CIN provides billing services, such services will most likely be provided by a third party firm, and bills for prohibited procedures (e.g., direct sterilizations) will be processed separately. Therefore, the billing function of the CMPS constitutes, at most, licit remote mediate material cooperation.

Questions may be raised regarding the interface of the CPMS and electronic prescribing. The CPMS will ordinarily not be used to submit electronic prescriptions. Independent physicians will do this via their own EHR or a stand-alone e-prescribing system.

2.4 Clinical Performance

CIN clinical protocols should not cover or include prohibited services. Systems should be established to make sure that this does not occur.

3. Conclusion

This analysis concludes that structures proposed for clinical integration networks provide sufficient moral distance between the delivery of prohibited procedures by independent physicians employed by independent physician practices and both the CIN (ordinarily not recognized as Catholic) and the local hospital (recognized as Catholic) so as to present no new problems from the perspective of Catholic teaching. CINs may, in fact, provide a new answer to the challenges of partnering with non-Catholic health care providers.

Clinically integrated networks are consistent with the mission of Catholic health care organizations and

Catholic health care itself and promise to achieve significant goods for persons and communities. At minimum, they provide a more rational approach to health care delivery, improving health outcomes for persons and communities, improving patient satisfaction, and reducing the crippling costs of health care in the U.S. They re-envisage payers and independent physicians from adversaries to valued collaborative partners; in doing so, Catholic health care organizations will forge new affiliations that offer possibilities to further the Church's health ministry: bearing witness to social teaching and its emphasis on human dignity; increasing access to care for the poor and marginalized; leveraging resources in the spirit of stewardship; and providing holistic care throughout the continuum.

These goods certainly provide a proper proportionality for cooperating with independent physicians who may, on occasion, engage in wrongdoing. This cooperation, however, will be licit, mediate, remote material cooperation, justifiable by: (1) the significant goods to be achieved by the CINs; (2) the threat to the viability of Catholic health care, and therefore the common good, if Catholic health care institutions are not able to align with independent physicians as clinical integration becomes the norm for health care delivery; and (3) the proper proportionality between the goods of clinical integration, the promotion of the common good, and the gravity of the procedures in question.

Although Catholic health care organizations through their local hospital(s) may technically own and will likely provide the initial funding for CINs, this analysis concludes that the governance, management, and financing structures currently being developed for CINs across Catholic health care prevent formal and implicit formal cooperation in the following ways:

- The ownership and governance/management of the CIN are ordinarily separate from one another.
- The ownership, governance, and management of the independent physician practices, where individual physicians may engage in prohibited acts, are completely separate from the CIN.
- Ordinarily, as an integrating infrastructure not directly involved in the provision of patient care (i.e., not a health care provider), CINs will not seek recognition as a Catholic entity nor be sponsored by a health system's Catholic sponsor.
- The CIN accrues no direct financial benefit from prohibited procedures. Payer coverage of these services is mandated by law.
- The CIN structure is neither necessary nor essential for enabling independent physicians to provide these services.
- With regard to implicit formal cooperation, the Catholic health care organization's object in establishing CINs is clearly distinct from an individual physician's object of providing contraceptive services. None of the agreements negotiated, written or consented to by the Catholic health care organization or the CINs will "establish the governance, management, or financing of the *immoral procedures* of another health care entity, or any institutional participation in those procedures and activities."¹⁸

This analysis concludes that such Networks, therefore, do not provide any essential circumstances for the provision of prohibited services. Therefore, CINs will not be engaged in immediate material cooperation.

The analysis also concludes that the following dimensions of the CIN structure constitute, at most, remote licit mediate material cooperation:

- Including contraception and sterilization within covered services negotiated with payers, due to the federal mandate and protected by the accommodation;
- Providing a CMPS that may be used by physicians for submitting bills for in-office sterilization procedures.

While ordinarily, CINs will not seek to be recognized as Catholic by their local bishops, this analysis has examined the CIN structure as if they were officially 'Catholic.' This analysis sees no intrinsic barriers to identifying these Networks as Catholic. If they are so recognized, the Networks would need to follow the *Ethical and Religious Directives for Catholic Health Care Services*. Doing so should not present any challenges for CINs. The independent physician practices would be under no obligation to follow the *Ethical and Religious Directives* insofar as they are neither owned nor managed by the Network, although they would certainly be encouraged to follow the ERDs as closely as they can.

