Supreme Court of New Jersey

Docket No. 087469

COMPREHENSIVE NEUROSURGICAL, P.C. d/b/a NORTH JERSEY BRAIN AND SPINE CENTER, PATRICK A. ROTH, MD, ROY D. VINGAN, MD, GEORGE J. KAPTAIN, MD, DANIEL E. WALZMAN, MD, HOOMAN AZMI, MD, HARSHPAL SINGH, MD, KANGMIN DANIEL LEE, MD, REZA J. KARIMI, MD, BRUCE ZABLOW, MD, UGO PAOLUCCI, MD and MOHAMMED FARAZ KHAN, MD, *Plaintiffs,* *(For Continuation of Caption See Inside Cover)*	:	CIVIL ACTION ON PETITION FOR CERTIFICATION FROM FINAL DECISION OF THE SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION DOCKET NO.: A-2866-19T1 Sat Below: HON. RICHARD S. HOFFMAN, P.J.A.D.; HON. MARY GIBBONS WHIPPLE, J.A.D.; HON. RICHARD J. GEIGER, J.A.D.

BRIEF OF *AMICI CURIAE* THE MEDICAL SOCIETY OF NEW JERSEY AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-RESPONDENTS

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vs.

THE VALLEY HOSPITAL, THE BOARD OF TRUSTEES OF THE VALLEY HOSPITAL, VALLEY HOSPITAL PRESIDENT AUDREY MEYERS, NEUROSURGICAL ASSOCIATES OF NEW JERSEY, P.C., and ANTHONY D'AMBROSIO, MD,

Defendants.

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STATEMENT OF INTEREST

Founded in 1766, the Medical Society of New Jersey (the "MSNJ") is the oldest professional society in the United States. The organization and its dues-paying members are dedicated to a healthy New Jersey, working to ensure the sanctity of the physician–patient relationship. In representing all medical disciplines, the MSNJ advocates for the rights of patients and physicians alike, for the delivery of the highest quality medical care. MSNJ's mission is to promote the betterment of the public health and the science and the art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.

The American Medical Association (the "AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including New Jersey.

The MSNJ and AMA submit this brief on their own behalf and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

PRELIMINARY STATEMENT

When a hospital board's decision furthers quality health care, such a decision is entitled to deference. However, when the decision is made in bad faith for pecuniary gain – and not in furtherance of quality health care – deference is not merited. At the conclusion of trial, a jury of the community found the formation of a contract and bad faith, and spoke accordingly.

It is easy for a hospital to take the general position that all of its decisions are made in furtherance of quality health care, but how does a court test the veracity of that assertion? The answer, factually, is a jury trial (which took place here) and, legally, is good faith and fair dealing as a litmus test.

STATEMENT OF FACTS

This matter arises out of the Valley Hospital's ("Valley") termination of Comprehensive Neurological P.C.'s ("Comprehensive") physicians from Valley's medical staff in order to enter into an exclusive arrangement with Neurosurgical Associates of New Jersey, P.C. (the "Columbia Group"), for privileges to use

Gamma Knife and biplane angiography to treat patients with stroke or circulatory disorders within the brain and to attend stroke patients in Valley's Emergency Department. Prior to the termination of Comprehensive's medical staff privileges on or about February 1, 2016, Comprehensive was instrumental in the development of a neurosurgery department at Valley, resulting in Valley becoming one of the few facilities in New Jersey to earn recognition as a Comprehensive Stroke Center by the Department of Health and Senior Services. [A6-A8.][1]

On January 16, 2016, Plaintiff filed an emergent application in the Chancery Division seeking a temporary injunction restraining the Valley Hospital defendants from terminating plaintiffs' medical privileges, compensatory damages, and counsel fees and costs. [A19- A20.]

On January 28, 2016, the Chancery Division denied the motion for a temporary restraining order, but ordered expedited discovery. [A20.] During expedited discovery, Defendants produced numerous emails between themselves and Valley's general counsel leading up to the revocation of Plaintiffs' privileges from the medical staff. [A20-A28.] The expedited discovery revealed Valley's plan to create a White Paper comparing the Columbia Group and Comprehensive in a "detailed study of the cost, quality and volume of neurosurgical services provided

[1] References to "A" are to the Appendix to the Petition of Valley Hospital for certification in this matter containing the Appellate Division opinion.

over several years, by the two largest neurosurgical groups." [A14 – A15.] This White Paper, which concluded that the Columbia Group exceeded Comprehensive's performance based on a variety of metrics, later served as a pretextual basis for Valley to enter into an exclusive arrangement with the Columbia Group over Comprehensive, which had also been referred to by Katherine Brennan, (Senior Analyst of Planning and Business Development at Valley, as "the group we do not want to align with." [A27, A35.]

