Bigger and Bigger

THE GROWTH OF CATHOLIC HEALTH SYSTEMS

COMMUNITY CATALYST

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COMMUNITY CATALYST 2020

This publication was made possible through generous support from the Tara Health Foundation

Acknowledgements

The authors wish to express their deep appreciation for the support of the Tara Health Foundation for research and analysis carried out for this publication. We especially benefitted from the insights of Tara Health Founder and President Ruth Shaber, M.D.; and Elise Belusa, Director of Programs and Operations. We also wish to thank colleagues who reviewed drafts of this publication and provided helpful comments and suggestions, especially Lori Freedman, Ph.D, of the University of California San Francisco, Debra Stulberg, M.D., of the University of Chicago; Phyllida Burlingame of the ACLU of Northern California; and Amy Zarin, a consultant with Community Catalyst's Women's Health Program.

About Community Catalyst

Community Catalyst is a national, non-profit consumer advocacy organization founded in 1998 with the belief that affordable quality health care should be accessible to everyone. We work in partnership with national, state and local organizations, policymakers and philanthropic foundations to ensure consumer interests are represented wherever important decisions about health and the health system are made: in communities, statehouses and on Capitol Hill. For more information, visit www.communitycatalyst.org. Follow us on Twitter @HealthPolicyHub.

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Introduction

For nearly 20 years, staff of the MergerWatch Project – now part of the Women's Health Program of Community Catalyst – have been tracking the growth of Catholic hospitals and health systems that use religious directives to restrict medical care. This report is the fourth in a series that began in 2002[1] and continued in 2013[2] and 2016[3]. This new report provides a 2020 update on the growth of Catholic health systems and the spread of religious restrictions on care.

Catholic hospitals operate under Ethical and Religious Directives (ERDs)[4] that are issued and enforced by the U.S. Conference of Catholic Bishops. The directives explicitly prohibit the provision of key reproductive health services, including contraception, sterilization, abortion and infertility services.[5] The ERDs have also been interpreted to curtail the provision of LGBTQ-inclusive care, such as gender-affirming care,[6] and prohibit patients from exercising death with dignity options in states where that choice is legal.[7] Our previous reports documented the spread of these restrictive religious policies through mergers of Catholic and non-Catholic hospitals and began to examine the creation of large regional and national Catholic health systems. We also examined existing public policies that permit these hospitals to receive government funding while using religious doctrine to restrict care.

Definitions: As in our previous publications, this report focuses on **short-term acute care hospitals,** sometimes referred to as *general hospitals.* Patients are most likely to encounter Catholic religious restrictions at these hospitals. Not included in this group of facilities are specialty hospitals, such as rehabilitation, chemical dependency treatment, psychiatric or orthopedic hospitals. Critical access hospitals have been excluded from our counts and analysis because those that are non-Catholic sometimes have affiliations with Catholic hospitals solely for the purpose of transferring patients for more advanced types of care. Such affiliations do not appear to impose Catholic restrictions on the critical access hospital. This report does, however, provide for the first time a count of all types of hospitals operated by large Catholic health systems — as well as the numbers of urgent care centers, ambulatory surgery centers and physician practices they own or operate — in order to fully depict the expanding size of these systems.

Methodology: For our 2020 analysis, we utilized hospital and health system data from Definitive Healthcare, which draws from hospital cost reports filed with the federal Centers for Medicare and Medicaid Services (CMS), proprietary research on health systems and from the annual American Hospital Association (AHA) survey. Hospitals

Because control of many hospitals has changed hands over the last two decades, there are now hospitals following the Catholic ERDs in all of the ownership categories.

self-identify their type of ownership or control as being one of these categories: government, non-profit church, non-profit other or for-profit. Because control of many hospitals has changed hands over the last two decades, there are now hospitals following the Catholic ERDs in all of the ownership categories. For example, historically-Catholic hospitals that were purchased by for-profit systems may still be following the Catholic ERDs as a condition of the sale. Non-Catholic non-profit hospitals that have merged with Catholic facilities are often required to adopt all or some of the ERDs. Public hospitals that are being managed by Catholic health systems may have agreed to eliminate any services that conflict with the ERDs.

We categorized hospitals as Catholic if they met two or more of the following criteria: membership in the Catholic Health Association, participation in a Catholic health system, Catholic affiliation stated in public materials (such as a hospital website), inclusion in local diocese lists or having been founded by Catholic entities. We also developed a discreet category of "Catholic-affiliated" for hospitals within a Catholic health system that do not meet at least two of the criteria. Using this methodology, we identified 544 Catholic hospitals and 33 Catholic-affiliated hospitals. Both "Catholic" and "Catholic-affiliated" have religious restrictions on care, although the "Catholic-affiliated" hospitals may not strictly follow all of the ERDs. Catholic and non-Catholic hospitals are entering into increasingly complex and non-transparent partnerships that make the comprehensive application of the ERDs difficult for both consumers and advocates to determine. In the findings that follow, the Catholic and Catholic-affiliated hospitals are grouped together and referred to as Catholic because all have restricted at least some services due to the partnership with a Catholic hospital or system. See further details in the Methodology section in Appendix A.

Executive Summary

In 2020, a new round of hospital data analysis has documented nearly two decades of growth by Catholic health systems. Through mergers, acquisitions, business partnerships and expansion into new types of care, these systems are extending the reach of Catholic health restrictions across the country.

1. **Catholic health systems are growing and exerting greater influence as they control more hospitals and physician practices, while expanding into the growing sectors of urgent care, retail health clinics and ambulatory surgery.**
   - The 10 largest Catholic health systems have grown and strengthened through mergers and acquisitions, and now control significantly more short-term acute care hospitals than they did two decades ago. These 10 systems own or control 394 short-term acute care hospitals, a 50 percent increase since 2001. The operational reach of these systems extends beyond traditional acute care hospitals and into all categories of inpatient facilities such as rehabilitation hospitals, substance abuse treatment centers and other inpatient specialty care programs. In aggregate, the 10 systems operate 1,106 hospitals of all types.
   - Four of the 10 largest health systems in the country are Catholic, with facilities in 41 states:
     - **# 2 CommonSpirit Health,** which was formed in 2019 by Dignity Health and Catholic Health Initiatives (CHI) to create the nation's largest non-profit mega system, with 114 short-term acute care hospitals.
     - **# 4 Ascension Health,** which has grown from 36 short-term acute care hospitals in 2001 to 80 in 2020 through a string of acquisitions rather than mergers with other Catholic systems, a path to growth differing from its Catholic peers.
     - **# 6 Trinity Health,** which is the result of the 2013 merger of Catholic Health East and Trinity Health.
     - **# 7 Providence St. Joseph Health,** which is a result of the 2016 combination of Providence Heath & Services and St. Joseph Health.
   - Nearly all Catholic hospitals have joined a health system, rather than remaining independent hospitals, potentially improving their stability in unsettled times. Our data show that 98 percent of all Catholic short-term acute care hospitals are members of a health system, compared to 80 percent of non-Catholic short-term acute care hospitals. System affiliation often enhances financial stability, access to capital, administrative infrastructure, negotiating strength, market share

The 10 largest Catholic health systems operate 864 urgent care centers, 385 ambulatory surgery centers and 274 physician groups.

and recruitment and retention of health professionals. However, hospital affiliation with a large system also tends to shift decision-making to system headquarters and can cause loss of community input. This loss of local control is exacerbated in Catholic systems by the additional layer of governance given to Catholic Bishops, who interpret and enforce the Ethical and Religious Directives for Catholic Healthcare Services (ERDs) at health care facilities within their dioceses.

- Catholic health systems are expanding outside the hospital setting. The 10 largest Catholic health systems operate 864 urgent care centers, 385 ambulatory surgery centers and 274 physician groups, along with other operations, such as clinics in retail pharmacies, imaging centers and home health services. Consumers may be unaware that Catholic health restrictions are in place at these facilities, particularly when a Catholic system is providing medical care under a management contract or joint venture with a retail pharmacy, secular urgent care company or publicly-traded operator of non-acute care health facilities.
- Catholic health systems are entering a broad range of alliances with non-Catholic entities as the health care industry evolves and transforms. Complex business partnerships between Catholic and non-Catholic institutions make the spread of Catholic health restrictions more difficult to recognize and trace. We highlight in Section 6 partnerships that Catholic systems pursued with secular non-profit and for-profit systems, public health systems and insurers.

2. The number of short-term acute care hospitals operating under Catholic health restrictions grew by more than 28 percent over the last two decades, even as the number of non-Catholic short-term acute care hospitals dropped by nearly 14 percent.

- Currently, 15.8 percent of all short-term acute care hospitals in the United States are Catholic-owned or are affiliated with a Catholic system, and thus following all or some of the Catholic health restrictions. One in every six acute care hospital beds (16.8 percent) is in a Catholic facility, up from one in seven in 2001. Catholic hospitals tend to be larger (194 bed average) than non-Catholic hospitals (185 bed average).

3. The number of communities reliant solely on a Catholic short-term acute care hospital has continued to grow, and in 10 states, 30 percent or more of all short-term acute care beds are in Catholic hospitals and 30 percent or more of all births happen in a Catholic hospital.

- In 2020, there are 52 hospitals operating under Catholic restrictions that are the sole community providers of short-term acute hospital care for people living in their geographic regions. By comparison, there were 30 Catholic sole community hospitals in 2013 and 46 in 2016. Most of these hospitals are in rural areas, where patients would have to travel long distances to find alternative hospitals

where care is not restricted by religious directives.

