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FY26 Massachusetts House vs. Senate Budget Comparison – Health Care Policy & Funding

Introduction

The Massachusetts House (H.4001) and Senate (S.2525) Fiscal Year 2026 budgets both make substantial investments in health care, reflecting roughly 46% of total state spending [1]. Each chamber's budget supports core programs like MassHealth (Medicaid) and public health, but there are key differences in line-item appropriations, new initiatives, and policy language. As a conference committee works to reconcile H. 4001 and S.2525, several health care issues – from mental health funding to hospital support – are poised to be major negotiating points. This report examines the critical divergences between the House and Senate budgets in the health care domain and highlights likely areas of contention based on funding gaps and strategic priorities.

MassHealth and Health Coverage

Both the House and Senate budgets fund MassHealth at approximately **$22.4 billion**, ensuring continued coverage for about 2 million residents (over one-quarter of the state's population) [2]. The House appropriates $22.43B for MassHealth [3], while the Senate allocates $22.41B [2] – effectively the same level, indicating consensus on fully funding Medicaid enrollment and services. However, the House budget earmarks **targeted provider rate increases** within MassHealth, including *$13.8 million* to boost primary care reimbursement and *$5.3 million* for outpatient behavioral health and addiction treatment rates [4]. The Senate did not highlight similar line-item increases for those providers, suggesting this House initiative may be a point for negotiation if the Senate prefers broader funding without specific earmarks.

The two budgets also diverge on **health coverage policy expansions**. The House proposes to **extend and broaden the ConnectorCare insurance pilot**, which offers subsidized health plans beyond Medicaid. H. 4001 would continue the pilot for a third year (through calendar 2026) and expand eligibility from 300% to **500% of the federal poverty level**, allowing more middle-income residents to qualify [5]. As of June 2024, over 51,000 people were enrolled under this pilot, and the House's expansion would further increase access [5]. The Senate budget contains *no parallel provision* – it omits this extension and expansion – making ConnectorCare's future a likely conference committee debate. In contrast, the Senate includes an outside section aimed at **reining in prescription drug costs**, authorizing action against high-cost drugs so that their prices "do not far exceed their value" [6]. This drug pricing provision (intended to empower state oversight of exorbitant pharmaceutical prices) is *absent from the House budget*, reflecting a Senate-specific policy priority. Negotiators will have to decide whether to adopt the House's coverage expansion, the Senate's drug-cost controls, or both in the final budget.

Notably, both chambers avoided any cuts to core MassHealth eligibility or benefits – a significant point given Medicaid's large budget share. Each budget increases MassHealth spending by roughly $2.3 billion over FY25 to keep up with caseload growth and the end of federal pandemic aid [2]. Thus, while **funding levels for Medicaid are aligned**, the **policy language differs**, with the House focused on expanding

affordable coverage (ConnectorCare) and provider access, and the Senate focused on cost containment (prescription drug pricing). These priorities will need to be balanced in conference.

Hospital Support and Health System Funding

A stark difference between H.4001 and S.2525 is how each addresses financial strains on hospitals, especially those serving high numbers of uninsured patients. The **Health Safety Net (HSN)**, a state fund that reimburses hospitals for uncompensated care, faces a major shortfall in FY25 and FY26. The House budget responds by **transferring $230 million** from the Commonwealth Care Trust Fund to stabilize the HSN [7]. In contrast, the Senate budget only authorized a transfer of "up to $15 million" to the HSN [7] – a **$215 million gap** relative to the House's plan. Hospital advocates have flagged this as an urgent issue, noting the shortfall could exceed $250M this year [8], and it is likely to be one of the most **contentious conference items**. The House's robust infusion would significantly aid safety-net hospitals, whereas the Senate's minimal transfer suggests caution or intent to address the issue outside the budget. Reconciling this difference will be critical for hospital financial stability [7].