After a four-week trial with twenty-two (22) witnesses, the trial court properly instructed the jury on the elements of contract formation, essentially reciting the model jury charge. Similarly, with no special reference to Valley's medical staff bylaws, the verdict sheet asked the jury: "Do you find by a preponderance of evidence that the Valley Hospital and Comprehensive Neurosurgical PC entered into a contract?" [Da93].[2] In response, the jury answered "yes" and found that Valley had entered into a contractual relationship with Comprehensive. The jury also found that Valley had breached the contract's implied covenant of good faith and fair dealing. In denying Valley Hospital's post-trial motions, the trial judge stated that plaintiffs "provided evidence that [d]efendant had made a predetermined decision to revoke [plaintiffs'] privileges, such as [d]efendant's own general counsel indicat[ed] that

[2] References to "Da" are to the Defendants' Appendix in the Appellate Division.

they needed to build 'a strong case ahead of time,' and evidence upon which the jury could conclude that the study was a sham." [A10.]

In its comprehensive unpublished decision, the Appellate Division affirmed, largely deferring to the jury's collective determination in this highly fact-sensitive case. As the panel noted, "at trial, [Comprehensive] presented substantial evidence to show that Valley Hospital . . . unfairly manipulated the data [as part of its proffered rationale for severing the contract with Comprehensive] to support its preferred outcome." [A62]. More specifically, the evidence allowed the jury to accept Comprehensive's contention that Valley had proffered a sham study to justify its predetermined decision to oust Comprehensive because Valley thought Comprehensive's physicians had too close a relationship with Hackensack University Medical Center ("HUMC"), Valley's major competitor, and were providing too many patient referrals to HUMC. This Court granted certification.

LEGAL ARGUMENT

POINT ONE

HOSPITALS MUST NOT BE PERMITTED TO MANIPULATE THE MEDICAL STAFF CREDENTIALING PROCESS FOR THE HOSPITAL'S OWN PECUNIARY GAIN.

The medical staff credentialing process is intended to ensure the qualifications and clinical competency of the providers who furnish services to a hospital's patients. A properly structured credentialing process can prevent the admission of

rogue healthcare workers with dubious qualifications, which also helps to ensure a better quality of patient care. Once credentialed, all healthcare providers are continuously monitored for their performance. Accordingly, healthcare providers are afforded due process when privileges from a facility are suspended or revoked. See Health Care Quality Improvement Act of 1986, 42 U.S.C.A. §§ 11101-11152 (requiring that a hospital (or other health care facility) provide fair investigation and hearing procedures).

In the instant matter, Comprehensive's providers were members of Valley's medical staff in good standing for many years.[3] Valley's conduct, specifically creating a pretextual White Paper for the sole purpose of attempting to justify the termination of Comprehensive's staff privileges under the guise of a quality improvement initiative, is an abuse of the credentialing process, and is demonstrative of a larger systemic issue in modern healthcare: the unchecked power of hospitals and health systems to prioritize profits over patient care.

During the past twenty years, the health care landscape has shifted significantly, and so, too, have the relationships between hospitals and physicians. There is now a large body of research showing that health care consolidation tends

[3] Comprehensive neurosurgeons began rendering services at Valley in or about 2003 and, thereafter, expanded their group from two neurosurgeons to twelve, between 2003 to 2015. [A8].

to raise prices without clear indications of corresponding quality improvements.[4] Even before the COVID-19 public health emergency, the U.S. health care system was becoming increasingly consolidated. The financial strains of the pandemic could increase the pace of consolidation among hospitals and physicians.[5] To understand the current dynamics of hospital-physician relationships, it is important to consider not only the operational and other factors motivating the parties, but also the significant competitive advantages enjoyed by hospitals, and in some instances, their predatory and unethical conduct.

