FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: HB 693	**COMPANION BILL:** None
TITLE: Health and Human Services	**LINKED BILLS:** HB 695 Redondo
SPONSOR(S): Redondo	**RELATED BILLS:** None

Committee References

Health Care Facilities & Systems
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Health & Human Services

SUMMARY

Effect of the Bill:
HB 693 addresses a host of federal requirements and policy priorities articulated in the federal "One Big Beautiful Bill Act" by codifying the federal requirements for the Medicaid program, Children's Health Insurance Program, and the Supplemental Nutrition Assistance Program.

The bill also adopts a broad set of health care policies. Specifically, the bill:

- Repeals the remaining Certificate of Need programs, which are for nursing homes, hospice services, and intermediate care facilities for the developmentally disabled.
- Joins the interstate licensure compacts for physician assistants and emergency medical service providers.
- Authorizes autonomous practice for all advanced practice registered nurse specialties.
- Eliminates the cap on the number of physicians assistants a physician can supervise.
- Authorizes dentists to delegate additional tasks to dental hygienists.
- Requires practitioners to inform patients when a referral is to an out-of-network provider and requires insurers to credit out-of-network costs to cost-sharing requirements, in certain circumstances.
- Requires insurers to credit patient payments for out-of-network providers toward their deductibles if certain conditions are met.

Fiscal or Economic Impact:
See Fiscal or Economic Impact.

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ANALYSIS

EFFECT OF THE BILL:

Supplemental Nutrition Assistance Program

Eligibility

HB 693 changes the eligibility criteria for the Supplemental Nutrition Assistance Program (SNAP) benefits to codify recent federal changes under the One Big Beautiful Bill Act (OBBBA). The bill establishes narrower immigration status requirements consistent with federal law under the OBBBA. (Section 16) Under the bill, SNAP eligibility is limited to:

- Citizens or nationals of the U.S.;
- Aliens lawfully admitted for permanent residence;
- Aliens who have been granted the status of Cuban or Haitian entrant;

- Individuals who lawfully reside in the U.S. in accordance with the Compacts of Free Association.

This change makes legally present asylees, refugees, parolees, and victims of human trafficking ineligible to receive SNAP benefits. The Department of Children and Families (DCF) has fully implemented these changes pursuant to federal law, which took effect July 4, 2025. This change results in approximately 10,000 fewer SNAP recipients.[1]

Work Requirements

HB 693 expands the population subject to mandatory SNAP Employment and Training (E&T) requirements, as required by the OBBBA. The bill:

- Increases the age for mandatory participation from age 59 to age 64; and
- Limits the exemption for adults in households which include minors to only those households with minors under age 14.

Mandatory participation in SNAP E&T still only applies to SNAP recipients who are able-bodied adults without dependents, or ABAWDs. DCF estimates that under these changes approximately 76,900 additional ABAWDs will be subject to mandatory SNAP E&T requirements.

The bill also expressly requires DCF to apply and comply with the exemptions from work requirements established by federal law. (Section 18) This will require DCF to comply with exemptions eliminated by the OBBBA, which includes exemptions for SNAP recipients who are homeless, veterans, and former foster youth age 24 and under. DCF estimates that by removing these exemptions 10,595 additional ABAWDs will be subject to work requirements.

These changes were required by federal law, effective July 4 2025, and DCF has already begun implementing them.

SNAP Payment Error Rates

HB 693 directs DCF to achieve a payment error rate below six percent by March 30, 2026, from its historically high rates averaging 12.1 percent over the last three years. (Section 17) Reducing the error rate to below six percent will avoid a new OBBBA federal penalty in the form of state matching funds. If Florida's most recent payment error rate (15.1 percent in 2024) were used to determine the penalty, the state would have to pay for 15 percent of the state's total of SNAP benefits, equaling nearly $1 billion annually. If, however, DCF is successful in reducing the payment error rate to below six percent, the state would not be required to contribute any match.

In addition, the bill directs DCF to modify its eligibility determination process to improve accuracy. The bill requires applicants, and recipients undergoing benefit redetermination, to provide documentation evidencing shelter and utility expenses, and prohibits DCF from relying solely on an individual's self-attestation of these expenses. DCF may adopt policies and procedures to accommodate an applicant or recipient who is temporarily unable to furnish adequate documentation of shelter or utility expenses due to recent residency changes. (Section 16)

The prohibition on self-attestation will result in fewer errors in benefit determinations, thereby reducing the state's payment error rate, as DCF attributes approximately two-thirds of its error rate to the practice of accepting expense attestations rather than requiring proof.

[1] *See*, Department of Children and Families, *2026 Agency Legislative Bill Analysis for HB 693*. On file with the Health Care Facilities & Finance Subcommittee.

Improvement Plan

In addition to the above changes to reduce the payment error rate, the bill requires DCF to submit a comprehensive food assistance payment accuracy improvement plan (improvement plan) to the Governor, the President of the Senate, and the Speaker of the House of Representatives by July 1, 2026. The improvement plan must address the root causes of payment errors, as identified by DCF through an in-depth, data-driven analysis. (Section 17) The improvement plan must include a plan for enhanced employee training incorporating standardized training at least annually for all economic self-sufficiency program staff. The training must review the most common reasons for payment errors, methods for preventing such errors, and utilize testing to measure staff proficiency.

DCF must also establish a quality assurance review process that frequently reviews a statistically significant sample of cases before final benefit determination. This process must incorporate real-time, corrective feedback and on-the-job training for program staff. This process may not delay benefit determinations for SNAP recipients. Finally, DCF must plan for improved data sourcing. DCF must maximize use of high-quality automated data sources to verify applicant and recipient income and expense information.

Progress Reports

Beginning October 1, 2026, the bill requires DCF to submit quarterly progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing:

- The most recent official and preliminary payment error rate;
- The most frequent and highest dollar value errors, categorized by DCF or recipient errors and whether the error resulted in over- or under-payment;
- Specific actions taken by DCF under the improvement plan during the preceding quarter and data related to those actions;
- Plans to correct the most recently identified deficiencies.

This bill automatically repeals the reporting requirement on October 1, 2028. (Section 17)

Florida's statutory policy on SNAP was an element scored by CMS for purposes of awarding grants under the Rural Health Transformation Program (RHT Program). Florida received maximum points for this because Florida law met the policy that was favored under CMS' scoring system, as published in the Notice of Funding Opportunity (NOFO).

Florida Medicaid and Kidcare

The bill implements the Medicaid and CHIP (Kidcare) related provision of the OBBBA that became law in July 2025. It makes Florida law consistent with applicable federal law that relates to Florida's Medicaid and Kidcare programs.

Eligible non-citizens

The bill establishes specific citizenship requirements consistent with federal law under the OBBBA. The bill narrows Medicaid and Kidcare eligibility for legal immigrants, making most non-citizens ineligible for coverage. The Agency for Health Care Administration (AHCA) estimates that approximately 12,975 individuals may have been affected by this portion of the OBBBA.[2] Medicaid and Kidcare eligibility is limited to:

[2] Agency for Health Care Administration, *2026 Agency Legislative Bill Analysis on HB 693*, on file with the Health Care Facilities & Systems Subcommittee.

- Citizens or nationals of the U.S.;
- Aliens lawfully admitted for permanent residence;
- Aliens who have been granted the status of Cuban or Haitian entrant;
- Individuals who lawfully reside in the U.S. in accordance with the Compacts of Free Association. (Sections 9, 10, and 12)

Medicaid Retroactive Coverage

The bill reduces the retroactive coverage period available to eligible pregnant women and children from 90 days to the two months prior to application. Retroactive Medicaid coverage will begin no earlier than the first day of the second month prior to the enrollee's application date for these participants. The beginning of coverage for other Medicaid participants is not affected. (Section 14)

Eligibility Monitoring

Medicaid and Kidcare – The bill ensures that only eligible individuals are able to participate in Medicaid and CHIP by directing AHCA to improve eligibility monitoring. AHCA must regularly obtain address information on participants from a reliable data source and act on changes that affect eligibility, primarily due a move out of state. (Sections 11 and 13)

The bill also requires AHCA to compare the identity of current Medicaid participants against a data file compiled by the Social Security Administration to identify deceased individuals who are still enrolled in Medicaid. (Section 13)

Medicaid Payments to Prohibited Entities

The bill codifies a federal spending ban on "prohibited entities" on an ongoing basis. For the federal fiscal year following the signing of the OBBBA, federal Medicaid matching funds are prohibited for certain abortion providers. The bill codifies that funding ban in Florida law, without limitation to the period established by the OBBBA. (Section 15)

The funding ban applies to any non-profit provider that:

- Is primarily engaged in family planning services, reproductive health, and related medical care,
- Provides abortions other than those allowed by the "Hyde Amendment" (that is, where the pregnancy is the result of an act of rape or incest or when necessary to save the life of the pregnant woman), and
- Received over $800,000 in federal and state funds, either directly or indirectly in Federal Fiscal Year 2023.

Certificate of Need

The bill eliminates Florida's Certificate of Need (CON) program. This eliminates the current requirement for health care facilities to obtain a certificate from the state documenting a need in the local market prior before constructing new facilities or offering new or expanded services. Florida's CON program only applies to nursing homes, hospices, and intermediate care facilities for the developmentally disabled (ICF/DDs); as a result of the bill, any person or entity wishing to build, replace, or add beds to one of these facilities need only obtain a license from AHCA, rather than obtain a license only if AHCA determines there is a need and competitively awards the entity a CON. All new and existing facilities will still be required to comply with the continued licensure requirements contained in existing law. (Section 2)

The bill includes conforming changes to amend or repeal all references to CON in Florida Statutes. (Sections 6 & 31)

Florida's statutory policy on CON was an element scored by CMS for purposes of awarding grants under the RHT Program. Florida did not receive maximum points for this because Florida law differs from the policy that was favored under CMS' scoring system, as published in the NOFO.

Physician Assistant Supervision

The bill removes the statutory cap on the number of physician assistants that a physician may supervise and authorizes a physician to supervise as many physician assistants as the physician can effectively supervise and communicate with within the circumstances of the specific practice setting. This allows physicians to supervise more than 10 physician assistants at one time, which is the limit in current law. (Sections 24 and 25)

Florida's statutory policy on physician assistant scope of practice and supervision was an element scored by CMS for purposes of awarding grants under the RHT Program. Florida did not receive maximum points for this because Florida law differs from the policy that was favored under CMS' scoring system, as published in the NOFO.

Interstate Licensure Compacts

The bill enacts the Emergency Medical Services Personnel Licensure Interstate Compact (EMS Compact) and the Physician Assistant Licensure Compact (PA Compact) and authorizes Florida to enter into both interstate compacts. (Sections 5 and 22)

The Emergency Medical Services Personnel Licensure Interstate Compact and the Physician Assistant Licensure Compact allows emergency medical technicians (EMTs), paramedics and physician assistants(PAs) in a compact member state to practice in any other compact member state without obtaining a separate license in each state. The EMS Compact allows practitioners to use their home state license in other states; under the PA Compact, the practitioner obtains a multi-state license.

Similarly, those practitioners in compact states will also be able to provide services remotely via telehealth to patients in other compact states. While Florida's open telehealth laws make it possible for practitioners licensed in other states to serve patients in Florida, this is less common in other states; only through a compact will Florida practitioners be able to serve patients in other states without a license specific to each state.

Florida's statutory policy on interstate compacts was an element scored by CMS for purposes of awarding grants under the RHT Program. Florida did not receive maximum points for this because Florida has not adopted these compacts, and is not a member state, which is policy that was favored under CMS' scoring system, as published in the NOFO.

Emergency Medical Services Personnel Licensure Interstate Compact

The Emergency Medical Services Personnel Licensure Interstate Compact (EMS Compact) grants an eligible EMT or paramedic who is licensed to practice emergency medical services in his or her "home state"[3] immediate "privilege to practice" in another state or remote state without obtaining an additional state license. The privilege to practice is the authorization granted by other compact member states to deliver emergency medical services, after an individual has obtained licensure in his or her home state.[4]

Under the EMS Compact, licensed EMTs and paramedics in Florida will have the privilege to practice in other compact member states or remote states, via telehealth and in person. Licensed EMTs and paramedics from remote states will also be able to practice in Florida via telehealth and in person.

[3] The home state is a compact member state in which an EMT or paramedic holds a current license to practice emergency medical services.
[4] The EMS Compact, *Facts & Benefits*, available at https://www.emscompact.gov/resources/benefits, (last visited November 12, 2025).

Home State Licensure Requirements

Under the Compact, a home state's license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

- Currently requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial licenses at the EMT and paramedic levels;
- Has a mechanism in place for receiving and investigating complaints about individuals;
- Notifies the Interstate Commission for EMS Personnel Practice (EMS Commission), in compliance with the terms of the compact, of any adverse action or significant investigatory information regarding an individual;
- No later than five years after activation of the Compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with US CFR §731.202 and submit documentation of such as adopted in the rules of the EMS Commission; and
- Complies with the EMS Commission rules.

Compact Privilege to Practice

To exercise the privilege to practice under the EMS Compact, an individual must:

- Be at least 18 years of age;
- Possess a current unrestricted license in a member state as an EMT, Advanced Emergency Medical Technician (AEMT), paramedic, or state recognized and licensed level with a scope of practice and authority between EMT and paramedic; and
- Practice under the supervision of a medical director.[5]

An individual providing emergency medical services in a remote state under the compact's privilege to practice is subject to the remote state's authority and laws. However, the individual may only practice in the remote state within the scope of practice authorized by the home state unless the authorization is modified by the appropriate authority in the remote state. A remote state may, in accordance with due process and the laws of the state, restrict, suspend, or revoke an individual's privilege to practice in the remote state and take any other actions to protect the health and safety of its citizens. If such actions are taken, the remote state must promptly notify the home state and the EMS Compact Commission.

If an individual's license to practice in a home state is restricted or suspended, the individual is prohibited from practicing in a remote state under the privilege to practice until the individual's home state license is restored. Likewise, if an individual's privilege to practice in any remote state is restricted, suspended, or revoked the individual may not practice in any remote state until the privilege to practice is restored.

Conditions of Practice in a Remote State

Under the EMS Compact, an individual may practice in a remote state under the privilege to practice only in the performance of the individual's EMS duties as assigned by an appropriate authority, as defined by EMS Commission rules, and under the following circumstances:

- The individual originates a patient transport in a home state and transports the patient to a remote state;

[5] Under current law, each basic life support or advanced life support ambulance service must employ or contract with a medical director to supervise and assume direct responsibility for the medical performance of the EMTs and paramedics providing emergency medical services for the ambulance service. S. 401.265, F.S.

- The individual originates in the home state and enters a remote state to pick up a patient and provide care and transport of the patient to the home state;
- The individual enters a remote state to provide patient care and/or transport within that remote state;
- The individual enters a remote state to pick up a patient and provide care and transport to a third member state; and
- As determined by the Commission's rules.

Coordinated Database

The EMS Compact requires member states to submit licensure information for all licensed EMTs and paramedics practicing under the EMS Compact to a coordinated database, including:

- Identifying information;
- Licensure data;
- Significant investigatory information;
- An indicator that an individual's privilege to practice is restricted, suspended or revoked;
- Non-confidential information related to alternative program participation;
- Any denial of application for licensure, and the reason(s) for such denial; and
- Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

The data system enables information sharing on licensure status, investigative and disciplinary information between member states.[6] Investigative information pertaining to a licensee in any member state will only be available to other member states. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state. (Section 5)

The bill requires the Department of Health (DOH) to report any investigative information relating to a license EMT or paramedic practicing under the EMS Compact to the coordinated database. (Section 20)

Interstate Commission for EMS Personnel Practice

The EMS Compact establishes the Interstate Commission for EMS Personnel Practice (EMS Commission) as the governing body and entity responsible for creating and enforcing the rules and regulations that administer and govern the Compact. The EMS Commission is composed of representatives from each compact member state. The licensing authority of each member state must select one delegate to serve on the Commission. The Compact requires the Commission to establish and elect an executive committee, which shall have the power to act on behalf of the EMS Commission.

Under the Compact, all commission and executive committee meetings must be open to the public unless confidential or privileged information is discussed. (Section 5)

The bill requires DOH to appoint a delegate to serve on the EMS Commission. The department is the licensing authority in Florida responsible for regulating the practice of emergency medical services.[7] The bill also authorizes DOH to take adverse action against a licensed EMT or paramedic's authority to practice under the EMS Compact and to impose disciplinary actions for violation of prohibited acts. (Sections 3 and 4)

Physician Assistant Licensure Compact

Under the Physician Assistant Licensure Compact (PA Compact), eligible individuals licensed as a physician assistant in Florida will be will be able to apply for a "compact privilege" to provide medical services to out-of-state

[6] The EMS Compact, *Facts & Benefits*, available at https://www.emscompact.gov/resources/benefits, (last visited November 14, 2025).
[7] S. 401.27, F.S.

patients in any "participating state"[8] or compact member state through telehealth and in person.[9] Licensed PAs in other participating states will also be able to apply for a compact privilege to provide services to patients in Florida via telehealth and in person.

Compact privilege is the authorization granted by a participating state to allow a licensee from another participating state to practice as a PA to provide medical services and other licensed activity to a patient located in the remote state under the remote state's laws and regulations. Under the PA Compact, a remote state is the compact member state where the licensee is seeking to exercise compact privilege. (Section 22)

Compact Privilege to Practice

To exercise compact privilege, a licensee must:

- Have graduated from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc. or other programs authorized by the Commission;
- Hold current National Commission on Certification of Physician Assistants (NCCPA) certification.
- Have no felony or misdemeanor convictions;
- Have never had a controlled substance license, permit, or registration suspended or revoked by the United States Drug Enforcement Administration;
- Have a unique identifier as determined by the Physician Assistant Licensure Compact Commission (PA Commission);
- Hold a qualifying license.
- Have no limitation or restriction on any state license or compact privilege due to an adverse action in the previous two years;
- Notify the PA Commission of their intent to seek a compact privilege in a remote state;
- Meet any jurisprudence requirements in the remote state in which the licensee is seeking to practice under the compact privilege; and
- Report to the PA Commission any adverse action taken by a non-member state within 30 days after the action is taken.