- In Alaska, 46 percent of all acute care beds are in a single Catholic hospital that is more than double the size of any other hospital in the state. In four other states (Iowa, South Dakota, Washington and Wisconsin), 40 percent or more of acute care beds are in hospitals operating under Catholic health restrictions. In another five states (Colorado, Missouri, Nebraska, Oklahoma and Oregon), between 30 and 39 percent of the acute care beds are in Catholic facilities.

4. **Despite their stated missions of serving the poor, Catholic hospitals as a group serve a lower percentage of Medicaid-insured patients than do other hospitals and provide slightly less charity care.**

   Medicaid-insured patients constitute 7.2 percent of discharges at Catholic hospitals compared to 8.3 percent at other non-profit hospitals and 13.6 percent at public hospitals. Charity care makes up a slightly lower percent of total expenses at Catholic (2.7 percent) than at non-Catholic hospitals (2.9 percent).

5. **Catholic hospitals and health systems receive nearly $48 billion of taxpayer dollars each year, in the form of Medicare and Medicaid reimbursements, while seeking expansion of government permission to use religious doctrine to restrict care.**

   The $47.8 billion in net patient revenues from Medicare and Medicaid reported for Catholic hospitals and health systems is up from $27 billion in 2011.[8] This 76 percent growth in net patient revenue is far greater than the overall 25 percent growth for all hospitals (from $241 billion to $300 billion)

There are 52 hospitals operating under Catholic restrictions that are the sole community providers of hospital care for people living in their geographic regions.

and is likely due to the increasing number of Catholic hospitals. Some of the largest Catholic health systems also received billions in federal COVID-19 bailout funds, the first round of which was based primarily on historic numbers of Medicare discharges, not COVID-19 patients treated. Meanwhile, these same systems have sought even greater exemptions from providing medical care (such as LGBTQ-inclusive care) or employee health benefits (such as contraceptive coverage) to which they have moral objections.

These trends require heightened attention to the growing impact of Catholic health restrictions on community access to needed health care services. We highlight the need for 1) greater transparency about hospital and health system ethics policies that prohibit specific health care services, 2) strengthened public oversight of hospital and health system mergers, acquisitions and affiliations and 3) greater protection of individual patients' rights. We urge health advocacy groups, public officials, insurers and employers offering employee health plans to consider explicit strategies to address these three priority areas.

Key Findings of 2020 Study

Key Finding 1: Catholic health systems are growing and exerting greater influence as they control more hospitals and physician practices, while expanding into the growing sectors of urgent care, retail health clinics and ambulatory surgery.

In 2020, four of the 10 largest health systems in the United States are Catholic, including the largest non-profit health system, CommonSpirit Health. Health systems are formed to achieve goals that are either unachievable or more challenging as individual hospitals, such as economies of scale, marketing strength and access to capital. Proprietary or for-profit systems operate like corporations and explicitly seek revenue growth, while non-profit systems often affiliate to strengthen market and financial position. Catholic systems have an additional objective: to protect and grow the Catholic health care ministry and its mission.

The three largest for-profit systems — HCA Healthcare, Tenet Healthcare and Community Health Systems (CHS) — have all been in operation for more than 20 years and operate 348 short-term acute care hospitals, an increase of 29 percent since 2001. HCA is the only system with consistent growth over the period. CHS grew significantly from 2001 to 2016, but has retrenched and now operates 94 short-term acute care hospitals, compared to 186 in 2016. Tenet had 86 short-term acute care hospitals in 2001 and now has 76. Creating a sustainable profitable model with an operational core of short-term acute care hospitals has challenged even those companies whose primary objective is financial.

By comparison, the four largest Catholic systems (CommonSpirit Health, Ascension Health, Trinity Health and Providence St. Joseph Health) operate 282 short-term hospitals, an increase of 83 percent since 2001. CommonSpirit, Trinity and Providence St. Joseph have all grown through mergers of existing Catholic systems to form even larger ones, while Ascension has grown through acquisition of hospitals. The Catholic health systems are not-for-profit entities, which gives them a financial advantage over the for-profit systems, as they are exempt from local and state property taxes, as well as state and federal income tax. These systems receive 41 to 43 percent of their Medicare funding from inpatient hospital services, with the remainder coming from outpatient hospital, physician services, skilled nursing, home health and other types of care. Moving forward, we expect to see these systems increasingly shift to ambulatory services, alternative sites of care

and investment in technology and services to enhance revenue and profitability.

By becoming larger, Catholic systems can gain greater geographic reach, market share, purchasing power and the ability to weather the financial challenges of the hospital business, while supported by tax exemption. Only nine states lack the presence of one of the largest four Catholic systems. Collectively, the 10 largest Catholic systems in the country operate a total of 394 short-term acute care hospitals and more than 76,000 short-term acute hospital beds. These large Catholic systems operate 1,106 (or 15.2 percent) of the 7,903 hospitals of all types that are operated by health systems nationwide.

TABLE 1

25 Largest Health Systems

Ranked by Staffed Beds in Short-Term Acute Care Hospitals (Catholic systems shaded in grey)

Rank	System	Short-Term Acute Care Hospitals	Short-Term Acute Care Staffed Beds	All Hospitals	Physician Groups	Ambulatory Surgery Centers	Urgent Care Clinics
1	HCA Healthcare (FKA Hospital Corporation of America)	178	39,575	426	300	322	215
2	CommonSpirit Health	114	19,106	385	100	137	227
3	Tenet Healthcare	76	15,153	157	34	420	114
4	Ascension Health	80	14,993	229	40	43	170
5	Community Health Systems (AKA CHS)	94	12,525	163	52	43	89
6	Trinity Health (FKA CHE Trinity Health)	47	10,129	111	53	43	106
7	Providence St Joseph Health (AKA Providence)	41	9,596	111	31	43	139
8	Kaiser Permanente	38	8,899	86	13	67	94
9	LifePoint Health (FKA LifePoint Hospitals)	75	8,897	120	56	27	45
10	AdventHealth (FKA Adventist Health System)	34	7,638	40	5	11	47
11	University of Pittsburgh Medical Center (AKA UPMC)	30	6,432	51	62	22	43
12	Prime Healthcare Services	42	6,184	64	20	7	7
13	Bon Secours Mercy Health	34	5,991	82	14	34	48
14	Northwell Health (AKA North Shore Long Island Jewish Health System)	20	5,666	25	7	17	55
15	Advocate Aurora Health	25	5,541	62	6	42	120
16	Universal Health Services	30	5,437	201	21	8	9
17	Atrium Health (FKA Carolinas HealthCare System)	22	5,055	51	20	30	52
18	Steward Health Care System	33	5,039	36	8	12	9
19	CHRISTUS Health	26	4,736	72	16	41	40
20	Banner Health	18	4,584	31	3	10	51
21	Cleveland Clinic Health System	16	4,447	23	8	30	38
22	Baylor Scott & White Health	39	4,266	53	17	37	22
23	Mercy (MO)	16	4,151	38	2	19	63
24	Hackensack Meridian Health	12	4,100	16	9	4	8
25	University of North Carolina Health Care (AKA UNC Health Care)	15	4,016	19	14	6	17
	TOTAL Top 25 Systems	**1,155**	**222,156**	**2,652**	**911**	**1,475**	**1,828**

Data Sources: Short-Term Acute Care Hospitals and Staffed Beds - Definitive Healthcare Hospital Database
All Hospitals, Physician Groups, Ambulatory Surgery Centers and Urgent Care Centers - Definitive Healthcare Hospital System Database

TABLE 2

Four Largest Catholic Health Systems | Facilities by State

State	#2 Common Spirit Health	#4 Ascension Health	#6 Trinity Health	#7 Providence St. Joseph Health
AK				H
AL		H	F	
AR		F		
AZ	H			
CA	H		H	H
CO	H			
CT			H	
DC		F		
DE			H	
FL		H	H	
GA	H	F	H	
HI				
IA	H		F	
ID			H	F
IL		F	H	
IN	F	H	H	
KS	H	H		
KY	H	F		
LA		F		
MA			H	
MD		H	H	
ME			F	
MI		H	H	
MN	F	F		
MO		F		

State	#2 Common Spirit Health	#4 Ascension Health	#6 Trinity Health	#7 Providence St. Joseph Health
MS		F		
MT				H
NC			F	
ND	H			
NE	H		F	
NH				
NJ			H	
NM	F			F
NV	H			
NY		H	H	
OH	H		H	
OK		H		
OR	F		H	H
PA	F		H	
RI				
SC				
SD			F	
TN	H	H		
TX	H	H		H
UT				
VA				
VT				
WA	H			H
WI	F	H		
WV				
WY				

