

**DECEMBER 2025 HEALTH LAW UPDATE**

Dear Health Law Section Members:

The Health Law Section (“HLS”) website has been updated with the following articles on significant developments in health law that may interest you in your practice.

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These articles are presented to HLS members for general information only and are not legal advice from The Florida Bar or its Health Law Section. HLS thanks the volunteers who have generously donated their time to prepare these articles for our members.

Best,

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## I. STATE LAWS AND REGULATIONS

### **All Eyes on Tallahassee: What’s Coming Down the Pike in 2026**

The Florida Legislature convenes every year for the constitutionally-mandated Legislative Session (“Session”) to pass a balanced budget and debate and pass legislative proposals.<sup>1</sup> During the 2025 Session, many healthcare bills failed to pass both chambers of the Legislature and be signed into law by the Governor; however, several of these bills are likely to reappear in the 2026 Session, most notably, Senate President Ben Albritton’s priority bill: Florida’s Rural Renaissance. This article will give a brief overview of what to look out for during the upcoming 2026 Session and discuss the timely intersection of Florida’s Rural Renaissance and the federal Rural Health Transformation Program (the “RHT Program”), embedded in H.R.1, the One Big Beautiful Bill Act (the “Big Beautiful Bill”).

#### **What to Look Out For: Key Currently Filed Bills for the 2026 Session**

*SB 68: Health Care Patient Protection* – This bill strengthens pediatric emergency care in Florida hospitals by requiring emergency departments to implement training policies and protocols for pediatric patients, ensuring that emergency department personnel are well-equipped to handle exigent circumstances.<sup>2</sup> SB 68 provides that hospital emergency departments must enforce procedures for pediatric care, conduct annual training sessions, and appoint a “pediatric emergency care coordinator.”<sup>3</sup>

*SB 138: Advanced Practice Registered Nurse Autonomous Practice* – This bill expands the scope of practice of psychiatric mental health advanced practice registered nurses (“APRNs”) to provide psychiatric mental health services independently under Board of Nursing Regulations.<sup>4</sup> The bill maintains existing autonomous practice scope in primary care while including mental health services for certain qualified APRNs.<sup>5</sup>

*HB 6003: Recovery of Damages for Medical Negligence Resulting in Death* – This bill addresses damages in wrongful death actions.<sup>6</sup> Seeking to expand the scope of damages available under Florida’s Wrongful Death Act, HB 6003 removes the limitations on recovery in medical negligence resulting in death cases, allowing children of a deceased parent, regardless of age or minority status, to recover in these actions.<sup>7</sup> Parents of a deceased child may recover for mental pain and suffering as of the date of injury notwithstanding their child’s age.<sup>8</sup>

#### **Florida’s Rural Renaissance**

During the 2025 Legislative Session, Senator Corey Simon filed SB 110 – Rural Communities, otherwise known as Florida’s Rural Renaissance.<sup>9</sup> Florida’s Rural Renaissance was a comprehensive approach to creating opportunities to improve the rural quality of life by expanding access to health care in Florida’s rural communities.<sup>10</sup> Florida’s Rural Renaissance had four healthcare-focused aims: (1) incentivize physicians and nurses to practice in rural areas; (2) train rural paramedics and emergency medical technicians (“EMTs”) in advanced stroke, cardiac, and obstetrics response; (3) expand the Rural Hospital Capital Improvement Program to cover mobile units and telemedicine kiosks; and (4) increase existing Medicaid payments for rural hospitals.

More specifically, SB 110 proposed creating a variety of new grant programs to attract physicians and autonomous APRNs to open practices in rural areas, and improve training for emergency personnel to increase access to high-quality stroke, cardiac and obstetric care.<sup>11</sup> As individuals in these areas face a scarcity of high-quality and accessible care, Florida’s Rural Renaissance aimed to address these realities by expanding educational and training initiatives through simulated, hands-on sessions and increasing financial incentives for providers to relocate to these counties.<sup>12</sup>

