



Recommendations for Administrators of Non-sectarian Hospitals

There are a number of important considerations that non-sectarian hospital administrators must take into account when approaching a business partnership with a Catholic hospital or health system. Stand firm in your commitment to preserve access to reproductive health services. Based on your knowledge of how other Catholic and non-sectarian hospitals have addressed their differences, be prepared to suggest a solution to preserve these services. Here is an overview of these issues that should be carefully thought through and negotiated before signing a transaction agreement. A checklist is also included as a reference.

Is a partnership with a Catholic hospital/system the best option?

First, be certain that such a partnership is absolutely necessary. Take the time to fully explore all alternatives -- including partnerships with other non-sectarian hospitals -- that could improve the finances and future stability of your nonsectarian hospital. If a Catholic partner is chosen, be prepared to explain to the community why other potential non-sectarian partners were ruled out.

What partnership structure would best protect the nonsectarian partner's mission?

If a partnership with a Catholic hospital or system is the only available option, the *form* of partnership must be carefully considered. Generally, looser forms of partnership, such as a joint venture, will allow greater latitude for the non-sectarian hospital to maintain its identity, mission and menu of services than will complete partnerships, such as full-asset mergers.

Which governance structure is best for the nonsectarian partner?

The governance structure of the partner entities will determine how much power the nonsectarian hospital will retain in the new business arrangement. Will the new merged entity have a joint parent board? If so, how many board members will there be and who will appoint them? If it is to be 50/50 representation, how will a tie be broken? If neither entity will get to have 50 percent of the board members, how will any at-large board members be selected? Will Catholic clergy be permitted as board members, potentially making it difficult for Catholic lay board members to speak up for services or options disapproved by Catholic teaching?

It is important to understand the powers members of the parent board will have. Will they have the power to 1) hire and fire the hospital(s)' CEO 2) approve or disapprove the hospital(s)' budget or 3) approve or disapprove addition or dismissal of services or expansion of the hospital(s) into new territories or through construction of new facilities? Will the parent board be considered an "active" or "passive" board from a legal standpoint? Will one of the partners maintain what are called "reserved

powers” allowing it to veto certain decisions of the parent board? If so, what kinds of powers, and over what aspects of the partnership?

Non-sectarian hospital leadership will also want to establish whether the individual hospital(s) will maintain their own boards of directors and if so, what powers they will have. Other questions to consider: What powers will they *not* have? Who will appoint the hospital(s)’ board of directors? Can the board of directors’ appointments or decisions be overruled or vetoed by either the parent board or the Catholic sponsoring partner?

It is imperative that administrators be clear about who will be responsible for interpreting application of the *Ethical and Religious Directives for Catholic Health Care Services*. Will it be an outside consultant from the diocese? A Catholic theologian who joins the staff of the hospital? The hospital’s ethics committee? Someone from the Catholic hospital or health system?

Are there any proposed prohibitions on services?

The effects of religious restrictions on patients’ access to care can be very serious, especially when there is a health care crisis. The *Directives* explicitly ban abortion, sterilization procedures and contraceptive services. More conservative interpretations of the *Directives* can affect how pregnancy emergencies are treated.

Make a list of reproductive health services that are currently offered at the nonsectarian hospital or in buildings on its campus, such as ambulatory surgery centers and physicians’ offices. Work with the medical staff to make sure *all* potentially problematic services are listed, such as contraceptive counseling, provision of contraceptive scripts or contraceptives themselves, provision of emergency contraception,¹ post-partum tubal ligations, non-post-partum or “interval” tubal ligations, vasectomies, elective abortions and emergency terminations of pregnancy to save the woman’s life or health, or in cases of fetal anomalies.

Use this list in conversations with the Catholic hospital to get specific answers about which services would become prohibited in the hospital or campus space that will be governed by the joint parent entity. This list needs to be extremely specific. In the final Memorandum of Agreement (MOA) between the two organizations, this list of prohibited services should be short and as specific as possible. It could include “elective abortions,” but not mention emergency terminations of pregnancy to save the woman’s life or health, thus meaning the latter would not be prohibited. Similarly, it could list vasectomies and interval tubal ligations, meaning that post-partum tubal ligations could continue.

