THE FLORIDA BAR

Health Law Section Newsletter

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The Florida Bar Health Law Section

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INSIDE:

Please Write for the Florida Bar Health Law Newsletter!

By: Shannon B. Hartsfield

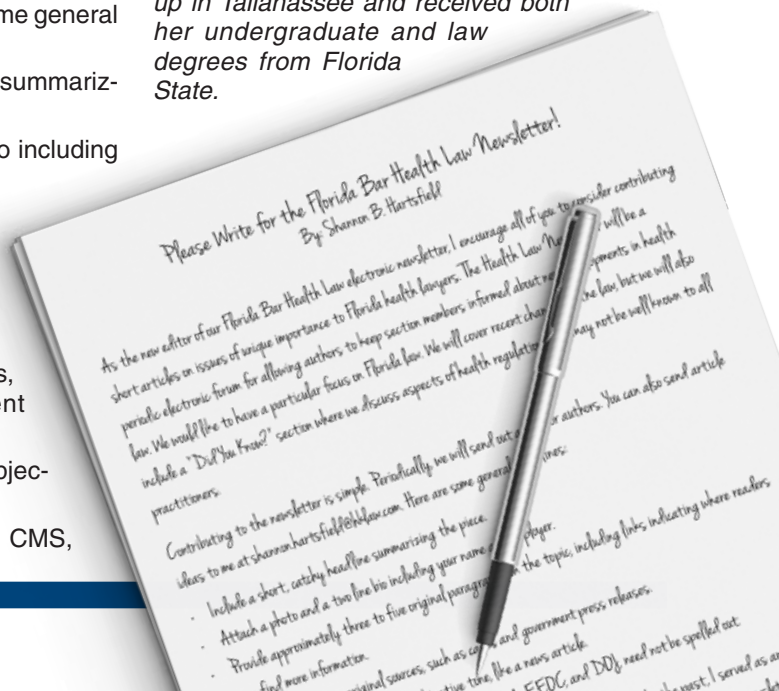
As the new editor of our Florida Bar Health Law electronic newsletter, I encourage all of you to consider contributing short articles on issues of unique importance to Florida health lawyers. The Health Law Newsletter will be a periodic electronic forum for allowing authors to keep section members informed about new developments in health law. We would like to have a particular focus on Florida law. We will cover recent changes in the law, but we will also include a "Did You Know?" section where we discuss aspects of health regulation that may not be well known to all practitioners.

Contributing to the newsletter is simple. Periodically, we will send out a call for authors. You can also send article ideas to me at shannon.hartsfield@hklaw.com. Here are some general guidelines:

- Include a short, catchy headline summarizing the piece.
- Attach a photo and a two line bio including your name and employer.
- Provide approximately three to five original paragraphs on the topic, including links indicating where readers can find more information.
- Cite authoritative, original sources, such as cases and government press releases.
- Articles should be written in an objective tone, like a news article.
- Common acronyms, like HIPAA, CMS, OIG, FDA, EEOC, and DOJ, need not be spelled out.

If you would like to write, but need suggestions for topics, please let me know. In the past, I served as an editor of the ABA Health Law Section's weekly "HLbytes" bulletin. That experience showed me that a newsletter containing succinct health law updates provides very useful information, and also makes it easy for busy lawyers to contribute. I look forward to hearing from you on topics you would like to cover.

Shannon Hartsfield has practiced health law with Holland & Knight LLP for 22 years. She focuses on regulatory compliance, with a special emphasis on data privacy, long term care, informed consent, hospital regulation, and the drug supply chain. She is Board Certified in Health Law by the Florida Bar Board of Legal Specialization and Education. She grew up in Tallahassee and received both her undergraduate and law degrees from Florida State.



What Does the Future Hold for HHS in the Post-Tom Price Era?

By: Zachary Merson

On Friday, September 29, 2017, HHS Secretary Tom Price announced his resignation following public outcry surrounding his use of taxpayer funds to pay for charter flights. Subsequently, President Donald Trump designated Eric Hargan, a member of the President's transition team, as acting Secretary for HHS.

