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## **Why Budget Priorities Now Amplify System Fragility** ***Commentary about the proposed FY 2027 Massachusetts State Budget*** ***(H.2)***

Massachusetts enters this moment with almost no margin for error. The Governor's FY27 budget reflects a defensive posture: approximately **\$22.5 billion for MassHealth** and another **\$10.8 billion for Health and Human Services**, yet **provider reimbursement remains largely flat**, benefits are tightened, and no new revenue is proposed.

Cost containment includes eliminating coverage for certain high-cost drugs, capping dental benefits, and seeking **\$120 million in savings through the Group Insurance Commission**. At the same time, more than **\$3.8 billion in Fair Share revenue** is now being used to stabilize operating budgets — including **\$470 million for MBTA operations and over \$550 million for education formula costs** — rather than building long-term system capacity. This is what fiscal constraint looks like in practice: maintaining minimum functionality while deferring structural investment. On paper, the Commonwealth projects a consolidated surplus and healthy reserves. On the ground, care systems operate without slack.

For older adults and people with disabilities, this means thinner staffing, tighter eligibility, slower service expansion, and greater reliance on unpaid family care. Flat rates translate directly into workforce instability. When wages lag inflation and overtime becomes the norm, facilities close beds, home care agencies reject referrals, and hospitals hold medically stable patients because downstream capacity no longer exists. This is precisely where immigration enforcement becomes a system accelerant rather than a standalone issue. Every caregiver lost to detention, parole expiration, or fear-driven attrition compounds a workforce already stretched thin by budget constraint. Care continuity collapses quietly — one canceled shift, one closed bed, one delayed discharge at a time — until crisis becomes visible.

Yet the Commonwealth's own reform framework has not prepared the system for this exposure. **Chapter 197 was intended to modernize long-term care**, but its commission structure fragmented responsibility without creating integrated operational authority. Workforce discussions focused on training pipelines rather than labor stability. Financial reviews framed "sustainability" without addressing staffing volatility or extraction dynamics. Discharge reform emphasized process improvements while capacity erosion continued. Immigration appeared primarily as a patient eligibility issue — not as a labor dependency embedded in care delivery. Implementation has already slipped. Required reports have missed statutory deadlines. Hospitals continue boarding medically stable patients for months. Recommendations remain largely advisory rather than binding.

In a tight fiscal environment, this matters. Without integrated, costed implementation plans, budget writers default to stabilization rather than transformation. Funding flows to pilots, coordination efforts, and short-term fixes — not to workforce stabilization, enforcement modernization, capacity planning, or contingency readiness. Fragmented reform produces fragmented budgets. Fragmented budgets cannot protect fragile systems.

The FY27 budget contains no meaningful contingency capacity to absorb workforce shock. There is no surge staffing reserve, no emergency placement infrastructure, no rapid discharge expansion authority — because the reform architecture never translated diagnosis into executable fiscal strategy. When governance drifts, budget policy becomes reactive rather than preventive.

This leaves older adults and people with disabilities exposed to cascading risk. A constrained budget magnifies every disruption. A delayed reform magnifies every staffing loss. Immigration enforcement now lands on a system already operating without slack — not because leaders lack concern, but because the architecture for coordinated action was never built.