Get clarification on how the partnership will affect treatments emerging from advancements in medical research. If new medical treatments become available, and they are disapproved by the U.S. Conference of Catholic Bishops (such as potential treatments to be derived from embryonic stem cell research), they may be prohibited. Specific language in the MOA should describe how this situation would be handled. Hopefully, decision-making would not be retained by the Catholic partner.

Share the proposed list of prohibited services with the medical staff to gain their insight on how these restrictions will affect community access to health care. Can local outpatient facilities provide all the

¹ Because some bishops believe that EC interferes with the implantation process, there are Catholic hospitals that require an ovulation test before providing the drug to sexual assault survivors. If the test determines that the patient is ovulating, she is denied EC when she needs it the most. It is known as the “Peoria Protocol.”

services for patients affected by these rules? Is there an acceptable hospital nearby that could absorb cases that require hospitalization? If not, openly discuss other ways of preventing the loss of key reproductive health services in the community (see “carve-out” option below).

Will there be any changes to medical staff by-laws?

Physicians, medical students or residents practicing in the historically nonsectarian facility may be required to sign statements promising to adhere to the *Directives*. If there will be two hospitals (one Catholic and one nonsectarian), or a Catholic-governed entity with a “carve out” area that is nonsectarian (see below for further discussion of this topic), then the medical staff by-laws should, at minimum, guarantee that physicians only be required to follow the Catholic *Directives* in specified Catholic facilities. Physicians’ ability to participate in pharmaceutical trials should be addressed, because there have been instances in which that ability has been curtailed due to Catholic disagreement with pharmaceutical company requirements that female patients be confirmed to be using contraception, so as to avoid potential consequences to a pregnancy.

Physicians may be restricted in what they can do outside of the hospital, including in their private offices or in other medical facilities. Physicians should maintain the freedom to provide medical information and services as they choose in their own offices, and to practice at other facilities, such as a Planned Parenthood clinic, without restriction. In one instance, a physician who had sold his practice to a hospital that later became Catholic was fired from his own practice for prescribing contraceptives.

Physicians practicing in the jointly-governed or Catholic-controlled hospital may be prohibited from providing information, counseling about or referrals for services that are prohibited by the Catholic *Directives*. If elective abortions, for example, become prohibited in the hospital, physicians still must be permitted to discuss this option with patients and provide referrals elsewhere.

Would Catholic restrictions affect the employee health insurance plan?

The prohibition of contraceptive services may extend to health insurance coverage for employees working in a Catholic hospital or health system. This potential change in employee benefits must be addressed during negotiations. (This issue may be resolved in August 2013, when employers will be federally required to offer contraception coverage without a co-pay. A narrow exemption for religious employers would not include hospitals, schools or charities.)

Use of a “carve-out” space to provide prohibited services

In several recent non-sectarian/Catholic hospital partnerships, a separately-incorporated space to protect patients’ access to comprehensive reproductive health services has been successfully employed. This approach, referred to in the hospital industry as a “carve-out,” has a number of components that must be adequately addressed before the hospital transaction is completed. Carve-out facilities can be located either within an existing non-sectarian hospital or nearby the hospital in an ambulatory surgery center setting.

If a carve-out space is being considered as an option, key stakeholders must be actively engaged in order to ensure the best solution for the entire community. State health officials, community members and Church officials will all want to negotiate how best to preserve services without going against Catholic teaching. Negotiations take time and the solution must be fully developed and incorporated into the finalized hospital merger agreement.

It is important that the space be governed appropriately. It should be separately-incorporated with its own funding stream, board and staff.

To qualify for Medicare reimbursement, the facility must be approved by The Center for Medicare & Medicaid Services. CMS will have very specific requirements to uphold their standards of what constitutes a “separate and distinct” medical facility. Early conversations with the appropriate regional CMS office about proposed plans are strongly recommended.

To uphold the mission of the facility as a key provider of comprehensive reproductive health services, there must be community representatives or experts in women’s health on the board. Board members interested in the preservation of reproductive health services will be essential to address any potential gaps in services promptly, foster provider recruitment efforts and ensure that the new entity maintains the ability to meet community needs.