The private practice of medicine, in which a practice is wholly-owned by physicians and not by hospitals, health systems, or other entities, provides physicians with the autonomy to furnish health care in the manner that best suits their patients. From deciding to invest in specialized equipment for the provision of additional services, to controlling providers' schedules, these operational and clinical decisions rest solely with the physician-owners of the practice. This autonomy has enabled

[4] See, e.g., Karen, Schwartz, Eric, Lopez, Matthew, Rae; and Tricia, Newman, What We Know About Provider Consolidation, Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/ (September 2, 2020) (last accessed August 27, 2023); see also, Elisabeth Rosenthal, Undoing Health System Monopolies May Be a Lost Cause, N.Y. Times, July 25, 2023, available at www.nytimes.com/2023/07/25/opinion/health/health-system-hospital-monopolies.html?smid=em-share.

private practitioners to pursue value-based initiatives[6] that appropriately incentivize and reward physicians who commit to the most efficient delivery of high-quality care. Only when physicians are independent can they drive the kind of innovation required to achieve value-based care objectives.

Notwithstanding these benefits, physician-owned practices have been challenged by a variety of factors including, but not limited to: (i) increasing complexity in payment systems, including the proliferation of value-based models that require size, money, and sophistication; (ii) the increasing cost and complexity of healthcare IT systems requiring capital and a more robust infrastructure; (iii) the proliferation of large medical practices affiliated with hospitals, private equity investors and health insurers that compete for physicians, network access, and patients; and (iv) the rise of a generation of physicians who may value lifestyle and a predictable income over entrepreneurism and maximization of income. Hospitals have been willing to enter into arrangements with private practicing physicians who

[6] Recognizing the risks of overutilization of services and fragmented care associated with the fee-for-service payment system, the U.S. Department of Health & Human Services has continued to develop various value-based payment mechanisms that incentivize increased quality outcomes and cost efficiencies. See, e.g., Management Challenge 2: Transitioning to Value-Based Payments for Health Care, U.S. Dep't of Health & Human Serv. Office of Inspector Gen., https://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge02.asp (last accessed August 29, 2023).

are vulnerable as a result of the aforementioned (and other) challenges. In 2022, 65% of U.S. neurosurgeons were employed by a hospital, up from 58% in 2019.[7]

Hospitals, facing declining inpatient rates and reimbursements, have sought to capture additional revenue from lucrative outpatient services and to achieve infrastructure economies of scale by consolidating into large health systems. Referrals to hospitals for inpatient care are made when a patient's condition requires an acute care setting, leaving no other suitable destination for the referral. However, referrals to a hospital's lucrative *outpatient* services are generated by physicians who, in many cases, have the option of directly furnishing the same outpatient services at a lower cost in their own medical offices or clinics, or in other ambulatory facilities not affiliated with the hospital. How can a hospital guarantee itself a steady stream of referrals for both inpatient and outpatient services? The answer is simple: by controlling the referral source. Offering to compensate a physician in a manner that exceeds the amount a private practice can afford to pay enables the hospital to recruit, employ, and retain physicians,[8] and to effectively drive referrals to itself by

[7] Which Physician Specialties Are Most Targeted for Corporate Roll-Ups?, Gist Healthcare, gisthealthcare.com/which-physician-specialties-are-most-targeted-for-corporate-roll-ups/ (March 24, 2023) (last accessed August 29, 2023).

[8] In New Jersey and other states with a strong corporate practice of medicine prohibition, the recruited physician is typically employed by a "captive practice" that is owned by a licensed physician who is already aligned with, and highly compensated by, the hospital.

preventing the "leakage" of patients outside of the hospital and/or its affiliated facilities. As explained below, these arrangements are extremely fruitful for hospitals, in part because hospital outpatient department ("HOPD") reimbursements are significantly higher than the fee schedules available to private practices *for identical services*.[9]

Private-practicing physicians who refuse to give up their independent autonomy and/or who maintain medical staff privileges at multiple competing hospitals (e.g., Comprehensive), are anathema to the hospital-physician employment model. Some hospitals have resorted to undermining the viability of these "hold out" private practitioners with such tactics as patient steering and/or tools of harassment, such as arbitrary terminations of staff privileges.