Both budgets seek to support health care providers broadly, but they do so in different ways. The House dedicates funding to implement last year's nursing home reform law, providing **$132 million for nursing facility rate increases** as required by Chapter 197 of the Acts of 2024 [9]. This helps long-term care facilities raise wages and improve quality in line with the law's mandates. The Senate likewise boosts nursing home funding – it specifies *$582.1 million* for nursing facility Medicaid rates, including *$112 million* in new base rate payments to improve worker wages [10]. Additionally, the Senate sets aside *$102 million* for **enhanced nursing home rates** to begin implementing the 2024 long-term care overhaul [11]. In essence, **both chambers invest heavily in nursing homes**, but the House cited a single total ($132M) while the Senate broke out base increases vs. an enhancement pool. The combined nursing home support in the final budget will likely reflect a middle ground or both funding mechanisms to ensure these facilities can recruit staff and maintain services.

The Senate also uniquely emphasizes maintaining certain state-run health facilities. S.2525 allocates *$237.7 million* for DPH-operated hospitals, including **$31 million to fully fund the Pappas Rehabilitation Hospital for Children** through FY26 [12], and it provides *$386.4 million* for Department of Mental Health services, including **$4.8 million to keep the Pocasset Mental Health Center open** on Cape Cod [12]. These line items suggest the Senate prioritizes preventing the closure or downsizing of these safety-net hospitals (Pappas is a pediatric chronic care hospital, Pocasset a mental health facility). The House budget did not highlight funding for Pappas or Pocasset – it's possible the House assumed lower funding or planned reforms for those facilities. The Senate's stance sets up a negotiation: the conference committee must decide whether to endorse the Senate's explicit support for those hospitals or consider cost-saving measures. Given stakeholder interest (patients, local communities) in keeping such facilities open, the Senate's position may carry weight in talks.

Beyond hospitals, the budgets provide other forms of health system support. The House's earlier-noted **MassHealth rate boosts for primary care** are meant to shore up community providers at "a time of severe strain" [4], addressing concerns about clinician shortages and financial stress in primary care practices. The Senate's approach to system support is more indirect – rather than earmarking funds to specific provider types (aside from nursing homes), the Senate focuses on system-wide measures like the prescription drug cost provision and a one-time deposit into a behavioral health trust (discussed below). In summary, on **hospital and provider funding**, the House took a more direct funding approach (especially for the HSN and

certain rates), while the Senate coupled funding with strategic policy measures. Expect the HSN funding level, nursing home payments, and support for specific state hospitals to be **major negotiation areas**, as they involve large dollars and different strategies for sustaining the health care safety net.

Mental Health and Behavioral Health Services

Investments in mental health are a prominent component of both budgets, yet there are **key differences in funding levels and initiatives**. The House funds the **Department of Mental Health (DMH) at $1.28 billion** total [13], a figure that continues the recent growth of mental health spending. Within that total, the House allocates about **$661.9 million for adult mental health services** (community placements, support programs) and **$128.6 million for child and adolescent mental health** services [14]. These figures indicate the House's commitment to expanding service capacity for individuals of all ages with mental health needs. By comparison, the Senate highlights specific parts of its DMH funding: *$386.4 million* for DMH state hospital and community-based services [12]. Notably, as mentioned, this includes a **$4.8M earmark to fully fund the Pocasset Mental Health Center** [12], which serves southeastern Massachusetts. The House did not call out Pocasset funding, implying a possible difference (House may not have provided full year funding for that facility). Ensuring resources for regional mental health hospitals like Pocasset could become a negotiating point, with the Senate clearly in favor of keeping it operational.