The future of HHS and its interest in enforcing HIPAA are largely dependent on the President's choice for permanent Secretary of HHS. News outlets have reported that President Trump has selected Alex Azar for Secretary of HHS. Azar currently performs consulting services for health insurance and pharmaceutical companies and has previously worked for Eli Lilly, as well as, acting as Deputy Secretary of HHS under President George W. Bush. It has been reported that Azar has been "skeptical" of value-based care and has opposed controlling the price of pharmaceutical drugs. In June of 2016, at the Bipartisan Policy Center's educational series on affordable medicines, Azar was quoted as saying, "I worry a lot when we talk about moving to value-based systems [because] we actually know in the U.S. with a competitive insurance market how to discern value." Regardless of whether Azar supports value-based care, the first head of the Office of the National Coordinator for Health IT, David Brailer, M.D., Ph.D., noted that Azar is "an unflinching supporter of health IT," which will be well received by the healthcare information technology community.

If confirmed by Congress, Azar will also be tasked with enforcing the HIPAA rules. In the past five months HHS has only announced one compliance agreement, a stark contrast to the months preceding that period, which was one of the most active enforcement periods in HHS history. Will the future mirror the aggressiveness of the Obama-era or recede into a more conservative, "business-friendly" approach with lower fines and less resolution agreements? Some believe that HIPAA enforcement is immune from the political winds and enforcement will continue forward regardless of who leads HHS in the future, including Azar. The future of HHS will remain unknown until Congress confirms Azar as the next HHS Secretary. However, if Azar is confirmed, the healthcare community will anxiously await his first move to gauge both his appetite for value-based care, as well as, his vision for HIPAA privacy and security enforcement.

Zac Merson is Corporate Counsel at Availity, LLC. He grew up in Baltimore, Maryland and Tampa, Florida and graduated from the University of Florida Levin College of Law.

This newsletter is prepared and published by the Health Law Section of The Florida Bar.

Information Sharing in the Midst of an Opioid Crisis

By: Cathrine Hunter

President Donald Trump issued a declaration on October 26, 2017, stating that the opioid crisis is now a national public health emergency. The HHS Office for Civil Rights subsequently released new guidance on when and how healthcare providers can share a patient's health information with family members, friends, and legal personal representatives when a patient is in opioid crisis.

The new HHS guidance allows healthcare professionals to disclose some health information without a patient's permission under certain circumstances, for example:

- A healthcare provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without the patient's permission.
- A healthcare provider may inform family, friends, or caregivers of a patient's opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.

HHS also noted in the guidance that if the healthcare provider's state law is more restrictive on the communication of health information, then the healthcare provider must abide by the more restrictive law. Florida has three laws that appear to stand in the way of HHS's new guidance:

- First, Fla. Stat. 456.057(7)(a), provides, in part, that medical records "may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient, the patient's legal representative, or other health care practitioners and providers involved in the patient's care or treatment, except upon written authorization from the patient."
- Second, Fla. Stat. 395.3025(4) prohibits hospitals from disclosing patient records "without the consent of the patient or his or her legal representative."
- Third, Fla. Stat. 397.501(7) provides, in part, that "individuals receiving substance abuse services from any service provider are guaranteed protection," and the records of such service providers which pertain to the "identity, diagnosis, and prognosis of and service provision to any individual are confidential" and "may not be disclosed without the written consent of the individual to whom they pertain."

The exceptions noted in Florida Statutes 456.057, 395.3025(4), and 397.501(7) do not address the permitted disclosures in the new guidance when a patient is in an opioid crisis.

Since Florida law is more restrictive than the new guidance from HHS, practitioners in this area of law should be cautious when advising clients. All of the protections under HIPAA and Florida's more restrictive laws are still critical, because people who experience and seek treatment for opioid abuse may experience discrimination from healthcare providers and others. Opponents to the new HHS guidance are concerned that the personal information may get in the hands of a patient's employer or police, who may want to punish the patient instead of making sure the patient receives proper care.

