



POLICY PAGE

Center for Public Policy Priorities | 900 Lydia Street Austin, Texas 78702 PH: 512.320.0222/FAX: 512.320.0227 www.cppp.org

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For More Information: Anne Dunkelberg, dunkelberg@cppp.org

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HHSC House and Senate Budget Comparison: Medicaid and CHIP

Health and Human Services Commission: Selected Exceptional Items

Exceptional Item	Agency request	House Bill	Senate Bill	Comments
1) Maintain Medicaid Cost Trends for FY 2008-09. (Agency request also assumes higher caseloads than LBB assumptions.)	\$1.53 <u>billion</u> GR (\$4.38 <i>Billion All Funds</i>)	\$375 million GR (<i>\$1.018 billion AF</i>)	\$549.5 million GR (<i>\$1.42 billion AF</i>)	House funds HHSC's 2008 projected costs @ LBB caseloads. Senate funds 2008 cost growth, and <u>partial</u> cost growth in fiscal year 2009, (assumes LBB caseloads).
2) Maintain CHIP Cost Trends for FY 2008-09	\$50.9 million GR (\$165.6 <i>million AF</i>)	\$19.3 million GR (\$64 <i>million AF</i>)	\$19.3 million GR (\$64 <i>million AF</i>)	Both Chambers include the requested amount to cover <u>2008</u> CHIP growth, but <u>not</u> the 2009 costs.
3) Maintain Office of Eligibility Services (OES) Staffing & Support	\$17.3 million GR (\$32.6 <i>million AF</i>)	\$14.2 million GR (\$32.6 <i>million AF</i>)	\$14.2 million GR (\$29.5 <i>million AF</i>)	House funds full requested amount, includes \$3.1 million TANF in total. Senate does not fund the \$3.1 million.
4) Wait and Interest List Demographic Growth (DADS, DARS, DSHS)*	4) \$58.8 million GR (<i>\$98.7 million AF</i>)	4) \$58.8 million GR (<i>\$98.7 million AF</i>)	4) \$0	Senate allocates funding to Exceptional Item #8, and House allocates most to #4. <i>Impact on number of persons served is summarized below in a separate table.</i>
8) Reduce HHS Waiting/Interest Lists	8) \$202.1 million GR (<i>\$447.8 million AF</i>)	8) \$6.3 million GR (GR only)	8) \$107 million GR (<i>\$237.5 million AF</i>)	
5) Fund <i>Alberto N et. al.</i> Settlement (2005 Lawsuit settlement related to in-home care for chronically ill and medically fragile children)	\$149.2 million GR (<i>\$375.7 million AF</i>)	\$0	\$0	House HHSC rider #45 and Senate HHSC rider #44 direct HHSC to use Medicaid appropriated funds to comply with settlement; and allow transfers to DSHS if needed.