In combination with these provisions, Florida’s Rural Renaissance would have widened the reach of the Rural Hospital Capital Improvement Program, a program to provide critical funding to rural hospitals to acquire, repair, improve, and upgrade systems, facilities, or equipment.<sup>13</sup> The bill proposed to add \$25 million in nonrecurring funding to cover mobile units to provide primary care services, behavioral health services, or obstetric and gynecological services in rural areas, and telemedicine kiosks to provide urgent care services remotely in rural areas.<sup>14</sup> Although both the House and Senate passed versions of the bill during the 2025 Session, the bill ultimately died when the two chambers could not agree on competing amendments. At the conclusion of the 2025 Legislative Session, a Senate spokeswoman confirmed that Senate President Ben Albritton “remains committed to passing the legislation when the Legislature returns in early 2026.”<sup>15</sup>

### **Rural Health Transformation Program**

On July 4, 2025, President Trump signed the Big Beautiful Bill into law.<sup>16</sup> The Big Beautiful Bill allocates \$50 billion in funding towards the RHT Program, a program designed to spur innovative and impactful solutions in rural America.<sup>17</sup> The Centers for Medicare and Medicaid Services (“CMS”) will evenly distribute half of the funds among states that submit a transformative plan and disburse the remaining funds based on submitted plans.<sup>18</sup> Transformative plans must clearly detail how a state plans to utilize digital technology in disease prevention and management, acquire and maintain a strong group of medical professionals, implement and leverage telemedicine capacities to reach rural populations, and create an efficient network between hospitals, emergency personnel, and other care providers.<sup>19</sup> In preparation for Florida’s plan submission, the Home Care Association of Florida (“HCAF”) urged the Agency for Health Care Administration (“AHCA”) to focus Florida’s plan on delivering high-quality services through home health agencies and remote monitoring.<sup>20</sup>

### **Outlook on the 2026 Session**

In combination with the expected Florida’s Rural Renaissance, if AHCA effectuates HCAF’s recommendations, the impact on Florida’s healthcare market will be far-reaching: the increase in grants for infrastructure, telehealth, and emergency training will create streamlined protocols and systems for residents in Florida’s rural communities to receive prompt in-person and virtual care. Through the financial and training incentives described in Florida’s Rural Renaissance, the likelihood of physicians, emergency personnel, and other medical staff relocating to rural communities heightens, creating greater opportunity for readily available providers to engage in the visionary home-health treatment stated in Florida’s Rural Renaissance and HCAF’s recommendations.<sup>21</sup> As home health agencies deliver medical care directly to a patients’ home, the proposed incorporation of this service model through the RHT Program and Florida’s Rural Renaissance will bridge the gap between high patient demands and insufficient transportation options, realities commonly presented in rural areas.

SB 138 and SB 68, currently filed bills, create a unique opportunity for expansion of health solutions in rural communities. As SB 138 broadens the autonomous care requirements for psychiatric mental health services, APRNs are increasingly likely to open their own private practices in “qualifying rural areas,” particularly in view of the grants that would be allotted to APRNs through Florida’s Rural Renaissance, if passed.<sup>22</sup> SB 68, if enacted, will sharpen training requirements and protocols in rural emergency departments, aligning with the training regime expressed in SB 110 for critical care.<sup>23</sup> This proposed legislation, in conjunction with the RHT Program, offer Florida’s rural residents impactful solutions to their long-unaddressed needs.

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<sup>1</sup> Art. III, §§ 3, 19, Fla. Const.

<sup>2</sup> Fla. SB 68 (2026).

<sup>3</sup> *Id.*

<sup>4</sup> Fla. SB 138 (2026).

<sup>5</sup> *Id.*

<sup>6</sup> Fla. HB 6003 (2026).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> See Senator Ben Albritton, *Memorandum*, FLA. S. (Feb. 19, 2025), [https://www.flsenate.gov/PublishedContent/Offices/2024-2026/President/Documents/2\\_19\\_25\\_Memo\\_Re\\_Rural\\_Renaissance.pdf](https://www.flsenate.gov/PublishedContent/Offices/2024-2026/President/Documents/2_19_25_Memo_Re_Rural_Renaissance.pdf).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> Fla. SB 110 (2025).

<sup>13</sup> *Id.*

<sup>14</sup> Albritton, *supra*, note 9.

<sup>15</sup> The News Service of Florida, *The Florida Senate's rural renaissance priority bill will have to wait*, WFSU PUB. MEDIA (June 3, 2025), <https://news.wfsu.org/state-news/2025-06-03/the-florida-senates-rural-renaissance-priority-bill-will-have-to-wait>.

<sup>16</sup> One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025).