Cathrine Hunter is a practicing attorney in Florida since 2003 and an Associate with Woodward, Pires & Lombardo in Naples. One of her areas of focus is healthcare law, including HIPAA and the HITECH Act. She is a member of The Florida Bar Workplace Health & Safety Committee and the Wage & Hour Administration Committee.

Taking Florida into the Future with Telemedicine

By: Kristina G. Maranges

On October 31, 2017, the Telehealth Advisory Council issued its recommendations to Florida Governor, Rick Scott, and the Florida Legislature on how to increase the use and accessibility of services provided via telehealth. The report comes on the heels of a state and national shortage of healthcare practitioners to serve our country's growing and aging population. Echoing HHS's designation of telehealth as a *means* or *method* of delivering healthcare, not a *type* of healthcare service, and noting Florida regulations include multiple definitions of "telemedicine" but no definition of "telehealth" and these terms are commonly used interchangeably, the Council recommended a definition of "telehealth" to replace all existing definitions. "Telehealth is defined as the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed health care practitioner, within the scope of his or her practice, who is located at a site other than the site where a recipient (patient or licensed health care practitioner) is located."

Recognizing the lack of adequate insurance coverage and reimbursement for healthcare services as barriers to the delivery and growth of telehealth services, the Council next recommended the Florida legislature require both coverage and reimbursement parity, excluding Medicare plans. Specifically, insurance policies must provide coverage for health care services delivered via telehealth if coverage is available for the same service provided in-person without the imposition of any additional conditions for coverage of services by the insurer, and payment rates must be the equivalent to rates for comparable in-person services. Regarding Medicaid, the Council recommended the Agency (1) modify its telehealth fee-for-service rule to include coverage of store-and-forward (transmission of recorded health history like X-rays and photos through a secure electronic communications system to a practitioner who uses the information to evaluate the case or render a service outside of a real-time or live interaction) and remote patient monitoring (personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support) modalities; and (2) develop a model that would allow Medicaid Managed Care plans to utilize telehealth in order to meet network adequacy.

As to licensure, in upholding the State's duty to assure patient protection and practitioner accountability, the Council unequivocally recommended that Florida maintain its Florida licensure requirement, but adopt laws allowing participation in health care practitioner licensure compacts if those compacts have equivalent or more stringent licensure requirements than Florida. The Council further recommended (1) including express recognition in Florida Statutes of the permissibility of establishing a practitioner-patient relationship through telehealth; (2) maintaining current consent laws, without any additional consent requirements that would add unnecessary barriers to utilization of telehealth services; and (3) including the prescription of medication via telehealth while limiting the prescription of controlled substances to emergencies and psychiatric treatment.

Lastly, to address technology-related barriers, the Council recommended that AHCA identify existing resources to expand the interoperability between telehealth technologies and integration into EHR platforms; continue the promotion of existing programs and services to increase access to technology and broadband networks; and task schools and healthcare associations with providing information and educational opportunities related to the use of telehealth for serving patients.

The detailed analysis and reasoning for the six obstacles addressed in the Council's report are far more extensive than this summary, but the Council's message is clear: Florida must expand its use of telehealth if it is going to meet the needs of its community in the future in a sufficient and cost-effective manner. The Council's full report, as well as all meeting information, speaker presentations, Survey results, and research materials are available on the Council's website, http://www.ahca.myflorida.com/SCHS/telehealth/.

Kristina Maranges is an attorney with the Healthcare Group of Broad & Cassel LLP's Miami Office. She focuses on hospital and healthcare provider operations, including medical staff issues and peer review litigation, as well as white collar criminal defense. Kristi grew up in Miami, serves on the Cuban American Bar Association's Board of Directors, and is a member of the Dade County Bar Association, Florida Association of Women Lawyers, AHLA, and the South Florida Chapter of the Women's White Collar Defense Association.