H One or more Short Term Acute Care Hospitals present in state

F One or more Other Inpatient Facilities present in state

No Hospitals or Facilities present in state

Brief profiles of the top four Catholic health systems

- **# 2 CommonSpirit Health** was formed in 2019 by Dignity Health and Catholic Health Initiatives (CHI), creating a mega-system that is the largest non-profit health system in the United States. Statements from the two merging systems predicted that the deal would "strengthen Catholic health care" and that "the potential of the combined ministry to achieve scale and impact for Catholic health care is compelling."[9] CommonSpirit operates at 700 locations in 21 states, including 114 short-term acute care hospitals, 137 ambulatory surgery centers and 227 urgent care centers. The system reported nearly $21 billion in operating revenue, an operating loss of $602 million and $9.6 billion in non-operating income (such as from investments), producing a total surplus of $9 billion, in its most recent audited financial statements for the period ending June 30, 2019.
- **# 4 Ascension Health** has grown from 36 short-term acute care hospitals in 2001 to 80 hospitals in 2020 through a continuous string of acquisitions, a path to growth differing from its Catholic peers. The system operates at more than 2,600 sites in 20 states and the District of Columbia with 229 total hospitals, 170 urgent care centers and 50 senior living facilities. CEO Joseph Impicciche said in a March 2020 interview: "We... are called to forge a path for the future of Catholic health care that is both sustainable and relevant. No matter the challenge, we commit to maintaining the Catholic identity that has been central to our past, present and future."[10] The system reported more than $25 billion in operating revenue, an operating surplus of $131 million, and a total surplus of $1.2 billion (of which most was non-operating income) in its audited financial statements for the period ending June 30, 2019.
- **# 6 Trinity Health** is the result of the 2013 merger of Catholic Health East and Trinity Health. The combined system has facilities in 21 states and operates 47 short-term acute care hospitals, 111 total hospitals and 106 urgent care centers. The system reported more than $19 billion in operating revenue, an operating surplus of $161 million, and a total surplus of $786 million (of which $673 million was non-operating income) in its most recent audited financial statements for the period ending June 30, 2019.
- **# 7 Providence St. Joseph Health** is a result of the 2016 merger of Providence Health and Services and St. Joseph Health. The system operates across eight Western states: Alaska, California, Idaho, Montana, New Mexico, Oregon, Texas and Washington. The system includes 41 short-term acute care hospitals, 111 total hospitals and 139 urgent care centers. The system reported more than $25 billion in operating revenue, an operating surplus of $214 million, and a total surplus of nearly $1.4 billion (of which $1.1 billion was non-operating income) in its most recent audited financial statements for the period ending December 31, 2019.

Financial data in these profiles are from 2019, and thus do not reflect the impact of COVID-19.

Nearly all Catholic hospitals are part of a health system

Our analysis found that 98.1 percent of all Catholic short-term acute care hospitals are part of a health system, compared to 80.3 percent of their non-Catholic counterparts. When hospitals join a health system, they can benefit from centralized guidance and support on regulatory issues, quality initiatives, technology infrastructure and operational efficiencies, as well as improved access to capital. System membership can better equip hospitals to weather a financial storm, as it improves access to resources including infrastructure and capital. Large systems tend to have more "days cash on hand" which is critical for withstanding financial stress, such as during the COVID-19 pandemic, which put many lucrative elective procedures on pause.

TABLE 3

Hospital Participation in Health Systems

	Hospitals	In a Health System	Percent in a Health System
Catholic Hospitals	577	566	98.1%
Non-Catholic Hospitals	3,082	2,475	80.3%
All Hospitals	**3,659**	**3,041**	**83.1%**

Based on 2018 data, hospitals with higher financial vulnerability were more likely to be small and rural. By contrast, those with high liquidity were more likely to be affiliated with health systems. Hospitals affiliated with health systems were also less reliant on revenue from outpatient services and surgical volume, and thus were at less risk for financial challenges due to COVID-19.[11] Catholic hospitals' high rates of system participation may improve their likelihood of survival due to the additional resources, while independent hospitals gradually disappear.

Catholic hospitals' high rate of system participation may improve their likelihood of survival, while independent hospitals gradually disappear.

While system membership may help a local hospital navigate financial challenges, this can come at the expense of community control. Strong community engagement is important to both governance and quality improvement activities of hospitals. A growing body of evidence suggests that this type of consumer engagement may result in both better health outcomes and reduced costs.[12] System membership often shifts governance and key decision-making to system headquarters and system-wide goals may take priority over local concerns. This shift in governance is exacerbated when a non-Catholic hospital joins a Catholic system, because it must comply with the ERDs and operate under the oversight of the local Catholic Bishop, and can result in the elimination of reproductive and other services that conflict with Catholic doctrine.

Catholic health systems are expanding outside of hospitals into urgent care centers, ambulatory surgery centers and ownership of physician practices.

Urgent care centers and retail health clinics are on the rise in both rural and urban areas, with claims increasing by 1,725 percent and 847 percent respectively between 2011 and 2016.[13] Conversely, visits to primary care providers are falling.[14] Given the increasing popularity of retail and urgent care settings, often referred to as "convenience care," we added an analysis of urgent care centers operated by Catholic health systems to this year's report.

Catholic health systems are actively expanding into the convenience care market, bringing with them new obstacles for people needing reproductive health care. CommonSpirit Health, the largest Catholic system, operates 227 urgent care centers, Ascension operates 170, Providence St Joseph has 139 and Trinity has 106. These four systems alone account for 489 urgent care centers that may be subject to the Catholic ERDs and restrict access to reproductive and gender-affirming health care. Similarly, major operators of retail health clinics are partnering with large Catholic health systems to deliver care. Existing partnerships include Kroger Health with Ascension Health and Walgreens with Providence St. Joseph Health.

Catholic health system policies against comprehensive reproductive and sexual health services could result in people being unable to access critical services such as birth control or emergency contraception at their local urgent care center or retail health clinics. In addition to these service restrictions, convenience care facilities operated by Catholic health systems may follow policies that prevent LGBTQ-affirming care.

TABLE 4

10 Largest Catholic Health Systems

Ranked by Staffed Beds in Short-Term Acute Care Hospitals

Rank	Rank Among All Systems	System	Short-Term Acute Care Hospitals	Short-Term Acute Care Staffed Beds	All Hospitals	Physician Groups	Ambulatory Surgery Centers	Urgent Care Clinics
1	**2**	CommonSpirit Health	114	19,106	385	100	137	227
2	**4**	Ascension Health	80	14,993	229	40	43	170
3	**6**	Trinity Health (FKA CHE Trinity Health)	47	10,129	111	53	43	106
4	**7**	Providence St Joseph Health (AKA Providence)	41	9,596	111	31	43	139
5	**13**	Bon Secours Mercy Health	34	5,991	82	14	34	48
6	**19**	CHRISTUS Health	26	4,736	72	16	41	40
7	**23**	Mercy (MO) (FKA Sisters of Mercy Health System)	16	4,151	38	2	19	63
8	**27**	SSM Health	20	3,765	57	10	22	42
9	**32**	OSF HealthCare	10	1,851	15	6	3	29
10	**34**	Catholic Health Services of Long Island	6	1,724	6	2	0	0
TOTAL Top 10 Catholic Systems			**394**	**76,042**	**1,106**	**274**	**385**	**864**

Data Sources: Short-Term Acute Care Hospitals and Staffed Beds - Definitive Healthcare Hospital Database
All Hospitals, Physician Groups, Ambulatory Surgery Centers and Urgent Care Centers - Definitive Healthcare Hospital System Database

Catholic urgent care centers frequently said they were unable to provide birth control refills or other urgent gynecological services, while non-Catholic centers frequently provided these services.

For example, the retail health clinics located inside Hy-vee grocery stores in Iowa and Nebraska are operated by CommonSpirit Health hospitals. Because a Catholic health system operates these clinics, some reproductive health care is not offered.[15] In 2016, MergerWatch, the ACLU of California and NHeLP conducted a secret shopper study to investigate how religious restrictions impact services at urgent care centers that are owned or managed by Catholic health systems. Callers contacted a sample of 38 urgent care centers in California and New York: 18 Catholic-affiliated centers and 20 non-Catholic, non-religious facilities The study found that Catholic urgent care centers frequently said they were unable to provide birth control refills, or other urgent gynecological services, while non-Catholic centers frequently provided these services.

Retail health clinics have a unique opportunity to fill gaps in access to reproductive health services by providing birth control pills and other forms of contraception without appointment in a convenient location. But if these clinics are owned or operated by large Catholic health systems, gaps may persist.

Catholic health systems are entering into a broad range of business partnerships with non-Catholic entities as the health care industry evolves and transforms.

As Catholic systems grow, they continue to partner with non-Catholic health entities in a range of cooperative business ventures. When this happens, it can be challenging to ascertain when and where Catholic health restrictions are in place and enforced. Consumers may assume access to comprehensive reproductive health services and LGBTQ-inclusive care, and then be surprised to encounter restrictions or outright denials of care. In effect, the spread of Catholic health restrictions has become more difficult to recognize and trace, not only for patients but also for purchasers of health plans, such as employers who are concerned about the adequacy of provider networks.

See case studies in Section 6 for more details and examples.

An update to the Catholic ERDs in 2018 has had important implications for future partnerships, limiting the ability of Catholic health providers to enter into business arrangements with non-Catholic entities that provide services not permitted under the ERDs. It states: “Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage… assist in carrying out, make its facilities available for, [or] make referrals for… immoral procedures.” This requirement would likely prompt Catholic hospitals to insist that any partnerships with non-Catholic entities follow the ERDs.

Key Finding 2: The number of Catholic-owned or affiliated short-term acute care hospitals grew by 28.5 percent over the last two decades, even as the number of non-Catholic hospitals declined by 13.6 percent.

Between 2001 and 2020, the total number of Catholic short-term acute care hospitals grew from 449 to 577. This is a growth rate of 28.5 percent over 19 years. During the same period, the number of non-Catholic short-term acute care hospitals fell by 13.6 percent. As a result, in 2020 Catholic facilities account for 15.6 percent of all short-term acute care hospitals, up from 11.2 percent in 2001.