<sup>17</sup> See *Rural Health Transformation (RHT) Program*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last modified Sept. 26, 2025, 4:50 PM), <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/rural-health-transformation-program-summary.pdf>.

<sup>18</sup> *Id.*

<sup>19</sup> *Rural Health Transformation Program Summary*, NAT’L RURAL HEALTH ASS’N, <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/rural-health-transformation-program-summary.pdf>.

<sup>20</sup> *HCAF Submits Recommendations to Strengthen Florida’s Excellence in Home Health Program*, HOME CARE ASS’N OF FLA. (Sept. 8, 2025), <https://members.homecarefla.org/news/Details/hcaf-submits-recommendations-to-strengthen-florida-s-excellence-in-home-health-program-287226>.

<sup>21</sup> *Id.*; see Fla. SB 110 (2025).

<sup>22</sup> Fla. SB 138 (2026); Fla. SB 68 (2026); Fla. SB 110 (2025).

<sup>23</sup> Fla. SB 68 (2026); Fla. SB 110 (2025).

## **Florida Announces Plan to Eliminate State Vaccine Mandates and Implications for Health Care Providers and Public Health Law**

On September 3, 2025, Florida’s Surgeon General, Dr. Joseph Ladapo, announced that the Florida Department of Health (the “Department”), in partnership with Governor Rob DeSantis, plans to end all vaccine mandates in Florida, which, by implication, would include those applying to school attendance and certain health-care employment settings. During a press conference with Governor DeSantis, Surgeon General Ladapo said the Department will engage in rulemaking to eliminate existing vaccine mandates from its rules and work with Governor DeSantis and the Florida Legislature to enact legislation to end statutory vaccine requirements.<sup>1</sup>

Reportedly, the Department intends to amend its rules to remove school entry vaccine requirements for Hepatitis B, Varicella, Haemophilus influenzae type b (Hib), and Pneumococcal conjugate vaccines.<sup>2</sup> In September, the Department published a Notice of Development of Rulemaking announcing plans to update the immunization and document requirements for school entry, including the applicable immunization certification and exemption forms and the immunization guidelines for Florida schools, childcare facilities, and family daycare homes. According to the notice, the Department’s rulemaking will also make changes to the Florida State Health Online Tracking System (SHOTS) program, the state’s online immunization registry.<sup>3</sup>

The effort to remove vaccine requirements poses a notable shift for Florida’s public health system. For years, the state has relied on vaccination requirements to help limit the spread of communicable diseases in schools, hospitals, and other licensed facilities.<sup>4</sup> The prospect of rolling those mandates back raises new public health questions for public and private stakeholders.

Florida law currently gives the Department of Health authority to set vaccination requirements. Under section 1003.22, Florida Statutes, the Department has authority to adopt rules identifying required immunizations for school attendance and create exemptions for medical or religious reasons. Additionally, Florida law empowers the Department to track and control communicable diseases. Among other things, physicians and laboratories must report certain conditions, and the Department has powers to investigate and prevent their spread.<sup>5</sup>

The Department’s immunization requirements and detailed procedures for disease reporting and surveillance appear in chapter 64D-3 of the Florida Administrative Code. Any effort to repeal or amend these rules would have to comply with the Florida Administrative Procedure Act,<sup>6</sup> which governs rulemaking by state agencies. However, section 1003.22, Florida Statutes, requires immunizations for poliomyelitis, diphtheria, rubeola, rubella, pertussis, mumps, and tetanus for school entry. Legislative action would be necessary to repeal those statutory requirements. The Legislature could take up the issue in the 2026 legislative session. Yet, until the Department amends its rules, or the Legislature enacts a statutory amendment, the existing immunization requirements will stay in place.