Who is on the Hook? Individual and Institutional Liability under the False Claims Act

By: David B. Honig

On September 19, 2015, Sally Quillian Yates, then the Deputy Attorney General, issued what came to be known as the *Yates Memo*, directing DOJ attorneys to focus on individual misconduct, rather than just corporate misconduct, while investigating False Claims Act cases. The change was almost immediate, and soon the DOJ was announcing civil settlements with health care executives as well as institutional providers. The best known was the $1 million settlement, plus a four-year exclusion from Federal health care program participation, with Tuomey Healthcare System's CEO, in South Carolina. Several others quickly followed, including two executives from an Ohio skilled nursing facility who entered into a $19.5 million joint and several liability agreement with their company, a $3.75 million personal settlement with Bostwick Laboratories' owner and CEO, and a $750,000 personal settlement with Freedom Heath, Inc.'s COO.

Under the Trump Administration, the Department of Justice has sent mixed messages about the balance between individual and institutional wrongdoing in fraud cases. In April, 2017, while addressing a Washington conference on enforcement of laws against bribery overseas, Attorney General Jeff Sessions appeared to favor individual enforcement to the exclusion of institutional enforcement, saying that:

> The Department of Justice will continue to emphasize the importance of holding individuals accountable for corporate misconduct . . . I do believe . . . that really something is not quite fair if honest corporate shareholders end up having to pay the price for dishonest corporate leadership.

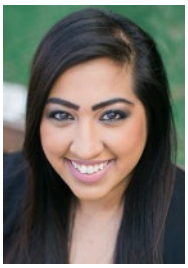
On October 6, 2017, Deputy Attorney General Rod J. Rosenstein announced that the *Yates Memo* was under review. Rosenstein stated that the DOJ would continue to focus on individual liability for corporate wrongdoing, but signaled a more institution-friendly leaning. He stated the government should not use criminal authority "unfairly," as he put it, "to extract civil payments." He also announced that the new policy would be based upon input "from stakeholders inside and outside the Department of Justice."

If Attorney General Sessions and Deputy Attorney General Rosenstein follow through on their messages to date, it appears likely that the trend toward individual liability in fraud cases that started with the *Yates Memo* will accelerate, with even more emphasis on executives and other individuals, and less on corporations and other institutions.

David B. Honig is a Shareholder at Hall, Render, Killian, Heath & Lyman, with offices in Indianapolis and Washington D.C. He grew up in Florida and graduated with honors from the University of Florida College of Law.

Florida v. Oxycodone, et. al.

By: Saamia Shaikh



On May 3, 2017, Governor Rick Scott promulgated Executive Order 17-146, officially declaring that the opioid epidemic threatens the State of Florida with an emergency. The opioid epidemic is an escalating public health crisis that plagues the entire nation. A number of interventions have been adopted in response by state and federal legislators, local police departments, and healthcare professionals. While opioids provide necessary analgesia to many patients, unnecessary prescribing has allowed for alarming rates of diversion, addiction, and death. Healthcare attorneys should counsel their clients to be cognizant of the current state of emergency and avoid overprescribing traps by remaining vigilant in watching for any drug-seeking patient behavior, registering for access to Florida's prescription drug monitoring program (PDMP), also known as E-FORSCE, staying up to date with best practices and guidelines for opioid prescribing, and using excellent documentation skills.