Exceptional Item	Agency request	House Bill	Senate Bill	Comments
6) Maintain TANF Cash Assistance Caseload (<i>base budget assumes caseloads in 08-09 will remain near current levels (3/07 enrollment is 130,765); HHSC assumes enrollment will grow by nearly 32,000 as of 2009.</i>)	\$3.2 million GR (\$50.4 million AF)	\$0	\$0	Neither chamber funds this item.
7) Maintain HIPAA Compliance (<i>federal electronic health care claims processing updates</i>)	\$5.2 million GR (\$15.0 million AF)	\$3.0 million GR (\$8.6 million AF)	\$3.2 million GR (\$9.1 million AF)	HHSC states that these funding levels will allow them to begin (not complete) compliance work.
9) Increase Office of Inspector General (OIG) Support	\$6.6 million GR (\$16.2 million AF)	\$0	\$6.6 million GR (\$16.2 million AF)	Senate Funding would increase OIG staffing by 85 FTEs, contingent on available GR in excess of current revenue estimate (HHSC rider #49)
10) Reform Medicaid Breast and Cervical Cancer treatment program rules	\$19.7 million GR (\$57.9 million AF)	\$4.0 million GR (\$10.96 million AF)	\$19.7 million GR (\$57.9 million AF)	Senate would allow any qualified medical provider to refer women for cancer treatment; House would leave 140 Texas counties with no health care provider who can refer a woman for Medicaid cancer treatment.
11) Expand Family Violence Services	\$2.0 million GR (& AF)	\$1.0 million GR	\$2.0 million GR	Senate will allow family violence services for 3,000 more; House would serve 1,500 more.
13) HHS Telecommunications and IT	\$20.9 million GR (\$39.2 million AF)	\$11.3 million GR (\$21.7 million AF)	\$35 million GR (\$63.7 million AF)	House funds portion of request for HHS data warehouse; Senate allocates \$35 million for <u>all</u> IT projects in all HHS agencies (including other EI requests, e.g. EBT & IBC) per HHSC Rider 47
20) Restore Medicaid and CHIP rates (from 2003 cuts)	\$235.6 million GR (\$603.3 million AF)	\$108.9 million GR (\$278.9 million AF)	\$108.9 million GR (\$277.2 million AF)	Both Chambers exclude portion of original request designated for Inpatient Hospital rates House funding is in HB 15 Senate AF difference is due to different federal match rate assumption
Rate Increase: Medicaid and CHIP <i>Note:</i> Additional rate increases detailed below in <i>Frew</i> section.		\$270.9 million GR (\$679.2 million AF)	\$409.5 million GR (\$1,034 million AF)	House funding for dentists, medical professionals, Pharmacies, is in Article IX contingent on creation of a Nursing Home "Quality Assurance Fee" (provider tax). Senate funds same providers plus ambulance, home health and PCCM (non-HMO Medicaid Managed Care). Senate amount includes \$240.8 million GR that is part of the \$706.7 million GR allocated for <i>Frew</i> lawsuit.

Other Major HHSC Funding Issues & Decisions

Medicaid Caseload and Cost Assumptions

Assumptions about growth in Medicaid caseloads and cost per client always have a significant impact on the budget. In the past as in the present session, the LBB and the Legislature have adopted lower caseload and cost assumptions than those projected by HHSC. Both the House and Senate adopted the LBB's caseload assumptions for Medicaid and CHIP, which have not changed from the base budget bill.

HHSC faced an especially difficult challenge projecting Medicaid caseloads for 2008 and 2009 because of the substantial caseload declines in 2006 resulting from the multi-faceted problems (including serious state eligibility staffing shortages) that plagued the attempted 2006 implementation of the Integrated Eligibility System. Some of the growth the agency predicted is related to recovery from caseload losses that resulted from these eligibility system errors and delays.

Medicaid Caseload Assumptions	Actual 06	Budgeted 07	FY 08	FY 09
	2,783,285	2,810,009		
LBB, House, Senate (2%, 2.6% increase)			2,865,192	2,939,751
HHSC (3.9%, 3.6% increase)			2,919,495	3,025,607

CHIP Caseload and Cost Assumptions & HB 109

LBB and HHSC CHIP caseload projections were similar, and the LBB assumptions are reflected in both chambers' budgets. The newly implemented CHIP Perinatal program affects how caseload assumptions are reported in budget documents. The total figure that appears now as "CHIP program Recipients" typically will include the Perinatal enrollees (mothers receiving prenatal care and newborns), in addition to the traditional CHIP children. The table below breaks out the CHIP enrollment assumed in both House and Senate budgets, and shows the subset of that number that is Perinatal enrollment.

Also detailed in the table below is the projected enrollment impact of CHIP reform legislation. The House budget allocated funds for the impact of enrollment in HB 109, which would restore 12-month continuous eligibility to CHIP. The **House** budget includes \$89.5 million GR (*\$253.2 million AF*) contingent on the passage of HB 109 or similar legislation (see also House HHSC rider #61), while the **Senate** made no funding provision for CHIP legislation. **Even with 12-month coverage restored, the budget assumes Traditional CHIP coverage of children will not reach the previous high levels seen in 2002 and 2003, before the Legislature's program cuts were implemented.**

CHIP Enrollment Assumptions	FY 08	FY 09
Total listed in both budget bills	440,677	460,225
Less Perinatal (pregnant women, their newborns)	92,196	101,977
Traditional CHIP kids	348,481	358,248
House Budget:		
Additional CHIP children projected with HB 109	68,537	102,224
Total traditional CHIP kids with HB 109	417,018	460,472

As the table above shows, HHSC tracks the Perinatal enrollees separately, up until newborns in that program have their first renewal (12-months from when the mother first enrolled in prenatal care), at which point they become part of either the Traditional CHIP pool or children's Medicaid. How realistic is it to

assume that Perinatal enrollment will grow to over 100,000 in 2009? March 2007 Perinatal enrollment was reported by HHSC at 8,357 mothers and 324 infants, for a total Perinatal enrollment of 8,681. Given that enrollment began in January, this is not a small number, and participation rates may be high. However, it is too soon to predict whether enrollment will hit the high mark projected in the budget.