Table 5 to the right shows changes in the number of Catholic and non-Catholic hospitals between 2001 and 2020 by hospital control category. The table displays the extent of Catholic-affiliated hospitals in control categories that are outside of the traditional "non-profit Church" category. In particular, the number of for-profit and "non-profit other" hospitals operating under Catholic restrictions grew significantly between 2001 and 2020. As Catholic health systems pursue partnerships with non-Catholic entities, these categories are critical to track for a comprehensive picture of the extent of Catholic-restricted health care. Another striking trend has been the growth in the number of formerly Catholic-owned hospitals now owned by for-profit systems that are still following the Catholic ERDs, according to our research. Such facilities increased in number from just four in 2001 to 49 in 2000.

TABLE 5

Short-Term Acute Care Hospitals by Category: 2001 to 2020

	2001	2011	2016	2020	Change 2001 to 2020
Total Catholic	**449**	**550**	**567**	**577**	**28.5%**
	11.2%	14.5%	15.0%	15.8%	
Non-Profit Church	329	381	361	346	5.2%
	8.2%	10.1%	9.6%	9.5%	
Non-Profit Other	97	140	161	173	78.4%
	2.4%	3.7%	4.3%	4.7%	
Public	19	11	9	9	-52.6%
	0.5%	0.3%	0.2%	0.2%	
For-Profit	4	18	36	49	1125.0%
	0.1%	0.5%	1.0%	1.3%	
Total Non-Catholic	**3,569**	**3,237**	**3,213**	**3,083**	**-13.6%**
	88.8%	85.5%	85.0%	84.2%	
Non-Profit Church	248	147	147	130	-47.6%
	6.2%	3.9%	3.9%	3.6%	
Non-Profit Other	1,840	1,573	1,562	1,597	-13.2%
	45.8%	41.5%	41.3%	43.6%	
Public	824	570	547	507	-38.5%
	20.5%	15.1%	14.5%	13.9%	
For-Profit	656	946	956	848	29.3%
	16.3%	25.0%	25.3%	23.2%	
All Hospitals	**4,018**	**3,787**	**3,780**	**3,660**	**-8.9%**

Data Sources: Short-Term Acute Care Hospitals and Staffed Beds - Definitive Healthcare Hospital Database

Hospital Control Categories

Hospital control categories used in this report are drawn from the American Hospital Association survey. Hospitals self-identify control as: public, for-profit, non-profit church or non-profit other. The non-profit church category is used by any non-profit that self-defines as operated by a church of any denomination. The non-profit other category is used by any non-profit that does not self-define as operated by a church.

In our report, these categories overlap with our Catholic or non-Catholic categories in important ways. Hospitals in the Catholic non-profit other category are hospitals that are Catholic by our criteria, but self-report to the American Hospital Association as not operated by a church. This category therefore includes historically secular hospitals that became part of Catholic systems. The Catholic public category includes public hospitals that are managed by or affiliated with Catholic systems, and thus follow some or all of the ERDs. For example, Natchitoches Regional Medical Center (NRMC) is owned by the Louisiana Natchitoches Parish Hospital Service District (and describes itself as a governmental hospital), but is managed by CHRISTUS Health, a Catholic non-profit hospital system. When these two entities affiliated in 1997, CHRISTUS became responsible for the day-to-day management of the hospital, while the hospital continued to be governed by a board appointed by the Parish Council. The management contract with CHRISTUS Health includes agreeing to Catholic restrictions on services. As a result, NRMC does not provide abortions or tubal ligations. The hospital's website lists the management by CHRISTUS Health Central Louisiana, but does not explain what this means for the services offered at the facility. This is the sole community hospital for people in this geographic region. See additional examples of state and city owned hospitals that entered into partnerships with Catholic systems in our 2016 report.

Key Finding 3: The number of communities with only a Catholic short-term acute care hospital has continued to grow, and some states have significant percentages of Catholic hospitals.

In 2020, we identified 52 Catholic short-term acute care Catholic hospitals designated by Centers for Medicare and Medicaid Services as the "sole community hospital" for their region, an increase from 30 in 2013 and 46 in 2016.

Designation as a sole community hospital means that the facility is located at least 35 miles away from other similar hospitals, or is located in a rural area and meets certain other criteria, such as being at least 45 minutes in travel time away from the nearest similar hospital.[16] Such hospitals are eligible to receive a higher level of Medicare reimbursement.

TABLE 6

Sole community hospitals

	Sole Community Hospitals	Percent of Sole Community Hospitals	Total Patient Discharges	Total Births
Total Catholic	**52**	**10.88%**	**314,545**	**31,693**
Non-Profit Church	33	6.9%	218,290	20,014
Non-Profit Other	15	3.1%	88,622	10,415
Public	2	0.4%	2,332	632
For-Profit	2	0.4%	5,301	632
Total Non-Catholic	**426**	**89.1%**	**1,839,701**	**216,764**
Non-Profit Church	8	1.7%	27,450	4,163
Non-Profit Other	231	48.3%	1,183,123	135,851
Public	119	24.9%	420,373	49,965
For-Profit	68	14.2%	208,755	26,785
All Hospitals	**478**		**2,154,246**	**248,457**

Includes short-term acute care hospitals, but not critical access hospitals.
From the most recent Medicare cost report submitted by each hospital.

Increasingly, where patients live determines what kind of care they can receive, especially if the only choice is a Catholic hospital.

These hospitals had a combined total of more than a million ER visits, 300,000 patient discharges and more than 30,000 births in 2019. The map on page 16 shows the distribution of Catholic sole community hospitals across the country in 2016 and 2019. Increasingly, where patients live determines what kind of care they can receive, depending on if the only choice is a Catholic hospital and how the local Catholic Bishop interprets the ERDs. As our previous reports have explained, each Bishop has latitude in applying and enforcing the ERDs within his own diocese.[17]

See a full list of Catholic sole community hospitals in Appendix B.

In 10 states, more than 30 percent of acute care hospital beds and more than 30 percent of births are in Catholic facilities.

Some states have particularly high percentages of short-term acute care beds operating under Catholic restrictions.

In South Dakota and Colorado, more than 40 percent of hospital births are in Catholic hospitals.

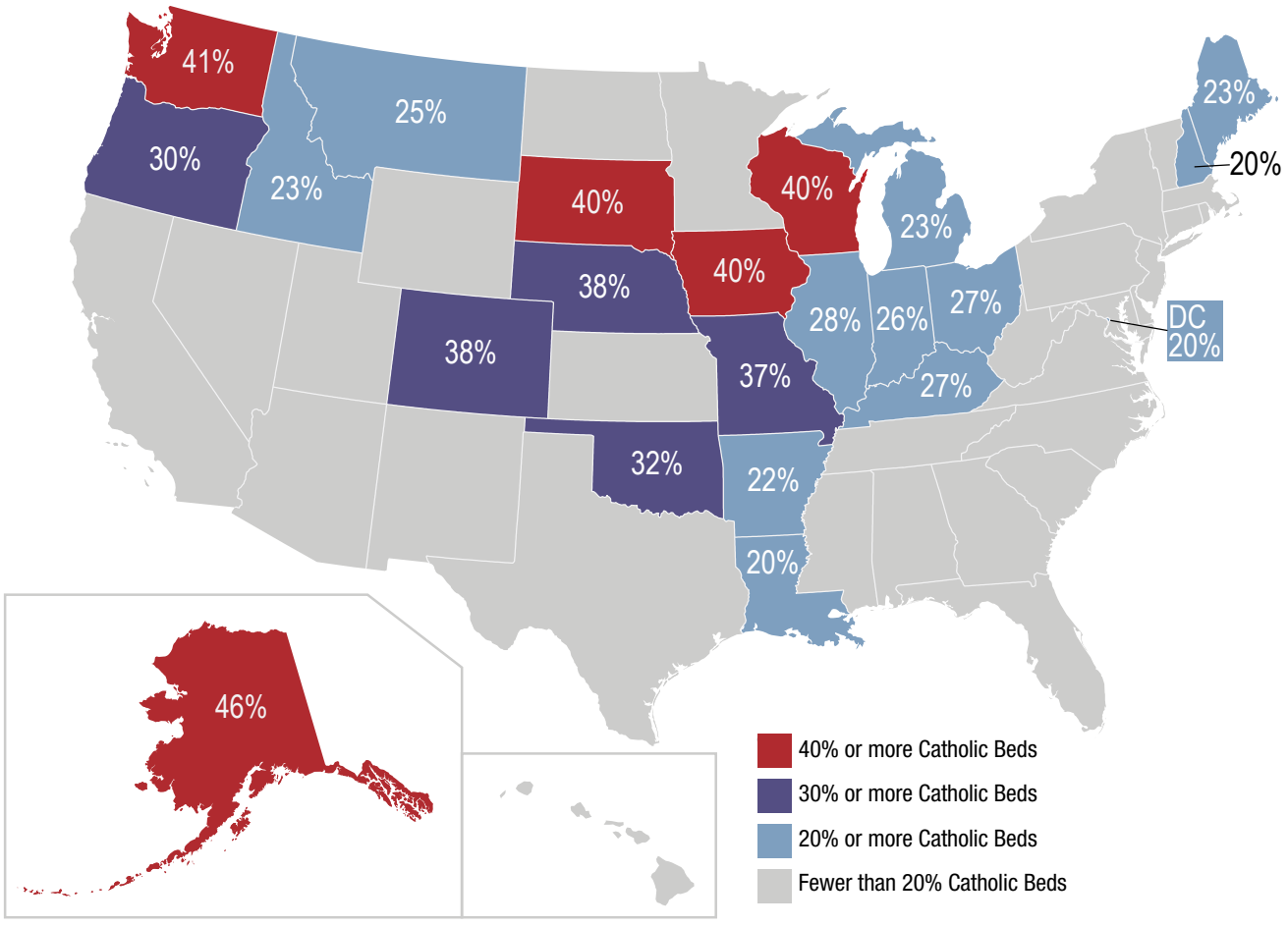
For example, in the five states shown below in red (Alaska, Iowa, South Dakota, Washington, and Wisconsin) 40 percent or more of all acute care beds in the state are in hospitals with Catholic restrictions. The highest percentage is in Alaska (46 percent), followed by the state of Washington (41 percent). A complete list of states with percentages of beds in Catholic hospitals can be found in the Appendix.