While the intended purpose of E-FORCSE is to identify rogue providers and to reduce drug abuse and diversion, it also serves an additional resource for healthcare professionals that could provide insight to a patient's behavioral attitudes and patterns. Similar to a patient's lab values, E-FORCSE provides additional data about a patient that could aid in decision making. Also, as of February 2017, prescribers and dispensers can assign a designee to access E-FORSCE on their behalf. Additionally, prescribers can view a history of dispensed prescriptions attributed to their DEA number using the Prescriber DEA Query function— a function not available to pharmacists and designees. Currently, prescribers of controlled substances are not required to use E-FORSCE, but dispensers must report all Schedule II-IV drugs filled within seven business days. However, pursuant to House Bill 557 which was passed by the 2017 Florida Legislature, effective January 1, 2018, the dispensing of a controlled substance must be reported no later than the end of the next business day, unless an extension has been granted. Also, on October 26, 2017, Governor Rick Scott announced that during the upcoming legislative session for 2018-2019, in addition to proposing legislation that will place a three-day limit on opioid prescriptions, he plans to introduce legislation that will require all healthcare providers that prescribe or dispense controlled substances to participate in Florida's PDMP. Currently, 49 states as well as the District of Columbia have PDMPs in place. On July 17, 2017, Missouri Governor Eric Greitens signed Executive Order 17-18 mandating the state's Department of Health to begin working on a PDMP.

Florida's largest healthcare insurer, Florida Blue, joined the war against prescription opioid misuse and abuse as it announced it will no longer cover prescriptions for OxyContin effective January 1, 2018. Alternatively, Florida Blue will provide coverage for Xtampza ER, which is formulated with improved abuse deterrence properties, reportedly. Cigna has also announced it will no longer cover OxyContin effective January 1, 2018. Also, Larry J. Merlo, President and CEO of CVS Health, announced that effective February 1, 2018, CVS will be utilizing a new approach for opioid management which will decrease the number of days opioid prescriptions can be dispensed for first-time users for acute conditions to seven days. There will also be restrictions on the daily dosage that can be dispensed based on the strength of the opioid, as well as requiring that patients use immediate release formulations before extended-release pain medication may be filled.

Most recently, in an attempt to combat the opioid epidemic at a local level, the Broward County Sheriff's Office has armed its deputies with Narcan, an intranasally administered opioid antagonist that can reverse an overdose in minutes by binding to opioid receptors. The Broward County Sheriff's Office is one of many police departments across the state to have started carrying Narcan kits. Also, Jacksonville recently launched Florida's Opioid State Targeted Response Project, a novel six-month pilot program aimed at addiction treatment with peer recovery specialists using various approaches including residential inpatient treatment services. If the program is successful, it could be implemented in ERs across Jacksonville.

Saamia Shaikh, JD, OMS-III is Of Counsel at Jones Health Law, P.A. She grew up in Orlando, Florida and graduated from Nova Southeastern University Shepard Broad College of Law with a concentration in health law. In addition to being a member of The Florida Bar, she is a student physician at Broward Health, where she is completing her third-year medical school rotations.

Did You Know? Untapped Financing for Health Care Facilities: the New Markets Tax Credit

By: Christin Decker Petroski

These days, healthcare providers and administrators are not only performing the duties for which they were highly educated; they must wear the hats of strategic planner and financial analyst as well. Healthcare clients are frequently discussing and planning proposed expansion of new facilities, building out of existing centers, and their need to refresh and replace aged equipment. Not surprisingly, healthcare facilities' budgets are stretched thin. There is often a gap between available funding and necessary funding to engage in these very needed activities. Enter: the New Markets Tax Credit.

In 2016, the New Markets Tax Credit (NMTC) financed at least 28 healthcare facilities across the country, including three drug treatment facilities and two additional clinics specializing in behavioral health and addiction. This number is expected to increase in 2017. Why the growing popularity? The NMTC is a gap financing tool which delivers additional capital for projects that are located in economically distressed communities. Healthcare facilities have taken notice, as so many facility expansions are taking place in rural and urban areas that qualify as economically distressed.