Waiting Lists for DADS, DSHS, and DARS programs - Additional Detail

HHSC made a consolidated request for funding to try to allow various HHS non-entitlement program capacities to keep up with population growth (EI #4), and to actually allow reductions (EI #8) in the size of waiting and “interest” lists (the latter term refers to lists in which the individual’s eligibility for a service has not already been determined). Combined, the GR requested to fully fund both items was almost \$261 million; the Senate’s proposed funding of \$107 million is the highest under consideration.

The table below compares the House and Senate budgets on the LBB assumptions of additional numbers served with the proposed funding. It should be noted that some programs (e.g., community care programs for individuals with disabilities) are considerably more costly per client than others (e.g., adult community MH services), so a higher number of additional persons served does not equate with a larger expenditure. Thus, even though the **Senate** has allocated about 65% more state dollars than the House for the waiting lists, the **House** proposal projects serving more additional persons.

<u>Department of Aging and Disability Services</u>	House		Senate	
	FY 08	FY 09	FY 08	FY 09
Medicaid Waivers				
Community-Based Alternative (CBA)	327	981	415	1,245
Home and Community-Based Services (HCS)	149	446	691	2,074
Community Living Assistance (CLASS)**	41	124	152	454
Deaf-Blind Multiple Disability (DBMD)	2	5	4	12
Medically Dependent Children program (MDCP)	28	83	107	322
Consolidated Waiver Program (CWP)	3	8	0	0
STAR+Plus CBA (MAO)	35	104	0	0
Other DADS				
Non-Medicaid Community Care (includes Title XX and GR funded services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Svcs. for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS))	557	1,671	0	0
In Home and Family Support	47	140	0	0
<u>Department of State Health Services</u>				
Adult Community Mental Health	2,253	2,253	662	663
Child & Adolescent Community Mental Health	307	307	144	144
Children with Special Health Care Needs	55	55	343	343
<u>Department of Assistive and Rehabilitative Services</u>				
Comprehensive Rehabilitation Services	110	109	91	92
Independent Services	71	102	46	46

Frew v. Hawkins Corrective Action Plan: Children’s Medicaid

The Senate budget includes allocations in Article IX to fund Medicaid program enhancements agreed to by the state and plaintiff’s attorneys in the *Frew* lawsuit (see Policy Page 282, March 13, 2007). In April, state officials and plaintiff’s attorneys agreed in principle to a \$706.7 million GR (\$1.78 billion AF) plan of action designed to improve access to preventive care, treatment, and supportive services for children in Texas Medicaid (subject to federal court approval). The Senate budget included a rider in Article IX (Section 18.06) reallocating funding across the budget for the corrective action plan. About \$240 million GR in Medicaid provider rate increases had already been included in the Senate bill, so reductions to fund the remaining \$469.85 million GR cost of the plan are allocated according to the rider approved on the Senate floor, and detailed in the table below. Senate Finance Chairman Ogden characterized this

arrangement as an interim or placeholder decision, which will be revisited and revised by the Conference Committee on the state budget.

The lion’s share of the *Frew* corrective action plan funds are dedicated to Medicaid provider rate increases. Physician and other medical professional fees are to be increased by 25%, at an estimated cost of \$203 million GR (\$511.3 million AF), and dental fees are to be increased by 50%, at a cost of \$258.7 million GR (\$661.6 million AF). Another \$50 million GR is to be used for targeted rate increases for pediatric specialists. While the rate increases carry a hefty price tag, it should be noted that the 25% increase will increase a Texas Medicaid Office visit fee (established patient) from \$41.46 to only \$51.83, while Medicare would pay \$97.78. A full dental exam fee will increase from \$18.02 to \$27.03, compared to a median national charge of \$43.00. These rate increases should be large enough to have a meaningful impact on provider willingness to accept Medicaid, but Texas Medicaid rates will remain well below Medicare and market rates.