In the instant matter, the record has established that in a clearly calculated fashion, Valley contrived a White Paper based on skewed, self-serving data to legitimize its decision to forcibly remove Comprehensive from its medical staff. In other words, Valley rewarded one practice for referrals (Columbia Group) while it excluded/punished another practice (Comprehensive) for maintaining a referral relationship with Valley's competitor, HUMC. Such abuses of the credentialing

[9] See James G. Hinsdale, M.D., Report of the Council on Medical Service: The Site-of-Service Differential (Resolution 817-I-17), CMS Report 4-I-18, American Medical Association, www.ama-assn.org/system/files/2018-12/i18-cms-report4.pdf (last access August 29, 2023).

process cannot be permitted, primarily because of the deleterious impact on patient care and the increased costs of care, but also because such tactics unfairly impugn qualified physicians, and may interfere with their ability to practice their profession. A physician's first and most sacred duty is to the patient. Hospitals cannot be allowed to punish physicians who refuse to become hospital employees, or otherwise refuse to pledge fealty to the hospital.

POINT TWO

HOSPITALS ENJOY COMPETITIVE ADVANTAGES THAT ENABLE THEM TO CONCENTRATE THEIR MARKET POWER IN A MANNER THAT THREATENS THE CONTINUING VIABILITY OF THE PRIVATE PRACTICE OF MEDICINE, THEREBY LIMITING PATIENT CHOICE AND INCREASING THE COSTS OF HEALTH CARE.

Hospitals have the opportunity to enrich their coffers in a variety of ways that are not available to private practitioners, in particular: enhanced HOPD reimbursement schedules. Some hospitals convert this competitive advantage into an *unfair* competitive advantage by using the massive profitability of HOPD reimbursements to compensate their employed physicians in a manner that would not otherwise be commercially reasonable or consistent with fair market value in an arms-length transaction, as an inducement for those physicians to refer patients to the hospital.

A hospital's consistently higher reimbursements for services facilitates its recruitment of private practice physicians who, as Hospital employees, may be

compensated in excess of the amount a private practice could afford to pay them in exchange for their referrals of patients to Hospital-affiliated facilities. In fact, professional medical practices that are owned by, or affiliated with, hospitals typically lose money because the physicians' compensation exceeds the professional fees collected by the hospital for the physicians' services.[10] Hospitals are financially able to subsidize the negative cash flows of these practices because the physicians are making referrals to the hospital and its affiliated facilities. These are potentially commercially unreasonable arrangements, tantamount to paying for referrals. By paying physicians commercially unreasonable compensation as a reward for referrals, hospitals create pressure on employed physicians to refer, which may result in overutilization and increased costs to the healthcare system. Likewise, it is improper, and raises questions about the relationship between a hospital and a physician, when a hospital makes credentialing decisions based upon the likelihood of a physician making referrals to the hospital. For the same reasons that providers cannot pay for referrals under federal law and parallel state law[11], hospitals cannot

[10] See also Timothy Smith, Physician Practice Losses: A Tale of Two Owners, Medical Group Management Association, www.mgma.com/articles/physician-practice-losses-a-tale-of-two-owners (October 30, 2018) (last accessed August 30, 2023) (discussing hospital mean and medical hospital losses ranging from $150,000 to $400,000 for each full-time employed physician in an analysis of 2017 data by the Medical Group Management Association).

[11] See N.J.S.A. 45:9-22.5.

utilize the credentialing process to punish physicians for their perceived lack of referrals or divided loyalties (i.e., to other hospitals). These arrangements may implicate the Stark Law[12] and the Federal Anti-Kickback Statute (the "AKS"),[13] as briefly described below. It may be reasonable for hospitals to enter into exclusive contracts under certain circumstances, but it is not reasonable when the motivation is simply to secure referrals.

POINT THREE

THE REWARD OF AN EXCLUSIVE CONTRACT BY A HOSPITAL TO A PRACTICE IT DEEMS LOYAL BASED ON ITS REFERRAL PATTERNS WITH COMPETING HOSPITALS, WHILE SIMULTANEOUSLY PUNISHING ANOTHER PHYSICIAN GROUP FOR ITS PERCEIVED DIVIDED LOYALTIES, MAY IMPLICATE THE FEDERAL ANTI-KICKBACK STATUTE, AND THE STARK LAW, AND ARE ANTITHETICAL TO A NONPROFIT HOSPITAL'S CHARITABLE PURPOSE.

The current economic landscape for hospitals includes strategic alignments that may be irreconcilable with requirements to maintain their tax-exempt status, and may also be unchecked by the available enforcement mechanisms under the Stark Law and the AKS.[14] It is well-settled that a physician's compensation may not be

[12] 42 U.S.C. § 1395nn.

[13] 42 U.S.C. § 1320a-7b(b).