How does it work? The NMTC is provided for under Section 45D of the Internal Revenue Code. The purpose of the credit is to encourage investment in low-income community businesses, while also effectively reducing the borrowing or financing costs to those businesses. The NMTC is generated when a "qualified equity investment" (which can be made up of an equity investment from the tax credit investor plus "leverage loans" from banks, affiliates of the qualified low-income community business, or other third parties) is made into a "community development entity." The community development entity then uses the proceeds of such investment to make loans or equity investments in "qualified active low-income community businesses" located in "low-income communities." The NMTC loan transactions are often structured very similarly to a traditional commercial real estate loan, but the NMTC benefit is used to reduce the financing costs to the borrower while providing the investor with additional return through the tax credit, or additional equity cushion where the tax credits are syndicated to third party tax credit investors. In addition to the extra equity cushion, borrowers frequently see other favorable terms, such as very low interest rates and lower required LTV ratios.

The NMTC program is the perfect example of a public-private partnership that works. It is a federal program that is privately implemented by leaders in the financial industry. Though the structure of the NMTC transactions may be intimidating at first, these transactions are a very effective way of filling the "gap" in funding that is necessary for the completion for all types of healthcare expansion projects. Their gaining popularity in the healthcare arena will allow healthcare facilities to build and offer services in underserved and economically distressed rural and urban communities where they are needed most.

Christin Decker Petroski is Senior Counsel at Holland & Knight LLP. She grew up in Union County, Florida and graduated from Florida State University and the University of Florida Levin College of Law.

Why are Medical Record Requests So Important?

By: Courtney G. Tito

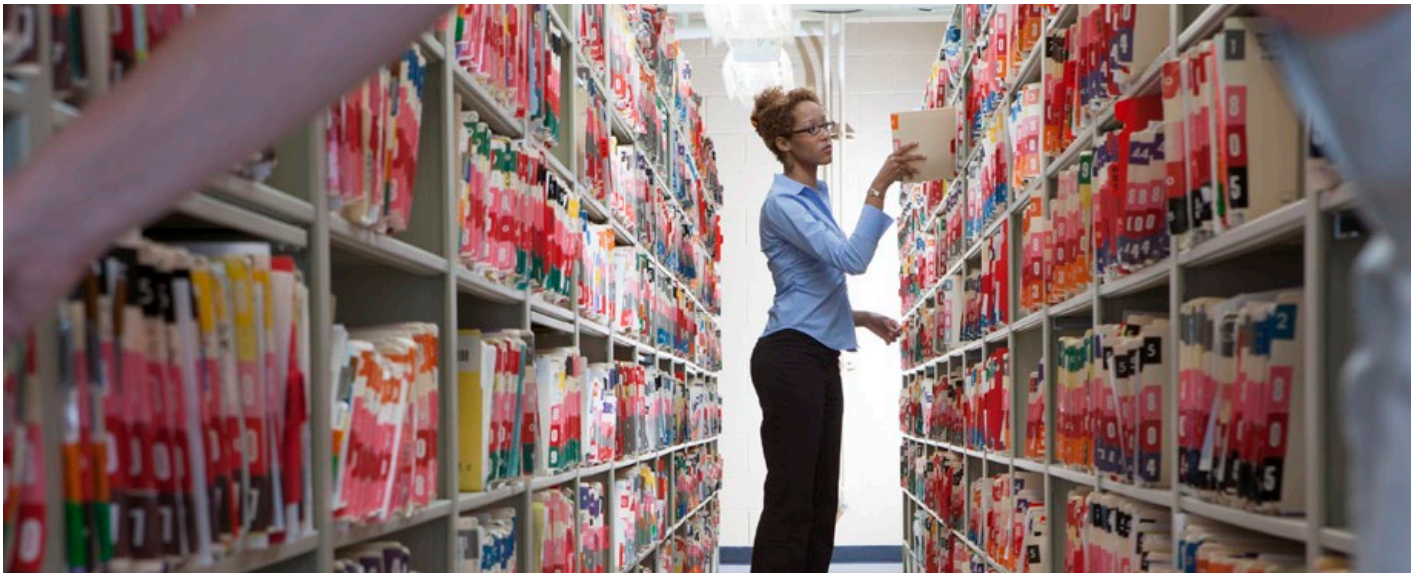
UPICs, operating on behalf of Medicare, have the right to reopen claims for good cause pursuant to 42 C.F.R. §405.986. These records requests are becoming more and more common and are also utilized by private payors. Typically, these records requests are the result of an outlier discovered in the utilization of data analytics by CMS or a private payor to determine if patterns of claims submissions and payments indicate there is a problem.