To maintain a compact privilege, the PA must continue to meet the requirements under the PA Compact. A compact privilege is valid until the expiration or revocation of the PA's license. If a participating state takes adverse action against a PA's license, the licensee shall lose compact privilege in all remote states until all of the following occur:

- The license is no longer restricted; and
- Two years have elapsed from the date on which the license is no longer limited or restricted due to the adverse action.

State Participation in the PA Compact

To participate in the PA Compact a state must:

- License PAs;
- Participate in the PA Commission's data system;
- Have a mechanism in place for receiving and investigating complaints against licensees and license applicants;
- Notify the PA Commission of any adverse action against or significant investigation information of a licensee or license applicant;

[8] A "participating state" is a state that has enacted the compact.
[9] The PA Compact defines "medical services" as health care services provided by diagnosis, prevention, treatment, cure, or relief of a health condition, injury, or disease, as defined by the state's law and regulation.

- Implement and utilize procedures for considering the criminal history records of licensees and reporting to the PA Commission whether the license applicant has been granted a license;
- Comply with the rules of the PA Commission;
- Utilize passage of a recognized national exam such as the Physician Assistant National Certifying Examination (NCCPA PANCE) as a requirement for PA licensure; and
- Grant a compact privilege to a holder of a qualifying license in another state participating in the PA Compact.

Designation of the State from Which Licensee is Applying for a Compact Privilege

Under the PA Compact, eligible PAs with a qualifying license in a participating state may apply for a compact privilege to practice in another compact member state. When applying for a compact privilege in a participating state, the licensee must identify to the PA Commission the participating state for which the licensees is applying for a compact privilege and:

- Provide the PA Commission with the address of the licensee's primary residence and thereafter shall immediately report to the Commission any change in the address of the licensee's primary residence; and
- Consent to accept service of process by mail at the licensee's primary residence on file with the PA Commission with respect to any action brought against the licensee by the Commission or a participating state, including a subpoena, with respect to any action brought or investigation conducted by the PA Commission or a participating state.

A licensee who does not hold a license in any participating state shall not be eligible to participate in the PA Compact.

Coordinated Data System

The PA Compact requires participating states to submit licensure information for all PAs practicing under the Compact to a coordinated database, including:

- Identifying information;
- Licensure data;
- Adverse actions against a license or compact privilege;
- Any denial of application for licensure, and the reason for such denial;
- The existence of significant investigative information; and
- Other information that may facilitate the administration of the PA Compact, as determined by the PA Compact Commission rules.

Significant investigative information pertaining to a licensee in any participating state shall only be available to other participating states. A participating state may designate information that may not be shared with the public without the express permission of the contributing state.

The bill requires DOH to report any investigative information relating to a license PA practicing under the PA Compact to the data system. (Section 20)

Physician Assistant Licensure Compact Commission

The PA Compact establishes the Physician Assistant Licensure Compact Commission (PA Commission) as the governing body and entity responsible for creating and enforcing the rules and regulations that administer and govern the PA Compact. The PA Commission is composed of representatives from each participating state. The licensing board of each participating state must select one delegate to serve on the PA Commission. The Compact

requires the PA Commission to establish and elect an executive committee, which shall have the power to act on behalf of the Commission.

Under the PA Compact, all PA Commission and executive committee meetings must be open to the public unless confidential or privileged information is discussed. (Section 22)

The bill requires the Board of Medicine and the Board of Osteopathic Medicine to jointly appoint a delegate to serve on the PA Commission. The bill also authorizes the Board of Medicine and the Board of Osteopathic Medicine to take adverse action against a licensed PA's privilege to practice under the PA Compact and to impose disciplinary actions for violation of prohibited acts. (Section 23)

Interstate Licensure Compacts: Impaired Practitioner Program

Under current law, a practitioner participating in an impaired practitioner program may not provide medical services.[10] The bill requires EMTs and paramedics to withdraw from practice under the PA Compact if he or she is in an impaired practitioner program. The bill also requires a PA to withdraw from practice under the PA Compact if he or she participates in an impaired practitioner program. (Section 21)

Interstate Licensure Compacts: Sovereign Immunity

The EMS Compact and PA Compact do not waive sovereign immunity by the member states or by the EMS Commission or the PA Commission. The bill authorizes certain individuals, when acting within the official scope of their employment, duties, and responsibilities with the EMS Commission or the PA Commission, as agents of the state for sovereign immunity purposes and requires the EMS Commission and PA Commission to pay any claims or judgements up to the statutorily waived amounts of sovereign immunity. The bill also authorizes the EMS Commission and the PA Commission to maintain insurance coverage to pay any such claims or judgements. (Section 32)

The bill delegates the EMS Commission and the PA Commission the authority to adopt rules to facilitate and coordinate the implementation and administration of the EMS Compact and PA Compact, respectively. The EMS and PA Compacts both specify that the rules of each Compact, have the force and effect of law and are binding in all compact member states. If a compact member state fails to meet its obligations under the EMS Compact or the PA Compact or the promulgated rules of these Compacts, the state may be subject to remedial training, alternative dispute resolution, suspension, termination, or legal action. (Sections 5 and 22)

Advanced Practice Registered Nurses

The bill authorizes advanced practice registered nurses (APRNs), who meet certain eligibility criteria, to practice autonomously in all specialties without an established physician protocol. This removes the current restriction that autonomous APRNs licensed as certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses can only practice autonomously in primary care services. The bill will eliminate the cost of supervision for autonomous APRNs which may increase access to care and reduce health care costs. (Section 26)

Florida's statutory policy on APRN scope of practice and supervision was an element scored by CMS for purposes of awarding grants under the RHT Program. Florida did not receive maximum points for this because Florida law differs from the policy that was favored under CMS' scoring system, as published in the NOFO.

Dental Hygienists

[10] Rule 64B31-10.001(1)(a), F.A.C.

The bill authorizes dentists to delegate additional tasks to dental hygienists including dental hygiene diagnosis and treatment planning, and prescribing, administering, and dispensing fluoride, fluoride varnish, and antimicrobial solutions. This eliminates the current prohibition against dentists delegating the writing of a prescription drug order and determining a diagnosis for treatment or treatment planning. A dental hygienist will only be able to perform the tasks if the dental hygienist meets any education and training requirements set by the Board of Dentistry and if a dentist delegates the tasks. A dentist is not required to delegate the tasks. The bill will increase the number of licensed professionals available to perform certain dental hygiene services which may increase access to dental hygiene. (Sections 27 & 28)

Florida's statutory policy on dental hygienist scope of practice and supervision was an element scored by CMS for purposes of awarding grants under the RHT Program. Florida did not receive maximum points for this because Florida law differs from the policy that was favored under CMS' scoring system, as published in the NOFO.

Out-of-Network Providers

The bill requires health care practitioners to notify patients in writing when referring them to out-of-network providers that the providers are out-of-network and that using such providers may result in higher out-of-pocket patient costs. This applies to all practitioners governed by ch. 456, F.S.[11] This will inform patients of the potential financial consequences of treatment by out-of-network providers. (Section 19)

The bill requires all health insurers and multiple-employer welfare arrangements[12] to apply patient payments for covered services by nonpreferred providers to the patient's deductible and out-of-pocket maximum under the policy. This applies only to non-emergency services[13] covered under the policy, and only if the cost of the out-of-network treatment is the same as or less than the insurer's average payments for that service or the statewide average on the Florida Health Price Finder website. This would eliminate the additional cost-sharing for the use of non-preferred providers that some insurers use to encourage the use of preferred providers. (Section 30)

The bill provides an effective date of July 1, 2026. (Section 48)

RULEMAKING:

Dental Hygienists

The bill directs the Board of Dentistry to establish education and training requirements that a dental hygienist must complete before prescribing, administering, or dispensing fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing, and other non-systemic antimicrobial agents.

Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.

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[11] Chapter 456 applies to professionals licensed under the following laws: s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; and ch. 491. These provisions apply to these occupations: behavioral analyst, nurse, acupuncturist, pharmacist, allopathic physician, dentist, osteopathic physician, dental hygienist, chiropractor, midwife, podiatrist, speech therapist, occupational therapist, medical physicist, radiology technician, emergency medical technician, electrologist, paramedic, orthotist, massage therapist, pedorthist, optician, prosthetist, hearing aid specialist, clinical laboratory personnel, dietician/nutritionist, respiratory therapist, athletic trainer, psychologist, clinical social worker, psychotherapist, marriage and family therapist, optometrist, mental health counselor, and genetic counselor.

[12] Multiple-employer welfare arrangements, or MEWAs, are employee benefit arrangements established to offer health insurance benefits to the employees of two or more employers. *See,* S. 624.437, F.S.

[13] Under the insurance code, nonemergency services are services other than those for medical conditions that manifest by acute symptoms of sufficient severity such that that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health of a pregnant woman or fetus, serious impairment of bodily functions, serious dysfunction of a bodily organ or part. *See,* ss. 627.62194, F.S., 641.74, F.S.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

Emergency Medical Responders Compact & Physician Assistants Compact

The Department of Health (DOH) will experience a recurring increase in workload associated with the implementation and enforcement of both the emergency medical responders (EMS) and physician assistants (PA) compacts. However, it is anticipated that existing resources are adequate to absorb the additional cost associated with the increased workload.

DOH will also experience a recurring and non-recurring increase in workload associated with additional systems supporting functions, including the Licensing and Enforcement Information System Database (LEIDS) and with developing and supporting data integrations, data sharing, and data exchange services as required by the compacts. DOH may request additional resources to implement the EMS and PA compact either through the Legislative Budget Request process or through the Legislative Budget Commission.

Advanced Practice Registered Nurses

DOH will experience an increase in workload associated with processing initial and recuring applications for autonomous advanced practice registered nurses. DOH is requesting 4 additional FTEs to process the applications.[14]

PRIVATE SECTOR:

Certificate of Need

Nursing homes, hospices, and ICF/DDs will experience a significant, positive fiscal impact resulting from the elimination of CON fees, which range from $10,000 to $50,000, should such facilities seek to establish new facilities or beds. The facilities will also avoid the costs of litigating the award of, or failure to award, a CON by AHCA.

By removing the CON review program, established providers are likely to realize increased competition for patients.

Advanced Practice Registered Nurses

APRNs who are registered for autonomous practice will achieve cost-savings since supervision will no longer be required. Consumers may experience greater access to specialty nursing care.

Dental Hygienists

Dental Hygienists must pay for additional education and training required by the Board of Dentistry (if any) to qualify to provide the additional services authorized by the bill, but may be able to earn more for providing these services. Supervising dentists may be able to serve more patients by expanding the functions they delegate to hygienists under the bill, thereby expanding access to services in the market.

Out-of-Network Providers

The bill's practitioner notice requirement may have a workload impact on practitioners to provide notices or look up insurer provider networks to identify an out-of-network referral. It may have a positive economic impact on insurers if the practitioner notice requirement results in greater fidelity to in-network referrals.

[14] Department of Health, *Agency Legislative Bill Analysis on HB 693*, on file with the Health Professions and Programs Subcommittee.

The bill's non-preferred provider provision may have a negative impact on insurers for the administrative costs of including out-of-network patient expenditures in deductible and out-of-pocket maximums. To the extent the bill results in a greater patient utilization of non-preferred providers, it may have a negative impact on insurers related revenue/expenditure assumptions insurers might make with regard to preferred provider service utilization volume; or may have a positive impact if the non-preferred providers cost less for the insurers.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Federal One Big Beautiful Bill Act of 2025

In July 2025, the U.S. Congress passed a budget reconciliation act known as the "One Big Beautiful Bill" (the OBBBA).[15] The bill contained numerous policy changes, including many significant changes to federal health and human services programs administered in partnership with states.

The OBBBA changed eligibility for Medicaid and supplemental nutrition assistance (SNAP) programs related to immigration status, limited Medicaid retroactive coverage, limited exemptions from work requirements in SNAP, and required states to make improvements in the accuracy of initial eligibility determinations and ongoing status confirmation. The OBBBA established penalties for state eligibility and payment errors in SNAP, and shifted some SNAP operational costs to the states. The OBBBA also restricted the use of federal Medicaid funding for certain types of providers.

Some of the OBBBA's provisions apply only to states which expanded Medicaid under the Affordable Care Act, so these do not apply to Florida. Others apply to all states participating in Medicaid and SNAP. These provisions will have the overall effect of reducing federal Medicaid and SNAP expenditures.

Rural Health Transformation Program

In addition to changing existing programs, the OBBBA established a new Rural Health Transformation Program (RHT Program) intended to improve access to health care, improve service quality and health outcomes, and enhance health care industry economic opportunity.[16] Through this program, the federal Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) will award grants to states to fund initiatives that will serve these purposes. The OBBBA appropriated $10 billion per year for the next five federal fiscal years (2026-2030), a total of $50 billion, to fund the state grants.

Grants to states will be awarded in two tranches. Half of the $50 billion ($25 billion) will be divided equally among states who apply. Since all 50 states applied, each state will receive at least $500 million ($100 million per federal fiscal year for five years). The second half of the appropriation is awarded based on competitive grant applications from states, which CMS scores in three areas:

- **State rural character:** Includes state metrics like percent of the population living in a rural area, proportion of rural health facilities in the state relative to the nation, level of disproportionate share hospital funding, etc.
- **State rural initiatives:** Includes the state's proposals (in its application) for ways to use the funds to improve rural clinical infrastructure, such as EMS services, community-based care, value-based Medicaid payment models, workforce recruitment/retention efforts, consumer-facing AI technology use, etc.

[15] Public Law No. 119-21, H.R. 1 An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, 119th Congress (2025-2026), July 3, 2025. The OBBBA was signed into law July 4, 2025.
[16] P.L. 119-21 s. 71401; 42 U.S.C. 1397ee(h) (2025).

- **State policy action status:** The extent to which the state's regulatory environment promotes access to care, including metrics on specific areas of practitioner scope of practice, practitioner supervision, telehealth, certificate-of-need, licensure compacts, etc.

CMS published a Notice of Funding Opportunity (NOFO) in September, with significant guidance for states developing their applications.[17] In particular, the NOFO specified the state regulatory issues CMS would score. The issues included, for example:

- Certificate of Need (CON) – the extent to which states had repealed (higher score) or maintained (lower score) CON
- Interstate Licensure Compacts – whether states are members of various practitioner licensure compacts to improve interstate mobility
- Nurse Practitioner Autonomy – whether states have authorized unsupervised practice for advanced practice nurses
- Scope of Practice – whether states have maximized scope of practice for physician assistants, dental hygienists, pharmacists, etc.

The NOFO included state-by-state scores on each item based on third-party analyses of each issue. For example, the Certificate-of Need score was set in an analysis done by the Cicero Institute.[18] Similarly, the score for dental hygienist scope of practice was found in an analysis done by the Oral Health Workforce Research Center.[19] While this category only accounts for one-third of the competitive score, Florida did not score well compared to other states.

Under the OBBBA, state applications for RHT Program funding were due November 5, 2025, and the OBBBA grants were awarded December 29, 2025. The Agency for Health Care Administration submitted Florida's proposal timely, proposing a series of initiatives, including funding rural and satellite clinics, mobile health services, community paramedicine, value-based purchasing programs, health and lifestyle programs, diagnostic technology support, onboarding assistance for onboarding facilities to the agency's Health Information Exchange and Emergency Notification Service, and telehealth-based virtual care initiatives for psychiatric care, specialty clinics, ICU monitoring, stroke services, pharmacy services and remote patient monitoring. AHCA also proposed funding additional outreach and access assistance for rural residents eligible for both Medicaid and Medicare.[20]

CMS awarded Florida a competitive grant of nearly $210 million ($209,938,195) over five years,[21] in addition to the $500 million spread equally among states without a competitive process. Under the OBBBA, AHCA must achieve the goals laid out in its grant application, or the CMS can rescind the funding.

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP) is the nation's food and nutrition program for low-income Americans; the program provides nutritional assistance to millions of individuals and families each year through

[17] Notice of Funding Opportunity CMS-RHT-26-001, September 15, 2025, available at https://grants.gov/search-results-detail/360442 (last visited Jan. 15, 2026).
[18] A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Need Laws in All 50 States, Cicero Institute, Dec. 2024, available at https://ciceroinstitute.org/wp-content/uploads/2024/12/50-State-CON-Rankings-Report-12-5-2024.pdf (last visited Jan. 16, 2026).
[19] Variation in Dental Hygiene Scope of Practice by State, Oral Health Workforce Research Center, Nov. 2024, available at https://oralhealthworkforce.org/wp-content/uploads/2024/11/Dental-Hygiene-SOP-by-State-Infographic-Nov-2024.pdf (last visited Jan. 16, 2026).
[20] Agency for Health Care Administration, Application for Federal Assistance, Funding Opportunity Number: CMS-RHT-26-001, Nov. 3, 2025, available at https://ahca.myflorida.com/content/download/27598/file/11032025_Grant%20Submission.pdf (last visited Jan. 16, 2026).
[21] "CMS Announces $50 Billion in Awards to Strengthen Rural Health in All 50 States", CMS, Dec. 29, 2025, available at https://www.cms.gov/newsroom/press-releases/cms-announces-50-billion-awards-strengthen-rural-health-all-50-states (last visited Jan. 16, 2026).

monthly benefits that can be used to purchase eligible food items[22] at authorized retailors via electronic benefit transfer (EBT).[23] The Food and Nutrition Service (FNS), under the U.S. Department of Agriculture (USDA), administers the SNAP at the federal level.[24] SNAP benefits reduce the effects of poverty and increase food security for families while supporting economic activity across communities, as SNAP directly benefits farmers, retailers, food processors and distributors, and their employees.[25]

As a federal program, federal regulations define eligibility requirements, benefit levels, and administrative processes which are, generally, nationally uniform.[26] At the state-level, SNAP is administered by the Department of Children and Families (DCF).[27] DCF is responsible for the day-to-day operations of the program and determines eligibility, calculates benefits, issues benefits to participants, and monitors compliance with work requirements.[28]

SNAP funding can be broadly categorized as either administrative or benefits expenses. Administrative costs are those a state uses to implement and administer the program, whereas benefit costs are strictly the allotment distributed to SNAP recipients. Until recently, the state and federal governments shared the administrative costs of the program equally, while the federal government funded 100 percent of the benefit amount distributed to recipients.[29] The OBBBA shifts the responsibility for SNAP funding such that beginning in Federal Fiscal Year 2027, states will be responsible for 75 percent of administrative costs and the federal share will decrease to 25 percent.[30]

In Federal Fiscal Year (FFY) 2024,[31] SNAP provided assistance to approximately 41.7 million people across the U.S. each month.[32] In Florida, there were 2,680,794 individuals, including 1,042,627 children, in 1,518,330 different households receiving SNAP benefits in November 2025.[33]

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[22] Benefits cannot be spent on tobacco, alcohol, or nonfood items. With limited exceptions, benefits cannot be used on foods sold hot. *See*, USDA, Economic Research Service, *Supplemental Nutrition Assistance Program (SNAP).* Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap (last visited December 16, 2025).