The Senate budget also creates or bolsters **targeted behavioral health initiatives**. It proposes to **re-capitalize the Behavioral Health Access and Outreach Trust Fund with $20 million** [15]. This trust fund (initially created by recent legislation) finances innovative programs to improve behavioral health access, such as community outreach, crisis intervention, and workforce development. The House budget contains no similar provision or new deposit into this fund. As a result, the Senate's $20M behavioral health trust investment – aimed at continuing last session's mental health reform momentum – will be a point of discussion. The House may agree to fund it in conference, or might redirect funds into other mental health programs instead. Both chambers, however, did show support for crisis services: each budget includes **$14.3 million for suicide prevention and intervention** programs [16] [17]. The Senate specified that this funding will *fully support the 988 Suicide & Crisis Lifeline*, including added support for Samaritans, Inc. and the Call2Talk hotline [17]. The House's allocation for suicide prevention is similar in amount [16], though without the explicit language about 988, so the final budget will likely maintain this funding and could adopt the Senate's earmarks to ensure the new 988 hotline system is robustly funded.

Another difference lies in addressing the **substance use disorder crisis**. The House budget allocates **$194.5 million to the Bureau of Substance Addiction Services (BSAS)** [16], which is roughly $15 million more than the Senate's **$179.9 million for BSAS** [18]. The House's higher funding could expand treatment and recovery programs – for example, adding capacity for opioid treatment, recovery centers, or harm reduction services. The Senate did include a notable BSAS initiative: *$1.5 million* in new funding to develop a **recovery coach workforce** (peer support specialists) as authorized by last year's Substance Use Disorder Workforce Act [18]. The House's budget does not mention a specific recovery coach program, potentially leaving it to the conference committee to incorporate the Senate's idea. Advocates will be watching how the final budget balances these figures – whether the House's greater dollar amount for addiction services prevails, and if the Senate's targeted workforce program is retained.

Workforce support in human services is another theme where the budgets align in intent but differ in execution. To combat provider shortages, the House includes **$5 million for a DMH loan forgiveness program** to incentivize and retain mental health professionals [14]. It also provides **$4.9 million for nursing**

workforce development (funding nurse recruitment bonuses, nursing faculty, and testing support) [19] to address the nursing shortfall in health care facilities. The Senate's budget does not single out those programs; instead, the Senate's broader workforce investments can be seen in accounts like the Personal Care Attendant (PCA) program. The Senate funds **$1.73 billion for PCAs**, including the cost of a landmark wage increase to a $25/hour rate [20] – a major expenditure that supports the largely female, diverse workforce providing in-home care. While not purely a mental health line item, PCA services enable many people with disabilities (including those with behavioral health needs) to live in the community. The House presumably also funds the PCA contract (since it's mandated), but did not call it out in press materials. The difference is one of emphasis: the House highlights smaller, targeted workforce incentives, whereas the Senate emphasizes large-scale workforce investments through core service budgets. In conference, legislators will likely agree to both types of supports – maintaining the big contractual commitments (like PCA wages) and including some targeted workforce initiatives (loan forgiveness, training funds) drawn from each version.

In summary, **mental and behavioral health funding** is a priority in both budgets, but they diverge on specific programs and allocations. The **likely areas of contention** will be: how much to deposit into the behavioral health trust fund (Senate wants $20M; House is silent), whether to fully fund certain mental health facilities (Pocasset) as the Senate insists, and the overall level of substance use treatment funding (House is higher). Despite these differences, both chambers' proposals reinforce the state's commitment to mental health access, so the debate will be about *where* and *how* to direct these new investments.

Public Health, Prevention, and Health Equity Initiatives

Both budgets strengthen public health programs and pursue health equity goals, yet each has distinctive priorities in this realm. The House funds the **Department of Public Health (DPH) at $1.05 billion** in FY26 [13], sustaining a wide range of public health services from disease prevention to community clinics. The Senate's total DPH funding is similar (around $1 billion), but the composition differs in certain line items and initiatives. One example is support for **community health centers (CHCs)**, which serve underserved communities: the House budget provides **$10.4 million for CHCs**, including an earmark of **$1 million to launch a new gender-affirming care program** [21] to expand services for transgender and non-binary patients. In contrast, the Senate budget sets aside **$5 million for CHC workforce support** – specifically for loan forgiveness programs to help community health center staff (such as clinicians from diverse backgrounds) repay student loans [22]. The House focuses on direct funding for CHC services (and a notable LGBTQ+ health initiative), while the Senate zeroes in on strengthening the CHC workforce pipeline. The final budget will likely incorporate both perspectives – some direct funding to CHCs (potentially including the House's new gender-affirming care pilot) as well as resources to recruit and retain CHC staff as in the Senate plan.