Senate Budget <i>Frew</i> Reduction Allocation, per rider 18.06 Article IX (Millions of dollars GR or GR-dedicated)				
	Senate Bill Allocation	<i>Frew</i> Reduction	<i>Frew</i> Addition	Revised Senate Funding
Article I – General Government	\$2,565.5	(\$15.14)		\$2,550.4
Article II – Health and Human Services	\$21,314.8	(\$125.76)	+\$469.85	\$21,658.9
Article III – Agencies of Education	\$43,649.6	(\$257.53)		\$43,392.0
Public Education	\$29,074.3	(\$171.54)		\$28,902.8
Higher Education	\$14,575.3	(\$85.99)		\$14,489.3
Article IV – The Judiciary	\$428.3	(\$2.53)		\$425.8
Article V – Public Safety and Criminal Justice	\$7,953.6	(\$46.93)		\$7,906.7
Article VI – Natural Resources	\$1,984.4	(\$11.71)		\$1,972.7
Article VII – Business and Economic Development	\$734.0	(\$4.33)		\$729.7
Article VIII – Regulatory	\$634.6	(\$3.74)		\$630.8
Article IX – General Provisions	\$44.8	(\$0.26)		\$44.5
Article X – The Legislature	\$25.6	(\$1.92)		\$23.6
		(\$469.85)*		

*Rider lists reallocation total as \$465.9 million; LBB in Senate Budget summary lists total as \$469.9 million.

Other provisions of the corrective action plan call for \$150 million GR in spending on “strategic dental and medical initiatives” (specifics under negotiation) intended to improve access to care in underserved rural and low-income urban areas. Implementing the rest of the corrective action plans—the parts unrelated to provider reimbursement—is projected to cost \$45 million GR (\$113.4 million AF). These costs are related to improved outreach; monitoring check-up rates and completeness of check-ups; improving medical transportation; studies of care received by children in HMOs; acceleration of services to children of migrant workers; reducing barriers to needed prescriptions and medical supplies; improved service on toll-free lines; better access to case managers for children and education of Medicaid health care providers about the availability of this help; more study of health outcomes of children on Medicaid and whether they improve over time; accredited training for health care professionals on the services available for children under Texas Health Steps; and more accurate lists of in-network providers in Medicaid health maintenance organizations.

Medicaid “Reform,” SB 10, and the Unclear Picture for Medicaid Hospital Payments

Readers may have noted that no funds were allocated by either chamber for restoration or increases of Medicaid inpatient hospital rates (the House does include \$150 million in its unfunded Article XI “wish list” for unspecified Medicaid rate increases that may include inpatient services). In addition, four other HHSC Exceptional Items related to hospital payments (Fund Private Urban Hospital UPL; Replace Non Recurring IGT; Funding Hospital Financing for IGT; and State Funding for Graduate Medical Education) were not funded at all by either chamber. (The House budget in Article IX (section 10.10) does appropriate at least \$94 million in non-Medicaid Trauma funds for allocation to hospitals through the Department of State Health Services.)

This appears to be the result of the unresolved situation related to Medicaid “Reform” legislation which would (among a number of things) pursue a federal Medicaid waiver to pool special Medicaid payments to hospitals: “upper payment limit” (UPL), and disproportionate share hospital (DSH) supplemental payments. Presumably, any Medicaid rate restorations or increases for hospitals have been tied to the negotiations around these legislative proposals. The language in the Senate version of this legislation (SB 10) is so general that it is not possible to say exactly what the resulting Texas “Health Opportunity Pool” (THOP) would mean

for hospital revenues, but several provisions of the LBB’s fiscal note may shed light on why hospitals are concerned about the bill.

According to the fiscal note, HHSC would seek a Medicaid waiver to implement the THOP using DSH and UPL funds (not including such payments made to state-owned hospitals), placing those funds into an account outside the General Revenue Fund. Funds would be distributed based on a methodology developed by the HHSC, to reduce the number of uninsured Texans and the need for uncompensated care provided by Texas hospitals, “and for any other purpose specified by the waiver.” The LBB assumes the THOP account would be established “using existing Medicaid DSH and UPL payments to non-state owned hospitals which total an estimated \$2.34 billion in All Funds (\$1.01 billion in DSH and \$1.33 billion in UPL payments).”