Even without state vaccine mandates, federal law would still cover most health care providers. Hospitals and long-term care facilities participating in Medicare or Medicaid must comply with the federal Conditions of Participation regulations promulgated by the Centers for Medicare and Medicaid Services (“CMS”), which, among other things, require infection control programs.<sup>7</sup> Employers in clinical settings must also meet the Occupational Safety and Health Act’s (“OSHA”)

duty to keep workplaces free of recognized hazards.<sup>8</sup> And the Equal Employment Opportunity Commission enforces federal protections that govern vaccination policies under both Title VII of the Civil Rights Act and the Americans with Disabilities Act.<sup>9</sup>

Although the Department's proposal concerns school-entry vaccine requirements, not health-care worker vaccination, the rule changes still have implications for health care providers because they reshape how the state manages communicable disease prevention overall. Health care systems routinely interact with school-based immunization requirements through SHOTS reporting, pediatric vaccination workflows, and documentation obligations, all of which the Department's rulemaking would modify. Federal law does not impose affirmative vaccine mandates, but CMS, OSHA, and federal anti-discrimination laws require facilities to maintain infection control and hazard mitigation programs. Because many providers rely on vaccination practices as part of those compliance structures, any reduction in state-level immunization requirements increases the importance of internal policies and federally driven standards. As a result, even if Florida eliminates all state vaccine requirements, hospitals, clinics, and long-term care facilities will still need to evaluate their internal vaccination procedures in line with federal regulatory expectations and accreditation requirements.

For Florida providers, these federal requirements will remain unchanged regardless of state action. Hospitals, clinics, and nursing homes must continue to maintain infection control policies that meet CMS and OSHA requirements, and accrediting organizations such as The Joint Commission will still expect documentation showing adherence to recognized prevention standards. If the Department scales back its vaccination rules, state and local health officials will continue operating under existing disease control laws, and providers will need to ensure their internal policies align with those frameworks.

Health care attorneys should continue to monitor any proposed rule changes in the Florida Administrative Register, along with updates from the Department and the Agency for Health Care Administration. It is a good time for providers to double-check their vaccination policies, confirm that contracts and insurance language are consistent with federal requirements, and review internal procedures to ensure compliance.

Although the Legislature and Department may address this issue in the near future, the state's existing vaccination requirements remain in effect until new rules or legislation take effect. Health care professionals and attorneys should monitor proposed rulemaking and legislation, but the focus should remain the same: following state and federal standards, meeting accreditation requirements, and keeping patient safety a top priority.

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<sup>1</sup> THE FLORIDA CHANNEL, Governor's Press Conference (Sept. 3, 2025), <https://thefloridachannel.org/videos/9-3-25-governors-press-conference/>.

<sup>2</sup> Mary Walrath-Holdridge, A State Hasn't Removed Vaccine Mandates for 45 Years. Can Florida Do It?, USA TODAY (Sept. 8, 2025), <https://www.usatoday.com/story/news/health/2025/09/05/florida-plan-end-vaccine-mandates-explained/85962974007/>; Ed White, Florida's Plan to Drop School Vaccine Rule Won't Start for 90 Days,

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Won't Cover All Diseases, AP NEWS (Sept. 7, 2025), <https://apnews.com/article/florida-vaccine-mandates-children-4e697db6085dc5dd4bd9b206ed9a51b6>.

<sup>3</sup> 51 Fla. Admin Reg. 176 (Sept. 10, 2025), [https://flrules.org/Gateway/View\\_notice.asp?id=29969913](https://flrules.org/Gateway/View_notice.asp?id=29969913).

<sup>4</sup> *Cf.* Fla. Stat. §§ 381.0011, 381.003.

<sup>5</sup> Fla. Stat. §§ 381.0011, 381.0031.

<sup>6</sup> Fla. Stat. ch. 120.

<sup>7</sup> *See* 42 C.F.R. §§ 482.42, 483.80.

<sup>8</sup> 29 U.S.C. § 654

<sup>9</sup> 42 U.S.C. §§ 2000e(j), 12112(b)(5).

## **AHCA Proposes New Rule Requiring Providers to Implement Data Breach Continuity Plans**

The Florida Agency for Health Care Administration (AHCA or the Agency) recently issued a [new proposed rule](#) that would require all “providers” licensed by AHCA to have a “continuity plan” for data and information technology disruptions. The proposed rule would also mandate the reporting of certain information to AHCA upon the occurrence of an “information technology incident.”

### **Continuity Plans**

Many providers that would be subject to the proposed rule (see section on Applicability below) are currently required by AHCA to have a Comprehensive Emergency Management Plan (CEMP) in place for patient care and operations in the event of a disaster or emergency. To satisfy the proposed rule’s continuity plan requirement, a provider would need to adopt a written policy detailing procedures and information designed to maintain critical operations and essential patient care services during an interruption of normal operations. In particular, the rule contemplates three specific types of procedures that continuity plans must address:

1. Procedures for the regular performance of secure, redundant on-site and off-site data backups and verification of the restorability of backed-up data;
2. Procedures for the restoration of critical operations and essential patient care services; and
3. Procedures for the secure restoration of backed-up data and reporting of information technology incidents.