For the first time in this year's analysis, we looked at the number of births in Catholic hospitals to better understand the use of these hospitals by

MAP 1

States with the most Catholic hospital beds

Percentage of staffed acute care hospital beds that are in Catholic facilities

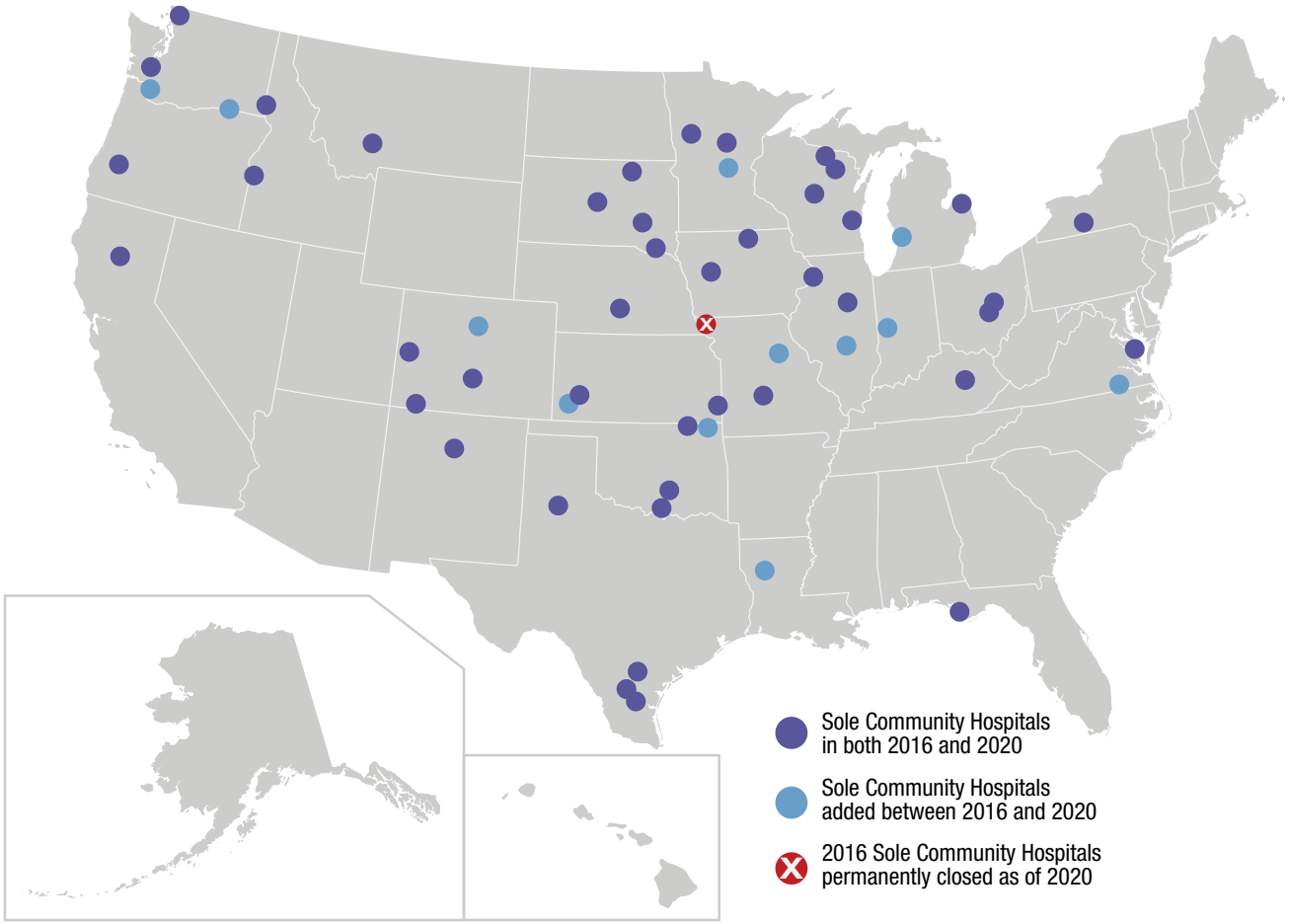


people seeking reproductive services. In South Dakota and Colorado, more than 40 percent of all hospital births are in Catholic hospitals. In an additional 10 states, more than 30 percent of hospital births are in Catholic hospitals.

See full list of states and percentages of Catholic acute care beds in Appendix B.

MAP 2

Catholic Sole Community Hospitals



Key Finding 4: Despite their stated missions of serving the poor, Catholic hospitals as a group serve a lower percentage of Medicaid-insured patients than do other types of hospitals and provide slightly less charity care.

The Ethical and Religious Directives for Catholic Health Care Institutions (ERDs) articulate a specific mission of serving the poor: "In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured."[18] Catholic health systems sometimes highlight this mission as a means of showing "shared values" with potential merger partners or to counter community concerns about loss of access to services in proposed Catholic acquisitions of non-Catholic facilities.[19]

While Catholic hospitals certainly provide critical care to many patients, and some serve as safety-net facilities, our research found that in aggregate, Catholic hospitals do not serve a higher percentage of Medicaid patients than do other types of hospitals.

Overall, 7.2 percent of discharges at Catholic short-term acute care hospitals were Medicaid patients, compared to 8.3 percent at other non-profit hospitals and 9.0 percent at for-profit hospitals. Public hospitals not affiliated with Catholic systems have the highest percentage of Medicaid discharges (13.6 percent). Medicaid discharge data provides a clear measure for hospital utilization by Medicaid patients.

Similarly, charity care data show that Catholic hospitals do not spend a significantly greater percentage on charity care than do all other types of hospitals. On average, at Catholic hospitals, charity care accounts for 2.7 percent of total expenses, compared to 2.9 percent for all hospitals combined. Public hospitals provide the highest level of charity care, as might be expected (4.2 percent). Among others, for-profit hospitals provide a larger percentage of charity care (3.8 percent) than do Catholic hospitals (2.7 percent). Other church-sponsored hospitals also provide more charity care (3.0 percent) than do Catholic hospitals. Catholic hospitals spend slightly more of their expenses on charity care than other non-profit hospitals (2.3 percent).

TABLE 7

Catholic hospitals and care for low-income patients

Hospitals		Medicaid Utilization			Charity Care	
		Percent of Total Patient Days	Hospital Discharges	Percent of Hospital Discharges	Costs	Percent of Total Hospital Expenses
Catholic Hospitals	**577**	**8.0%**	**374,348**	**7.2%**	**$ 3,812,426,376**	**2.7%**
Non-Catholic Hospitals	**3,082**	**9.7%**	**2,375,424**	**9.2%**	**$ 23,539,759,481**	**2.9%**
Non-Profit Church	130	8.9%	95,202	7.0%	$ 1,049,796,425	3.0%
Non-Profit Other	1,597	8.9%	1,298,296	8.3%	$ 12,089,658,802	2.3%
Public	507	12.3%	547,971	13.6%	$ 6,663,881,741	4.2%
For-Profit	848	9.7%	433,955	9.0%	$ 3,736,422,513	3.8%
All Hospitals	**3,659**	**9.4%**	**2,749,772**	**8.9%**	**$ 27,352,185,857**	**2.9%**

From the most recent Medicare cost report submitted by each hospital.

Definitions: Charity Care

According to the American Hospital Association, charity care consists of services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay.

Key Finding 5: Catholic hospitals and health systems receive nearly $48 billion in taxpayer money each year, in the form of Medicare and Medicaid reimbursements, while maintaining and seeking expansion of government permission to use religious doctrine to restrict care.

The nearly $48 billion in net patient revenues from Medicare and Medicaid reported for Catholic hospitals and health systems in 2020 was up from $27 billion in 2011.[20] This 76 percent growth in net patient revenue is far greater than the overall 25 percent growth for all hospitals (from $241 billion to $300 billion) and is likely due to the increasing number of Catholic hospitals.

Our data show that Catholic hospitals have a slightly higher percent of net patient revenue from Medicaid than do other types of hospitals (except public ones), despite having a lower percentage of Medicaid discharges. This disparity may be related to billing practices and payment structures. Medicaid discharge data measures population use of the hospital, while Medicaid revenue can be affected by a number of factors, including length of stay, intensity of service and payment models.

Some of the largest Catholic systems were among the systems receiving billions in federal COVID-19 bailout funds.