The fiscal note further states that, “no other funds are assumed to be included in the THOP account,” and “that local public hospitals continue to provide intergovernmental transfers to draw federal funds for the THOP account.” The LBB notes that this “would have an impact on the transferring public hospitals that provide the state share for the non-state owned DSH funds that are (currently) distributed to about 174 other hospitals.” Although the current DSH program “provides a mechanism to ensure that the transferring hospitals receive at least the same amount they transfer...it is not known at this time if the THOP distribution methodology would hold harmless the hospitals that provide the state share.” “In addition, public hospitals receiving UPL payments...currently provide the state share and receive all the federal funds under federal UPL provisions...(but) the THOP’s distribution methodology may reduce the amount of UPL payments currently distributed to these hospitals. Hospital losses should be offset somewhat (emphasis added) from reimbursement related to formerly uninsured clients, now covered by the premium assistance program.”

In summary, it is not at all clear how either the proposed budget or the proposed Medicaid waiver will ultimately affect Texas safety net hospitals. It would seem that many significant questions remain unanswered at this time.

Other Notable Items

Minimum Wage Increase Adjustments

Adjustments totaling \$45.2 million GR (*\$106 million All Funds*) to cover the impact on costs of care provided by contracted workers from an increase in the federal minimum wage were included in the Senate budget for DADS (\$37.2 million GR), DFPS (\$1.3 million GR), and HHSC (\$6.7 million GR).

Nurse-Family Partnership

The Senate bill includes a rider (HHSC #49) directing expenditure of \$2.7 million GR and \$5.2 million TANF to implement a nurse-family partnership program to serve 2,000 families. Such programs, which have been highly effective in other states, typically pair health care professionals with young women during pregnancy, helping to improve birth outcomes and to foster healthy early childhood development. Senate Bill 156 by Shapiro and HB 424 by Madden would establish programs of this type.

Medicaid Breast and Cervical Cancer Treatment Program

Texas' administrative set-up for Medicaid coverage of Breast and Cervical Cancer treatment has created a cruel catch-22 for an untold number of uninsured low-income cancer patients. Congress created this coverage in 2000 law, and the coverage is provided at the same enhanced matching rate as CHIP. In Texas, currently an uninsured woman can get access to Medicaid Breast and Cervical Cancer treatment program (BCC Medicaid) coverage only if she is actually screened and/or diagnosed by an entity using funds from the separate, sister program, the CDC Breast and Cervical Cancer Early Detection Program. As a result, uninsured Texas women with cancer have been denied coverage simply because they were diagnosed by the "wrong" health care provider. Under federal policy, states may allow any appropriately licensed medical provider to refer a woman for coverage, and the 2001 Texas law establishing BCC Medicaid (Senator Jane Nelson's SB 532) did not require Texas to use this approach. The results are stark: by using the broader referral policy Georgia—with less than half of Texas' population—served roughly 3.5 times as many cancer patients over the same period.

SB 1696 by Nelson, passed by the Senate and awaiting referral to committee in the House, would direct the state to move to the most flexible referring provider definition. The **Senate** budget provides full funding of HHSC Exceptional item #10 (same funding needed for SB 1696), but the **House** bill would fund only a small increase in referring providers. **At the House's level of funding, 140 Texas counties will still have no health care provider who can refer a woman for Medicaid cancer treatment.** The Senate bill and budget funding would ensure that Texas can harness the health care provided by doctors and clinics around the state (often for free or at reduced rates), stop wasting limited federal cancer screening funds on women who have other sources of care, and take advantage of the generous enhanced federal matching rate. Most importantly, it will eliminate a horrible bureaucratic barrier to desperately needed care.

Proposed Program Transfers

The **House** bill would transfer the CHIP "look-alike" coverage program for school district employees from HHSC C.1.3. (these children are prohibited from federally funded CHIP because their insurance is subsidized through the state budget) to the Teacher Retirement System (TRS) budget pattern, which would also change the method of finance for this coverage. The House bill also proposes to move Nutrition Assistance Programs at HHSC D.1.2. to the Department of Agriculture (TDA). This would not move activities related to Food Stamp administration (currently at HHSC and TWC), but would relocate all of HHSC's "Special Nutrition Programs" which includes the Summer Food Service Program, the Child and Adult Care Food Program, the Commodity Supplemental Food Program, the Texas Commodity Assistance Program, the Food Distribution Program, and the National School Breakfast/Lunch Program in private schools and residential child care facilities (TDA already operates this program in public schools). This rider is contingent on passage of legislation to transfer these programs.