The proposed rule would require the off-site data backups addressed in a provider’s continuity plan to be stored within the continental United States.

Importantly, the proposed rule’s broad definition of “data” is not limited to information that would constitute “protected health information” under HIPAA or even “personal information” under the Florida Information Protection Act of 2014 (FIPA). Instead, it would apply to data used for both business and clinical operations.

### **Incident Reporting**

The proposed rule’s “information technology incident” reporting requirements would be triggered upon the occurrence of any “observable occurrence or data disruption or loss in an information technology system or network that permits or is caused by unauthorized access of data in electronic form.” However, good faith access by authorized employees would be exempt so long as the applicable data is not used in an unauthorized manner or for unauthorized purpose.

Providers would be required to report the occurrence of an information technology incident to AHCA no later than 24 hours after the provider reasonably believes such an incident may have occurred. Note that this 24-hour reporting deadline is much more aggressive than other breach-reporting deadlines. For example, the HIPAA breach-notification rule generally allows up to 60

days from the breach’s discovery to report the breach, and FIPA allows up to 30 days to report certain breaches involving confidential personal information.

Additionally, providers would be required to provide the following information to AHCA upon the Agency’s request:

1. A police report, incident report, or computer forensics report;
2. A copy of the policies in place regarding information technology incidents;
3. Information disclosed in the information technology incident;
4. Steps that have been taken to rectify the incident; and
5. The provider’s continuity plan.

Notably, the proposed rule does not specify whether the documents a provider must produce to AHCA would remain confidential and exempt from a public records request.

### **Applicability**

The proposed rule would apply to all “providers” licensed by AHCA, including the following:

- Laboratories authorized to perform testing under the Drug-Free Workplace Act
- Birth centers
- Abortion clinics
- Crisis stabilization units
- Short-term residential treatment facilities
- Residential treatment facilities
- Residential treatment centers for children and adolescents
- Hospitals
- Ambulatory surgical centers
- Nursing homes
- Assisted living facilities
- Home health agencies
- Nurse registries
- Companion services or homemaker services providers
- Adult day care centers
- Hospices
- Adult family-care homes
- Homes for special services
- Transitional living facilities
- Prescribed pediatric extended care centers
- Home medical equipment providers
- Intermediate care facilities for persons with developmental disabilities

- Health care services pools
- Health care clinics
- Organ, tissue, and eye procurement organizations

### **Next Steps**

AHCA held a rulemaking workshop on September 17, 2025, but has yet to publish any additional information about this proposed rule.

**Submitted and Authored by Elizabeth F. Hodge, Esq., Thomas A. Range, Esq., and John C. Hood, Esq., Akerman LLP. © 2025 Akerman LLP. This article was originally published in the Akerman Health Law Rx blog on September 4, 2025, <https://www.healthlawrx.com/2025/09/ahca-proposes-new-rule-requiring-providers-to-implement-data-breach-continuity-plans/>, and it is reprinted by permission of Akerman LLP.**

## II. FEDERAL LAWS AND REGULATIONS

### Medicare Telehealth Flexibilities Extended by Federal Funding Bill

On September 30, 2025, Medicare telehealth flexibilities expired, reverting the system to pre-pandemic restrictions. However, on November 12, 2025, the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act (the “Funding Bill”), which ended the federal government shutdown, retroactively reinstated the Medicare telehealth flexibilities from October 1, 2025, through January 30, 2026.<sup>1</sup> This short-term extension, while providing immediate relief and ensuring continuity of care for patients, postpones the debate on a permanent legislative solution for Medicare telehealth coverage.

If the flexibilities expire on January 30, 2026, the return to pre-pandemic restrictions would impact the accessibility of Medicare telehealth services. Specifically, these changes would reintroduce geographic limits on where a patient could receive care and narrow the use of audio-only communication. These changes would also restrict the types of providers who would be permitted to provide telehealth services.<sup>2</sup>

During the shutdown, the Centers for Medicare and Medicaid Services released an [FAQ](#) providing clarification on the practical impact of expired flexibilities for both patients and providers.<sup>3</sup> Although Congress retroactively reinstated the flexibilities after its release, the FAQ nonetheless illustrates how the expiration of the telehealth waivers would reintroduce limitations that may impact patient access by reinstating originating site and geographic restrictions.