[23] U.S. Department of Agriculture, Economic Research Service. *Supplemental Nutrition Assistance Program (SNAP) Overview*. Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/ (last visited December 16, 2025).

[24] The Food Stamp Program (FSP) originated in 1939 as a pilot program for certain individuals to buy stamps equal to their normal food expenditures: for every $1 of orange stamps purchased, people received 50 cents worth of blue stamps, which could be used to buy surplus food. The FSP expanded nationwide in 1974. Under the federal welfare reform legislation of 1996, Congress enacted major changes to the FSP, including limiting eligibility for certain adults who did not meet work requirements. The Food and Nutrition Act of 2008 renamed the FSP the Supplemental Nutrition Assistance Program (SNAP) and implemented priorities to strengthen program integrity; simplify program administration; maintain states' flexibility in how they administer their programs; and improve access to SNAP. *See,* U.S. Department of Agriculture, Food and Nutrition Service. *Short History of SNAP*. Available at https://www.fns.usda.gov/snap/short-history-snap (last visited December 16, 2025).

[25] U.S. Department of Agriculture, Economic Research Service. *Supplemental Nutrition Assistance Program (SNAP) Economic Linkages.* Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/economic-linkages/ (last visited December 30, 2025).

[26] USDA, Economic Research Service, *Supplemental Nutrition Assistance Program (SNAP).* Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap (last visited December 16, 2025).

[27] S. 414.31, F.S.

[28] USDA, Economic Research Service, *Supplemental Nutrition Assistance Program (SNAP).* Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap (last visited December 16, 2025).

[29] Center on Budget and Policy Priorities. *Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)*. Available at https://www.cbpp.org/research/food-assistance/the-supplemental-nutrition-assistance-program-snap. (last visited December 16, 2025).

[30] H.R., 119th Congress (2025), Section 10106. According to DCF, this will cost the state, approximately an additional $50.6M in General Revenue each year. *See*, Presentation by Chad Barrett, Department of Children & Families Assistant Secretary for Administration, *Supplemental Nutrition Assistance Program and State Share of Administrative Cost,* on December 2, 2025 to the Health Care Budget Subcommittee. Available at https://www.flhouse.gov/Sections/Documents/loaddoc.aspx?MeetingId=14944&PublicationType=Committees&DocumentType=Meeting%20Packets (last visited December 30, 2025).

[31] October 1, 2023 – September 30, 2024.

[32] Jones, J. W., Todd, J. E., & Toossi, S. (2025). The food and nutrition assistance landscape: Fiscal year 2024 annual report (Report No. EIB-291). U.S. Department of Agriculture, Economic Research Service. https://doi.org/10.32747/2025.9227996.ers

[33] Email from Chancer Teel, Legislative Affairs Director, Department of Children and Families. Re: Information Request. Received December 17, 2025.

The OBBBA of 2025 contained several provisions affecting SNAP. The changes that directly affect state-level administration of SNAP relate to immigration status, work requirements, and payment error rates.

SNAP Eligibility

SNAP is available to all households that meet the program's income and asset criteria, subject to certain work and immigration status requirements. To be eligible for SNAP, households must meet the following basic criteria: (1) gross monthly income must be at or below 130 percent of the poverty level; (2) net income must be equal to or less than the poverty level; and (3) assets must be below the limits set based on household composition.[34] Individuals may be deemed ineligible for SNAP for any of the following:[35]

- Conviction for drug trafficking;
- Fleeing a felony warrant;
- Breaking SNAP or TANF[36] program rules;
- Failure to cooperate with the child support enforcement agency; or
- Being a noncitizen without qualified status.

SNAP eligibility is limited to U.S. citizens, and the following categories of non-citizens:

- Lawful permanent residents;[37]
- Cuban and Haitian entrants;[38] and
- Compact of Free Association (COFA) citizens of Marshall Islands, Micronesia and Palau.

Prior to the enactment of OBBBA,[39] SNAP benefits were also available to the following legally present, non-citizen, immigrants:[40]

- Asylees (1,810 individuals);
- Refugees (7,689 individuals);
- Parolees (160 individuals); and
- Victims of Trafficking (94 individuals).

The OBBBA modified non-citizen eligibility for SNAP benefits such that lawful permanent residents, Cuban and Haitian Entrants, or Compacts of Free Association citizens are the only individuals with non-citizen statuses who may receive SNAP benefits.[41] This eliminated eligibility for asylees, refugees, parolees and victims of human trafficking.

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[34] U.S. Department of Agriculture, *Indicators of Diet Quality, Nutrition, and Health for Americans by Program Participation Status, 2011-2016: SNAP Report. Final Report* (2021). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/Indicators-Diet-QualitySNAP.pdf (last visited December 16, 2025).

[35] Florida Department of Children and Families, *SNAP Eligibility.* Available at https://www.myflfamilies.com/services/public-assistance/supplemental-nutrition-assistance-program-snap/snap-eligibility (last visited December 16, 2025). *See also*, s. 414.32, F.S.

[36] The Temporary Assistance for Needy Families (TANF) program is a federal block grant that funds state-level benefits and services for low-income families. TANF funds Florida's Temporary Cash Assistance (TCA) program which provides direct cash assistance to families who meet specific technical, income, and asset requirements. DCF administers TCA in Florida. *See*, ss. 414.045-414.295, F.S.

[37] As defined in the Immigration and Nationality Act; *see*, U.S. Department of Homeland Security, Office of Homeland Security Statistics, *Lawful Permanent Residents* (2025). Available at https://ohss.dhs.gov/topics/immigration/lawful-permanent-residents (last visited January 23, 2026).

[38] As defined in the Refugee Education Assistance Act of 1980; *See*, U.S. Department of Homeland Security, U.S. Citizenship and Immigration Services, *Information for SAVE Users: Cuban-Haitian Entrants* (2024). Available at https://www.uscis.gov/save/resources/information-for-save-users-cuban-haitian-entrants (last visited January 23, 2026).

[39] H.R., 119th Congress (2025), Section 10108.

[40] Estimated populations as of August 2025. *See*, Department of Children and Families, *2026 Agency Legislative Bill Analysis for HB 693*. On file with the Health Care Facilities & Finance Subcommittee.

[41] H.R., 119th Congress (2025), Section 10108.

SNAP Work Requirements

Able-bodied, non-elderly adults are generally required to participate in work activities in order to be eligible for SNAP. Federal policy outlines two tiers of work requirements for SNAP recipients: the general work requirement and the Able-Bodied Adult Without Dependents (ABAWD) work requirement.

The general work requirement applies to all recipients between 16 and 54[42] years of age, unless they qualify for an exemption.[43] The general work requirements include requiring a recipient to register for work, participating in SNAP Employment and Training (E&T) or workfare if assigned, taking a suitable job if offered, and not voluntarily quitting a job or reducing work hours below 30 hours per week without a good reason.[44]

The ABAWD work requirement applies to adults between age 18 and 64, who are able-bodied, and without dependents. This population may only receive SNAP benefits for 3 months out of a 36-month period, unless the participant works or participates in a qualifying workforce program for at least 80 hours per month. All ABAWDs are subject to this additional work requirement and time limit, unless otherwise exempt.[45] Until recently, ABAWD work requirements applied to adults ages 18-54.[46]

The OBBBA expanded the age range subject to the ABAWD work requirements and eliminated several exceptions resulting in an increase in the number of SNAP recipients that the ABAWD requirements apply to.

The OBBBA expanded the population subject to the ABAWD requirements in the following ways:[47]

- Expanded the age range to 18-64 (55,137 individuals).
- Limited the exception for parents and caregivers from those with dependents under age 18 to under age 14 (33,464 individuals).
- Eliminated exceptions for:
    - Veterans (875 individuals).
    - Individuals age 24 or under who aged out of foster care (475 individuals).
    - Homeless individuals (91,266 individuals).[48]

SNAP Benefit Allotment

After DCF determines that a household is eligible to enroll in SNAP, DCF will next calculate the household's monthly benefit allotment. The calculation accounts for the size of the household, the maximum benefit for the

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[42] Federal law previously imposed work requirements for this group up to age 54; thereafter, Florida law raised the age to 59. [7 U.S.C s. 2015.; s. 414.455, F.S. On July 4, 2025, H.R., 119th Congress (2025), Section 10102 was signed into law, changing the age limit from 54 to 64.
[43] A person may be excused from the general work requirement if he or she is already working at least 30 hours per week, meeting the work requirements for another program, taking care of a child under 6 or an incapacitated person, unable to work due to a physical or mental limitation, participating regularly in an alcohol or drug treatment program, or studying in school or a training program at least half-time. *See*, U.S. Department of Agriculture, Food and Nutrition Service. *SNAP Work Requirements*. Available at https://www.fns.usda.gov/snap/work-requirements (last visited December 16, 2025).
[44] U.S. Department of Agriculture, Food and Nutrition Service. *SNAP Work Requirements*. Available at https://www.fns.usda.gov/snap/work-requirements (last visited December 16, 2025).
[45] *Id*. *See also*, U.S. Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program (SNAP) ABAWD Policy Guide* (2023). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-ABAWD-Policy-Guide-September-2023.pdf (last visited December 30, 2025). Adults who are unable to work due to a physical or mental limitation, are pregnant, have someone under 14 in their SNAP household, are excused from the general work requirement, or are eligible for Indian Health Services are exempt from the ABAWD requirements.
[46] Federal law previously imposed work requirements for this group up to age 54; thereafter, Florida law raised the age to 59. [7 U.S.C s. 2015.; s. 414.455, F.S. On July 4, 2025, H.R., 119th Congress (2025), Section 10102 was signed into law, changing the age limit from 54 to 64.
[47] H.R. 1, 119th Congress (2025), Section 10102. *See also*, Congressional Research Service, Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits – updated September 29, 2025. Available at https://www.everycrsreport.com/files/2025-09-29_R42505_97291714b6b908467cf5d2713f53153111f423cb.pdf (last visited December 30, 2025). The OBBBA also created a new exception for individuals who are Indian, Urban Indian, and California Indians
[48] *Supra*, note 40.

fiscal year, and the household's net income; benefits increase with household size and decrease with household income.

The maximum monthly benefit allotment is tied to the cost of purchasing a nutritionally adequate, low-cost diet, as measured by the USDA-developed Thrifty Food Plan (TFP). The TFP is a minimal cost food plan which reflects current nutrition standards and guidance, the nutrient content and cost of food, and consumption patterns of low-income households to serve as the basis for the determination of SNAP benefits.[49] The maximum allotments are set at the monthly cost of the TFP for a four-person family consisting of a couple between ages 20 and 50 and two school-age children, adjusted for family size, and rounded down to the nearest whole dollar.[50]

The formula used to determine SNAP benefits assumes that a household will spend 30 percent of their net income on food purchases. A household's monthly benefit amount is the difference between the maximum allotment for their household size under the Thrifty Food Plan and 30 percent of their net income.[51] The structure of this formula ensures that the lowest income households receive the most benefits.

SNAP Payment Error Rates

The payment error rate (PER) is a performance measure calculated by the USDA and used to gauge the accuracy of a state's benefit determination process. In calculating the PER, the USDA validates a subsample of cases which have been reviewed by DCF for benefit determination accuracy as part of DCF's quality control process. The quality control process involves DCF re-determining the household's benefit amount at the time of the review and comparing it against the original benefit determination. These benefit determinations occur at different points in time and do not account for potential changes in the household's circumstances. Any difference in the benefit amount is considered a payment error and negatively affects the state's PER, regardless of the accuracy of the benefit amount calculated at the time of the original determination.[52]

Each month DCF reviews a sample of eligibility and benefit amount determinations for accuracy. The USDA reviews a subsample of cases for validation and publishes the individual state PER every June.[53] Payment errors are largely unintentional and may be the result of errors by either DCF or the SNAP applicant.[54] Payment errors as a result of intentional fraud on the behalf of the recipient are rare.[55] Payment errors include both underpayments, when a household receives less benefits than they are entitled to receive, and overpayments, when a household receives more benefits than they are entitled to. States are required to correct errors once identified either by reimbursing underpayments or recouping overpayments so that each household gets exactly what they are eligible to receive.

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[49] U.S. Department of Agriculture, Food and Nutrition Service. *Nutrition Assistance Program Report: Barriers That Constrain the Adequacy of Supplemental Nutrition Assistance Program Allotments: Survey Findings* (2021). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-Barriers-SurveyFindings.pdf (last visited December 15, 2025).

[50] Congressional Research Service, Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits. Available at https://www.everycrsreport.com/files/2025-09-29_R42505_97291714b6b908467cf5d2713f53153111f423cb.pdf (last visited December 15, 2025).

[51] U.S. Department of Agriculture, Food and Nutrition Service. *Nutrition Assistance Program Report: Barriers That Constrain the Adequacy of Supplemental Nutrition Assistance Program Allotments: Survey Findings* (2021). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/SNAP-Barriers-SurveyFindings.pdf (last visited December 15, 2025).

[52] *Supra*, note 40

[53] U.S. Department of Agriculture, Food and Nutrition Service, *SNAP Quality Control*. Available at https://www.fns.usda.gov/snap/qc (last visited December 15, 2025).

[54] *Supra*, note 7.

[55] In 2023, approximately 5,000 cases of recipient eligibility fraud were referred for prosecution in Florida – roughly 0.001% of the state's SNAP recipients. Individuals suspected of intentional benefit fraud are subject to investigation which can result in civil, criminal, or administrative legal action where sufficient evidence exists. *See*, U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program – State Activity Report, FY 2023* (2025). Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-sar-fy23.pdf (last visited January 23, 2026). For more information on errors and fraud in SNAP, see, Congressional Research Service, Supplemental Nutrition Assistance Program: Errors and Fraud (2025). Available at https://www.congress.gov/crs-product/IF10860 (last visited January 23, 2026).

Florida's PER has risen every year since 2014, when it was 0.42 percent.[56] The table below shows Florida's PER from 2017-2024.[57] Note that the USDA was unable to establish PERs in 2020 and 2021 due to the suspension of reporting requirements at the height of the COVID-19 public health emergency.[58]

Florida Payment Error Rates	
August 2025 Estimate[59]	13.3%
2024	15.1%
2023	12.6%
2022	8.59%
2021	No Data Available
2020	No Data Available
2019	5.33%
2018	4.39%
2017	6.42%

According to DCF, approximately five points of the 15.1 percent error rate are attributable to administrative problems within the department, including simple mistakes like typographical errors and transposition, staff turnover and training problems, missing information available in the system but not easily viewable, and the nature of the older information system used for this program. DCF plans to make significant improvements in this area.[60]

DCF attributes approximately 9 points of the 15.1 percent error rate to having incorrect information on applicants' household composition and living expenses, such as wages and income, shelter and utility expenses, which DCF uses to determine eligibility and calculate the benefit. This is largely the result of DCF reliance on individual attestations of expenses, instead of interviews, and a lack of agency verification of self-reported information. While SNAP applicants are generally required to participate in an interview during the benefit determination and recertification processes, DCF waived this requirement for significant stretches of the last several years. Federal flexibilities permitted during the COVID-19 Public Health Emergency and following Hurricane Ian allowed the required interviews to be waived. DCF relied solely on attestations in lieu of interviews for the periods of April 1, 2020 through October 1, 2020; November 25, 2020 through June 30, 2021; October 1, 2022 through January 31, 2023; and March 1, 2023 through February 29, 2024.[61]

In 2025, DCF ceased relying solely on individual attestations and now requires evidence of expenses such as an applicant's lease and utility bills. Additionally, DCF has reinstituted standard case reviews, in which a supervisor reviews a determination with the responsible employee, has set performance expectations for staff and is actively tracking performance,[62] and has used data from the quality review process to make statewide training adjustments.[63]

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[56] U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program: Payment Error Rates, FY 2014*. Available at https://fns-prod.azureedge.us/sites/default/files/resource-files/2014-rates.pdf (last visited December 30, 2025).
[57] USDA, Food and Nutrition Service, *SNAP Payment Error Rates – Payment Error Rates by Fiscal Year*. Available at https://www.fns.usda.gov/snap/qc/per (last visited December 16, 2025).
[58] See, USDA, Food and Nutrition Service, *SNAP Quality Control Error Rate Announcements for FY 2020-2021*. Available at https://www.fns.usda.gov/snap/qc-error-rate-announcements-fy-2020-2021 (last visited December 16, 2025).
[59] *Supra*, note 40.
[60] Human Services Subcommittee staff meeting with DCF staff re: OBBBA SNAP policy, August 7, 2025.
[61] *Id*. Email from Christopher Klaban, Deputy Legislative Affairs Director, Department of Children and Families. Re: HR 1/SNAP Follow-Up. Received August 27, 2025.
[62] *Id*.
[63] *Supra*, note 40.