Eligibility System Funding: Children's Medicaid Rolls Still Down

As noted in the Exceptional item table, HHSC requested funds in EI #3 to maintain current staffing in the Office of Eligibility Services (i.e., for the eligibility system for Medicaid, TANF, Food Stamps and CHIP) of 7,200 positions (about 6,800 of which are actually in eligibility field offices). Both chambers allocated those funds. However, workload measures and timeliness and accuracy in application processing measures indicate that more staff are needed. Workload has increased dramatically over the last two years, from an average workload per worker of 700 cases to almost 1000 cases. This is the result of a significant loss of staff in the lead-up to and months after the Integrated Eligibility project was launched. HHSC eligibility staff numbered around 12,000 in 1996 (when both caseloads and application rates were lower than today), and despite legislative cuts, staff remained over 8,000 in 2003.

New technology has not yet succeeded in reducing worker processing times, because of both computer problems and flaws in the business model. A primary unsolved problem has been an inability to construct a processing system model that defines a role for untrained private contractors that does not introduce errors because of those workers' lack of knowledge of the eligibility system and criteria.

Timeliness in initial application processing is also well below federal standards across all programs. Federal law requires that Food Stamp and Medicaid applications be processed within certain timeframes (30 days for Food Stamps and 45 for Medicaid). States must process 95% of applications within these

timeframes. HHSC offices have been unable to meet federal 45-day timeliness standards for Medicaid application processing throughout the last 9 months, and possibly longer (HHSC first posted the statistics in July 2006, so earlier 2006 values are not known). The Central Texas, Dallas-Fort Worth, and Houston areas reported deeply sub-standard rates, with Central Texas reporting rates from 50 to 68% of applications timely from July 2006 to January 2007. February and March 2007 saw the first signs of improvement, but the statewide rate remains below 91%.

As a result of the staffing shortages, compounded by troubled performance by the Texas Access Alliance (Accenture and its subcontractors), children enrolled in Medicaid plummeted by 100,000 from December 2005 to April 2006. HHSC reports confirm that computer systems automatically closed cases of children when workers were unable to process their renewal papers on time. Texas children's Medicaid enrollment remains in trouble, as March 2007 enrollment remains 71,615 children below December 2005 enrollment.

CPPP has advocated for HHSC eligibility staffing levels to be returned to at least their 2003 levels of roughly 8,000 workers in the field. HHSC needs the flexibility to increase staffing levels to ensure timeliness and accuracy in the delivery of services to clients. While neither chamber has directed funds for increased staffing to correct the current woes in the eligibility system, both chambers include riders specifically authorizing HHSC to increase staffing as needed to replace contractor staff no longer serving the system due to the ongoing restructuring of the eligibility system, in the wake of the termination of the TAA (Accenture) contract. (see HHSC riders Senate #43, House #57.)

What's Missing?

According to LBB analysis, the House bills (appropriation for 2008-2009, plus the HB 15 supplemental appropriations bill) would allocate \$52.4 billion All Funds, and the Senate \$53.9 billion All Funds for Article II. For HHSC alone, the House allocates \$742.6 million GR less than the Senate. This is of even greater note considering that the larger Senate budget still does not fund several major items: CHIP restoration, Medicaid and CHIP cost growth, or any restorations or increases in inpatient hospital rates. Moreover, at least \$466 million GR of the *Frew* corrective action plan is only funded at the expense of other state services, including public education. Unless the Conference Committee on the budget adds new funds for *Frew*, they will have to cut other budget areas.

As previously noted, Texas can afford to meet all its needs. Texas has at least \$3 billion more in General Revenue that the legislature could appropriate. In addition, the legislature could redirect \$1.4 billion in the House and Senate proposals that would only undo past payment deferrals. "Undoing" these payment deferrals has no purpose except to shelter money to pay for tax cuts after 2009. If the legislature appropriated this entire \$4.4 billion to meet today's needs, Texas would still have another \$4.3 billion in its Rainy Day Fund to meet an emergency of any sort.

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