As Catholic health care organizations move forward into these new forms of affiliation, they should seek the endorsement of the relational structure of CINs from local Ordinaries and discuss CIN naming with them. They should design and implement strategies that address Catholic identity considerations in relationships with independent providers in a robust way. Attention to details of marketing, signage, disclaimers and communication with various stakeholders remains critical. Proactive conversations with local Ordinaries designed to pre-emptively address potential issues of scandal are strongly recommended.

¹ Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org).

² According to the IRS, “an LLC with only one member is treated as an entity disregarded as separate from its owner for income tax purposes (but as a separate entity for purposes of employment tax and certain excise taxes), unless it files Form 8832 and affirmatively elects to be treated as a corporation.” See: [http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Limited-Liability-Company-\(LLC\)](http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Limited-Liability-Company-(LLC)). Most CINs will likely elect to be treated as corporations and will, therefore, be considered separate entities from the local hospital or ministry organization for tax and other legal purposes. It is also important to note that in some cases the Catholic system or hospital will not take the lead in establishing the CIN. Rather, it may facilitate another party in establishing the LLC with the Catholic party being a Member with reserved powers.

³ In some cases, based on pre-existing arrangements, the Network may assume a joint venture structure. Separate analyses of moral cooperation would be needed in these instances.

⁴ It must be kept in mind that each party within the CIN is reimbursed for what they provide. This can be established as a percentage of the total care provided by each provider. Thus the Catholic party is provided payment only for what it does, not for what it doesn't do. This ensures that Catholic providers are not paid for or benefit financially from procedures or other interventions that do not conform with the ERDs.

⁵ National Catholic Bioethics Center, “Cooperating with Non-Catholic Partners,” *Ethics and Medics* 23.11 (1998): 2; and Kevin D. O'Rourke and Philip J. Boyle, eds. *Medical Ethics: Sources of Catholic Teachings*. 4th ed. Washington, DC: Georgetown University Press, 2011, p. 13; M. Therese Lysaught, *Caritas in Communion*:

Theological Foundations of Catholic Health Care. St. Louis: Catholic Health Association, 2014, pp. 55-72.

⁶ Catholic Health Association, *Report on a Theological Dialogue on the Principle of Cooperation*. St. Louis, MO: Catholic Health Association, 2007, p. 9.

⁷ CHA *Report*, p. 12.

⁸ Peter Cataldo and John Haas, “Institutional Cooperation: The Ethical and Religious Directives,” *Health Progress* 83 (6) (Nov/Dec 2002): 54.

⁹ Cataldo and Haas, p. 54. See also Kevin D. O'Rourke, “Catholic Health Care and Sterilization: The “principle of cooperation” provides the necessary ethical guidelines,” *Health Progress* 83 (6): 47-48.

¹⁰ NCBC, “Cooperating with Non-Catholic Partners,” p. 3.

¹¹ Cataldo and Haas, p. 51.

¹² For more on the goods provided by CINs, see the Conclusion below.

¹³ Peter J. Cataldo, “Compliance with Contraceptive Insurance Mandates: Licit or illicit cooperation in evil?” *National Catholic Bioethics Quarterly* 4 (1) (Spr 2004): 110.

¹⁴ Cataldo, “Compliance with Contraceptive Insurance Mandates,” pp. 110-111.

¹⁵ Edward J. Furton, Peter J. Cataldo, Albert S. Moraczewski, and National Catholic Bioethics Center. *Catholic Health Care Ethics: A manual for practitioners*. 2nd ed. Philadelphia, PA: National Catholic Bioethics Center, 2009, pp. 96-7.

¹⁶ Where requested by local bishops, CINs should request that independent physicians who wish to provide contraception and in-office sterilization include in their signage and forms language indicating that the practice is independent of the Catholic hospital or health system and that although aligned, the system does not approve of these procedures.

¹⁷ Furton, et al., 99-101.

¹⁸ NCBC, “Cooperating with Non-Catholic Partners,” p. 3, emphasis added.