The OBBBA attempted to rein in the significant increase in state payment error rates caused by the federal flexibilities granted to states during the public health emergency. The OBBBA imposes fiscal penalties on states with high payment error rates. Beginning in Federal Fiscal Year 2028, states with payment error rates greater than six percent will be responsible for up to 15 percent of the state's total SNAP benefits, on a sliding scale indicated by the table below.[64]

State Share of Cost by Error Rate	
Payment Error Rate	**State Share of Benefit Cost**
0 - 5.99%	0%
6 - 7.99%	5%
8 - 9.99%	10%
10% or greater	15%

Under the OBBBA, states can choose the 2025 PER or the 2026 for the USDA to count when determining the penalty. A PER above 13.33 percent will delay the implementation of the penalty by one year, thus giving the state more time to improve before penalties go into effect. If Florida has a lower error rate, but still higher than six percent, the penalty would be lower, but would not be delayed. The table below indicates the applicable penalty in Florida based on the sliding scale.

Sliding Scale Penalties and Florida Share of Benefits Cost			
Error Rate	**State Share Percentage**	**Florida Share of Costs** (based on 2024 benefits costs - $6,604,797,000)	**Impact Year** (2025 benchmark)
0 - 5.99%	0%	$0	2028
6 - 7.99%	5%	$330,240,000	2028
8 - 9.99%	10%	$660,480,000	2028
10 – 13.33%	15%	$990,720,000	2028
13.34% or more	15%	N/A (delayed implementation)	2029

To avoid any penalty, DCF must rapidly improve its error rate from 15.1 percent (from 2024) to under six percent.

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid Program, licensing and regulating health facilities, and providing health care quality and price information to Floridians.[65] The Department of Children and Families is the primary agency for making Medicaid eligibility determinations.[66]

[64] H.R. 1, 119th Congress (2025), Section 10105.
[65] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration*, https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Jan. 3, 2026).
[66] S. 409.963, F.S. The Social Security Administration determinations for Supplemental Security Income recipients are used for Medicaid eligibility, too.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[67] The federal government also sets the minimum mandatory benefits to be covered in every state's Medicaid program.[68]

For November 2025, Florida Medicaid recorded a monthly enrollment total of 3,997,975 people, with 72.5 percent enrolled in managed care plans, 27.3 percent enrolled in fee-for-service plans, and 0.1 percent enrolled in the Program of All-Inclusive Care for the Elderly (PACE).[69, 70]

Medicaid Eligibility

Medicaid eligibility in Florida is determined either by DCF or the Social Security Administration for Supplemental Security Income recipients. Since Medicaid is designed for low-income individuals, Medicaid eligibility is based on an evaluation of the individual's income and assets.

Eligible non-citizens

Medicaid eligibility is limited to United States citizens and non-citizens who are admitted to the United States as:

- an individual refugee or who is granted asylum,
- one whose deportation is withheld, who is paroled into the country for more than a year, or granted conditional entry,
- a Cuban or Haitian entrant, or
- a noncitizen who has been admitted as a permanent resident.

Eligible non-citizens also include an individual who, or an individual whose child or parent, has been battered or subject to extreme cruelty in the United States by a spouse, a parent, or other household member, and has applied for or received protection under the federal Violence Against Women Act, if certain criteria are met.[71]

Retroactive Eligibility

Federal law authorized states to make Medicaid enrollment retroactive for pregnant women and children; that is, these programs will pay for medical expenses incurred prior to the date they applied for coverage.
Florida law makes eligibility retroactive for 90 days for pregnant women and children. Otherwise, a Medicaid participant's coverage begins with the first day of the month that their application is submitted.

Eligibility Monitoring

AHCA is required to maintain an online system that includes the ability to prevent eligibility fraud.[72] AHCA and DCF are also responsible for a process for participants and nursing homes and hospitals to timely update a participant's address upon admission to such facilities.[73] Otherwise, there is no specific state statutory requirement for regular monitoring of changes in eligibility, aside from annual eligibility redeterminations.[74]

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[67] Title 42 U.S.C. §§ 1396-1396w -5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725).
[68] S. 409.905, F.S. Florida Medicaid Managed Care sets a minimum benefit package that build on top of the federal minimum benefits package. S. 409.973, F.S.
[69] The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. Medicaid, PACE, https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE (last visited Jan. 3, 2026).
[70] Florida Agency for Health Care Administration, Current Comprehensive Medicaid Managed Care Enrollment Reports, (Nov. 2025) https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited Jan. 3, 2026). Select the "Medicaid" tab on the lower toolbar of the Excel Spreadsheet.
[71] Ss. 409.902 and 414.095(3), F.S.
[72] S. 409.902(4)(c), F.S.
[73] S. 409.90201, F.S.
[74] Department of Children and Families, *Florida's Medicaid Redetermination Plan*, https://www.myflfamilies.com/medicaid, and https://www.myflfamilies.com/document/26241, (last visited Jan. 3, 2026).

Florida Kidcare Program

The Florida Kidcare Program (Kidcare or Program) was created by the Florida Legislature in 1998 in response to the passage of the Children's Health Insurance Program (CHIP) in 1997.[75] The CHIP provides federal funding to states to provide subsidized health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements.[76]

Kidcare encompasses four programs.

1. Medicaid for children
2. The Medikids program
3. The Children's Medical Services Network (for children with special needs)
4. The Florida Healthy Kids program

Kidcare is governed by part II of ch. 409, F.S., and is administered jointly by AHCA, DCF, the Department of Health (DOH), and the Florida Healthy Kids Corporation (Corporation) established in ch. 624, F.S. The chart below delineates the roles of each agency and the Corporation.

State Agency	Responsibilities

Agency for Health Care Administration (AHCA) (MediKids and Children's Medical Services)	• Administers the:
	  ○ Medicaid program (Title XIX)
	  ○ MediKids program (Title XXI, ages 1-4)
	  ○ Children's Medical Services (Titles XIX and XXI, ages 0-18 with special health care needs)Serves as lead Title XXI contact with the federal Centers for Medicare and Medicaid Services
	• Distributes federal funds for Title XXI programs
	• Manages the Florida Healthy Kids Corporation contract
	• Develops and maintains the Title XXI Florida Kidcare State Plan

Department of Children and Families (DCF) (Medicaid for Children)	• Determines Medicaid (Title XIX) eligibility • Administers the CMS Behavioral Health Network (Title XXI, ages 0-18)
Florida Healthy Kids Corporation (Healthy Kids)	• Performs administrative functions for Florida Kidcare (eligibility determination, premium collection, marketing, and customer service) • Administers Florida Healthy Kids program (Title XXI, ages 5-18)

Eligible non-citizens

Alien children are not eligible for CHIP, unless the child is domiciled in Florida and lawfully present in the United States, meets Medicaid or CHIP residency requirements, and may be eligible for medical assistance with federal financial participation as provided under s. 214 of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, and related federal regulations.[77]

[75] CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, Pub. L. No. 105.33, s. 4901).
[76] When created, CHIP was initially authorized and allotted funding for 10 years. However, due the program's capped funding structure, the federal government has had to repeatedly reauthorize and extend funding. Most recently, the 2023 Consolidated Appropriations Act extended federal funding for CHIP through fiscal year 2029. Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, s. 5111.
[77] Centers for Medicare and Medicaid Services, Medicaid.gov, *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women* https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-of-lawfully-residing-children-pregnant-women#:~:text=The%20Children's%20Health%20Insurance%20Program,Islands%20(CNMI)*** (last visited Jan. 3, 2026).

Certificate of Need

State Certificate of Need (CON) laws require a determination of market need and competitive approval by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost.

State CON programs were originally a federal requirement. The federal National Health Planning and Resources Development Act of 1974 ("the Act"), required each state to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs such as Medicaid. The Act established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[78] At the time the Act was enacted, federal Medicare and Medicaid programs compensated providers (hospitals in particular) for their actual expenses, known as "cost-plus reimbursement". Because providers were reimbursed for whatever amount providing the service cost, regardless of efficiency, Congress was concerned that this incentivized unchecked spending by providers, and determined that the solution was to limit the number of providers and scope of services they could provide in the entire market, not just the Medicaid and Medicare market. Today, Medicaid and Medicare reimburse providers on a fee-for-service basis or at a daily rate: the use of a set fee schedule, regardless of a provider's actual expenses, eliminates the original problem CON laws were intended to address.[79]

The Act was repealed in 1986, based on a lack of clear evidence of effectiveness[80], but many states continued their CON programs.

CON and Cost Restraint

CON programs were designed to restrain health care costs and provide for directed, measured planning for new services and facilities.[81] Such programs were originally established to regulate the addition of new facilities, or new beds in hospitals and nursing homes, and to prevent overbuying of expensive equipment, under the economic theory that excess capacity directly results in health care price inflation.[82] When a hospital or health care service provider cannot meet its obligations, fixed costs must be met through higher charges for the beds that are used or for the number of patients using the service.[83] Larger institutions have higher costs, so CON supporters believe government should limit facilities to building only enough capacity to meet actual needs.[84]

In addition to cost containment, CON regulation is intended to create a *quid pro quo* in which profitability of covered medical services is increased by restricting competition and, in return, medical providers cross-subsidize specified amounts of indigent care, or medical services to the poor that are unprofitable to the provider.[85] Some states require facilities and providers that obtain a CON to provide a certain amount of indigent care to underinsured or uninsured patients.[86]

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[78] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.
[79] *See*, Grace Bogart, Iowans Need Change: The Case for Repeal of Iowa's Certificate of Need Law, 45 J. Corp. L. 221, 232 (2019); Clark C. Havighurst, Regulation of Health Facilities and Services by "Certificate of Need", 59 Va. L. Rev. 1143, 1157 (1973) (calling cost-plus reimbursement "[b]y far the most important factor[] occasioning entry and construction controls.").
[80] https://nashp.org/should-we-re-invent-state-health-planning-and-certificate-of-need-programs/ (last viewed December 22, 2025).
[81] National Conference of State Legislators, *CON-Certificate of Need State Laws,* available at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last viewed October December 13, 2025).
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] Thomas Stratmann and Jacob Russ, *Do Certificate-of-Need Laws Increase Indigent Care?* Mercatus Center at George Mason University, July 2014, pg. 2, available at: https://www.mercatus.org/system/files/Stratmann-Certificate-Need.pdf (last viewed December 13, 2025).
[86] For example, see Delaware (Del. Code Ann. tit. 16 § 9303), Georgia (es sps spe), Rhode Island (R.I. Code R. §6.2.4(B)), and Virginia (12 Va. Admin. Code §5-230-40 and §5-220-270).

Studies have found that CON programs do not meet the goal of limiting costs in health care and are anti-competitive.[87] A 2004 literature review on hospital CON by the Federal Trade Commission (FTC) and the Department of Justice concluded that:

> [O]n balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. [. . . .] Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.[88]

A 2018 FTC review of research on the impact of CON repeal found that repealing or narrowing CON laws can reduce the per-patient cost[89] of health care and improve the quality of certain types of care.[90]

Studies are split on whether CON regulation has improved access to care for the underinsured and uninsured. While there is limited research on the subject, some studies have found that access to care for the underserved populations has increased in states with CON programs,[91] while another has found little, if any, evidence to support

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[87] Most formal analyses of CON impacts focus on hospitals.

[88] *Improving Health Care: A Dose of Competition: A Report by the Federal Trade Commission and the Department of Justice*, July 2004, pg. 22, available at: https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice (last viewed December 13, 2025): "[t]here is near universal agreement among the authors [of studies on the economic effects of CON programs] and other health economists that CON has been unsuccessful in containing health care costs"); Daniel Sherman, Federal Trade Comm'n, *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis* (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, *Competition Among Hospitals 82*(1987) (empirical study concluding that CON regulation led to higher prices and expenditures).

[89] *Statement of the Federal Trade Commission to the Alaska Senate Committee on Labor & Commerce on Certificate-of-Need Laws and SB 62*, February 6, 2018, at pp. 4 and 8, n. 15, available at https://www.ftc.gov/system/files/documents/advocacy_documents/statement-federal-trade-commission-alaska-senate-committee-labor-commerce-certificate-need-laws/p859900_ftc_testimony_before_alaska_senate_re_con_laws.pdf (last viewed December 13, 2025). See, e.g., Vivian Ho and Meei-Hsiang Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 Medical Care Research & Review 185, 202 (2012) (finding an association between the lifting of CON laws and a reduction in mean patient costs for coronary artery bypass graft surgery, and finding that these cost savings slightly exceed the fixed costs of new entrants); Patrick A. Rivers et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 Journal of Health Care Finance 1, 11 (2010) (finding a positive relationship between the stringency of CON laws and health care costs per adjusted admission and concluding that the "results, as well as those of several previous studies, indicate that [CON] programs do not only fail to contain [hospital costs], but may actually increase costs as well" (emphasis in original)). While other studies evaluate the impact of repealing CON laws (with varying results), many of these studies are less persuasive because they do not account for preexisting cost differences between the states. Compare Michael D. Rosko and Ryan L. Mutter, *The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation*, 71 Medical Care Research & Review 1, 15 (2014) (finding "a plausible association between CON regulation and greater hospital cost-efficiency"), with Gerald Granderson, *The Impacts of Hospital Alliance Membership, Alliance Size, and Repealing Certificate of Need Regulation on Cost Efficiency of Non-profit Hospitals*, 32 Managerial and Decision Economics 159, 167-68 (2011) ("[R]epealing state CON programs contributed to an improvement in hospital cost efficiency.").

[90] Id at pp. 5 and 8, n. 17; See Suhui Li and Avi Dor, *How Do Hospitals Respond to Market Entry? Evidence from a Deregulated Market for Cardiac Revascularization*, 24 Health Economics. 990, 1006 (2015) (finding that repeal of Pennsylvania's CON program improved "the match between underlying medical risk and treatment intensity"); Ho and Ku-Goto, *Supra*, note 89, at 199 (finding association between lifting of CON laws and shorter lengths of stay and fewer strokes during admission for coronary artery bypass patients, finding no significant association between lifting CON laws and three other complications during admission for coronary artery bypass graft patients, and finding no significant associations between lifting of CON laws and length of stay or need for coronary artery bypass graft surgery for percutaneous coronary intervention patients); David M. Cutler et al., *Input Constraints and the Efficiency of Entry: Lesson from Cardiac Surgery 2:1,* American Economic Journal: Economic Policy 51, 52 (2010) (finding that new entry after repeal of Pennsylvania's CON program "had a salutary effect on the market for cardiac surgery by directing more volume to better doctors and increasing access to treatment"). Additional empirical evidence suggests that, "[a]t least for some procedures, hospital concentration reduces quality." Martin Gaynor & Robert Town, *Impact of Hospital Consolidation- Update, Robert Wood Johnson Foundation: The Synthesis Project*; see also Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare* (Fed. Trade Comm'n Bureau of Econ., Working Paper No. 307, 2010), https://www.ftc.gov/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston (last visited December 13, 2025).

[91] Tracy Yee, Lucy B. Stark, et al, *Health Care Certificate-of-Need Laws: Policy or Politics?*, Research Brief, National Institute for Health Care Reform, No. 4, May 2011, pg. 6, available at: http://nihcr.org/wp-content/uploads/2015/03/NIHCR_Research_Brief_No._4.pdf (last viewed

such a conclusion.[92] A study of New Jersey's hospital CON requirements found that they actually contributed to historical disparities in the access to cardiac angiography services between white and African American patients.[93] The study also found that reform to New Jersey's CON laws, which led to an increase in new providers, contributed to reducing the disparity by creating competition for incumbent providers.[94] According to another study, states with hospital CON programs have 13 percent fewer hospital beds per 100,000 persons than states without hospital CON programs.[95]

Studies specific to the efficacy of CON requirements for nursing homes and hospices are limited. The studies specific to nursing homes found that states with CON laws:

- Experience faster growth of Medicare and Medicaid spending.[96]
- Do not have fewer health complaints in the nursing home industry.[97]
- Tend to produce significantly lower health survey scores.[98]

The studies specific to hospices found that:

- States with CON laws may have a modest, but beneficial impact on hospice quality outcomes.[99]
- States without CON laws are associated with greater geographic access to hospice care.[100]

In Florida, the Statewide Medicaid Managed Care (SMMC) program requires all managed care plans to comply with provider network standards that ensure access to care for beneficiaries and imposes significant penalties if access to care is impeded within the program. The accountability standards within the SMMC program apply regardless of whether Florida has a CON program.

Florida's CON Program

Overview

Florida's CON program has existed since July 1973. Until 1986, program specifics were largely dictated by the federal National Health Planning and Resources Development Act of 1974, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[101].

In Florida, a CON is a written statement issued by AHCA evidencing local market need for a new, converted, expanded, or otherwise significantly modified health care facility or health service.

December 13, 2025) (citing Elana C. Fric-Shamji and Mohammed F. Shamji, *Impact of U.S. Government Regulation on Access to Elective Surgical Care*, Clinical & Investigative Medicine, vol. 31, no. 5 (October 2008) and Ellen S. Campbell and Gary M. Fournier, *Certificate-of-Need Deregulation and Indigent Hospital Care*, Journal of Health Politics, Policy and Law, vol. 18, no. 4 (Winter 1993)).

[92] Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, Journal of Health Politics, Policy and Law, vol. 23, no. 3, pg. 478 (June 1998).

[93] Derek DeLia, Joel C. Cantor, Amy Tiedemann, and Cecilia S. Huang (2009), *Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey*, Journal of Health Politics, Policy, and Law Vol. 34, No. 1, pp. 63-91, available at http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.825.9156&rep=rep1&type=pdf (last viewed December 13, 2025).

[94] *Id* at p. 84.

[95] *Supra*, note 92.

[96] Rahman M, Galarraga O, Zinn JS, Grabowski DC, Mor V. *The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures*. Med Care Res Rev (February 2016), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC4916841/ (last visited December 15, 2025).

[97] Fayissa B, Alsaif S, Mansour F, Leonce TE, Mixon FG Jr. *Certificate-Of-Need Regulation and Healthcare Service Quality: Evidence from the Nursing Home Industry*. Healthcare (Basel) (October 23 , 2020), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7711714/ (last visited December 15, 2025).

