

2026 In-House Counsel Training

January 21-23, 2026

Virtual

“DAY IN THE LIFE OF A GENERAL COUNSEL” SCENARIO

Howard Smith is the new - and first - Chief Operating Officer of Dakotas Health Care System (“Dakotas”), and you are trying to build a collaborative working relationship with him and help him navigate the system. Dakotas operates five (5) acute care hospitals in two states, including one urban, tertiary care facility, three (3) community hospitals and one (1) critical access, rural hospital. Dakotas has about 3,500 affiliated physicians and 12,000 employees. About 20% of Dakotas’ patient population consists of fee for service Medicare patients, and Dakotas is losing approximately \$25-30M per year on this population. And the percentage of fee for service Medicare is increasing year over year as the “baby boomers” age into Medicare.

Approximately 12% of Dakotas’ patient population consists of Medicaid patients, and Dakotas is losing close to \$10M per year on this population.

Dakotas treats a Medicare Advantage population through Americas Health Care and is losing money on that managed care product as well. (Investors and rating agencies are starting to notice the steadily declining operating margins, EBITDA, and days cash on hand. And you have been wondering about Dakotas’ bond covenants and Line of Credit requirements in light of the declining financial performance.) The Americas Health Care Plan has issued a report on Dakotas’ population claiming that Dakotas’ risk adjusted scores for this population are “lower than the average scores submitted by other similarly situated hospitals in the same geography.” The plan is threatening to not renew its Medicare Advantage contract with Dakotas.

Interestingly, a coding employee at the Dakotas tertiary care hospital has expressed a concern to her hospital CEO that the risk adjusted scores for certain diagnoses are not supported by the medical record – meaning that the assigned RAF score is higher than it should be based on the documentation in the medical record. In fact, she has come forward with a written report identifying multiple patients in certain HCC (diagnosis) codes

where the medical record documentation does not support the higher RAF score assigned. (This report was not done under AC PRIV.)

The hospital leadership thinks she is wrong – after all, the Americas Health Plan has shown them data indicating that their hospital RAF scores are indeed “low.” The hospital president has made it known that he thinks this employee is just a pain and he “has more important things to deal with,” like meeting budget expectations. The Chief Strategy Officer raised this “whole RAF score issue” out of the blue at the last Executive Team Meeting, expressing her strong opinion that the employee raising concerns about the risk scores and the Medicare advantage billing is an “attention seeking alarmist” and “off the mark” given the report from the Americas Health Plan with supporting data.

During this same Executive Team meeting, the Chief Financial Officer raised his concerns about the current risk based “book of business,” the inability to accurately track costs and the “problem” of physicians referring their patients outside the Dakotas network, thereby costing Dakotas more money on these risk patients. He also noted the contradictory information coming forward about the accuracy of Dakotas’ risk adjusted factor scoring – a hospital employee has concerns that certain RAF scores are NOT supported by the documentation in the medical record, and a health plan says are scores are too low. The CFO also notes that he cannot get accurate data on where the money was being spent on these risk-based patients – Dakotas does not have a mature cost tracking system - but the money was being spent somewhere because the system was losing money.

As the General Counsel, you also noted your concern about the reports coming forward from the coding employee about those HCC codes with RAF scores that were allegedly unsupported. You explained that these concerns should be objectively evaluated – and “frankly should have been addressed sooner at the hospital level.” You also expressed concern about the email traffic “flying around” on this topic and asked that it stop immediately. And you decided to keep going while you have the floor – stating that Dakota’s “immature” cost of care infrastructure needed to be addressed before Dakotas took on any more risk-based products, including Medicare Advantage. The CFO then piled on, noting that the physicians have historically refused to change their referral patterns. They continue to refer risk-based patients out of network because of their long standing relationships with specialists outside of the Dakotas system. You enthusiastically agree with this, noting that while physician leadership appears to be on board with addressing these out of network referrals, physician leadership is not leading in this area because the rank and file physicians are not changing their behavior.

In response to this conversation at the Executive Team meeting, the Chief Physician Executive becomes visibly upset, says he feels “ambushed” since physician relations,

utilization management and risk adjusted factor scoring are his accountabilities. He gets up and leaves the room, slamming the door as he exists. The other members of the Executive Team sit there in stunned silence.

The CEO angrily states that he does not want to hear anything further about the risk adjusted factor scoring controversy and that “finance better figure out how to make money on these risk-based patients” because Dakotas “was going after more of these patients.” The CEO quickly moves to the next agenda item and there is no further team discussion on these issues. The Chief Physician Executive never returns to the meeting but is seen going into the CEO’s office shortly after the meeting adjourned.

The Chief Compliance Officer (“COO”) somehow hears about the “dismissive attitude” of both the hospital president and senior leaders at the Executive Team (how did she find out???) and she catches you as you are leaving the rest room. She is clearly impatient to raise her concerns with you – particularly as regards what she calls “a cultural attitude of non-compliance.” The CCO reports to you as the General Counsel but has been very vocal about this reporting relationship, as has her team, and it has created friction between you and the CCO and the legal department and the compliance department. The compliance team complains about taking “direction” from “legal” and the legal team complains about the compliance team “not doing their own work and sending everything to the legal team.” The compliance teams attributes what they perceive as an “attitude of non-compliance” to the fact that the CCO does not report to the CEO and “no one takes compliance seriously.” The CCO has hinted in the past about taking her concerns to the Compliance Committee of the Board.