Some of the largest Catholic health systems were among the systems receiving billions in federal COVID-19 bailout funds, the first round of which was based primarily on historic numbers of Medicare discharges,

TABLE 8

Medicaid and Medicare Net Patient Revenue

	Number of Hospitals	Net Patient Revenue	Medicaid Percent of Net Patient Revenue	Medicaid Net Patient Revenue	Medicare Net Patient Revenue	Medicaid + Medicare Net Patient Revenue	Medicare Percent of Net Patient Revenue	Medicaid and Medicare Percent of Net Patient Revenue
Total Catholic	**577**	**$142,285,353,598**	**13.2%**	**$18,817,200,044**	**$28,925,824,893**	**$47,743,024,937**	**20.3%**	**33.6%**
Non-Profit Church	346	$90,412,670,029	13.8%	$12,499,801,237	$18,715,859,089	$31,215,660,326	20.7%	34.5%
Non-Profit Other	173	$44,157,855,513	11.8%	$5,223,236,481	$8,389,369,504	$13,612,605,985	19.0%	30.8%
Public	9	$753,253,808	20.9%	$157,411,204	$143,625,928	$301,037,132	19.1%	40.0%
For-Profit	49	$6,961,574,248	13.5%	$936,751,122	$1,676,970,372	$2,613,721,494	24.1%	37.5%
Total Non-Catholic	**3,082**	**$822,617,863,465**	**12.7%**	**$104,384,613,732**	**$148,292,685,111**	**$252,677,298,843**	**18.0%**	**30.7%**
Non-Profit Church	130	$34,982,945,341	12.4%	$4,343,558,215	$7,055,213,550	$11,398,771,765	20.2%	32.6%
Non-Profit Other	1,597	$533,795,096,032	11.3%	$60,351,634,764	$96,153,853,053	$156,505,487,817	18.0%	29.3%
Public	507	$144,159,028,345	18.4%	$26,541,259,615	$23,957,438,150	$50,498,697,765	16.6%	35.0%
For-Profit	848	$109,680,793,747	12.0%	$13,148,161,138	$21,126,180,358	$34,274,341,496	19.3%	31.2%
All Hospitals	**3,659**	$964,903,217,063	12.8%	$123,201,813,776	$177,218,510,004	$300,420,323,780	18.4%	31.1%

Catholic health systems have sought even broader religious exemptions from having to comply with government policies they contend conflict with the ERDs.

not COVID-19 patients treated. For example, the Providence Health System received at least $509 million in bailout funds, while sitting on $12 billion in cash it uses for investments, according to the New York Times.[21] Ascension Health received at least $211 million in bailout funds, even though it had $15.5 billion in cash on hand, the New York Times reported.[22]

As our first report ("No Strings Attached: Public Funding of Religious-Sponsored Hospitals in the U.S.") noted in 2002, Catholic hospitals and health systems have received such public funds, despite using religious doctrine to restrict care.

Federal and state exemptions have allowed such hospitals to refuse to provide some of the care that conflicts with Catholic doctrine, such as abortion and sterilizations. Catholic health systems have sought even broader religious exemptions from having to comply with government policies they contend conflict with the ERDs. For example, the Franciscan Health System sued to overturn an Obama administration rule prohibiting discrimination in health care based on gender identity or pregnancy termination.[23] Dignity Health (now part of CommonSpirit Health) has also argued that it should not be required to comply with state law that prohibits discrimination in health care based on gender identity.[24]

Key Finding 6: Catholic hospital partnerships with non-Catholic entities lack transparency and have grown more complex.

Our 2020 study of Catholic hospitals and health systems uncovered examples of partnerships with non-Catholic systems that have become increasingly complex and opaque. The result has been to increase the likelihood that health consumers will be unaware of religiously-based restrictions on care, as would employers evaluating health insurer provider networks in choosing employee health plans. We also found that large Catholic health systems are seeking partnerships with non-Catholic insurance plans and with public university systems.

Premier Health: Secular health system with 22 percent Catholic health system ownership.

Premier Health is the largest health system in southwest Ohio. Through a business transaction in January 2018, the Catholic Health Initiative system (now part of CommonSpirit Health) obtained a 22 percent ownership stake in Premier Health. As part of the governance structure, Premier has CHI representatives on its board of trustees. In response to requests to establish a transfer agreement with the only remaining abortion clinic in the Miami Valley region, Premier declined, citing the CHI arrangement: "Our ownership includes a Catholic organization. Under our governing documents, we have long been – and continue to be – prohibited from entering into certain arrangements,

Large Catholic health systems are seeking partnerships with non-Catholic insurance plans and with public university systems.

which include transfer agreements with this type of provider [abortion provider]."

Premier Health's website does not identify any Catholic restrictions at the five network hospitals and does not provide any information about restrictions that may have been placed on access to care because of this business arrangement, making it impossible for someone seeking care to know what services they can and cannot receive. Our team made multiple calls to the Patient Experience team, the Chaplain's office and the Patient Administration department of Premier Health's hospitals and none of the representatives was able to provide information on the impact of this arrangement on health services.

Prime Healthcare | Saint Clare's Denville Hospital, Saint Clare's Dover Hospital and St. Mary's Hospital, New Jersey: These Catholic hospitals were sold to a secular for-profit system but have been allowed to maintain Catholic health restrictions.

In 2015, Prime Healthcare, a for-profit system based in California, acquired the three New Jersey hospitals. In the agreement with St.

The proposed partnership of Providence Plan Partners with CareOregon, the state's largest Medicaid insurer, raised concerns that Medicaid patients could lose access to basic reproductive and sexual health services.

Mary's, Prime agreed to allow the hospital to continue honoring the Catholic ERDs without a specific time limit. When the system acquired Saint Clare's, it again agreed to honor the ERDs, including bans on abortions, but in this case for a limited period of five years – a term that should expire this year.

Essentia Health, Dignity Health and CommonSpirit: Catholic health systems including non-Catholic hospitals that comply with limited service restrictions.

Essentia Health and Dignity Health are examples of Catholic systems which include some hospitals that are historically Catholic and some that are designated as "non-Catholic" or are subject to a more limited set of restrictions. Essentia has some explicitly Catholic hospitals that are designated as such on their website. It also has some hospitals that it lists as not Catholic. There is no publicly available information about whether these "non-Catholic" facilities are subject to all or some of the ERDs, making it difficult for consumers to know which services are available and which are not.

Dignity Health (now part of CommonSpirit Health) is a Catholic system that includes a group of hospitals that were not historically Catholic. Instead of adopting all of the ERDs, these hospitals were allowed to follow a *Statement of Common Values*.[25] These hospitals typically prohibit abortion, in vitro fertilization and death with dignity options, but allow contraception, gender affirming care and some assisted reproductive services. These hospitals were considered "non-Catholic" by an assessment commissioned by the California Attorney General. (We have categorized them as Catholic-affiliated because of their system membership and their adherence to some of the ERDs).

In 2019, Dignity Health merged with Catholic Health Initiatives to form CommonSpirit. The Attorney General of California approved the merger under the condition that existing reproductive health services at the group of historically non-Catholic Dignity system hospitals be maintained for five years. For an additional five years, CommonSpirit must notify the Attorney General prior to eliminating reproductive health services. After that time period, CommonSpirit is under no further obligation and has free rein to eliminate these services in order to better adhere to the Bishop's prescriptions. The Attorney General also required Dignity to expand its charity care.

Providence Plan Partners and CareOregon: lessons from a canceled partnership

Providence Plan Partners, a health insurer and administrative services subsidiary of Providence St. Joseph Health, pursued a transaction with CareOregon, the state's

largest Medicaid insurer. Providence is the only insurer in the state not required to cover abortions and other reproductive health services, as a result of an exemption it secured in Oregon's 2017 Reproductive Health Equity Act.[26, 27]

The proposed partnership raised significant concerns that Medicaid patients could lose access to basic reproductive and sexual health services. The transaction was called off in May 2020, following statements from key advocates and Congressional representatives urging caution. The ACLU of Oregon, Basic Rights Oregon, Compassion & Choices, Forward Together, NARAL Pro-Choice Oregon, Planned Parenthood Advocates of Oregon and SEIU Local 49 issued this joint statement:[28]

"For years, Providence has been allowed to put religious views ahead of patient health, limiting access to the full range of care and impacting our ability to make personal decisions with providers that is best for our health. It's clear that this corporation is at odds with Oregon values, and we are deeply concerned that a merger with CareOregon will only hurt Medicaid patients who already face barriers to health care."

The decision to call off the partnership was explained by Providence Plan Partners and CareOregon in this way: "The organizations… have been unable to align on operating principles necessary to finalize their agreement. In light of this development and the immediate focus for both organizations to meet the needs of patients, provider partners and members impacted by the COVID-19 pandemic, CareOregon and Providence Plan Partners have decided to suspend discussions to combine."[29]

> It was revealed that medical centers throughout the University of California system already had contracts with Dignity Health that placed UC clinicians in Catholic hospitals and required them to adhere to religious restrictions on the care they could provide.

University of California San Francisco (UCSF) considered an expanded partnership with Dignity Health System hospitals.

In 2019, UCSF proposed an expanded partnership with hospitals in the Dignity Health System. The potential partnership brought widespread criticism for its potential to involve a public university system (which is a leading provider of comprehensive reproductive health care) with a Catholic system that restricts such care. The initial deal would have expanded a limited existing partnership between UCSF and four Dignity hospitals in the San Francisco Bay Area, allowing Dignity hospitals to share UCSF's branding and reputation, placing UCSF providers

and training programs within Dignity hospitals and transferring some UCSF patients to Dignity facilities.