Another notable difference is in **local public health infrastructure**. The State Action for Public Health Excellence (**SAPHE**) grant program, which funds local and regional health departments to improve their capabilities, is funded in both budgets but at different levels. The House (following the Governor's recommendation) proposes about **$9.2 million for SAPHE grants** [23]. This is a *reduction* from FY25, reflecting a concern that the House budget might leave local boards of health with fewer resources. During its budget debate, the Senate signaled stronger support for local public health; reports indicate the Senate boosted SAPHE funding, partially restoring prior-year levels (the Senate Ways & Means proposal was reportedly just a **9% decrease from last year**, versus the Governor/House's deeper 28% cut) [24]. While exact Senate figures aren't in the press releases, it's clear the Senate wants to invest more in local public

health capacity (an issue highlighted by the pandemic and a new SAPHE 2.0 law). Consequently, **public health infrastructure funding** for cities and towns will be a subject of negotiation: House conferees may agree to the Senate's higher funding given bipartisan acknowledgment of the need for strong local health systems, but the precise dollar amount will be worked out in conference.

The budgets also introduce different **health equity initiatives** aimed at underserved populations. The House emphasizes continued support for HIV/AIDS prevention and treatment, allocating **$35 million for HIV/AIDS programs** [16]. The Senate did not separately highlight an HIV line item, so it may have funded it at a status quo level (likely lower than $35M, meaning the House is pushing more investment there). The Senate, on the other hand, includes a new **$2 million grant program to improve reproductive health access and infrastructure** [25]. This funding is designed to bolster providers in the wake of national reproductive health challenges – it can fund facility security upgrades or expand services like abortion access. The House budget has no explicit parallel item for reproductive health infrastructure, making this a Senate initiative that advocacy groups will watch in conference (especially given Massachusetts' stance on protecting reproductive rights). Compromise may entail the final budget funding both priorities – maintaining the House's higher HIV/AIDS funding and incorporating the Senate's reproductive health grants – as both address critical health equity concerns (supporting communities disproportionately affected by HIV, and safeguarding reproductive care).

Maternal health equity is another area where the Senate took the lead. In the wake of the 2024 maternal health omnibus law, the Senate added funding to kick-start new programs: *$1.1 million* for expanding **freestanding birthing centers** across the state, and *$220,000* to implement the "Moms Matter" **maternal mental health grants** program [26]. These modest but symbolic investments were adopted via Senate amendments to ensure the initiatives created by last year's law actually reach communities (e.g. supporting midwifery-led birth centers and postpartum depression support). The House budget did **not fund these new maternal health programs** – likely due to timing or different priorities – so the conference committee will decide if they make it into the final budget. Given the widespread concern about maternal health disparities, there may be consensus to include them (the amounts are relatively small), but it exemplifies how the Senate prioritized **health equity for mothers and infants**, whereas the House budget was silent on it.