[14] For the avoidance of doubt, the Amicus Curiae are not alleging that Valley has engaged in conduct that violates the Stark Law or the AKS, but rather, providing information to the Court about a widespread issue impacting the health care system.

based upon referrals. The compensation of hospital-employed physicians may only be based on professional revenues they generate; basing their compensation on the volume or value of their referrals is a blatant violation of the Stark Law and the AKS. The Stark Law prohibits physicians from referring patients to receive certain designated health services ("DHS") payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. 42 U.S.C. § 1395nn(a)(1). Financial relationships include both ownership/investment interests and compensation arrangements. 42 U.S.C. § 1395nn(a)(2).

Even under a *bona fide* employment arrangement, the Stark Law requires that any referral requirement must comply with certain criteria, including but not limited to: allowing patient choice, taking into account third-party payor requirements, and deference to the referring physician's own judgment regarding the patient's best medical interest. 42 C.F.R. § 411.354(d)(4). Furthermore, the Stark Law's 2021 Final Rule made clear that "neither the existence of the compensation arrangement nor the amount of the compensation [can be] contingent on the number or value of the physician's referrals to the particular provider, practitioner, or supplier." 42 C.F.R. § 411.354(d)(4)(vi).

Similarly, the AKS prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business

involving any item or service payable by the Federal health care programs. 42 U.S.C. § 1320a-7b(b). Remuneration includes anything of value, and includes excessive compensation paid to referral sources. 42 U.S.C. § 1320a-7b(b)(1), (2).

The provision of services in a hospital setting versus a community practice setting increases costs to Federal healthcare programs and consumers. Owing to a lack of transparency in pricing, the impact described herein goes largely unrecognized by the general public.[15] Individuals in need of life-saving treatment should be able to trust that their physicians' recommendations regarding the site-of-service are not tainted by financial pressure from hospitals.

There has been some action to address these concerns. For example, a Missouri hospital that purchased a community-based infusion center to convert it to an HOPD that enjoyed the additional advantage of 340(B) program discounts to acquire the infusion drugs at a low price. The hospital then compensated the physicians in violation of the Stark Law in order to "make them whole" for the compensation reductions the physicians incurred from losing the ability to profit from the ancillary services provided once their center was purchased. This

[15] While Section 2718(e) of the Public Health Service Act (PHSA) requires that hospitals publish a list of the hospital's "standard charges" for items and services provided by the hospital, a consumer is not made aware of the differences between the HOPD rate and charges for identical services in an independent physician office setting. Public Health Service Act § 2718(e), 42 U.S.C.A. § 300gg-18(e) (2010).

arrangement resulted in a large qui tam settlement.[16] Sacramento-based Sutter Health (the largest health system in Northern California) entered into a $575M settlement to resolve allegations that its anticompetitive practices drove up healthcare prices in Northern California.[17]

Multiple studies have confirmed that market consolidation results in higher costs to consumers.[18] Exclusive contracts between hospitals and other practices are

[16] See Missouri Hospitals Agree to Pay United States $34 Million to Settle Alleged False Claims Act Violations Arising from Improper Payments to Oncologists, U.S. Department of Justice Office of Public Affairs, https://www.justice.gov/opa/pr/missouri-hospitals-agree-pay-united-states-34-million-settle-alleged-false-claims-act (last accessed August 29, 2023).

[17] Final Approval Order August 21, 2021, available at https://oag.ca.gov/system/files/attachments/press-docs/Final%20Approval%20Order%20Sutter.pdf (last accessed August 29, 2023); see also Saint Alphonsus Med. Center-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775 (9th Cir. 2015) (affirming the decision by the U.S. District Court in the District of Idaho, which held that the acquisition violated Section 7 of the Clayton Act and the Idaho Competition Act, and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets).

[18] See, e.g., MedPAC, March 2020 Report to the Congress: Medicare Payment Policy (March 13, 2020), available at https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/ (last accessed August 29, 2023) (noting that most of the literature suggests hospital consolidation is associated with higher prices); see also The Nicholas C. Petris Center, Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums (March 26, 2018), available at https://petris.org/consolidation-in-californias-health-care-market-2010-2016-impact-on-prices-and-aca-premiums/ at 9 (last accessed August 29, 2023) (concluding that "[c]onsumers are paying prices for health care that are considerably above what a more competitive market would produce" and "[t]he vast majority of

a form of consolidation that reduces patient choice and increases costs. It also potentially skews medical decision-making, and of significant additional import, may cause an additional financial burden to patients with serious and/or chronic health conditions.