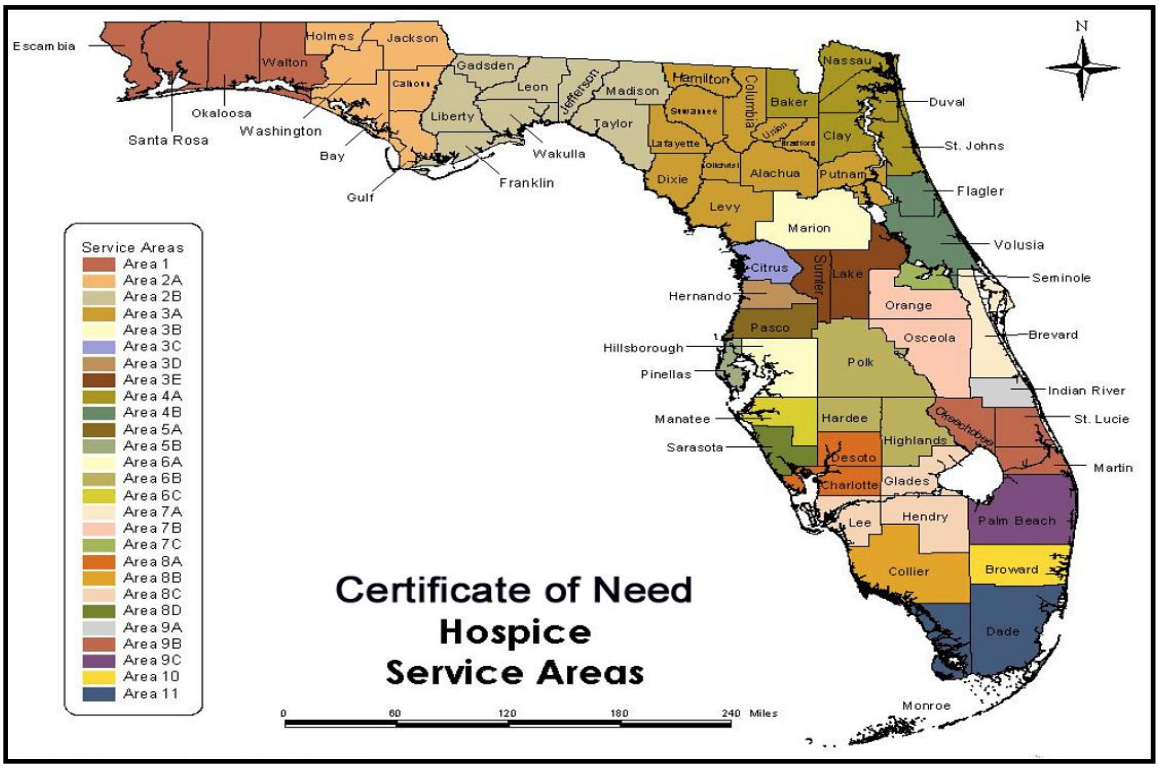
[98] *Id*.

[99] Gaines AG, Cagle JG. *Associations Between Certificate of Need Policies and Hospice Quality Outcomes*, Journal of Palliative Care (May 2024), available at https://pubmed.ncbi.nlm.nih.gov/37256687/ (last visited December 15, 2025).

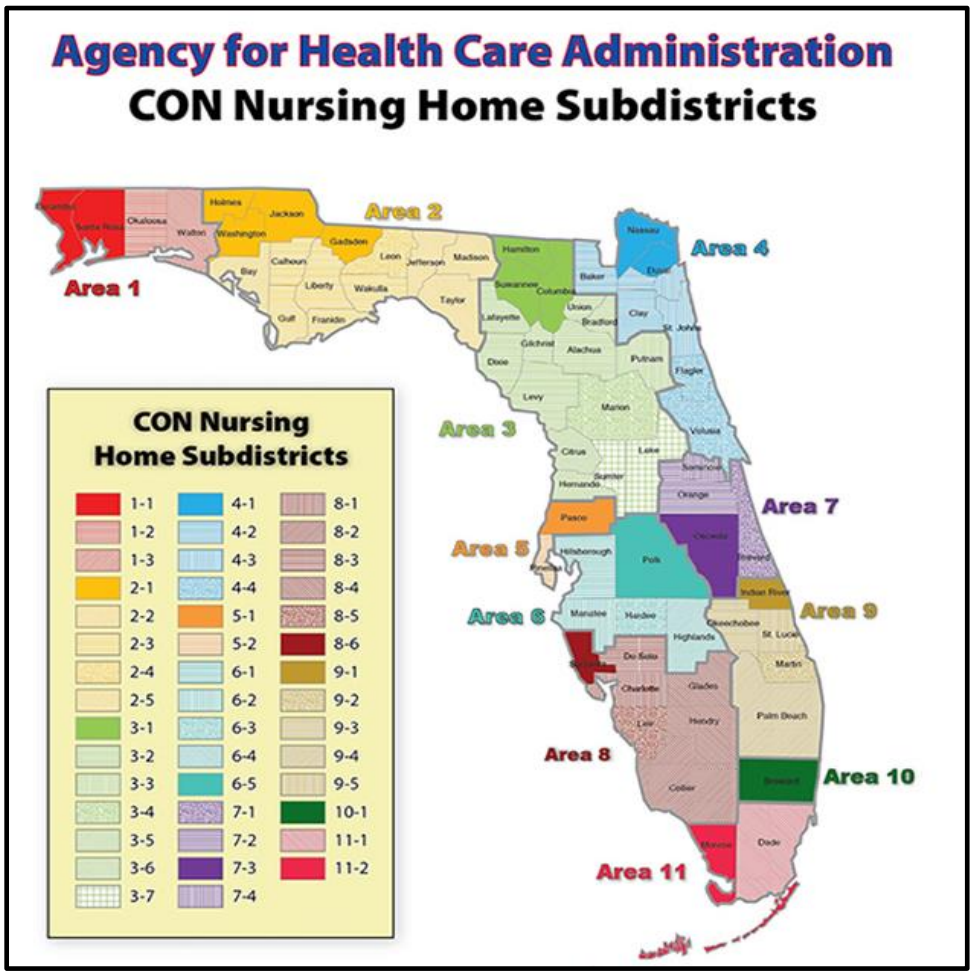
[100] Carlson MD, Bradley EH, Du Q, Morrison RS. *Geographic access to hospice in the United States*, Journal of Palliative Care (November 2010), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC3000898/ (last visited December 15, 2025).

[101] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.

CON determinations are based on a calculation that there is additional need for services and projects, or will be in the future. AHCA conducts this calculation by geographic area. For hospices, the geographic areas are known as "hospice service areas", and, for nursing homes, they are known as "nursing home subdistricts". The hospice service areas and the nursing home subdistricts are illustrated below.[102]



[102] Florida Agency for Health Care Administration, *Service Area Maps*, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/certificate-of-need-con-program-overview/service-area-maps (last visited December 15, 2025).



CON Determination of Need and Application and Review Process

The future need for services and projects is known as the "fixed need pool",[103] which AHCA publishes for each CON batching cycle. A batching cycle is a means of grouping, for comparative review, CON applications submitted for beds, services or programs having a like CON need methodology, or licensing category in the same planning horizon and the same applicable district or subdistrict.[104] The CON review process for new or expanded hospices, nursing homes, and ICF/DDs consists of four batching cycles each year, including two batching cycles each year for each facility type. Chapter 59C-1, F.A.C., provides complex need formulas to calculate the fixed need pool for certain

[103] Rule 59C-1.002(16), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.
[104] Rule 59C-1.002(4), F.A.C.

services, including the addition of nursing home beds,[105] the establishment of new hospice programs, and the construction of inpatient hospice facilities.[106]

Upon determining that a need exists, AHCA publishes the fixed need pool identifying the number of new beds and facilities needed for the applicable planning horizon. Upon publication of the fixed need pool, an applicant must file a letter of intent with AHCA prior to submitting a complete application. A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[107] Applications for CON review must be submitted by the specified deadline for the particular batch cycle[108], and must include a fee. The base filing fee is $10,000.[109] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed $50,000.[110]

AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[111] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[112]

Upon receiving a batch of applications, AHCA conducts a comparative review. The program has three levels of review: full, expedited, and exempt.[113] Projects required to undergo full comparative review include:

- New construction of a nursing home, hospice or ICF/DD;
- Adding beds in community nursing homes or ICF/DDs;
- Converting one type of health care facility to another;[114]

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[105] Rule 59C-1.036, F.A.C., provides the need formula to determine the net need in a subdistrict for nursing home beds as follows:

1. A = (POPA × BA) + (POPB × BB) where: A is the projected age-adjusted total number of nursing facility beds to be licensed under chapter 400, F.S., at the planning horizon for the district in which the subdistrict is located. POPA is the projected population age 65-74 years in the district. POPB is the projected population age 75 years and older in the district.

BA is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 65-74 years in the district. BB is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 75 years and over in the district.

2. BA = LB / (POPC + (6 × POPD)) where: LB is the number of nursing facility beds licensed under Chapter 400, F.S., in the District as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31. POPC is the current population age 65-74 years in the district. POPD is the current population age 75 years and over in the district.

3. BB = 6 × BA 4. SA = A × (LBD/LB) × (OR/.92) where: SA is the subdistrict allocation of community nursing facility beds to be licensed under Chapter 400, F.S., at the planning horizon. LBD is the number of nursing facility beds licensed under Chapter 400, F.S., in the subdistrict as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31. Or is the average 6 month occupancy rate for nursing facility beds licensed in the subdistrict under Chapter 400, F.S. For fixed bed need pools published between January 1 and June 30, occupancy rates shall be based upon patient days in nursing facilities licensed under Chapter 400, F.S., for the 6 month period from July 1 through December 31 of the previous year; for fixed bed need pools published between July 1 and December 31, occupancy rates shall be based upon patient days in nursing facilities licensed under Chapter 400, F.S., for the 6 month period from January 1 through June 30 of the year the fixed bed need pool is published. .92 equals the desired average 6 month occupancy rate for nursing facility beds licensed under Chapter 400, F.S., in the subdistrict.

5. The net bed need allocation for a subdistrict at the planning horizon is determined by subtracting the total number of licensed and approved beds for facilities licensed under Chapter 400, F.S., in the subdistrict from the bed allocation determined under subparagraphs (c)1. through (c)4. unless, as defined in subparagraph (c)4. is less than 85% percent, in which case the net bed need allocation is zero. The number of licensed beds that is subtracted from the bed need allocation shall be the number licensed under Chapter 400, F.S., as of the most recent published deadline for Agency initial decisions prior to publication of the Fixed Bed Need Pool. The number of approved beds that is subtracted shall be the number for which the Agency has issued a Certificate of Need, a letter stating the Agency's intent to issue a Certificate of Need, a signed stipulated agreement, or a final order granting a Certificate of Need, as of the most recent published deadline for Agency initial decisions prior to publication of the Fixed Bed Need Pool.

[106] Rule 59C-1.0355(4)(a), F.A.C. provides the need formula for establishing new hospice programs and building new hospice inpatient facilities.

[107] S. 408.039(2)(c), F.S.

[108] Rule 59C-1.008(1)(g), F.A.C.

[109] S. 408.038, F.S.

[110] *Id.*

[111] S. 408.039(3)(a), F.S.

[112] *Id.*

[113] S. 408.036, F.S.

[114] S. 408.036(1), F.S.

Certain projects, mostly nursing home projects, are eligible for expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include:

- Transfer of a CON;
- Replacement of a nursing home within the same district;
- Replacement of a nursing home if the proposed site is within a 30-mile radius of the existing nursing home;
- Relocation of a portion of a nursing home's beds to another facility or to establish a new facility in the same district, or a contiguous district, if the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the state does not increase; and
- Construction of a new community nursing home in a retirement community under certain conditions.[115]

Section 408.036(3), F.S., provides exemptions to CON review for certain projects, many involving hospitals. A request for a CON exemption must be accompanied by a $250 fee.[116] Exemptions include:

- Adding hospice services or swing beds[117] in a rural hospital, the total of which does not exceed one-half of its licensed beds.
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, so long as the conversion of the beds does not involve the construction of new facilities.
- Adding nursing home beds at a skilled nursing facility that is part of a retirement community offering a variety of residential settings and services.
- Building an inmate health care facility by or for the exclusive use of the Department of Corrections.
- Adding nursing home beds in a number not exceeding 30 total beds or 25 percent of the number of beds licensed in the facility being replaced in certain circumstances.
- State veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs.
- Combining within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.
- Dividing into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict.
- Adding nursing home beds licensed in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater; or, for adding nursing home beds licensed at a facility that has been designated as a Gold Seal nursing home in a number not exceeding 20 total beds or 10 percent of the number of licensed beds in the facility being expanded, whichever is greater.
- Replacing a licensed nursing home on the same site, or within 5 miles of the same site if within the same subdistrict, if the number of licensed beds does not increase, except in certain circumstances.
- Consolidating or combining of licensed nursing homes or transfer of beds between licensed nursing homes within the same planning district, by nursing homes with any shared controlled interest within that planning district, if there is no increase in the planning district total number of nursing home beds and the site of the relocation is not more than 30 miles from the original location.
- Adding beds in state developmental disability centers providing for the care, habilitation, and rehabilitation of clients with developmental disabilities.
- Establishing a health care facility or project that meets all of the following criteria:
    - The applicant was previously licensed within the past 21 days as a health care facility or provider that is subject to CON;
    - The applicant failed to submit a renewal application and the license expired on or after January 1, 2015;

[115] S. 408.036(2), F.S.
[116] S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.
[117] S. 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

- The applicant does not have a license denial or revocation action pending with the agency at the time of the request;
- The applicant's request is for the same service type, district, service area, and site for which the applicant was previously licensed;
- The applicant's request, if applicable, includes the same number and type of beds as were previously licensed;
- The applicant agrees to the same conditions previously imposed on the CON or on an exemption related to the applicant's previously licensed health care facility or project; and
- The applicant applies for initial licensure as required under s. 408.806 within 21 days after the agency approves the exemption request. If the applicant fails to apply in a timely manner, the exemption expires on the 22nd day following the agency's approval of the exemption.

The following chart illustrates the volume of CON applications received and the number of applications approved by AHCA for nursing homes, hospices, and ICF/DDs in 2022-2024.[118]

Proposed Project	Applications Received	Applications Approved
Hospices	56	18
Nursing Homes	35	28
ICF/DDs	6	2
Total	97	48

AHCA received approximately $2,826,000 in fees for the 97 applications submitted 2022-2024, which consisted of $1,670,474 from nursing home applications, $990,268 from hospice applications, and $165,920 from ICF/DD applications.[119]

CON Award and Administrative Challenge

Within 60 days of receiving the completed applications for a batch, AHCA must either deny the CON or issue a State Agency Action Report and Notice of Intent to Award a CON for a project. AHCA may approve a project in its entirety or a portion of the project.[120] AHCA must then publish the decision within 14 days in the Florida Administrative Weekly.[121] If no administrative hearing is requested, the State Agency Action Report and the Notice of Intent to Award the CON become a final order of AHCA.[122]

Florida law allows competitors to challenge CON decisions. A competing applicant in the same review cycle, or an existing provider in the same district, may challenge a CON award based on whether the provider will be substantially affected by the award. Competitors must submit the request for an administrative hearing within 21 days after the award decision is published in the Florida Administrative Weekly.[123] A challenge to a CON decision is an administrative appeal under Ch. 120, heard by an Administrative Law Judge in the Division of Administrative Hearings, who evaluates the evidence and issues a Recommended Order to AHCA.[124] AHCA must render a Final

[118] Agency for Health Care Administration, *CON Decisions and State Agency Action Reports, Nursing Homes and ICF/DDs*, batching cycles for April, 2022, October, 2022, April 2023, October, 2023, April, 2024, and October, 2024, and *CON Decisions and State Agency Action Reports, Hospices,* batching cycles for February, 2022, August, 2022, February, 2023, August, 2023, February, 2024, and August, 2024, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/certificate-of-need-con-program-overview/certificate-of-need-competitive-review-batching-cycles-2025/con-decisions-state-agency-action-reports (last visited December 15, 2025).
[119] Fees were calculated by staff of the Health & Human Services Committee for the 97 total applications submitted.
[120] S. 408.039(4)(b), F.S.
[121] S. 408.039(4)(c), F.S.
[122] S. 408.039(4)(d), F.S.
[123] S. 408.039(5)(c), F.S.
[124] *Id.*

Order within 45 days of receiving the Recommended Order[125], and any party may challenge a Final Order to the District Court of Appeal for judicial review[126] within 30 days after the Final Order.[127] CON awards are often litigated by multiple competitors, and can cost providers millions of dollars in litigations costs.

CON Deregulation

Florida's CON program has been reformed several times over the course of the past 15 years. In 2000, CON review was eliminated for establishing a new home health agency.[128] The number of home health agencies doubled over the ten-year period immediately succeeding the elimination of CON review for establishing a new home health agency. Since 2010, the number of home health agencies has slowly increased from 2,362 to 2,825.[129]

In 2007, CON review was eliminated for adult cardiac catheterization and adult open heart surgery services.[130] Since the elimination of CON review for adult cardiovascular services, the number of hospitals with a Level I[131] adult cardiovascular services license has more than doubled from 25 to 71[132], while the number of hospitals with a Level II adult cardiovascular services license has only marginally increased from 73 to 79.[133]

In 2019, CON review was eliminated for hospitals and tertiary hospital services including organ transplantation and neonatal intensive care services.[134] Since the elimination of CON review for hospitals, the number of licensed hospitals has increased moderately from 309 to 348.[135] The number of hospitals with organ transplantation licenses has almost doubled from 10 to 19, and the number of hospitals with neonatal intensive care licenses has increased from 69[136]to 72.[137]

CON in Other States

Currently, there are fifteen states with no CON requirements for any type of health care facility or service, including Arizona, California, Colorado, Idaho, Kansas, Minnesota, New Hampshire, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, Wisconsin, and Wyoming.

