Essay

Will Catholic hospitals survive without government reimbursements?

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This brief essay will begin to address the feasibility of operating a Catholic healthcare system without reimbursement from government healthcare programs such as Medicare and Medicaid. This question stems from the recent ACA/HHS “Nondiscrimination in Health Programs and Activities” final rule.

Summary: The average hospital in the United States receives 40–50 percent of its net revenues from governmental sources. Participation in Medicare is contingent upon the hospital having a Medicare provider agreement. Participation in other governmental programs (Medicaid) as well as most commercial insurance is also contingent upon that agreement. Hospitals, including “Catholic” hospitals, cannot survive without a Medicare provider agreement. That agreement may be terminated for non-compliance with Medicare and other governmental regulations such as the recent ACA/HHS “Nondiscrimination in Health Programs and Activities” final rule, which could require “Catholic” hospitals to provide services which violate moral principals of the Church.

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Reflection on the recent ACA/HHS “Nondiscrimination in Health Programs and Activities” final rule raises the question of the feasibility of operating a Catholic healthcare system without reimbursement from government healthcare programs such as Medicare and Medicaid. This brief analysis will ask more questions than it will answer. It provides an overview for physicians and other healthcare professionals of the challenges Catholic hospitals and health systems would face in operating without government-funded healthcare programs. The questions raised will require further research by legal, financial, and regulatory professionals. Ultimately it will be very difficult if not impossible to

operate without governmental reimbursement and Medicare certification.

On May 13, 2016, HHS issued the “Nondiscrimination in Health Programs and Activities” final rule, implementing Section 1557 of Affordable Care Act. (HHS 2016) It is too early for the publication of commentaries regarding the *final rule* but it appears to prohibit insurers and providers from categorically denying gender transition procedures as well as abortion services.¹ The final rule does not contain any specific religious or conscience exemption but relies on existing federal law.² Healthcare and civil rights attorneys will need to address the specific requirements and the viability of protection of Catholic hospitals

under the Religious Freedom Restoration Act or other federal law.³

Virtually all general acute-care hospitals in the US accept Medicare and Medicaid patients and in order to be paid for those services must have a Medicare provider agreement/Medicare certification. Among other requirements, Medicare certification requires adhering to the Centers for Medicare and Medicaid Services “Conditions of Participation.” A healthcare attorney would need to research how the new final rule is covered under the “Conditions of Participation,” but this essay assumes that not complying with the new final rule would cause a hospital to be out of compliance with the “Conditions of Participation” and would place it in “immediate jeopardy” of losing its Medicare certification. Further non-compliance would result in the loss of the hospital’s Medicare certification within a matter of days.

When asked the question as to the feasibility of hospitals operating without governmental reimbursement, my initial response was no, it would not be feasible. In writing this essay, and giving much more thought to the issue, my answer remains a very narrowly qualified no. As will be shown, the complexities and inter-relationships of strategic, financial, and operational facets of hospitals make it very difficult if not impossible to operate without governmental reimbursement and Medicare certification.

IS IT FEASIBLE FOR A HOSPITAL TO SURVIVE WITHOUT GOVERNMENT FUNDING?

Having made the assumption that Catholic hospitals would be required to comply with the final rule, non-compliance would ultimately result in loss of the hospital’s Medicare provider agreement and Medicare certification. Without Medicare

certification, the hospital would not be able to bill Medicare or any other federal healthcare program (Medicaid, Tri-Care, Medicare Advantage). The resultant loss of revenue and margin would be catastrophic. According to the 2014 Tennessee Department of Health Joint Annual Report of Hospitals, the average Tennessee not-for-profit acute-care hospital received 48 percent of its net revenue from government sources.⁴ A reduction of this magnitude would be devastating for any organization, let alone one as complex as a hospital. A hospital would perhaps be able to sustain this reduction in net revenue if it occurred over an extended period of time (years) allowing it to develop a strategic plan for downsizing. But in the case of Medicare certification and its loss for non-compliance the process takes days not years.