In addition to the foregoing concerns, there is a colorable argument that when hospitals overpay physicians in order to induce them to refer patients, the hospitals are engaged in private inurement. The law governing tax-exempt entities provides that: "[a]n organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.[19] Therefore, when a non-profit hospital benefiting from tax-exemption utilizes its excess profits (likely generated by HOPD services) to financially reward physicians who generate referrals that result in additional excess profits for the hospital, the continuing tax-exempt status of the hospital may be in jeopardy.[20]

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counties in California warrant concern and scrutiny according to the DOJ/FTC Guidelines.").

[19] 26 C.F.R. § 1.501(c)(3)–1(c)(2).

[20] See U.S. Gov't Accountability Office, GAO-20-679 Opportunities Exist to Improve Oversight of Hospitals' Tax Exempt Status (Sept. 2020), available at www.gao.gov/assets/710/709485.pdf at 6 (noting in pertinent part that, under the factor analysis of the community benefit standard, "[a] hospital that restricts its medical staff privileges to a limited group of physicians is likely to be operating for the private benefit of the staff physicians rather than for the public interest."); see also Judith Garber, Eye-Popping' Executive Salaries Led These Hospitals to Lose

POINT FOUR

PATIENTS' FREEDOM OF CHOICE OF PROVIDER, INCLUDING THEIR ABILITY TO CHOOSE LOWER COST OPTIONS FOR CARE, WILL BE IRREPARABLY HARMED IF HOSPITALS ARE PERMITTED TO BREACH THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING WITH PHYSICIANS BY UTLIZING THE MEDICAL STAFF CREDENTIALING PROCESS AS A MECHANISM TO REWARD PHYSICIANS WHOSE REFERRALS TO THE HOSPITALS ARE ASSURED.

Physicians in the private practice of medicine are uniquely able to shape the patient experience. For example, private practitioners can control their own schedules and workflows to ensure that they spend ample time in the examination room discussing diagnoses and treatment options, addressing questions, and generally building trust with patients. Unrestrained by the inherent layers of bureaucracy in hospital or health system employment, private practitioners are not only more autonomous with respect to clinical decision-making, but they are also able to control other factors that contribute to the overall satisfaction of patients, including, but not limited to hiring and training the optimal support staff (both clinical and non-clinical), and creating a culture of empathy and respect.

Their Property Tax Benefits, Lown Institute, lowninstitute.org/eye-popping-executive-salaries-led-these-hospitals-to-lose-their-property-tax-benefits/ (March 3, 2023) (last accessed August 30, 2023) (discussing a Pennsylvania hospital's loss of property tax exemption as a result of private inurement to hospital executives).

Apart from the more subjective experience of a health care encounter, an objective factor that cannot be overlooked is the cost of care. Even insured patients have some degree of personal financial liability for health care services they receive, e.g., premium contributions, deductibles, copays, coinsurance, and out-of-pocket costs for uncovered care. The maneuvering by hospitals to drive services to their HOPDs (in addition to their inpatient services) is insidiously raising health care costs for every payor in the continuum: Federal health care programs, commercial health plans, self-funded plans, employers, and patients.

In the instant matter, Valley, not unlike other hospital systems, appears to be motivated entirely by the financial benefits it will receive by excluding Comprehensive, a practice that Valley perceives to have divided loyalties between Valley, and its fiercest competitor, HUMC. If Valley's motivation had truly been related to patient care, it would not have manipulated the data in the White Paper, but instead, would be seeking to engage the best neurosurgical group to service the community (or better yet, it would be allowing both practices to treat inpatients, as that would promote patient access and choice), rather than using the data to support a predetermined outcome. See, A21, A34, A35. Instead, after years of Comprehensive's high-quality service, innovation, and enhancement of Valley's reputation as a neurosurgical center of excellence, Valley has surreptitiously crafted a pretext to limit staff privileges to a group of physicians whose clinical decision-

making (i.e., referrals) Valley can control. This conduct by Valley is unconscionable and cannot be permitted to continue unchecked.