Of the 35 states that still have CON requirements, 34 states have CON requirements for nursing homes, 22 states have CON requirements for ICF/DDs, and 14 states have CON requirements for hospices. States with CON laws most often regulate hospitals, outpatient facilities, and nursing homes.[138]

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125 S. 408.039(5)(e), F.S.
126 S. 120.68(1), F.S., a party who is adversely affected by final agency action is entitled to judicial review. A preliminary, procedural, or intermediate order of the agency or of an administrative law judge of the Division of Administrative Hearings is immediately reviewable if review of the final agency decision would not provide an adequate remedy.
127 S. 408.039(6), F.S.
128 Ch. 2000-256, Laws of Fla.
129 Florida Health Finder, *Facility/Provider Search for Home Health Agencies,* available at https://quality.healthfinder.fl.gov/Facility-Provider/HHA?&type=1 (last visited December 15, 2025).
130 Ch. 2007-214, Laws of Fla.
131 S. 408.0361, F.S., requires AHCA to adopt rules for the establishment of two hospital program licensure levels: a Level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery. Rule 59A-3.2046, F.A.C., provides the licensure requirements for Level I and Level II adult cardiovascular services licensure.
132 Florida Health Finder, *Facility/Provider Search for Hospitals with a Level I Adult Cardiovascular Services License,* available at https://quality.healthfinder.fl.gov/Facility-Provider/Hospital?&type=1 (last visited December 15, 2025).
133 Florida Health Finder, *Facility/Provider Search for Hospitals with a Level II Adult Cardiovascular Services License,* available at https://quality.healthfinder.fl.gov/Facility-Provider/Hospital?&type=1 (last visited December 15, 2025).
134 Ch. 2019-136, Laws of Fla.
135 Florida Health Finder, *Facility/Provider Search for Hospitals*, available at https://quality.healthfinder.fl.gov/Facility-Provider/Hospital?&type=1 (last visited December 15, 2025).
136 Agency for Health Care Administration, *Hospital Beds and Services List* (January 2019), January2019_HospitalBedsandServicesList.pdf (last visited January 26, 2026).
137 Agency for Health Care Administration, *Hospital & Outpatient Services Unit Reports, NICU Levels II-IV,* available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/reports (last visited December 15, 2025).
138 *Id.*

A recent study ranked the CON programs of all 50 states from least to most restrictive. The study ranked Florida as tied for 14th least restrictive state, with only states without CON requirements being ranked better.[139]

Over the past several years, states have increasingly proposed and passed legislation to make their CON programs less restrictive.[140] In 2021, at least six states (Michigan, Montana, New York, North Carolina, Tennessee and Washington) and the District of Columbia, enacted CON legislation. Montana's legislation was the most sweeping of these bills, exempting all facilities except long-term care facilities from CON review. In 2022, at least 12 states (Arizona, Connecticut, Kentucky, Louisiana, Maryland, Michigan, Mississippi, New York, Ohio, Oklahoma, Vermont and Virginia) and the District of Columbia, enacted legislation modifying their CON laws in some capacity. In 2023, at least 10 states (Connecticut, Iowa, Maine, North Carolina, South Carolina, Tennessee, Vermont, Virginia, Washington and West Virginia) enacted legislation altering their CON laws in some capacity. In 2024, at least 12 states (Connecticut, Georgia, Iowa, Kentucky, Massachusetts, Nebraska, Oklahoma, South Carolina, Tennessee, Virginia, Washington, and West Virginia) passed legislation to adjust their CON laws in some capacity that may require further study or review.

Nursing Home Licensure

A nursing home is a facility that provides 24-hour nursing care, personal care, or custodial care to individuals who are ill or physically infirm.[141] Nursing homes are licensed and regulated by AHCA under part II of ch. 400, F.S., and rule 59A-4, F.A.C., which contains minimum standards for nursing homes on issues such as:

- Staffing;
- Admission and discharge procedures;
- Physician and nurse procedures;
- Resident assessments and care plans;
- Food and nutrition services;
- Pharmacy services;
- Physical environment;
- Disaster preparedness;
- Emergency environmental control; and
- Physical plant codes and standards.

As of December 15, 2025, there were 696 licensed nursing homes in Florida.[142]

Hospice Licensure

A hospice is a centrally administered corporation providing a continuum of palliative and supportive care for a terminally ill patient and his or her family.[143] Hospice services may be provided in a facility or in the home.

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[139] Cicero Institute, *A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Need Laws in All 50 States* (December, 2024), available at https://ciceroinstitute.org/research/ranking-certificate-of-need-laws-in-all-50-states/ (last visited December 15, 2025). The methodology for the rankings consisted of reviewing relevant statutes in all 50 states as of January 1, 2024, nine areas of CON restrictions were isolated—medical inpatient, medical outpatient, behavioral inpatient, behavioral outpatient, long-term care facilities, day services, ancillaries, imaging, and other. States were awarded points to each area to provide lawmakers with an actionable playbook for repeal. Points were assigned pursuant to each CON or CON-equivalent barrier present in that state's statutes on a 100-point basis. The most restrictive states are burdened with 100 points, reflecting CON barriers in every category measured. Meanwhile, the states with 0 points do not have any CON or CON-equivalent statutes limiting market entry in the measured categories.

[140] National Conference of State Legislators, *Certificate of Need State Laws* (April 29, 2025), available at https://www.ncsl.org/health/certificate-of-need-state-laws (last visited December 15, 2025).

[141] Section 400.021(7), F.S.

[142] Florida Health Finder, *Facility/Provider Search for Nursing Homes*, available at https://quality.healthfinder.fl.gov/Facility-Provider/Nursing-Home?&type=1 (last visited December 15, 2025).

[143] S. 400.601(3), F.S.

Hospices are licensed and regulated by AHCA under part IV of ch. 400, F.S., and rule 59A-38, F.A.C., which contains licensure requirements for hospices on issues such as:

- Licensure procedures;
- Administration of the hospice;
- Coordinated care programs;
- Quality assurance and utilization reviews;
- Quality assessment and performance improvement Plans;
- Demographic and provision of care data reporting;
- Medical direction;
- Nursing services;
- Spiritual counseling services;
- Counseling and social services;
- Volunteer services;
- Bereavement services;
- Nutritional services;
- Advance directives and Do No Resuscitate Orders;
- Physical plant;
- Emergency management plans; and
- Employee training.

As of December 15, 2025, there were 68 hospices in Florida.

ICF/DD Licensure

In 2014, the moratorium on the granting of CONs for additional community nursing home beds was repealed.[144] In addition to the repeal, the Legislature imposed limitations on the issuance of CONs for community nursing home beds to limit the growth through July 1, 2017. AHCA could not approve a CON application for new community nursing home beds following the batching cycle in which the cumulative number of new community nursing home beds approved from July 1, 2014, to June 30, 2017, equaled or exceeded 3,750.[145] AHCA reached the cap of 3,750 beds in February of 2016, and a moratorium on additional beds was in place until June 30, 2017.[146] AHCA published a fixed need pool for additional community nursing home beds on September 29, 2017, and began taking applications for additional nursing home beds during the October, 2017, batching cycle.[147] In the most recent need projections, AHCA found a net need for 440 beds statewide.[148]

ICF/DDs provide care and residence for individuals with developmental disabilities.[149] ICF/DDs are licensed and regulated by AHCA under part VIII of ch. 400, F.S., and rule 59A-26, F.A.C., which contains licensure requirements on issues such as:

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[144] Ch. 2014-110, Laws of Fla.
[145] S. 408.0436, F.S.
[146] Agency for Health Care Administration, *Certificate of Need (CON) Program-Presentation before the Health Innovation Subcomittee, January 11, 2017*, slide 12 (on file with the Health Market Reform Subcommittee staff).
[147] *Florida Nursing Home Bed Need Projections by District and Subdistrict, Background Information for Use in Conjunction with the July 2020 Planning Horizon*, available at https://ahca.myflorida.com/content/download/10042/file/FloridaNH_UtilizationbyDistrict_Subdistrict-July2016-June2017.pdf?version=1 (last viewed December 15, 2025).
[148] Agency for Health Care Administration, *Florida Nursing Home Bed Need Projections by District and Subdistrict, Background Information for Use in Conjunction with the July 2028 Planning Horizon*, available at: https://ahca.myflorida.com/content/download/27211/file/FloridaNH_UlilzationDistrict_Subdistrict-July%202024-June%202025.pdf (last visited December 15, 2025).
[149] Agency for Health Care Administration, Intermediate Care Facilities, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/long-term-care-services-unit/intermediate-care-facilities (last visited December 16, 2025). *See also* s. 393.063 (25), F.S., which defines an intermediate care facility for the developmentally disabled as a residential facility licensed and certified under part VIII of chapter 400.

- Fiscal standards;
- Admission policies and requirements;
- Personnel Standards;
- Training;
- Dietary services;
- Dental services;
- Psychological services;
- Drugs and pharmaceutical services;
- Administration of medications;
- Physical plant and housekeeping;
- Fire protection and life safety;
- Construction and physical environment; and
- Disaster preparedness.

Florida Medicaid covers comprehensive, all-inclusive services in ICF/DDs for eligible recipients, including nursing, therapies (physical, occupational, speech, mental health), dental, pharmacy, dietary, social services, and room/board. To be eligible for care in an ICF/DD, an individual must: be enrolled in Medicaid; have determined need for ICF/DD level of care (assessed by APD); and, meet the requirements for the Institutional Care Program.[150]

As of December 15, 2025, there were 105 licensed ICF/DDs in Florida.[151]

Emergency Medical Services

Emergency Medical Responders

An emergency medical responder is an out-of-hospital practitioner whose primary function is to initiate immediate lifesaving care to critical patients while ensuring patient access to the emergency medical system.[152] There are two classes of emergency medical responders; emergency medical technicians (EMTs) who are certified to provide basic life support (BLS), and paramedics who are certified to provide both basic and advanced life support (ALS) to patients. BLS refers to any emergency medical service that uses only basic life support techniques.[153] BLS includes non-invasive medical interventions provided to maintain the life functions of a person having a medical or traumatic emergency until more advance care can be provided.[154] The services provided may include starting cardiopulmonary resuscitation (CPR), stabilization and maintenance of airway and breathing, using an automated external defibrillator, some pharmacological interventions, trauma care, and transportation to the appropriate medical facility.[155]

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[150] Agency for Health Care Administration, *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services*, available at https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/medical-and-behavioral-health-coverage-policy/behavioral-health-and-health-facilities/intermediate-care-facility-for-individuals-with-intellectual-disabilities-icf-iid-services (last visited December 16, 2025).

[151] Florida Health Finder, *Facility/Provider Search for ICF/DDs,* available at https://quality.healthfinder.fl.gov/Facility-Provider/Intermediate-Care?&type=1 (last visited December 15, 2025).

[152] U.S. Department of Transportation, National Highway Safety Administration, *National EMS Scope of Practice Model, August 2021,* pg. 32, available at *https://www.nremt.org/getmedia/d82edd97-1425-423f-954c-fdd63cf1daa3/National_EMS_Scope_of_Practice_Model_2019_Change_Notices_1_and-_2_August_2021#:~:text=1.,Contract%20or%20Grant%20No.,* (last visited November 10, 2025).

[153] Ss. 401.23(8) and (9), F.S.

[154] National Library of Medicine: National Center for Biotechnology Information, Journal of Medicine and Life, *Importance of Basic Life Support Training for First and Second Year Medical Students – a Personal Statement-*, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC3019063/, and Butler Medical Transport, *Understanding the Difference Between BLS and ALS Ambulance Services*, available at https://butlermedicaltransport.com/news/understanding-the-difference-between-bls-and-als-ambulance-services/#:~:text=What%20Is%20Basic%20Life%20Support,is%20not_%20required%20during%20transit. (last visited November 10, 2025).

[155] *Id.*

ALS refers to any emergency medical transport or non-transport service which uses advanced life support techniques.[156] ALS includes the assessment or treatment of a person by a qualified individual, such as a paramedic, who is trained in the use of techniques such as the administration of drugs or intravenous fluid, telemetry, cardiac monitoring, and cardiac defibrillation.[157]

Emergency Medical Responder Certification

In Florida, the Division of Medical Quality Assurance within DOH certifies and regulates EMTs and paramedics to ensure competency and safety to practice.[158] Chapter 401, F.S., sets forth the certification requirements, as well as the requirements for certification renewal, continuing education, discipline and professional conduct.

Emergency Medical Technician

To be certified as an EMT, a person must:[159]

- Complete an approved Florida EMT training course;
- Submit an application to DOH;
- Pass the National Registry for Emergency Medical Technicians (NREMT) certification examination;[160]
- Successfully complete CPR training and hold a current American Heart Association or American Red Cross CPR card; and
- Submit certification and examination fees.

Paramedic

To be certified as a paramedic, a person must:[161]

- Complete an approved Florida paramedic training course;
- Submit an application to DOH;
- Pass the NREMT paramedic certification examination;[162]
- Hold a certificate of successful completion in advanced cardiac life support from the American Heart Association or its equivalent; and
- Submit certification and examination fees.

Current law also requires an applicant seeking certification as an EMT or paramedic to attest that he or she is not addicted to alcohol or any controlled substance and is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties as an EMT or paramedic.[163]

Physician Assistants

[156] S. 401.23(3), F.S.
[157] S. 401.23(2), F.S.
[158] DOH, *Licensing and Regulation, Emergency Medical Technicians and Paramedics*, available at https://www.floridahealth.gov/licensing-and-regulation/emt-paramedics/index.html, (last visited November 13, 2025).
[159] S. 401.27, F.S., and Florida Department of Health, *Licensing*. Available at https://www.floridahealth.gov/licensing-and-regulation/emt-paramedics/licensing/index.html (last visited November 10, 2025).
[160] The NREMT exam must be taken within two-years of completing an approved Florida EMT training program.
[161] S. 401.27, F.S., and Florida Department of Health, *Licensing*. Available at https://www.floridahealth.gov/licensing-and-regulation/emt-paramedics/licensing/index.html (last visited November 10, 2025).
[162] The NREMT paramedic certification exam must be taken within two-years of completing an approved Florida paramedic training program.
[163] S. 401.27(4)(b) and (c), F.S.

A physician assistant (PA) is a health care practitioner who practices under the direct or indirect supervision of an allopathic or osteopathic physician. PAs may provide a number of medical services, including:[164]

- Physical examinations;
- Diagnosis and treatment of illness;
- Counsel on preventative health care;
- Assistance in surgery; and
- Prescribing of medication.

In Florida, PAs may only practice under the supervision of an allopathic or osteopathic physician, and are governed by the respective physician practice acts in ch. 458 (allopathic physicians) and ch. 459 (osteopathic physicians). PAs are regulated, by the Council on Physician Assistants (Council) within DOH, in conjunction with either the Board of Medicine (BOM) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (BOOM) for PAs licensed under ch. 459, F.S.

PA Scope of Practice

The scope of practice of a PA is limited to the scope of practice of the physician under which the PA is practicing and to tasks and procedures that have been delegated by the physician. PAs may only practice under the responsible supervision, direct or indirect, of an allopathic or osteopathic physician with whom they have a clinical relationship.[165] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[166] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than ten PAs at any time.[167]

The BOM and BOOM have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA.[168] Whether the supervision of a PA is adequate is dependent upon the:[169]

- Complexity of the task;
- Risk to the patient;
- Background, training and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[170]

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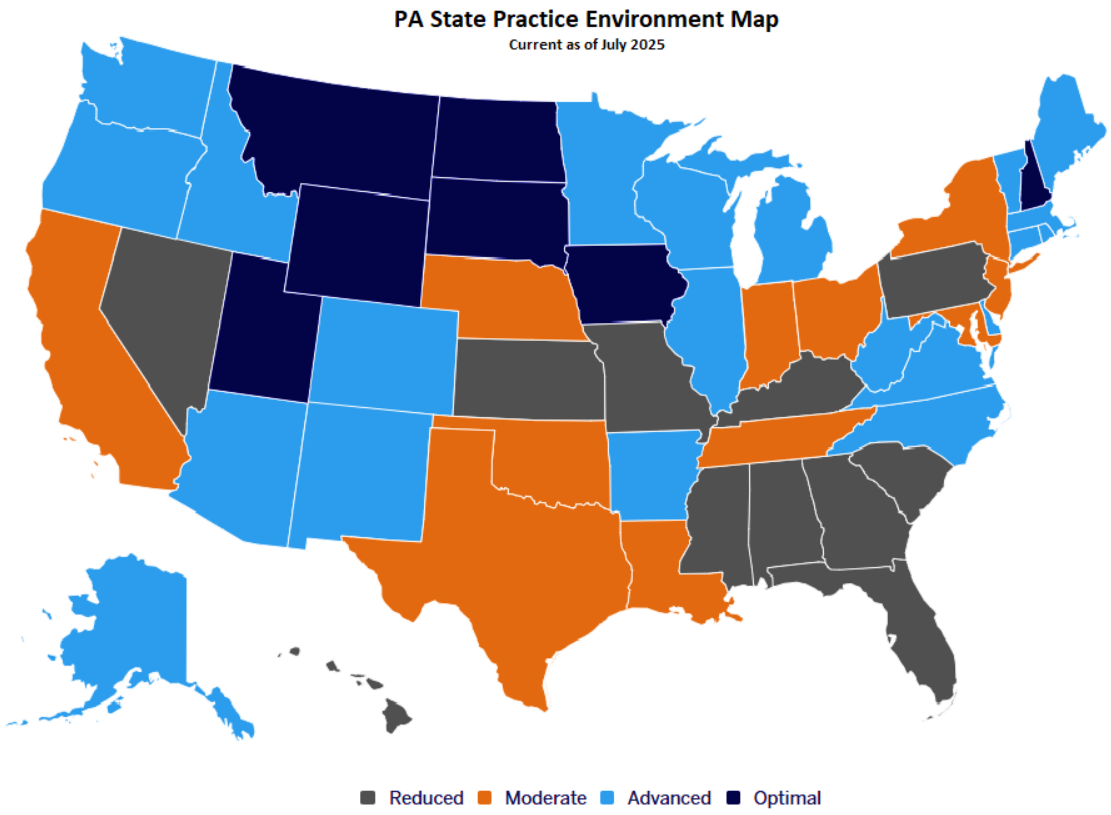
[164] Florida Academy of Physician Assistants, *What is a PA?*, available at https://www.fapaonline.org/page/whatisapa (last visited November 18, 2025).
[165] S. 458.347(2)(g), and 459.022(2)(g), F.S., defines supervision as responsible supervision and control which requires the easy availability or physical presence of a licensed physician for consultation of the PA. Easy availability includes the ability to communicate by way of telecommunication.
[166] Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[167] Ss. 458.347(3), and 459.022(3), F.S.
[168] Rules 64B8-30.001(3), 64B8-30.012, 64B15-6.001(3), and 64B15-6.010, F.A.C.
[169] *Id.*
[170] "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *See* Rules 64B8-30.001, and 64B8-30.012, F.A.C., and 64B15-6.001, and 64B15-6.010, F.A.C.