Back to the story...

By the time you get back to your office after the Executive Team meeting, there is an email from the CEO to you. She wants you to figure out how to stop taking new fee for service patients AND see if Dakotas can “force” its existing Medicare fee for service patients into a Medicare managed care plan in which Dakotas participates. She tells you that she has instructed the Chief Contracting Officer to capture more of the Medicare Advantage population through commercial insurers and has instructed the Chief Physician Executive to get his coders “in line” and do something about Dakotas “low RAF scores.” The CEO also wants YOU to figure out how to “incentivize” the physicians to keep their referrals in-network. She wants you to approve increasing the number of medical directorships in every hospital in the system and also wants you to change out the fair market value consultant who does the FMV work relative to physician compensation. The CEO opines that the consultant your team has been using is “too conservative.” She also tells you to

“deal with” the employee who raised the concerns about the RAF scoring associated with those certain HCC codes. This is all in a potentially unprotected email.

You are still absorbing the importance of this email when Mr. Smith, the COO, shows up at your door. He looks around furtively, then just walks in and closes the door. He wants to talk with you “under AC PRIV.” He agrees with the concept of trying to move away from Medicare fee for service and agrees that the physician relationships need to be better secured. But, given his experience, he has seen the risks of moving forward in this space too quickly and Mr. Smith feels the Board (comprised largely of directors with no experience in health care) has not been adequately apprised of the risks of launching these initiatives with Dakotas’ current capabilities. However, he is the “new guy,” and the CEO has strong opinions about this. Mr. Smith has “mentioned” his concerns to the CEO, but more in passing, as he is reluctant to “buck” the CEO. More importantly, he wants YOU to tell the Board Chair that there are significant risks involved in getting deeper into Medicare managed care – or ANY risk-based product. He thinks you have an established relationship with the Board Chair and the Board and they “will listen to you.” He says, “there is no point in trying to talk to the CEO.”

The COO also tells you that the CEO is entirely focused on a potential merger with another healthcare system which would result in a multi-state healthcare enterprise. In fact, the CEO has told the COO to “land this deal” along with the Chief Strategy Officer and leave “operations to the hospital presidents for now.” Interestingly, this “target” system has its own struggles with managing and tracking its costs of care. That system is also losing money on Medicare fee for service and Medicare Advantage. The COO then shows you a memo from your CEO to the Board Chair of the “target” system wherein the CEO “touts” Dakotas’ total cost of care infrastructure. The memo actually says “Dakotas has the infrastructure and expertise to both manage and track the total cost of care and has a mature utilization management function. Dakotas can bring that expertise to your health system to improve its financial performance in Medicare Advantage and other risk-based products.” You have never seen this memo before. In fact, you were only vaguely aware that the CEO was “exploring” a potential merger. You had no idea that the CEO was interacting with the target system’s board. The COO is understandably concerned about these representations, as are you, and he is “wondering” if the Board is aware that these discussions are as far down the track as they are. Did the Board authorize this memo? Is the Board even aware of this memo? You don’t have the answer to either of those questions.

You are then interrupted by your executive assistant. One of your employees – a long term paralegal who has been with the legal department for 23 years – wants to see you on an urgent matter. It can't wait.

You politely excuse yourself from your conversation with the COO and go into an adjacent conference room where the paralegal, an African American woman, is waiting. She tells you she wants to discuss a troubling situation in the legal department. She has shared her concerns with her supervisor and her supervisor's boss and is now coming to you. She explains that she was passed over for a promotion and the position was given to a young, white female who had only been with the department for 2 years. Your paralegal was not given a good reason as to why she did not get the job, and she presumes it is because of her race or age or both. She claims that she was told that she was "not a good fit" for the job, She does not actually allege "discrimination" but says "it makes me wonder." She wants you to "look into this," especially since it involves your #2 leader in the department. Your paralegal politely, but directly, states "I'm sorry to have to bring this to you - everyone in the department knows that you and your #2 are close friends. I know this is awkward for you." You thank her for the information and tell her that you appreciate her coming to see you.

As she is leaving, your executive assistant hands you a letter which has just arrived in the mail, with no return address. It is a three (3) page typed letter from "a concerned employee" citing seven (7) instances over the last fifteen (15) years where minorities in the department have been denied promotions in favor of white candidates. Notably, all of the instances involve your #2 or her direct reports. All of this is a surprise to you. You notify your #2 and your SVP for HR that you have received these statements of concern. Your #2 says its "nonsense" and these are just disgruntled employees. Since there is no actual allegation of discrimination, she does not think this situation requires further action from you.

You reply that you will take her views into consideration as you decide next steps. As you are leaving her office, your number #2 says "by the way, I'm expecting to receive an offer from another health system for a larger role. I just wanted you to know." You had no idea she was interested in leaving the system. You thank her for the information and exit to return to your office, where you plan to close the door and try to breathe normally. On the way, you think about offering your #2 more money to stay, but she is not your only Deputy General Counsel.