After the expiration of the telehealth waivers, for most non-behavioral health telehealth services to be covered by Medicare, patients will generally no longer be able to connect from their homes. To receive virtual care the patient will need to be in a rural area and will be required to receive the care from an approved medical facility.<sup>4</sup> Health care providers will be required to use two-way, real-time audio technology for any telehealth service provided to a Medicare beneficiary. The health care provider must possess the technical ability to conduct the visit using a two-way audio and video system. To use audio-only technology, the patient must be unable to use video technology or withhold consent to using video technology.<sup>5</sup>

Further, upon expiration of the flexibilities, certain categories of providers that are currently authorized to bill Medicare for telehealth services will be removed from the approved list. This change means that physical therapists, occupational therapists, speech-language pathologists, and audiologists would no longer be permitted to furnish services to Medicare beneficiaries via telehealth.<sup>6</sup>

These changes are only a portion of the changes that would take effect if the Medicare telehealth flexibilities permanently expire on January 30, 2026. To ensure permanent availability, advocates are pushing for the passage of specific long-term solutions currently in Congress, like the Telehealth Modernization Act and the Creating Opportunities Now for Necessary and Effective Care Technologies (“CONNECT”) for Health Act.

The Telehealth Modernization Act, introduced in September 2025, aims to serve as a two-year bridge, extending most of the Medicare telehealth waiver provisions through September 30, 2027.

This temporary measure is intended to prevent sudden disruption for patients and providers while Congress considers long-term solutions.<sup>7</sup>

For a permanent legislative change, the CONNECT for Health Act was reintroduced in April 2025. This bill proposes to make key Medicare telehealth flexibilities a permanent part of the health care system, including removing geographic requirements and expanding the types of eligible practitioners. Both bills have been referred to committees for consideration. However, as of November 2025, neither bill has been passed into law.<sup>8</sup>

While the Funding Bill ensures continuity of care for Medicare patients through January 30, 2026, it only postpones the larger debate surrounding the permanent status of telehealth flexibilities.

**Submitted and authored by Gabriela Gonzalez, Esq., Florida Department of Health. The opinions expressed herein are solely the author's and do not express the views or opinions of her employer.**

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<sup>1</sup> Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, Pub. L. No. 119-37, § 6208 (2025), <http://www.govinfo.gov/content/pkg/BILLS-119hr5371eas/pdf/BILLS-119hr5371eas.pdf>.

<sup>2</sup> Ctrs. for Medicare & Medicaid Servs., *Telehealth FAQ* (Oct. 1, 2025), <http://www.cms.gov/files/document/telehealth-faq-updated-10-15-2025.pdf>.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> Telehealth Modernization Act, H.R.5081, 119th Cong. (2025), <http://www.congress.gov/bill/119th-congress/house-bill/5081/text>.

<sup>8</sup> CONNECT for Health Act of 2025, S.1261, 119th Cong. (2025), <http://www.congress.gov/bill/119th-congress/senate-bill/1261/text>.

## **Breaking Down the One Big Beautiful Bill: Reshaping the Federal Health Care Landscape**

Enacted in July 2025 as the Trump Administration’s signature legislative victory, the One Big Beautiful Bill Act (H.R. 1) consolidates sweeping tax, spending, and entitlement reforms into a single omnibus package. While its public framing emphasized “economic revival” and “border security,” the legislation’s under-the-radar effect is a fundamental restructuring of how federal health care programs are financed and administered. It modifies Medicaid eligibility, revises Affordable Care Act (ACA) mandates, alters health-related tax incentives, and caps future federal growth in several public health programs.

