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# Advisory | Health Care & FDA Practice



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## Outlook 2026: Texas Health Care

1. **Increased Financial Distress for Providers** — Due to a variety of factors, including wage and supply inflation, increased reimbursement pressure from all payors, and decreases in Medicaid and Patient Protection and Affordable Care Act coverage (emerging out of federal legislation), in 2026 we may see greater financial distress for providers across all sectors. This distress may lead to some greater transactional activity, as providers look for additional sources of capital. Another result may be more delayed, as providers look for additional sources of revenue, or less-established business models, which may lead to future enforcement down the road. There may also be an increase in providers seeking restructuring through consensual restructuring or bankruptcy.
2. **Workforce and Immigration Issues Continue to Hinder Health Care Goals** – There is currently a workforce shortage in the health care industry. Recent federal immigration policies and visa complexities and fees may exacerbate these issues, as hiring of foreign nationals in the H-1B category may be impaired if they are coming to the United States from overseas due to the recent, significant filing fee increase. These changes have prompted both federal and state legislative efforts to streamline pathways to provide additional workforce personnel. H.R. 5283, or the Healthcare Workforce Resilience Act, is a bill that was introduced in September 2025 to the U.S. legislature that is currently pending and aims to reduce the shortage of nurses and physicians by recapturing green cards that Congress previously authorized but were unused. The legislation would allot up to 25,000 immigrant visas for nurses and 15,000 immigrant visas for physicians.

   Texas H.B. 2038, or the DOCTOR Act, is a bill that recently passed in the Texas legislature that works to create a new licensure pathway for internationally trained physicians and establish a license type for

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U.S. medical school graduates who do not match into a residency program. For internationally trained physicians to be eligible for the program, they must be proficient in English, be in good standing to practice, free of disciplinary action, and pass required parts of the U.S. licensing exam.

3. **Continued Scrutiny of Private Equity and Private Ownership of Health Care Entities** – Private ownership, including private equity ownership, of health care entities continued at a high pace in 2025 and reached global highs in deal value with many investments in such entities as nursing homes, hospitals, and certain specialties like dentistry, anesthesia and emergency medicine, and dermatology. A consequence of the high levels of deal volume has been increased attention and scrutiny by many state governments of transactions between private equity and certain health care entities. According to the *Texas Insider* on Feb. 27, 2025, Texas has almost 100 hospitals backed by private equity. Texas medical societies are now focusing on (1) setting ethical guidelines for clinical practices with private equity investment and (2) compliance with the Corporate Practice of Medicine (CPOM) doctrine.

   Thirty-five states have some form of health care transaction review law. Texas failed to pass a reporting law in the most recent legislative session. These health care transaction reporting requirements differ from those of other corporate transactions such as change of ownership or facility closure. Health care transaction reporting requirements are broader and relate more specifically to the financial and ownership interests by a business in a health care entity.

   Texas providers may wish to consider the effect of the CPOM doctrines on prospective equity and private ownership deals. That doctrine prohibits nonphysicians from practicing medicine or owning a medical practice[1]. The participation of outside third parties who seek to own or control a medical practice by investing or managing it may trigger potential CPOM violations if not structured correctly. Approximately 33 states have CPOM doctrines, and although many states did not always enforce these laws/doctrines, they have considered using these to address potential corporate practice violations with private equity and other nonphysician ownership arrangements. For example, Oregon passed legislation in 2025 that prohibits management services organizations from owning or controlling a majority interest in professional medical entities[2].

   In 2026, investors may be more targeted in their investments. The state of Texas may also continue to evaluate the impact of private ownership and equity on the cost of health care.

4. **Digital Health** – The adoption of digital health technology, including artificial intelligence/machine learning (AI/ML) systems and tools, is accelerating at an exponential pace. Already this year, the U.S. Food and Drug Administration (FDA) has reissued final guidance documents impacting general wellness products and clinical decision support software, which may continue to shape how industry approaches product development, adoption, and compliance. AI governance, risk management, and transparency might be key issues for developers and deployers of AI/ML in the health care industry this year, while compliance with fragmented and divergent state AI and data privacy laws, and the lack of uniform federal laws and regulations, presents unique challenges to the market.

5. **Federal Regulatory Changes** – Regulatory changes taking effect in 2026 under the One Big Beautiful Bill Act (OBBBA) may have a significant impact on the access to and cost of care. Federal agencies and some academic institutions have been impacted by federal reductions in funding and staff. We already see changes in CMS/HHS' historical emphasis on access, coverage, and cost of health

[1] With the exception of nonprofit health corporations that permit nonphysician sponsorship of a health care entity that can employ physicians.
[2] *See*, e.g., Oregon HB 3410 and SB 951.

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care as well as changes to the health policies affecting the various health agencies that focus on the public's health. Significant changes include:

- Vaccine and Public Health Policy Shifts. Removal of CDC leadership and some staff resignations have impacted the CDC's ability to provide regular and consistent guidance to its constituents that rely on this data for making decisions related to health and wellness. HHS has enacted major changes to vaccine policy, including removing certain universal childhood vaccine recommendations and shifting expert advisory roles to those who do not support traditional childhood vaccine programs. Several West Coast states have formed the West Coast Health Alliance to preserve science-based immunization recommendations, representing a more decentralized public health program where payers and providers must navigate different vaccine schedules, reporting requirements, and reimbursement, potentially creating operational complexity in managing global outbreaks.
- Reduced Federal Health Spending. The OBBBA imposes a reduction in health care spending that may affect how states finance and administer their Medicaid programs, the most significant being an estimated $1 trillion reduction in funding for the program and changes in State-Directed Payments (SDPs). SDPs will be subject to annual reductions based on Medicare rates in expansion states, in effect, setting limits to the amount the state can fund its Medicaid program. Work requirements will also be instituted for healthy adults without dependents by Dec. 31, 2026. The CBO estimates that this requirement will have the greatest effect on spending and coverage. Other provisions of OBBBA may reduce Medicare spending by $326 billion over 10 years, potentially resulting in 5.3 million more uninsured people.
- Health Care Access and Coverage Changes. ACA subsidies, through enhanced premium tax credits, expired at the end of 2025. Although Congress is currently trying to address alternatives to funding, enrollment in the marketplace programs has declined, leading to fewer affordable plans and increases in insurance rates. This impacts the providers, particularly those in rural communities that are already under stress. Some stakeholders consider the proposed "Rural Health Transformation Program," intended to provide $10 billion to states from FY 2026 to 2030, insufficient to offset Medicaid losses and cover the need among rural providers. Also, the future of the Medicare program is unclear as plans, payers, enrollees, providers, and vendors try to plan for 2026 under an uncertain future Medicare policy.

The implementation of OBBBA may affect coverage, access, costs, providers, and systems as it shifts the U.S. health care landscape towards tighter eligibility, more cost-sharing, and administrative complexity with significant implications for continuity of care, safety-net service delivery, and public health programs.

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