UCSF leaders argued that this affiliation was necessary to address capacity issues at UCSF facilities and expand access to care to the underserved. They argued that Dignity was a good partner for affiliation because it is the largest provider of care to Medi-Cal enrollees in California. Dignity is, in fact, the largest hospital system in the state and therefore the largest Medicaid provider group. However, the four Dignity hospitals under consideration in the San Francisco Bay Area did not display evidence of high levels of service to low-income people. UCSF officials ultimately backed away from the proposed partnership after considerable community outcry.[30]

Subsequently, it was revealed that medical centers throughout the University of California system already had contracts with Dignity Health and other systems that placed UC clinicians in Catholic hospitals and required them to adhere to religious restrictions on the care they could provide.[31, 32] UC is now in the process of adopting new guidelines governing its health care affiliations. While leaders of the UC health system continue to advocate for the existing affiliations with Catholic hospitals, many in the UC community, as well as more than 69 organizations focused on reproductive health, LGBTQ rights and health equity have demanded that UC, a public entity, draw a clear line prohibiting religious restrictions on UC providers, students and patients.

This case provides an important example of how Catholic systems can have outsized influence and impose restrictions beyond the walls of the hospitals they control directly. A Catholic system may be a financially alluring choice for affiliation, even for institutions such as UCSF with historically strong commitments to comprehensive reproductive health care.

Conclusion and Recommendations

Catholic health care has a growing presence across the United States as Catholic health systems effectively navigate a transforming health care delivery system. Catholic systems are merging to form ever-larger entities that are actively and quickly expanding beyond hospital walls into a broad array of ambulatory initiatives for growth and profitability. The overall number of Catholic hospitals is growing, while non-Catholic hospitals are declining in number, signifying an increase in both the number and proportion of hospitals subject to Catholic Ethical and Religious Directives (ERDs) that restrict care and treatment options.

As Catholic health systems expand and strengthen, we are witnessing a "snowball effect" – these systems become more attractive business partners, setting them up for further growth with an ever-widening network of non-Catholic hospitals, urgent care centers, physician practices, ambulatory surgery centers and other health care providers. This growth expands religious restrictions to more and more hospitals and, increasingly, to locations outside of the hospital where people seek care. The consequences are especially concerning for maintaining access to comprehensive reproductive health care and LGBTQ-inclusive care, as well as legal end-of-life options in some states.

These trends require heightened attention to the growing impact on community access to needed health care services and the need for 1) greater transparency about hospital and health system policies that prohibit specific health care services, 2) strengthened public oversight of health industry mergers, acquisitions and affiliations and 3) greater protection of individual patient rights. We urge health advocacy groups, public officials, insurers and employers offering employee health plans to consider ways of addressing these three priority areas. We offer some potential approaches here:

1. **Ensure greater transparency surrounding hospital and health system policies that prohibit the delivery of specific health care services, or the provision of information and counseling about prohibited services.**

This report highlights significant challenges facing consumers and institutional health care purchasers when it comes to determining whether Catholic restrictions are in place at a hospital, urgent care center, physician practice or ambulatory surgery center. Some health providers that appear to be non-religious actually follow some or all of the Catholic ERDs as a result of affiliations or management contracts with Catholic health systems. Other hospitals that were historically Catholic still follow the ERDs,

even though they have been purchased by secular health systems. These arrangements, combined with marketing trends towards less religious-sounding hospital names (such as the transformation of Catholic Healthcare West into Dignity Health and now its merger into a bigger system called CommonSpirit Health), as well as a dearth of public information, make it difficult for a consumer trying to choose a hospital, or a health purchaser assembling a provider network, to determine which services are, or are not, provided.[33, 34] Qualitative research on the experiences of patients at Catholic hospitals shows that women are often unaware of religious restrictions until encountering them at the hospital, and they want more and earlier information about restrictions. Without transparency, many patients do not have the information necessary to make informed decisions about care.[35]

Catholic and Catholic-affiliated hospitals and health systems can and should be more transparent about their ethical and religious policies, through disclosure on hospital websites and information provided to patients upon, or prior to, admission of which services, information and counseling are not provided. In the absence of widespread adoption of such disclosures, hospital transparency should be a public policy priority. State and federal policymakers have potential policy options to consider. For example, state health departments could require hospitals to publicly post and report policies on the provision of reproductive and LGBTQ-inclusive care, as well as end-of-life treatment options. On the federal level, CMS' Conditions of Participation require hospitals to notify patients upon admission if the hospital does not honor a patient's advance directives for end-of-life care because of religious objections. CMS could expand the Conditions of Participation to similarly require hospitals to notify patients of any restrictions on the provisions of reproductive or LGBTQ-inclusive care.

In the private sector, employers and insurers could require full disclosure of any service restrictions as a condition of participation in health plan networks and utilize that information to ensure access to health providers offering the full range of covered services for enrollees and their families. Health plans could further disclose to enrollees which hospitals and other providers operate under religious restrictions, in order to improve patients' ability to make the best-suited choice of in-network providers.

2. Strengthen public oversight of proposed hospital mergers, affiliations and acquisitions in order to identify and address any potential loss of reproductive health care and other vital health services, or creation of unfair negotiating power.

Greater oversight is needed as Catholic systems continue to pursue mergers and acquisitions as a key element of strategic growth and increasingly enter affiliations with non-Catholic partners. State regulatory processes should scrutinize proposed hospital and health system transactions to assess their likely impact on health equity, specifically whether community access to vital health care services, such as reproductive care, will be eliminated. If a proposed hospital transaction will result in the discontinuation of any vital community health care, state

regulators should require a plan of affirmative steps to ensure continued patient access to such services. State regulators should implement active post-transaction monitoring and assess penalties if involved entities fail to fulfill promised steps to maintain access. Advocates and state officials must ensure that the legal authority exists for meaningful review of all mergers and other hospital affiliations.

At the federal level, anti-trust regulators should consider how the emergence of large multi-state health systems (including, but not limited to, Catholic ones) can give systems increased bargaining power in negotiations with insurers seeking coverage across multiple states, and how that power affects both prices and consumer access to care. Proposed mergers of regional health systems may not give the resulting combined system dominance in any one market – which is usually the trigger for anti-trust enforcement – but still tip the balance of negotiating power with large regional and national health insurers.[36] Evaluation and update of the current state and federal oversight of hospital markets is needed to account for these trends.

3. Restore the balance of public policy by creating greater protection for individual patients' rights.

The ever-expanding use of religious doctrine to restrict and deny access to health care is threatening individual patient ability to obtain timely, affordable access to a range of vital health services locally. This is particularly true in the 52 communities around the country where patients have only a Catholic hospital available, and in the states where 30 percent or more of acute care hospital beds are located in Catholic hospitals.

Steps must be taken to restore patients' rights in the face of federal policies and court decisions that give preference to the rights of institutional health providers to deny care they deem objectionable. Patients must be protected from discrimination in access to health care and helped to obtain needed reproductive health services, LGBTQ-inclusive care and legal end-of-life treatment options. State and federal anti-discrimination policies must be strengthened and enforced in the health care industry. For those communities where patients have no other option besides a Catholic hospital, the federal designation of "sole community hospital," which carries with it supplemental funding, should include stronger requirements to ensure that patients are informed about where to obtain needed services and aided in obtaining those services. In emergency situations, sole community hospitals should be expected to provide the needed care.

Appendix A: Methodology

In our 2001 and 2013 reports, we had counted as Catholic hospitals only those non-profit hospitals that were either Catholic owned or were community hospitals that had merged or affiliated with a non-profit Catholic system. Since then, we have witnessed a changing industry in which hospital business partnerships and system affiliations are increasingly complex. In 2016, we started to count as Catholic and highlight two additional types of hospitals: (1) hospitals that were historically Catholic and continue to follow Catholic directives, even though they are now owned by secular health systems and (2) public hospitals that are managed by Catholic systems.

For this report, we developed a new set of criteria to comprehensively assess a hospital's Catholic identity and document why we have categorized it as Catholic. The criteria are:

1. Member of the Catholic Health Association of the United States. The Catholic Health Association publishes a list of its members. This list is updated semi-regularly and relies on self-reporting.
2. Catholic system affiliation or management: Confirmation of affiliation and management was accomplished by referring to hospital and health system websites and reviewing news articles describing the terms of partnership transactions in which each hospital was involved.
3. Hospital website clearly states Catholic affiliation: Supporting what other studies have found, we found that Catholic hospitals often do not explicitly list their religious identity on their website.[37, 38] We reviewed the statements of mission and values of every hospital to determine Catholic affiliation.
4. Local diocese lists hospital: Many local dioceses maintain lists of Catholic hospitals as a resource for their constituents.
5. Historically Catholic: By reviewing websites and news articles, we identified hospitals that were founded by nuns, orders of sisters or other Catholic entities.

We deemed as Catholic any hospital that met two or more of these criteria. Hospitals that met only one criteria were subject to additional review. In cases where a hospital's relationship to the ERDs was unclear, "secret shopper" calls were made to the hospital to ask about key services of interest and key informant interviews were conducted with hospital administrators and local diocese offices. We also sought input from key state health research and advocacy partners about specific hospitals and conducted deeper research about systems with unclear relationships to the ERDs. We developed a discreet category for "Catholic-affiliated" hospitals, which in this report are defined as having some relationship with a Catholic health system, but not meeting at least two of the criteria.