A significant factor of the loss of revenue from government payer sources is the broad nature of the patients and programs affected. If it were only Medicare, some programs, maternal-child health for example, would not be impacted. But as the loss of revenue would include Medicare, Medicaid, and Tri-care, it would impact all programs within the hospital or system. With such a dramatic reduction in net revenue, the hospital would need to reduce expenses to a greater degree than the reduction in net revenue, to maintain a margin necessary to meet its other obligations, such as long-term debt payments. Assuming a 6 percent net income margin, a 48 percent reduction in net revenue would require a 51 percent reduction in expenses to maintain the same dollar margin to meet obligations. This three-point differential may not seem significant, but assuming annual net revenue of \$500 million it would represent \$15 million. Exacerbating this difficulty would again be the broad nature of the programs impacted and the number that would be unable to achieve the 51 percent reduction in

expenses without closure. Many programs or units would often face minimum staffing requirements. Most impacted would be areas such as labor and delivery, NICU, and smaller or more specialized critical care units. The severity of reduction would require consolidating many units with the resultant loss of specialization. This in turn would likely result in the defection of the most specialized and best nurses and ancillary personnel to unaffected hospitals that would be thriving due to the influx of patients and revenue. Equally damaging would be the defection of the majority of the medical staff to the same providers.

The loss of all government revenues would place the hospital in an immediately critical condition. And much like the frail elderly, it would set in motion a cascade of system failures that would prove fatal.

IS IT POSSIBLE FOR A HOSPITAL TO CARE FOR COMMERCIALLY INSURED PATIENTS WITHOUT MEDICARE CERTIFICATION?

Not only is the hospital's government revenue dependent upon Medicare certification but much if not all of its net revenue from commercial payers is dependent upon it. An example from a large national commercial payer is as follows:

Licensure of Facility. Facility is licensed to operate acute care hospital(s) and/or other outpatient facilities ("Facilities") listed in Exhibit B under the laws of the state in which it resides and shall remain licensed at all times for the duration of this Agreement. Further, acute care hospital Facilities are accredited by The Joint Commission ("The Joint"), as well as certified to participate in the Medicare program. The Joint accreditation includes maintaining standards for credentialing healthcare providers who perform services for which Facility is responsible under this Agreement. Company or Facility shall notify PPO in writing of any loss of

its licenses, accreditation by The Joint, or other substantial changes in the services provided that could materially impair the ability of Facility to carry out the duties and obligations of this Agreement.⁵

According to the 2014 Tennessee Department of Health Joint Annual Report of Hospitals, the average Tennessee not-for-profit acute-care hospital received 42 percent of its net revenue from commercial payers.⁶ Combining this with the reduction of government net revenue results in a loss of 90 percent of the average hospital's net revenue. No organization can survive such a catastrophic loss of revenue. Again, over the longer term, it may be possible to renegotiate commercial payer contracts to substitute Joint Commission or other certification for Medicare, but the hospital would be faced with accomplishing this in a matter of days not years. As more insurers move into Medicare Advantage or Managed Medicaid programs, even this longer term solution is disappearing. Insurers typically negotiate a base agreement with a hospital that has addendums that address the specific plans. Those base agreements need to be flexible enough to encompass all specific plans to include Medicare Advantage and Managed Medicaid. Not requiring Medicare certification would make it impossible to contract with the hospital for those government-funded plans the insurer wishes to market in the hospital's service area.

IS IT POSSIBLE FOR A HOSPITAL TO REMAIN CATHOLIC AND NOT CARE FOR MEDICARE AND MEDICAID PATIENTS?

An additional consideration is the mission of the not-for-profit Catholic hospital. The Emergency Medical Treatment and Labor Act (EMTALA) requires Medicare participating hospitals to stabilize and treat any patient coming to their emergency room (CMS 2012). EMTALA only applies to

Medicare participating hospitals. If a Catholic hospital were no longer subject to EMTALA, would it turn away government-funded emergent patients? If it were to do so, would it be achieving its mission as a Catholic hospital? Directive number 3 of the *Ethical and Religious Directives for Catholic Health Care Services* states:

In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons. (USCCB 2009)

The Catholic hospital which turned away emergent patients, especially the elderly, the disabled, and the poor would not be in compliance with directive number 3. Seeking to avoid abandoning its Catholic nature, the hospital would continue to care for these patients without reimbursement from government payers. So not only would the hospital have given up the revenue associated with these patients, it would still face the expense of their care.