The menu of services offered in this space must be well-defined ahead of time. Ideally, all maternity services would be located in this space to ensure long-term stability and to allow the provision of post-partum tubal ligations. If maternity services will not be included, it is important to ensure that a wide range of services, including but not limited to reproductive health, are offered in the space. The reasons are: 1) to ensure security by making it more difficult to identify any women who may be entering the space to obtain prohibited services; and 2) to make the space more financially viable. An entity offering only vasectomies and tubal ligations is likely to struggle financially and require significant financial subsidies from a sponsor.

The future financial viability and stability of the carve-out space must be carefully considered. In addition to offering a broad array of services, as noted above, the carve-out space can be made more financially viable in three important ways: a) ensuring adequate start-up funding, such as through a grant from the nonsectarian facility² or public funding; b) through mechanisms that permit use of the space by the jointly-governed hospital on a leased basis for other services, thus providing revenue to the carved-out entity; and c) through mechanisms that permit sharing of staff, such as by having staff of the carved-out entity leased to the main facility when needed.

Is there an exit strategy in place?

Administrators must be prepared for the possibility that, after the partnership is formed and the “carve-out” space is created, the arrangement is unsuccessful. What happens next? An exit strategy is an essential component of the planned affiliation and should be carefully considered and spelled out in the MOA. The exit strategy should prohibit the Catholic partner from buying out the nonsectarian facility, ensure that assets of the nonsectarian facility are protected, and define what will happen to the assets of the nonsectarian “carve-out” entity.

² Typically, funding for a carve-out facility cannot come from the Catholic partner, because it would be seen by Catholic authorities as cooperating with the provision of immoral services.

Checklist for Administrators of Non-sectarian Hospitals

Consideration of all options

- Is seeking a partnership at this time necessary?
- Have all other potential partners been thoroughly considered?

Potential forms of partnerships with a Catholic hospital

- Joint Venture
- Alliance
- Affiliation
- Full-asset merger
- Acquisition

Governance structure of new merged entity

- Will new entity be governed by a joint parent board?
 - If so, how many members?
 - Who will appoint them?
- If parent board is to be 50/50 representation, how will a tie be broken?
- If neither entity gets 50% membership, how will at-large board members be selected?
- Will Catholic officials be permitted as board members?
- Will the parent board:
 - have power to hire/fire the CEO?
 - have voting authority over hospital budgets?
 - have voting authority over potential expansion of services or capital development?
 - act as an “active” or “passive” body?
- Will one partner maintain “reserved powers” to veto decisions made by parent board?
 - If so, what kinds of powers?
 - Over what aspects of the partnership?
- Will individual hospitals of the new entity maintain their own boards of directors?
 - If so, what powers will they have?
 - What powers won't they have?
 - Who will appoint the hospital(s)' board of directors?
 - Can their decisions be overruled or vetoed by either the parent board or the Catholic partner?

Services that could become curtailed

- Contraceptive counseling and prescriptions
- Provision of contraceptive devices
- Post-partum tubal ligation
- Interval tubal ligation

- Vasectomy
- Treatment of miscarriage
- Ectopic pregnancy
- Provision of emergency contraception. Will an ovulation test be required?
- Elective abortion
- Therapeutic abortion
- IVF Treatment
- Contraception provision related to drug trial
- Contraception provision related to cancer treatment
- Pharmacy dispensary. Will any drugs be excluded?
- HIV/AIDS counseling that includes discussion of condom use
- End of life decision-making
- Future medical advances (embryonic stem cell)

Potential changes in medical by-laws

- Requirement to sign agreement to adhere to the *Directives*?
- Who is responsible for interpretation of *Directives*?
- Effect on private practice?
- Ability to provide information, counseling or referrals for prohibited services?

Potential changes to employee benefits package

- Loss of coverage for birth control?
- Change in eligibility for birth control coverage?
- Loss of coverage for sterilization procedures?
- Loss of abortion coverage?

Use of a “carve-out” space to provide prohibited services – Key requirements

- Engage key stakeholders during development stage
- Separately-incorporated
- Separate board
- Separate staff
- Mechanisms to ensure “separate and distinct” status
- Community/women’s health representation on board
- Mixed menu of services
- Mechanisms to ensure future sustainability
- Approval from local and federal regulatory agencies

Exit Strategy

- Is there an exit strategy spelled out in MOA?
- Does it protect the non-sectarian hospital from a buyout by Catholic partner?
- Does it protect assets of the non-sectarian hospital?

- What happens to the “carve-out”?