Appendix B: Catholic Hospitals by State

Catholic Hospitals by State | Ranked by Catholic Percent of All Hospitals

HOSPITALS				STAFFED BEDS				BIRTHS			
STATE	CATHOLIC HOSPITALS	ALL HOSPITALS	CATHOLIC PERCENT OF ALL HOSPITALS	STATE	CATHOLIC HOSPITALS	ALL HOSPITALS	CATHOLIC PERCENT OF ALL HOSPITALS	STATE	CATHOLIC HOSPITALS	ALL HOSPITALS	CATHOLIC PERCENT OF ALL HOSPITALS
WI	32	74	43%	AK	391	845	46%	SD	3,690	8,642	43%
SD	7	18	39%	WA	4,052	9,868	41%	CO	25,776	62,028	42%
IA	14	37	38%	WI	4,437	11,014	40%	WA	32,330	82,086	39%
CO	19	53	36%	SD	742	1,866	40%	AK	1,936	4,926	39%
NE	8	24	33%	IA	2,316	5,861	40%	OK	17,197	45,866	37%
WA	18	54	33%	NE	1,420	3,761	38%	WI	21,864	58,333	37%
IL	39	131	30%	CO	2,908	7,703	38%	IA	11,723	32,137	36%
OR	10	34	29%	MO	5,812	15,502	37%	NE	6,534	19,054	34%
MO	22	76	29%	OK	3,205	9,905	32%	ND	3,010	8,804	34%
IN	25	96	26%	OR	1,728	5,724	30%	MO	23,688	69,331	34%
OH	36	143	25%	IL	7,244	26,286	28%	OR	12,099	38,162	32%
KY	16	69	23%	OH	7,264	26,579	27%	OH	40,753	132,641	31%
MT	3	13	23%	KY	3,203	11,962	27%	IN	19,489	77,388	25%
ND	2	9	22%	IN	3,874	14,642	26%	MT	1,828	7,311	25%
OK	17	84	20%	MT	465	1,887	25%	IL	34,319	145,440	24%
ME	4	20	20%	MI	4,958	21,415	23%	KY	10,911	46,513	23%
MI	20	105	19%	ID	558	2,454	23%	MD	15,626	67,644	23%
ID	3	16	19%	ME	572	2,527	23%	WV	3,515	17,555	20%
NV	4	23	17%	AR	1,583	7,263	22%	MI	22,876	114,708	20%
AZ	10	58	17%	NH	413	2,023	20%	CA	87,519	445,597	20%
AK	1	6	17%	LA	2,665	13,358	20%	AZ	15,147	80,530	19%
DC	1	6	17%	DC	393	2,008	20%	ID	2,152	11,911	18%
CA	50	312	16%	KS	1,203	6,252	19%	AR	4,918	27,662	18%
ALL STATES	577	3,659	16%	CA	11,124	66,056	17%	ALL STATES	605,632	3,741,178	16%
MN	8	52	15%	ALL STATES	112,066	676,912	17%	NV	5,200	34,147	15%
NH	2	13	15%	ND	314	2,024	16%	NH	1,558	10,609	15%
NJ	11	73	15%	AZ	1,763	11,569	15%	NJ	13,891	99,933	14%
MD	7	47	15%	WV	783	5,275	15%	KS	3,700	26,627	14%
NY	26	180	14%	NJ	2,771	19,411	14%	LA	9,219	69,292	13%
DE	1	7	14%	TX	7,858	56,874	14%	ME	1,436	11,080	13%
MA	10	70	14%	MA	2,075	15,113	14%	CT	4,977	38,547	13%
LA	14	100	14%	TN	2,143	15,635	14%	TN	11,266	95,805	12%
WV	4	29	14%	CT	897	6,652	13%	VA	11,244	98,071	11%
AR	7	51	14%	MN	1,304	9,988	13%	AL	5,864	54,577	11%
KS	7	54	13%	SC	1,248	10,262	12%	MN	6,824	64,135	11%
TX	44	350	13%	NY	5,326	44,859	12%	FL	23,093	223,571	10%
VA	10	82	12%	NV	576	5,331	11%	MA	6,737	71,683	9%
TN	12	99	12%	VA	1,718	16,095	11%	TX	35,556	382,181	9%
CT	4	34	12%	MD	850	8,129	10%	NY	22,608	255,454	9%
SC	7	60	12%	DE	180	2,025	9%	SC	3,500	44,361	8%
RI	1	10	10%	AL	1,124	13,080	9%	PA	10,131	139,341	7%
FL	15	205	7%	FL	4,029	52,421	8%	DC	811	15,529	5%
NM	2	29	7%	RI	163	2,129	8%	GA	6,507	124,828	5%
PA	11	167	7%	PA	2,519	32,960	8%	MS	1,483	35,119	4%
AL	5	87	6%	MS	571	9,339	6%	DE	374	9,703	4%
GA	6	109	6%	NM	204	3,416	6%	NM	543	19,306	3%
PR	1	53	2%	GA	953	18,854	5%	PR	210	17,698	1%
MS	1	65	2%	PR	167	8,026	2%	AS	0	0	0%
AS	0	1	0%	AS	0	120	0%	GU	0	1,775	0%
GU	0	2	0%	GU	0	266	0%	HI	0	6,823	0%
HI	0	13	0%	HI	0	2,159	0%	MP	0	970	0%
MP	0	1	0%	MP	0	74	0%	NC	0	118,208	0%
NC	0	98	0%	NC	0	22,006	0%	RI	0	11,429	0%
UT	0	35	0%	UT	0	4,119	0%	UT	0	45,774	0%
VI	0	2	0%	VI	0	184	0%	VI	0	1,195	0%
VT	0	6	0%	VT	0	793	0%	VT	0	4,052	0%
WY	0	14	0%	WY	0	963	0%	WY	0	5,086	0%

Appendix C: List of Catholic Sole Community Hospitals

Catholic Sole Community Hospitals by State

Hospital Name	City	State	Health System
St Elizabeth Community Hospital	Red Bluff	CA	CommonSpirit Health
Good Samaritan Medical Center	Lafayette	CO	SCL Health
Mercy Regional Medical Center	Durango	CO	CommonSpirit Health
St Marys Medical Center	Grand Junction	CO	SCL Health
Ascension Sacred Heart Hospital on the Gulf	Port St Joe	FL	Ascension Health
MercyOne Clinton Medical Center	Clinton	IA	CommonSpirit Health
MercyOne North Iowa Medical Center	Mason City	IA	CommonSpirit Health
St Anthony Regional Hospital	Carroll	IA	N/A
St Joseph Regional Medical Center	Lewiston	ID	LifePoint Health
HSHS Good Shepherd Hospital	Shelbyville	IL	Hospital Sisters Health System
OSF Saint James - John W Albrecht Medical Center	Pontiac	IL	OSF HealthCare
Franciscan Health Crawfordsville	Crawfordsville	IN	Franciscan Health
Ascension Via Christi Hospital in Pittsburg	Pittsburg	KS	Ascension Health
Bob Wilson Memorial Grant County Hospital	Ulysses	KS	CommonSpirit Health
St Catherine Hospital	Garden City	KS	CommonSpirit Health
St Claire Regional Medical Center	Morehead	KY	N/A
Natchitoches Regional Medical Center	Natchitoches	LA	CHRISTUS Health
Ascension St Joseph Hospital	Tawas City	MI	Ascension Health
Mercy Health Hackley Campus	Muskegon	MI	Trinity Health
Essentia Health - St Josephs Medical Center	Brainerd	MN	Essentia Health
Essentia Health St Marys - Detroit Lakes	Detroit Lakes	MN	Essentia Health
St Cloud Hospital	Saint Cloud	MN	CentraCare Health System
Mercy Hospital Lebanon	Lebanon	MO	Mercy (MO)
SSM Health St Marys Hospital - Audrain	Mexico	MO	SSM Health
St James Healthcare	Butte	MT	SCL Health
CHI Health Good Samaritan	Kearney	NE	CommonSpirit Health
CHRISTUS St Vincent Regional Medical Center	Santa Fe	NM	CHRISTUS Health
St James Hospital	Hornell	NY	University of Rochester Medical Center
Genesis Hospital	Zanesville	OH	Franciscan Sisters of Christian Charity Sponsored Ministries Inc
Ascension Jane Phillips Medical Center	Bartlesville	OK	Ascension Health
Mercy Hospital Ada	Ada	OK	Mercy (MO)
Mercy Hospital Ardmore	Ardmore	OK	Mercy (MO)
Saint Francis Hospital Vinita	Vinita	OK	Saint Francis Health System
CHI Mercy Health Mercy Medical Center	Roseburg	OR	CommonSpirit Health
Saint Alphonsus Medical Center - Ontario	Ontario	OR	Trinity Health
Avera Queen of Peace Hospital	Mitchell	SD	Avera Health
Avera Sacred Heart Hospital	Yankton	SD	Avera Health
Avera St Lukes Hospital	Aberdeen	SD	Avera Health
Avera St Marys Hospital	Pierre	SD	Avera Health
CHRISTUS Spohn Hospital Alice	Alice	TX	CHRISTUS Health
CHRISTUS Spohn Hospital Beeville	Beeville	TX	CHRISTUS Health
CHRISTUS Spohn Hospital Kleberg	Kingsville	TX	CHRISTUS Health
Covenant Health Plainview	Plainview	TX	Providence St Joseph Health
Southampton Memorial Hospital	Franklin	VA	Bon Secours Mercy Health
PeaceHealth St John Medical Center	Longview	WA	PeaceHealth
PeaceHealth St Joseph Medical Center	Bellingham	WA	PeaceHealth
Providence Centralia Hospital	Centralia	WA	Providence St Joseph Health
Providence St Mary Medical Center	Walla Walla	WA	Providence St Joseph Health
Ascension Howard Young Medical Center	Woodruff	WI	Ascension Health
Ascension St Marys Hospital	Rhinelander	WI	Ascension Health
Marshfield Medical Center - Marshfield	Marshfield	WI	Marshfield Clinic Health System
St Agnes Hospital	Fond Du Lac	WI	SSM Health

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