IS IT POSSIBLE TO DEVELOP A DE NOVO HOSPITAL?

Could a new hospital be developed that would not receive governmental revenue? This option would have a higher likelihood of success than conversion of an existing hospital. It could be sized

appropriately with a narrower set of product lines. Perhaps it could negotiate commercial payer contracts that would not require Medicare certification. Nonetheless, it would be difficult if not impossible to overcome the incongruence of mission discussed in the prior section.

The one option that comes to mind would be the development of a women's hospital. If it was focused primarily on obstetrics, it could survive without caring for Medicare patients. In some states it could operate without an emergency room, limiting its exposure to government-funded patients. It would not be the first Catholic hospital to skirt directive number 3 of the *Ethical and Religious Directives* but it would be difficult to argue for the authenticity of its mission. Perhaps if we turned the "seamless garment" inside out we could justify this strategy, arguing that one must sacrifice care for the poor in order not to participate in intrinsically evil acts.

CONCLUDING THOUGHTS

1. It is impossible for all but a very few existing acute-care hospitals to operate without government-sponsored insurance and the accompanying Medicare certification. Those few able to survive would struggle to operate in compliance with the *Ethical and Religious Directives for Catholic Health Care Services*.
2. In a few very narrow circumstances it may be feasible for a de novo hospital to be developed and operate without Medicare certification. Again it is difficult to see how such a hospital could operate in compliance with the *Ethical and Religious Directives for Catholic Health Care Services*.
3. The expansion of healthcare sharing may offer some relief in developing funding and healthcare systems independent of government-sponsored programs.

4. It would appear to be much more feasible to begin to develop an outpatient system that caters to patients participating in healthcare sharing and other insurance models.
5. Existing Catholic healthcare systems appear to be faced with four options — (a) comply with the mandates in violation of the ERDs; (b) not comply with the mandates and mount a legal battle to overturn them and/or be exempted from them; (c) not comply with the mandates and force the government to face the prospect of closure of a sixth of the hospital beds in the US; or (d) sell their current hospitals and devote those resources to creating physician practices, outpatient treatment centers, and perhaps de novo hospitals.
- 2 HHS (2016) §92.2(2) “Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required.”
- 3 For a thorough legal analysis, see [National Catholic Bioethics Center et al. \(2015\)](#).
- 4 Data are from individual hospital JARs and were prepared for the author by the Tennessee Hospital Association. Data for for-profit and specialty hospitals were then removed.
- 5 Language from confidential payer agreement with large national commercial payer. As is discussed later, most national payers are selling Medicare Advantage or Managed Medicaid plans. Due to the need for the flexibility to do this, they are typically requiring Medicare certification in their master agreements with hospitals.
- 6 See note 4 above.

I assume Catholic hospitals will mount a vigorous legal challenge to the final rule, preemptively if feasible. Healthcare attorneys need to weigh in, but in reading some of the responses to the proposed rule, there seems to be ample legal arguments contrary to the rule. If such efforts were to fail, I would favor the last option. Bearing stewardship in mind, it would seem prudent for Catholic systems to sell their hospitals and invest the proceeds in smaller healthcare services that are unaffected by the final rule. Perhaps devoting more of those resources to primary care for the poor would bring Catholic health care back to its roots.

NOTES

- 1 The categorical denial of gender transition or abortion services as it relates to a hospital provider would, for example, prohibit a hospital that allows orchiectomy for testicular cancer from not allowing orchiectomy as a part of gender transition. Similarly, a hospital that allows the performance of a D & C for a missed abortion could not prohibit its performance for elective abortions.

REFERENCES

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BIOGRAPHICAL NOTE

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