Indeed, one way to check this conduct is to hold hospitals to the standard of good faith and fair dealing. The New Jersey Supreme Court in Palisades Properties, Inc. v. Brunetti, 44 N.J. 117, 130 (1965) stated that "[i]n every contract there is an implied covenant that neither party shall do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract; in other words, in every contract there exists an implied covenant of good faith and fair dealing." (citation omitted) Courts "imply a covenant of good faith and fair dealing in order to protect one party to a contract from the other party's bad faith misconduct or collusion with third parties where there is no breach of the express terms of the contract." (citation omitted) Kapossy v. McGraw-Hill, Inc., 921 F. Supp. 234, 248 (D.N.J. 1996).

Here, Plaintiffs reasonably expected that Valley, a hospital accredited by the Joint Commission, would exercise its discretion reasonably, such that Comprehensive and its providers would not be ousted from the Valley's Medical Staff based on a White Paper that utilized skewed data to justify Valley's predetermined decision to align with the Columbia Group.

The Joint Commission standards for hospital accreditation include standards for oversight of the medical staff, including the Joint Commission Ongoing

Professional Practice Evaluation (OPPE) requirements intended to identify professional practice trends that may impact the quality and safety of care rendered by practitioners granted privileges via the medical staff.[21] Under these standards, both quantitative and qualitative measures may be used to determine whether to revoke or suspend a practitioner's privileges. Id. However, "[e]vidence of these determinations would need to be available at the time data is reviewed [by the Joint Commission]." Id. Valley's pretextual White Paper feigned a quality-of-care concern to justify its termination of Comprehensive, obscuring its actual motive: punishing Comprehensive for maintaining medical staff privileges at HUMC, and securing a more guaranteed referral stream from the Columbia Group. Valley's conduct was an abuse of the discretion afforded to hospitals, and a breach of the reasonable expectation of Plaintiffs. Hospitals, including Valley, must abide by the implied covenant of good faith and fair dealing in its dealings with physicians on its medical staff. Moreover, Valley's conduct may violate its ongoing truthfulness obligation to the Joint Commission insofar as hospitals are generally required to make data used in medical staff decision-making available to the Joint Commission, and the record before the Court clearly demonstrates that Valley's White Paper relied

[21] See, What are the key elements needed to meet the Ongoing Professional Practice Evaluation (OPPE) requirements?, Joint Commission, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001500/ (last accessed August 30, 2023).

on misleading information that was specifically manipulated to serve its ultimate agenda: securing physician referrals to Valley.

POINT FIVE

HOSPITALS THAT ALREADY ENJOY COMPETITIVE ADVANTAGES, AND CHOOSE TO ENGAGE IN PREDATORY CONDUCT, HARM PATIENTS AND THREATEN THE CONTINUING VIABILITY OF THE PRIVATE PRACTICE OF MEDICINE.

As described herein, several competitive advantages place hospitals in a position of financial strength that enables them to aggressively pursue market dominance. Beyond advantages such as inflated HOPD reimbursements, some hospitals are attempting to augment their power by unscrupulously engaging in bad faith conduct, such as using misinformation to steer patients and the weaponizing of the medical staff credentialing process for reasons other than patient care.[22] Whether by systematically adopting weak due process in the hospital's bylaws to facilitate the easy removal of physicians, or the more targeted strategy by Valley in the instant

[22] See, e.g., Desai v. St. Barnabas Med. Ctr., 103 N.J. 79 (1986) (invalidating hospital conduct to credential new physicians affiliated with physicians already on the medical staff despite closed staff policy); Greisman v. Newcomb Hospital, 40 N.J. 389 (1963) (striking bylaw requirement as to membership in County Medical Society and graduation from a certain medical school where nonprofit hospital which constituted a virtual monopoly in area received funds from public sources and received tax benefits); Walsky v. Pascack Valley Hosp., 145 N.J. Super. 393 (Ch. Div. 1976), aff'd, 156 N.J. Super. 13 (App. Div. 1978) (finding that a private hospital could not deny staff membership to two physicians who had, or intended to seek, other hospital affiliations).

case, conduct that places a hospital's financial bottom line above patient choice, optimal clinical care, and the right of physicians to engage in the private practice of medicine, cannot be tolerated.

CONCLUSION

For the reasons set forth herein, Valley should not be permitted to arbitrarily and/or pretextually terminate the staff privileges of Comprehensive so that it may, in turn, reward another practice for its assured referral stream. A Board is not entitled to deference when its decision does not further quality health care and does not afford the terminated practice's due process. The jury found such and thus, the decision of the Appellate Division should not be disturbed.

Respectfully submitted,

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