### **Key Health-Related Provisions**

- **Medicaid Work and Eligibility Requirements** – Requires able-bodied adults under 65 to verify employment, job training, or community service to maintain Medicaid coverage. States must adopt compliance systems or risk reduced federal matching funds.
- **Block-Grant and Spending Caps** – Converts portions of federal Medicaid funding into fixed allotments, limiting growth even if enrollment rises. Encourages state-level “innovation waivers” to redesign benefits and cost-sharing.
- **ACA Rollbacks** – Repeals individual-mandate penalties entirely, relaxes essential health-benefit standards, and grants insurers greater pricing flexibility across state lines.
- **Employer and Tax Incentives** – Expands small-business health-insurance deductions and restores certain flexible-spending-account benefits, intended to shift coverage responsibility back to the private market.
- **Public Health and Safety-Net Reductions** – Freezes funding for several federal grant programs (community health centers, behavioral-health block grants, and public-health emergency preparedness) at FY 2024 levels.

### **Political and Economic Context**

H.R. 1 embodies the administration’s “state-driven, market-reinforced” approach to health policy. Supporters view the law as restoring fiscal discipline and empowering states to tailor programs to local needs. Critics warn that converting Medicaid to capped allotments will inevitably cut coverage during recessions or public-health crises. Economists estimate that by FY 2027, federal Medicaid spending will decline roughly 10–12 percent relative to prior baselines, while private insurance enrollment will rise modestly through expanded employer incentives.

### **Implications for Health-Law Practitioners**

Attorneys advising hospitals, insurers, and state agencies will encounter new regulatory and contractual risk as implementation unfolds.

- States must draft Medicaid waiver amendments to align with federal caps and work requirements.

- Providers should anticipate increased uncompensated-care exposure if disenrollment rises.
- Health plans and employers will need revised plan documents to reflect expanded pre-tax contribution rules and adjusted coverage mandates.
- Litigation is likely under the Administrative Procedure Act and Equal Protection Clause, particularly around work-requirement enforcement and benefit reductions.

### **Rural Health Transformation (RHT) Program**

The Rural Health Transformation (RHT) Program was authorized by the One Big Beautiful Bill Act ([Section 71401 of Public Law 119-21](#)) and empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. Through innovative system-wide change, the RHT Program invests in the rural healthcare delivery ecosystem for future generations. The RHT Program seeks to further the following strategic goals:

- **Make Rural America Healthy Again** – Support rural health innovations and new access points to promote preventative health and address root causes of diseases. Projects will use evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care.
- **Sustainable Access** – Help rural providers become long-term access points for care by improving efficiency and sustainability. With RHT Program support, rural facilities work together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services.
- **Workforce Development** – Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities. Help rural providers practice at the top of their license and develop a broader set of providers to serve a rural community’s needs, such as community health workers, pharmacists, and individuals trained to help patients navigate the healthcare system.
- **Innovative Care** – Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements. Develop and implement payment mechanisms incentivizing providers or Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings.
- **Tech Innovation** – Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients. Projects support access to remote care, improve data sharing, strengthen cybersecurity, and invest in emerging technologies.

You can learn more information about the RHT Program [here](#).

## **2026–27 Outlook**

Implementation guidance is expected from HHS and CMS in early 2026, beginning a phased transition toward state block grants by FY 2027. Parallel appropriations fights will determine whether public-health programs receive back-fill funding. For now, the One Big Beautiful Bill Act stands as the most consequential health-finance reform since the ACA—shifting costs, authority, and accountability away from Washington and toward states, employers, and individuals. The coming year will reveal whether that shift yields flexibility or fragmentation in the nation’s health-care system.

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### III. FEDERAL CASE LAW

#### **Eleventh Circuit Allows *Qui Tam* Relators to Avoid Compliant Dismissal By Using Information Obtained in Discovery**

The U.S. Court of Appeals for the Eleventh Circuit held in *United States ex rel. Sedona Partners LLC v. Able Moving and Storage Inc.*, No. 22-13340 (11th Cir. Jul. 25, 2025), that while a district court has the discretion to dismiss a relator’s complaint before or once discovery has begun, it may not disregard the allegations of *qui tam* relators at the motion to dismiss stage solely because those allegations reflect information obtained in discovery.

The Eleventh Circuit in *Sedona* reversed a contrary decision of the U.S. District Court for the Southern District of Florida, which had relied on an unpublished 2019 case, *Bingham v. HCA Inc.*, 783 F. App’x 868 (11th Cir. 2019), when it considered the matter in 2022.

According to the Eleventh Circuit, the district court had erred in both ignoring the allegations in question—relating to the defendant shipping companies’ requests to waive a requirement to use U.S. carriers in favor of foreign ones—and in striking those allegations from the relator’s second amended complaint.