Preventive health services in schools and communities also see differing emphasis. The Senate invests **$22.6 million in school-based health centers and programs** [27], a significant boost to ensure students have access to medical and mental health services on school grounds. The House did not call out school-based health funding in its summary, suggesting the Senate's number is an increase over the House. This could be a point of enhancement in the final budget if conferees agree that bolstering school health centers aligns with shared goals (especially for mental health support in schools). Additionally, both budgets address **nutrition and food security**, albeit with different allocations: The House provides **$55 million for the Emergency Food Assistance Program** (which supplies food banks) [28], whereas the Senate provides $42 million for that program while putting more into nutritional incentives. The Senate commits **$25.4 million for the Healthy Incentives Program (HIP)**, which gives SNAP recipients extra benefits for buying local produce [29] – higher than the House's $20 million for HIP [28]. The House also funds a SNAP employment & training incentive ("SNAP for low-income workers") at $8.4M [28], which the Senate did not highlight. These differences reflect a common objective of fighting food insecurity, but with a tilt: the House prioritized direct food pantry support, while the Senate favored programs that improve nutrition for low-income families. The final budget will likely meet somewhere in the middle, ensuring both food banks and healthy food incentives are sufficiently funded [29] [28].

Another small but notable policy difference is in health service delivery modernization. The House budget creates a **task force to examine interstate telehealth barriers** and recommend how to improve access to telemedicine across state lines [30]. This acknowledges the growing role of telehealth and the challenges patients face when providers are out-of-state. The Senate budget has no comparable provision. While a task force is a policy matter more than a fiscal one, it could easily be included in the final budget's outside sections if there is mutual support (it costs little but could yield long-term recommendations). Thus, we may see the telehealth study authorized in the conference compromise, especially given broad interest in telehealth expansion post-pandemic.

Conclusion

The House and Senate FY26 budgets for Massachusetts both channel historic levels of funding into health care, yet they diverge on important details that reflect each chamber's priorities. The **House version** tends to invest more in **expanding access and provider rates** – evident in its ConnectorCare insurance expansion [5], higher funding for substance use treatment [16], targeted primary care and mental health rate increases [4], and large one-time support for the hospital safety net [7]. The **Senate version**, meanwhile, places weight on **cost containment and targeted innovations** – such as prescription drug price controls [6], a behavioral health trust fund infusion [15], and seed money for equity initiatives like birth centers [26]. The Senate also generally favored increasing certain health appropriations (school health, local public health, reproductive health access) that the House had level-funded or not highlighted.

In conference committee, the most **likely areas of contention** will be those with significant funding disparities or unique policy riders. Top among these is the **Hospital Safety Net funding** ($230M vs. $15M) [7], which pits the House's aggressive response to hospital financial stress against the Senate's cautious approach – a gap almost certain to be negotiated given hospital industry pressure. **Medicaid coverage policy** is another, as conferees must reconcile the House's push to broaden coverage via ConnectorCare with the Senate's omission of that plan. **Mental health and substance use funding** levels (DMH, BSAS) will need alignment, although both sides agree on the importance of these services. Differences in **health equity initiatives** – for example, whether to fund new maternal health and gender-affirming care programs from one chamber's budget or the other's – will be worked out, likely by incorporating many of these smaller initiatives since they complement each other. And for **public health infrastructure** like local health departments and school health centers, the conference committee will determine how far to go in boosting those investments, using the House and Senate figures as the range.

Overall, the final FY26 budget is expected to blend the House's and Senate's priorities, resulting in a comprehensive health care funding package. Analysts anticipate that the **House's focus on access (coverage, provider supports) and the Senate's focus on sustainability (cost controls, targeted funds)** will both be reflected in the compromise. The result should address immediate needs – mental health care capacity, hospital stability, equitable health access – while also laying groundwork through policies and reserves to contain costs and improve outcomes. The conference committee's task is to craft a balanced approach that all stakeholders in the health care system can support, ensuring Massachusetts continues to lead in health coverage and care for its residents. The areas discussed here – mental health, Medicaid, hospital support, health equity, and public health – will determine how far the state goes in FY26 toward those goals, depending on how differences are resolved [7] [6]. Each decision made in conference will signal the Commonwealth's strategic priorities in health policy for the coming year.

Sources: House Bill 4001 and Senate Bill 2525 budget documents and summaries; Massachusetts legislature press releases and analyses [4] [2] [7] [5] [6], as well as reports from advocacy organizations and news outlets tracking health-related appropriations [16] [15] [26].

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