Picture this: ABC Labs receives a medical records request from AdvanceMed, one of CMS's UPICs, which states that AdvanceMed has good cause to reopen claims pursuant to 42 C.F.R. §405.986. AdvanceMed is requesting records for 100 claims from 70 beneficiaries for a specific date of service range. ABC Lab is extremely busy and assigns the project to an employee in its billing department. The employee gathers the requisitions and lab reports for all 100 claims and submits them to AdvanceMed within the deadline. Not long after, ABC Lab receives a letter stating that it is subject to a payment suspension and a pre-payment review of all claims based, at least in part, on AdvanceMed's review of the records and AdvanceMed's determination that the claims were not reasonable and medically necessary. ABC Labs also gets notification that of the 100 claims reviewed, AdvanceMed determined that 100% should have been denied and accordingly, AdvanceMed has extrapolated an overpayment amount of several million dollars to represent 100% of the claims submitted by ABC Lab during that date of service range.

Alternatively, ABC Labs contacts its health law attorney upon receipt of the request. The attorney informs ABC Labs about its obligations to maintain and produce documentation sufficient to establish medical necessity and that ABC Labs needs to reach out to each ordering physician to obtain their records as well. The attorney, alone or in conjunction with a consultant, reviews all the records to determine if attestations are required for missing signatures or other amendments are necessary to correct insufficient documentation. With the attorney's advice, ABC Labs sends a much more robust response to the medical records request. AdvanceMed makes a determination that only 10 of the 100 claims should have been denied and extrapolates that denial out to 10% of all the claims submitted during that date of service range and the resulting overpayment is only six figures.

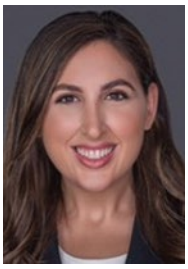
Obviously, there are no guarantees that an attorney's assistance will make such a dramatic difference, but health law attorneys are dealing with medical records requests, payment suspensions and overpayment demands on a daily basis and typically have a wealth of experience in responding to each of these. Getting an attorney involved early can be critical for planning a course of action for responding to future notifications and demands. There is a lot of information on-line, for example, CMS has MLN fact sheets regarding medical record documentation, and a provider's attorney can help a provider navigate CMS requirements, UPIC requirements and even requirements for responding to private payors. Hiring an attorney can be expensive in the short term, but can also result in a great deal of savings in the long term if brought in early. Regardless of whether the records request is from a federal or private payor, it is important for a provider to get an attorney involved as soon as it receives a medical records request from either a UPIC or private payor. Failure to properly and completely comply with a records request can lead to a substantial overpayment demand or other penalties.

Courtney is a member of the Health Law group at McDonald Hopkins, LLC's West Palm Beach office. Her health law practice focuses on representing providers in federal and private payor audits and disputes, and internal investigations.



The Impact of the OIG's 2017 Revisions to the AKS Safe Harbors and the CMP Rules on Access to Healthcare in Rural Communities

By: Jocelyn E. Ezratty



On January 6, 2017, the HHS OIG implemented regulatory revisions to the Anti-Kickback Statute (AKS) Safe Harbors and the Civil Monetary Penalty (CMP) regulations. The purported goals were to advance the needs of the providers and patients while "promoting improved access to quality care in rural and other underserved areas."

These revisions from the OIG's Final Rulemaking included both additional Safe Harbors to the AKS and exceptions to unlawful "remuneration" in the CMP regulations. It promised to promote value-centered, patient-centered care with increased "flexibility . . . to engage in health care business arrangements." Specifically, the OIG added two new waivers to otherwise prohibited "cost-sharing" practices: a safe harbor for the Medicare Coverage Gap Discount Program, and a safe harbor for free or discounted local transportation for patients to get necessary health care. This was in addition to broadening protection from CMP liability. For instance, a new exception was created to protect copayment reductions for outpatient hospital services.