The American Association of Physician Assistants (AAPA) evaluated and ranked the states based upon key laws and regulations that support PA practice modernization. Utilizing a variety of factors including, autonomous practice and the number of PAs a physician may supervise, the AAPA established 4 categories of modern practice for PAs – optimal, advanced, moderate and reduced. Florida received the lowest ranking, reduced, due to its lack of modernization of its PA laws and regulations.[171]



CMS utilized the AAPA modernization categories as one of the elements to determine the amount of funding awarded to the states under the Rural Health Transformation Program.[172]

Licensure of Physician Assistants

To qualify for a PA license, an applicant must submit a completed application form to DOH and pay the required fee set by the BOM and BOOM. DOH must issue a license to an applicant certified by the Council as having met all of the following requirements:[173]

- Is at least 18 years of age;
- Has graduated from an approved program:
  - For an applicant who matriculated **after** December 31, 2020, has received a master's degree from an approved program;

[171] PA Practice Modernization, American Association of Physician Assistants, July 2025, available at https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment/ (last viewed December 30, 2025).
[172] Rural Health Transformation Program, Department of Health and Human Services, Centers for Medicare & Medicaid Services, appendix, page 87, available at https://grants.gov/search-results-detail/360442 (last viewed December 30, 2025).
[173] Ss. 458.347(6), and 459.022(6), F.S.

  - For an applicant who matriculated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program;
  - For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.
- Obtained a passing score on the Physician Assistant National Certifying Examination as established by the National Commission on Certification of Physician Assistants and has been nationally certified.[174]

The BOM and BOOM may also grant a license to an applicant who does not meet the preceding educational requirements but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants.[175]

Licensure by Endorsement

Licensure by endorsement is the licensure of a practitioner already licensed in another state. It is an alternative to licensure by examination, for those who have already passed the applicable national licensure exam. In Florida, the Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act, establishes a single standardized process for licensure by endorsement for all health care professions regulated by DOH, including EMTs, paramedics, and PAs.[176]

Under the MOBILE Act, DOH or the applicable board, may grant a license to applicants seeking licensure by endorsement to any applicant who meets the following criteria:[177]

- Holds an active, unencumbered license issued by another state, the District of Columbia, or a territory of the U.S. in a profession with a similar scope of practice, as determined by the Board or DOH;
- Has obtained:
  - A passing score on a national licensure examination or holds a national certification recognized by the Board, or DOH if there is no board, as applicable to the profession for which the applicant is seeking licensure; or
  - If the profession applied for does not require a national examination or national certification and the applicable Board, or the DOH, if there is no board, determines that the jurisdiction in which the applicant currently holds an active, unencumbered license:
    - Meets established minimum education requirements; and
    - The work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in Florida;
- Has actively practiced the profession for at least three years during the four-year period immediately preceding the application submission;
- Attests that he or she is not, at the time of application submission, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the U.S. Department of Defense for reasons related to the practice of the profession for which he or she is applying;
- Has not had disciplinary action taken against him or her in the five years preceding the application submission application;
- Meets the financial responsibility requirements of s. 456.048, F.S., or the applicable practice act; and
- Submits a set of fingerprints for a background screening pursuant to s. 456.0135, F.S.

In the absence of an interstate licensure compact, a licensed practitioner who moves to Florida would have to go through the process of licensure by endorsement to practice.

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[174] *See* ss. 458.347(6), and 459.022(6), F.S. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.
[175] Ss. 458.347(6)(a)2.e., and 459.022(6)(a)2.e., F.S.
[176] S. 456.0145, F.S.
[177] *Id.*

Interstate Licensure Compacts

An interstate compact is a legal contractual agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[178] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[179] To join a compact, states must enact compact legislation and meet the requirements of the compact.

Interstate health care licensure compacts allow health care practitioners to practice in multiple states without the necessity of obtaining a separate license in each individual state. Compacts create greater practitioner mobility and vary from mutual recognition models, one license for all states, to expedited licensure models.[180] Florida is a party to multiple interstate health care licensure compacts, including the Nurse Licensure Compact,[181] the Interstate Medical Licensure Compact,[182] the Professional Counselors Licensure Compact,[183] and the Psychology Interjurisdictional Compact.[184]

Emergency Medical Services Personnel Licensure Interstate Compact

The Emergency Medical Services Personnel Licensure Interstate Compact (EMS Compact) was created to facilitate multistate practice of licensed emergency medical services personnel (EMTs and paramedics).[185] The EMS Compact is governed by the Interstate Commission for EMS Personnel Practice (EMS Commission), which is responsible for creating and enforcing the rules and regulations that administer and govern the EMS Compact.

Under the EMS Compact, an EMT or paramedic with an unrestricted license in his or her home state is granted an immediate privilege to practice in other compact member states without obtaining additional state licenses.[186] This operates similarly to a driver's license, under which the home state license is recognized by other states.

When practicing in a remote state under the compact privilege, an EMT or paramedic is subject to the scope of practice authorized by his or her home state, not that of the remote state. This creates a situation in which licensees practicing in a single location might have different scopes of practice depending on their states of origin; for example, practitioners from a compact member state but practicing in Florida might have a broader or narrower scope of practice than Florida-licensed practitioners. However, under Florida law, EMTs and paramedics are subject to supervision by a medical director, who would limit the scope of practice to those services authorized under Florida law.[187]

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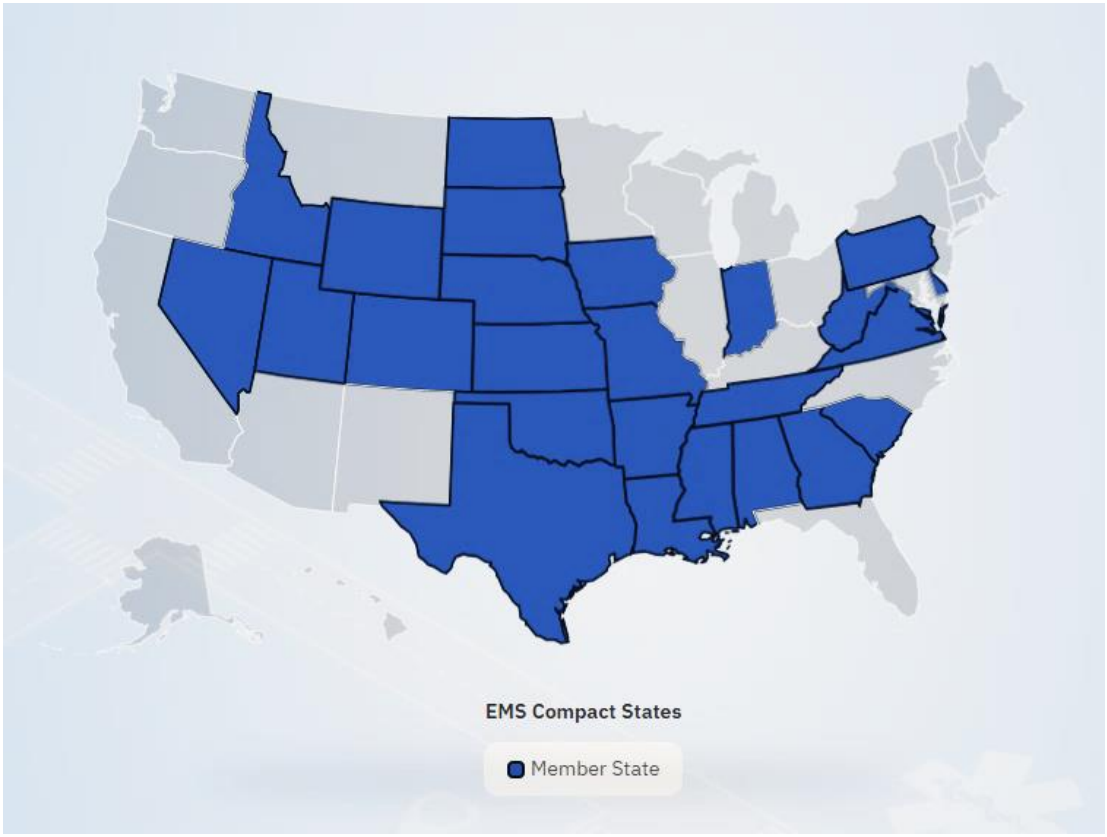
[178] ASLP-IC, *What is Compacts?,* at https://aslpcompact.com/wp-content/uploads/2019/08/80057-What-is-a-Compact_Final.pdf, (last visited November 3, 2025).
[179] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[180] An example of an expedited licensure model includes compacts which authorize health care practitioners to obtain a "compact privilege" in each state they intend to practice rather than obtaining the equivalent license. In general, obtaining a compact privilege is faster and more efficient process due to the centralized nature of compacts than proceeding through the standard state licensure process of each of the various states.
[181] s. 464.0095, F.S.
[182] s. 456.4501, F.S.
[183] S. 491.017, F.S.
[184] S. 490.0075, F.S.
[185] The EMS Compact, *Facts & Benefits*, available at https://www.emscompact.gov/resources/benefits, (last visited November 14, 2025).
[186] *Id.*
[187] S. 401.265, F.S., requires each basic life support transportation service or advanced life support service providing services in this state to employ or contract with a medical director. The medical director must be a Florida licensed physician and is responsible for supervising and assuming direct responsibility for the medical performance of EMTs and paramedics operating for that emergency medical services system.

The EMS Compact states that the compact becomes effective on the date on which the compact is enacted into law in the tenth member state. The EMS Compact became effective in 2017 after the tenth state enacted the compact.[188] However, the compact did not become operable until March 15, 2020, when compact's privilege to practice was formally activated.[189] Currently, the EMS Compact has 25-member states,[190] which are identified in the map below.[191]



Physician Assistant Licensure Compact

The Physician Assistant Licensure Compact (PA Compact) was created to strengthen access to medical services by providing a streamlined process, via a compact privilege, for PAs to practice across states without the need to obtain multiple state licenses.[192] The PA Compact is governed by the Physician Assistant Licensure Compact Commission (PA Commission), which is responsible for creating and enforcing the rules and regulations that administer and govern the PA Compact.

Under the Compact, an eligible licensed PA in a participating state may apply for a compact privilege, which is equivalent to a license, to practice in other compact member states.[193] The PA applicant must obtain a separate compact privilege for each state; the Compact does not automatically grant the privilege for every member state of the compact.

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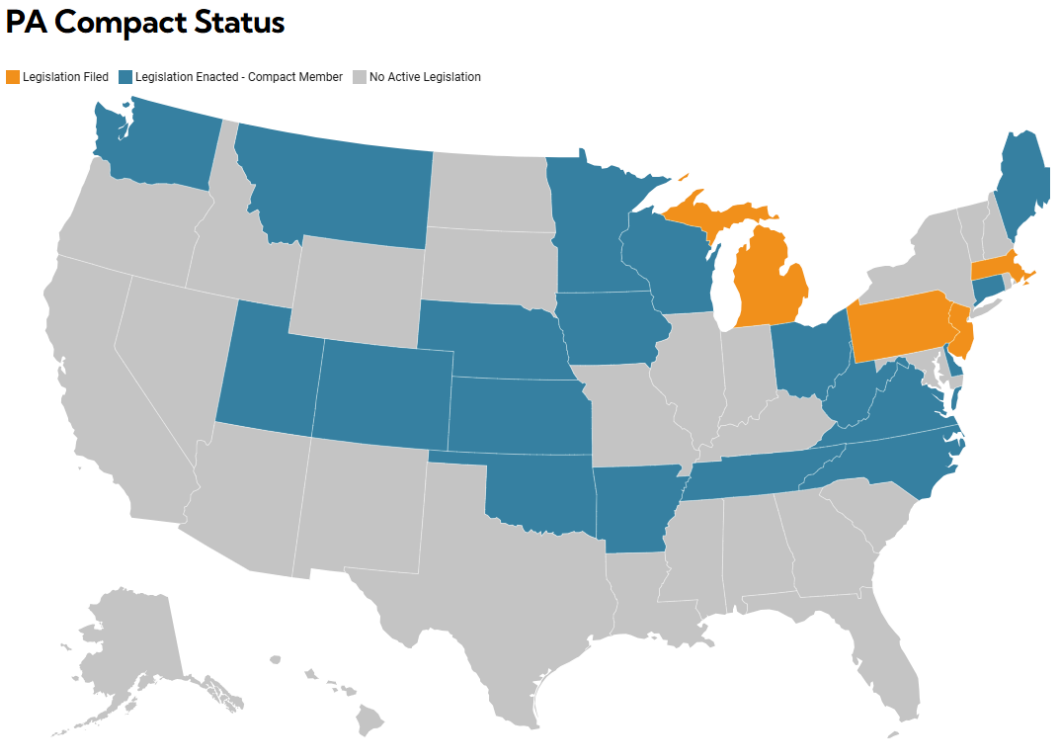
[188] *Id.*
[189] *Id.*
[190] The EMS Compact, *States & Commissioners*, available at https://www.emscompact.gov/the-commission/commissioners, (last visited November 17, 2025).
[191] The EMS Compact, *The United States Emergency Medical Services Compact*, available at https://www.emscompact.gov/, (last visited November 17, 2025).
[192] PA Compact, *PA Licensure Compact Overview*, available at https://www.pacompact.org/siteassets/pa-licensure-compact/pdf/brochure.pdf, (last visited December 8, 2025).
[193] *Id.*

A PA practicing and delivering medical services in a participating state under the PA Compact must comply with the practice laws of the state licensing board in the state in which the PA's patient is located.

The PA Compact states that the compact shall become effective on the date on which the compact is enacted into law in the seventh participating state. The PA Compact became effective in April 2024 after the seventh state enacted the compact.[194] However, the compact is not yet operational; therefore, eligible PAs are currently unable to apply for a compact privilege. The process to operationalize the PA Compact is expected to take between 18 to 24 months. Once operationalized, eligible PAs will then be able to complete a single application to receive a compact privilege from each compact member state in which he or she intends to practice.[195]

Currently, the PA Compact has 19 participating states and legislation to enact the compact is currently pending in five states, plus Florida.[196]



Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[197] or a registered out-of-state-health care provider is authorized to provide health care services to Florida patients via telehealth.[198] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

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[194] American Academy of Physician Associates (AAPA), *PA Profession Secures Passage of Licensure Compact Legislation in Seven States*, *April 5, 2024*, available at https://www.aapa.org/news-central/2024/04/pa-profession-secures-passage-of-licensure-compact-legislation-in-seven-states/, (last visited December 8, 2025).

[195] *Id.*

[196] Note the PA Compact Status map does not show legislation filed in Florida. *See* PA Compact, *PA Compact Status*, available at https://www.pacompact.org/, (last visited December 8, 2025).

[197] Florida is a member of the Nurse Licensure Compact, *see* s. 464.0095, F.S., and the Interstate Medical Licensure Compact, see s. 456.4501, F.S.,

[198] S. 456.47(4), F.S.

Under current law, in-state and out-of-state licensed or registered health care practitioners may use telehealth to provide health care services to patients physically located in Florida.[199] The law does not allow health care practitioners, including Florida certified EMTs and paramedics and licensed physician assistants, to use telehealth to provide services to out-of-state patients.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law.[200]

Current law partially waives sovereign immunity, allowing individuals to sue state government and its subdivisions.[201] Individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

Impaired Practitioner Program

The impaired practitioner treatment program provides resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[202] For a profession that does not have a program established within its individual practice act, DOH is required to designate an approved program by rule.[203] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[204]

Advanced Practice Registered Nurses

An advanced practice registered nurse (APRN) is a registered nurse who is additionally licensed in an advanced nursing practice, including:

- **Certified nurse midwives,** which manage and provide obstetrical and gynecological care, deliver babies, and provide women's health services.[205]
- **Certified nurse practitioners,** which manage and provide primary and acute care, diagnose illnesses, prescribe tests and medications, and promote health and wellness.[206]
- **Certified registered nurse anesthetists (CRNAs),** which provide pain medication, specifically anesthesia, to patients before, during, and after surgery.[207]

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[199] S. 456.47(1) and (4), F.S.
[200] Fla. Const. art. X, s. 13.
[201] S. 768.28, F.S.
[202] S. 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[203] S. 456.076(1), F.S.
[204] Rule 64B31-10.001(1)(a), F.A.C.
[205] Florida Association of Nurse Practitioners, *Nurse Practitioners*, https://www.flanp.org/page/NursePractitioners (last visited December 11, 2025).
[206] *Supra* note 205.
[207] University of Florida, College of Medicine, *Spotlight on Career Paths: CRNA*, https://distance.physiology.med.ufl.edu/spotlight-on-career-paths-crna/ (last visited December 11, 2025).

- **Clinical nurse specialists,** which provide clinical expertise to effect system-wide changes to improve health care programs and improve outcomes on individual patients.[208]
- **Psychiatric nurses,** which provide mental health care to families, individuals, and populations across the lifespan.[209]

Currently, approximately 66,600 APRNs are licensed to practice in Florida, including:[210]

- certified nurse midwives 1,249
- certified nurse practitioners 57,695
- CRNAs 7,993
- clinical nurse specialists 283
- psychiatric nurses 5,501

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (BON), housed within DOH, is responsible for establishing by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices. The BON is also responsible for disciplining an APRN who violates the practice act.

To be eligible for licensure as an APRN, an applicant must apply and provide proof that he or she;

- Holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing under the Nurse Licensure Compact;
- Is certified by the appropriate specialty board; and
- Has a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.