#### **The Facts: Foreign Flag Waivers**

The district court dismissed the second amended complaint of *qui tam* relator Sedona Partners after striking its discovery-based allegations. The FCA suit alleged that defendants, a specific group of transportation service providers (TSPs), had engaged in a scheme to defraud a federal program assisting federal employees in shipping their belongings when accepting new posts overseas.

Sedona, also a TSP, alleged that defendants fraudulently used less expensive foreign vessels instead of American shipping carriers in violation of a policy requiring the use of American carriers. Defendants would allegedly submit fraudulently low bids to win competitive contracts and routinely apply for a “foreign flag waiver” by certifying that no U.S. vessels were available to carry out the contracts. Other TSPs submitted higher bids, reflecting the higher cost of U.S. carriers. Since the amount paid by the government did not vary based upon whether U.S. or foreign vessels were used, Defendants allegedly profited from the scheme.

Defendants moved to dismiss, contending that Sedona failed to state a claim under Federal Rule of Civil Procedure (FRCP) 12(b)(6) and failed to plead fraud with particularity under Rule 9(b)—arguments that were repeated after the relator filed a second amended complaint identifying at least 96 shipments for which defendants allegedly submitted false certifications. Sedona had obtained the additional information to include in the second amended complaint from the defendants and from a third-party shipping line in discovery.

Defendants also moved to strike allegations derived from materials obtained in discovery under Rule 12(f), asserting that in the Eleventh Circuit, “permitting a [r]elator to use the discovery process to cure a defective pleading constitutes an impermissible end-run around the gatekeeping functions of Rule 9(b).”

A magistrate judge and subsequently the district court judge agreed, concluding that under the unpublished *Bingham* case, courts may strike “allegations based on materials obtained during discovery if it prevents relators from circumventing the particularity requirement of Rule 9(b).” The district court found that Sedona’s allegations identifying the 96 shipments involving false waiver requests were derived from discovery materials, consequently struck those allegations, and dismissed the second amended complaint with prejudice. Sedona appealed.

### **Eleventh Circuit: Rule 9(b)**

The Eleventh Circuit rejected the defendants’ arguments that Rule 9(b) would be nullified if relators were allowed to rehabilitate deficient FCA claims with information learned from discovery.

“*Bingham* is not binding on us, and we do not find it persuasive because . . . Rule 9(b) does not prohibit pleaders from using, or courts from considering, allegations based on information obtained during discovery,” Circuit Judge Jill Pryor wrote for the panel.

The court reasoned that the text of Rule 9(b) places no restrictions on the source of the information that may be used to satisfy the rule; and the FRCP allow a party to amend the pleadings to reflect information gained from any source, as long as the amendment is otherwise proper under Rule 15.

The Eleventh Circuit also held that the district court abused its discretion when it struck Sedona’s discovery-based allegations under Rule 12(f), under which a “court may strike from a pleading any redundant, immaterial, impertinent, or scandalous matter.” A Rule 12(f) motion, the court said, is a drastic remedy to be used “only when required for the purposes of justice” and “should be granted only when the pleading to be stricken has no possible relation to the controversy.”

Finally, the court declined to affirm the district court on the basis that (1) the allegations in Plaintiff’s second amended complaint still failed to plead fraud with sufficient particularity, even with the information obtained in discovery, or that (2) the allegations failed to allege that the defendants knew the claims were false. Since the district court never reached those issues, the Eleventh Circuit chose to return them to the lower court.

We note here that the Eleventh Circuit did not address the potential applicability of the public disclosure bar. The district court in *Sedona* concluded that it did not apply, stating that “it is not clear from the record that all of the shipping information relied upon by Relator, including historical data, is accessible from internet websites.” *U.S. ex rel. Sedona Partners LLC v. Able Moving & Storage, Inc.* (S.D. Fla. 2022).

### **Takeaways**

Though the underlying facts of the *Sedona* case concern the shipping industry, its principles apply, with equal force and effect, to all FCA cases, including those in health care and life sciences industries. While the Rule 9(b) heightened pleading standard requires particularity in cases alleging fraud or mistake, the Eleventh Circuit made clear that plaintiffs can use material obtained in discovery to revive a faulty complaint. Therefore, relators may look to initiate earlier discovery as a means to support—and possibly amend—their claims during the motion to dismiss phase.

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