Hospitals serve as hubs of health care services in a community. They recruit physicians from across the nation, draw in health professionals from surrounding communities, and increase the number of skilled health workers through increased demand. Hospitals are also better equipped to handle procedures that otherwise could not be performed at physician practices or stop-in clinics. By way of example, a Policy Brief from the University of Minnesota Rural Health Research Center, published in April 2017, reported that the loss of rural hospitals adversely impacted access to obstetric services in those communities. Access to health care could be largely attributed to whether there is a hospital in the community to provide the necessary services. The presence of hospitals has a disproportionately high impact on rural communities' access to health care.

However, since these new OIG regulatory revisions, the hospital industry has remained on the decline. Hospitals continue to be both shut down and sold. Rather, the health systems that have proven to be most profitable are straying away from hospital-based care. One of these profitable health systems, Ascension Health, has rebranded itself. It reports focusing on new modes of care, such as telemedicine, over traditional health system services to stay competitive. The OIG's regulatory revisions implemented in January 2017 may be too little, too late to save access to health care in rural and under-served areas through hospital-based services. Instead, many of these hospital-based services may be replaced sooner than we think by technological advancements. Although the regulatory revisions focused on increasing access to health care through hospital-based services, telemedicine may instead be the better solution to improved access to health care in these underserved communities.

Jocelyn E. Ezratty is an attorney at David Di Pietro & Associates, P.A. She grew up in New York and graduated from the University of Miami School of Law.

Hurricanes and the Future

By: Nicholas W. Romanello

The Health Law Section's 2017-2018 year is off to a whirlwind start … literally.

This summer, Harvey and his sister, Irma, wreaked havoc on the Caribbean Basin and Gulf States. Grateful for our own blessings, we continue to hold our friends, colleagues and clients in Texas and Puerto Rico in our thoughts and prayers as they recover and rebuild after a hurricane season we will be glad to put behind us. While the Health Law Section was forced to cancel its September meeting and delay some initiatives, we are pleased to now be getting back to business. The publication of this newsletter is only the beginning of what promises to be an active year for the Section.

Watching the destruction of Puerto Rico's infrastructure was eye opening. Roads, power plants and hospitals were degraded and now must be rebuilt. It got me thinking about the future of Puerto Rico and specifically what the future of healthcare could look like on the Island.

With a population of 3.4M people, Puerto Rico is slightly larger than Miami-Dade County. A quick internet search reveals that the Island has 69 hospitals (Miami-Dade County has 30). With Telsa installing solar powered batteries to restore electricity to some facilities, it will be months before we know Irma's full impact upon the Island's delivery system. So here is a question: how would you rebuild Puerto Rico's health care system?

With technology empowering consumers like never before – does Puerto Rico devote resources to rebuild 60 brick and mortar acute care hospitals or concentrate on ambulatory surgery centers and clinics? Faced with a physician shortage – does the Island re-establish residency programs or look to leverage mid-level providers to deliver care? Labs versus apps? Stethoscopes or smart phone? See where I am going? The opportunities are endless.

Eight years after the enactment of the Affordable Care Act, healthcare continues to be a red-hot political issue. Today we are but a tweet away from mass shifts in public health policy. We on the mainland no longer agree on what passes as facts or news – it's no wonder why we can't get our act together on healthcare.

Maybe all of the suffering my friends in Puerto Rico are enduring will result in some change – let's hope.

Nicholas W. Romanello *is the Senior Vice President, General Counsel for Health First which is Florida's only fully integrated delivery network (IDN). The interpretations of law and opinions contained in this note are personal to the author and not those of Health First, its Board of Trustees or executive management and staff. He can be reached at 321-434-4356 and Nicholas.Romanello@health-first.org.*