In addition to the practice of professional nursing, APRNs perform advanced-level nursing acts approved by the BON as appropriate for APRNs to perform by virtue of their post-basic, specialized education, training, and experience. APRNs may only perform advanced nursing and medical acts if the APRN is supervised by a physician.[211] APRNs can be supervised by physicians licensed under chapters 458 (allopathic physicians), 459 (osteopathic physicians), or 466 (dentists), F.S.[212] Both general and specialty nursing acts must be authorized by a written supervisory protocol. Autonomous APRNs, however, are not subject to supervision by a physician.

Autonomous Advanced Practice Registered Nurse

Current law authorizes an APRN who meets certain eligibility criteria to register for "autonomous" practice, wherein they may then perform specified health care services without physician supervision or a written protocol.[213] To engage in autonomous practice, an APRN must hold an active and unencumbered Florida license, or a multi-state license,[214] and:[215]

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[208] *Supra* note 205.
[209] University of Florida, College of Nursing, Psychiatric-Mental Health Nurse Practitioners, https://nursing.ufl.edu/programs/doctor-of-nursing-practice-dnp/bsn-to-dnp/psychiatric-mental-health-nurse-practitioner/#:~:text=The%20psychiatric%2Dmental%20health%20nurse,or%20having%20a%20psychiatric%20diagnosis (last visited December 11, 2025).
[210] Email from JP Bell, Director of Legislative Planning, Department of Health (December 1, 2025. If each specialty was added together, the sum would not be the same as listed since an APRN can hold more than one specialty at once.
[211] S. 464.012, F.S.
[212] *Supra* note 211.
[213] S. 464.0123, F.S.
[214] S. 464.0095, F.S. A multi-state license allows APRNs to practice in all states that are part of the Nurse Licensure Compact
[215] S. 464.0123, F.S.

- Complete at least 3,000 clinical practice hours or clinical instructional hours supervised by a physician with an active license within the five-year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Complete three graduate-level semester hours, or the equivalent, in pharmacology and three graduate-level semester hours, or the equivalent, in differential diagnosis within the five-year period preceding the registration request;[216] and
- Meet any other registration requirements provided by BON rule.

The registration must be renewed biennially coinciding with licensure renewal. Currently, 14,601 APRNs are registered for autonomous practice in Florida[217], including:

- certified nurse midwives 120
- certified nurse practitioners 14,198
- CRNAs 107
- clinical nurse specialists 26
- psychiatric nurses 1,765

Scope of Practice

Autonomous APRNs are authorized to admit patients to a health care facility, manage the patient's care in such facility, and discharge the patient from the facility unless otherwise prohibited by federal law or rule. An autonomous APRN may also provide any signature or other affirmation that is otherwise required by law to be provided by a physician.

All APRNs are eligible for autonomous practice. However, they may not engage in autonomous practice in all specialties: autonomous APRNs may only practice midwifery and primary care services, which includes family medicine, general pediatrics, and general internal medicine, and general APRN functions as related to primary care.[218] Only certified midwives are allowed to practice in their specialty area without physician supervision: psychiatric nurses and CRNAs may not practice psychiatric nursing or provide nurse anesthetist services without supervision; they may only provide primary care.[219]

Dental Hygienists

Dental hygiene is the rendering of educational, preventative, and therapeutic dental services and any related extra-oral procedures within the scope and practice area of a dental hygienist.[220] A dental hygienist is an individual who is licensed to provide educational, preventive and therapeutic dental services under the supervision of a licensed dentist.[221] Dental hygienists are regulated by the Board of Dentistry (board) within DOH under Ch. 466, F.S. Currently, there are approximately 21,618 dental hygienists licensed to practice in Florida.[222]

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[216] *See* Rule 64B9-4.020(3), F.A.C.; The Board of Nursing (BON) has defined the equivalent of three graduate-level semester hours in pharmacology and the equivalent of three graduate-level semester hours in differential diagnosis as equal to forty-five (45) Continuing Education credits offered in those areas by the entities set forth in Section 464.013(3)(b), F.S. and Fla. Admin. Code R. 64B9-4.002(2), (2023).

[217] Email from JP Bell, Director of Legislative Planning, Department of Health (December 1, 2025. The total includes duplication, reflecting APRNs that hold more than one specialty license.

[218] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions". Rule 64B9-4.001 (12), F.A.C

[219] S. 464.0123, F.S.

[220] S. 466.003, F.S.

[221] Ss. 466.003, 466.023, F.S.

[222] Email from JP Bell, Director of Legislative Planning, Department of Health (December 1, 2025).

Dental hygienists perform under the supervision of licensed dentists, who may delegate various dental hygiene tasks to the hygienists.[223]

Supervision

There are three levels of supervision within the practice of dentistry: direct, indirect, and general. Under direct supervision, a dentist diagnoses the condition to be treated, authorizes the procedure to be performed, remains on the premises while the procedures are performed, and approves the work performed before dismissal of the patient. Under indirect supervision, a dentist examines a patient, diagnoses a condition to be treated, authorizes the procedure, and remains is on the premises while the procedures are performed. Under general supervision, a dentist examines the patient, diagnoses the condition to be treated, and authorizes the procedure being carried out, but need not be present when the authorized procedure is being performed: the authorized procedure may be performed at a place other than the dentist's usual place of practice.[224]

All levels of supervision require that a dental hygienist receive the appropriate formal training or on-the-job training to be qualified to perform delegated tasks.[225]

Delegated Tasks

Functions in the practice of dentistry fall into two categories: irremediable tasks and remediable tasks.[226]

Irremediable tasks are intraoral treatment tasks which are irreversible and create unalterable changes within the oral cavity or the contiguous structures or which causes an increased risk to the patient.[227] For example, the administration of anesthetics, other than topical anesthesia, is considered to be an irremediable task.[228] A dentist may not delegate irremediable tasks unless granted specific authority in law.[229]

Remediable tasks are intraoral treatment tasks which are reversible, do not create unalterable changes within the oral cavity or the contiguous structures, and which do not cause an increased risk to the patient. Dentists can delegate remediable tasks to a hygienist. The board designates which tasks are remediable and delegable, except for the following tasks that are designated by law.[230]

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance.
- Placing periodontal dressings.
- Removing periodontal or surgical dressings.
- Removing sutures.
- Placing or removing rubber dams.
- Placing or removing matrices.
- Placing or removing temporary restorations.
- Applying cavity liners, varnishes, or bases.
- Polishing amalgam restorations.
- Polishing clinical crowns of the teeth for the purpose or removing stains but not changing the existing contour of the tooth.

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[223] S. 466.003, F.S.
[224] S. 466.003, F.S.
[225] S. 466.024, F.S.
[226] S. 466.003, F.S.
[227] *Id.*
[228] *Id.*
[229] S. 466.017, F.S. Dentists can delegate the administration of local anesthesia to dental hygienists if certain criteria are met.
[230] S. 466.024, F.S.

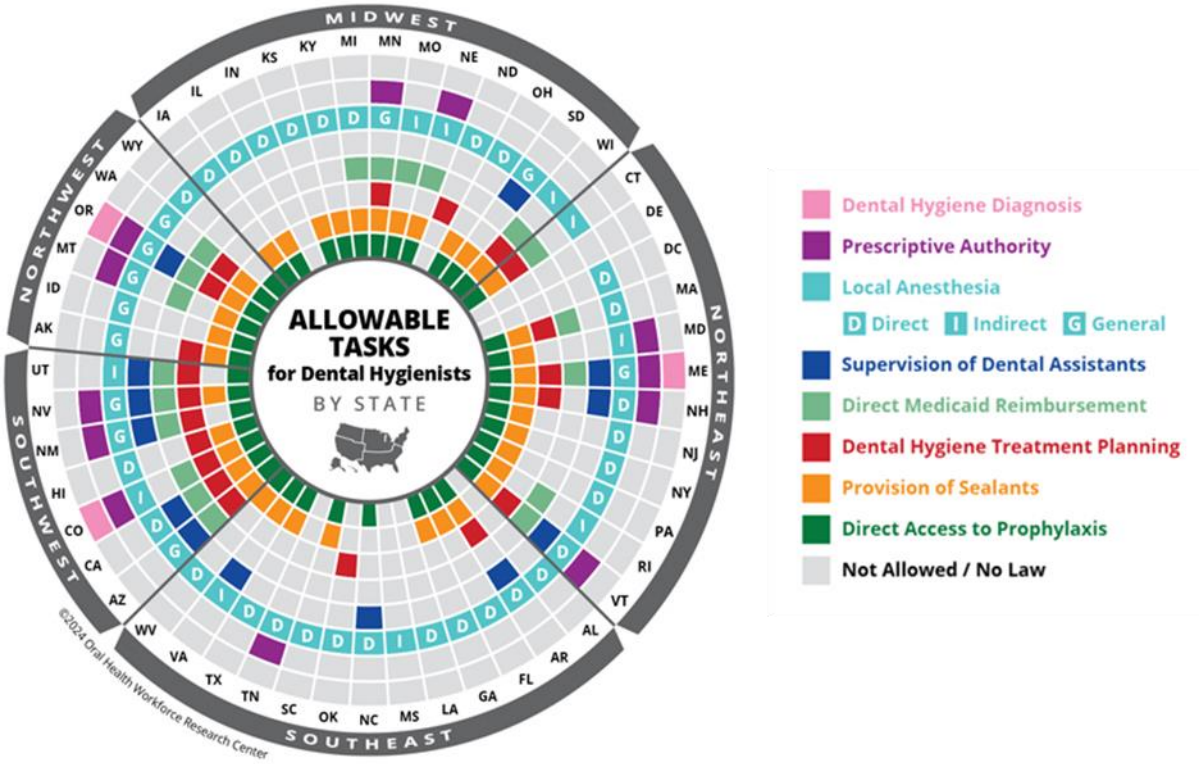
- Obtaining bacteriological cytological specimens not involving cutting of the tissue.
- Administering local anesthesia pursuant to s. 466.017(5), F.S.

A dentist may only delegate remediable tasks to a dental hygienist when the tasks pose no risk to the patient. Dentists are prohibited from delegating the writing of a prescription drug order and determining a diagnosis for treatment or a treatment plan.[231]

An authorization for remediable tasks to be performed under general supervision is valid for 13 months; after which, no further treatment under general supervision can be performed without another clinical exam by a licensed dentist.[232]

Other States

The tasks a dental hygienist can perform vary greatly amongst the states. The graphic below demonstrates the range and variety.[233]



Currently, 12 states allow dental hygienists to prescribe, administer, and dispense fluoride and topical medications. Additionally, 3 states allow dental hygienists to diagnose dental hygiene conditions and 20 states allow dental hygienists to assess dental hygiene conditions and formulate dental hygiene treatment plans.[234] Florida has one of

[231] S. 466.024(8), F.S.
[232] S. 466.024, F.S.
[233] Oral Health Workforce Research Center, *Variation in Dental Hygiene Scope of Practice by State*, https://oralhealthworkforce.org/infographics/variation-in-dental-hygiene-scope-of-practice-by-state/ (last visited December 8, 2025).
[234] *Supra* note 233.

the more restrictive regulatory structures for dental hygienists compared to other states, and does not currently allow dentists to delegate these functions.

Out-of-Network Providers

Health Insurance Networks

Health insurers contract with a limited number of providers to serve their enrollees, called a provider network. Insurers may encourage patients to use in-network providers by imposing higher cost-sharing, such as co-payments, for out-of-network provider treatment, and may not apply any patient expenditure to the patient's deductible[235] or out-of-pocket maximum[236].

Preferred Providers

A Preferred Provider Organization (PPO)[237] is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the patient, or member, is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers.

However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. In addition, the terms of the policy may prohibit the patient from receiving credit for out-of-pocket (cash) expenditures for such services toward the patient's out-of-pocket maximum or deductible obligations. In addition, because a non-participating provider does not have a contract with the insurer delineating the reimbursement rates, the provider may bill the patient for the difference between what the provider bills the insurer and what the insurer chooses to pay – called balance-billing. Current law requires insurers to include an express warning to enrollees in the policy, advising them of the possible financial consequences of using a non-participating provider.

Current law requires each health insurer that uses a preferred provider model to give the policy-holder a list of the participating providers and publish that list on its website.[238]

Health Care Price Finder

Current law requires AHCA to maintain a Florida Center for Health Care Information and Transparency to collect, analyze and disseminate health care information data and statistics (s. 408.05, F.S.). As part of its functions, the agency administers a website of health care paid-claims data to assist consumers identify the costs of care. The Florida Health Price Finder[239] website accesses national paid-claims data for at least 15 billion claim lines from multiple payers, and current law requires all authorized insurers in Florida to provide claims data to the AHCA vendor managing the website. The site allows a consumer to search for prices health care providers were paid by insurers, expressed as a range of averages, for providers in the consumer's geographic location. Prices are searchable by specific service or as a bundle of all the corollary services part of a major service.

Health Price Finder includes data on most hospitals in Florida, although AHCA limits data on hospitals in some geographic areas with little competition or few payers to avoid the possibility that specific reimbursement amounts might be identified. The payment information available on the website is limited; for example, a patient

[235] A deductible is the amount of money a patient must pay before an insurer begins paying for covered services, in a given plan year or other policy term.
[236] An out-of-pocket maximum is a limit set on the amount a patient much pay for services covered by an insurance policy in a given plan year or other policy term.
[237] See generally s. 627.6471, F.S.
[238] s. 627.6471, F.S.
[239] Available at https://price.healthfinder.fl.gov/#.

cannot search by specific facility or provider, so it has limited usefulness for a patient searching for a provider based on cost or comparing providers based on cost.

Health Care Practitioners

Health care practitioners are regulated by DOH under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by DOH; some are regulated directly by DOH without a board or council.

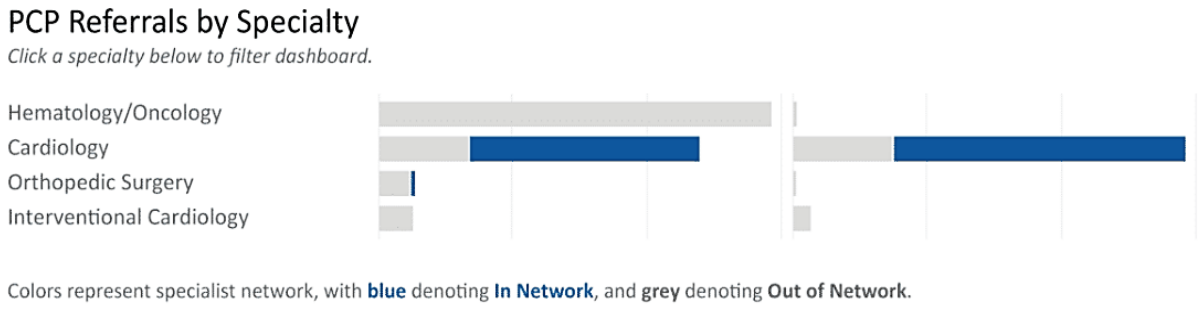
Chapter 456 and individual practice acts delineate standards of licensure and practice, and the boards, or department if there is no board, enforce violations of those standards under the Administrative Procedures Act. Boards and the department may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[240]

Out-of-Network Referrals

Health care practitioners may refer patients to other health care practitioners for the patient to obtain additional, possibly more specialized diagnosis or treatment. Sometimes, the referred practitioner does not participate in the patient's insurer's provider network, which may result in increased costs for the patient – or delays in care while the patient goes back to the referring provider for an alternative referral. However, this is common practice. For example, one survey of primary care providers (PCPs)[241] found:

- 79 percent refer patients out-of-network.
- 34 percent of out-of-network referrals could be avoided if providers had more information on other providers' specialties and areas of focus.
- 72 percent refer to the same provider for a specialty, rather than determining whether another provider has more specific expertise or earlier appointment time.
- 60 percent of PCPs did not always know whether their patient required re-referral.

An analysis of PCP referrals in the Washington, D.C. area found significant out-of-network referral patterns, as indicated by graphic below.[242]



That analysis, showed significant variation in referral patterns by PCPs, with some making non-participating providers 100 percent of their referrals; others referring out-of-network at much lower rates.

[240] See, s. 456.072, F.S.
[241] Kyruus Health, *2018 Referral Trends Report*, at https://kyruushealth.com/new-physician-referral-report-identifies-top-barriers-to-patient-retention-and-care-coordination-within-health-system-networks/ (last visited January 20, 2026).
[242] CareJourney, *Using Healthcare Analytics to Understand & Optimize Physician Referrals at the Point of Care* (2021), at https://carejourney.com/healthcare-analytics-to-optimize-physician-referrals-at-point-of-care/ (last visited January 20, 2026).

Current law does not obligate practitioners to inform patients when referring them to other providers who are not in the patient's insurance network, or the possible financial consequences of treatment by out-of-network providers.

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOUSE/*SENATE* SPONSOR(S)	OTHER INFORMATION
2025	HB 1101 - Out-of-network Providers	Albert/ *Burton*	Died in House Returning Messages
2025	HB 883 - Advanced Practice Registered Nurse Autonomous Practice	Shoaf/ *Simon*	Died in Senate
2024	HB 771 - Autonomous Practice for Certified Psychiatric Nurses	Barnaby/ *Rodriguez*	Died in House
2023	HB 1067 - Autonomous Practice by an Advanced Practice Registered Nurse	Giallombardo/ *Rodriguez*	Died in House
2021	HB 111 - Autonomous Practice by an Advanced Practice Registered Nurse	Maggard/ *Brandes*	Died in House
2025	HB 649 - Autonomous Practice by a Certified Registered Nurse Anesthetist	Giallombardo/ *Rodriguez*	Died in Senate
2024	HB 257 - Autonomous Practice by a Certified Registered Nurse Anesthetist	Giallombardo/ *Ingoglia*	Died in House

OTHER RESOURCES:

Emergency Medical Services Personnel Licensure Interstate Compact
Physician Assistant Licensure Compact

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	12 Y, 4 N	1/29/2026	Lloyd	Lloyd
Health & Human Services Committee			Calamas	Lloyd