Department of Health and Human Services

FY 2003 Financial Management Five Year Plan

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INTRODUCTION

This FY 2003 HHS Financial Management Five Year Plan continues the tradition of evolving to reflect current strategies in Federal financial management and financial management within HHS, in particular. We continue to prepare this document for a largely internal Federal audience to communicate the HHS' financial management priorities to our financial managers. We also continue to present our strategies, goals and targets in a format supportive of the Government Performance and Results Act (GPRA), similar to the approach taken by HHS program areas.

The Office of the Assistant Secretary for Budget Technology and Finance (ASBTF) has two primary financial management objectives: retaining a "clean" opinion on the Department's financial statements while accelerating the reporting date to November 15, and building the Unified Financial Management System (UFMS).

These two priorities, as well as our numerous performance measures, embody the Deputy CFO's two strategic goals which were identified in 1998:

- Decision Makers Should Have Timely, Accurate, and Useful Program and Financial Information; and
- All Resources are Used Appropriately, Efficiently, and Effectively.

This Plan is prepared as referenced in the Federal Register Notice, Vol. 68 Number 47, (page 11555)-March 11, 2003.

IMPROVING FINANCIAL PERFORMANCE

HHS is committed to meeting the President's Management Agenda (PMA) and is working to achieve "green" OMB status and progress ratings on the PMA Scorecard for Improving Financial Management. HHS provides information to OMB quarterly that reflects our progress on improving the status of elements of the scorecard.

Strong financial management provides a solid and necessary foundation for effective program performance, and improving HHS' financial management and related infrastructure is one of Secretary Thompson's highest priorities. The Department's efforts to improve financial management are focused in areas which are the main focus points of the PMA Financial Management Element: 1) maintaining clean opinions on the HHS annual financial statements while accelerating the reporting timeframe, 2) implementing an integrated financial management system across the Department, and 3) identifying and reducing improper payments.

Accelerating Financial Reporting and Maintaining Clean Opinions

HHS has achieved "clean" opinions on its Department-wide audited financial statements annually since FY 1999. However, we recognize that we do not have fully integrated financial management systems. This impairs our ability to prepare financial statements without manual, time-consuming processes that would not otherwise be required in a fully-integrated financial management system.

The FY 2002 Department-wide financial statements were published in the Performance and Accountability Report on January 29, 2003. This was two days earlier than the OMB deadline of January 31. HHS' goal is to meet the November 15 (45 days after the fiscal year end) reporting deadline beginning with the FY 2003 financial statements, a year ahead of the OMB mandate. This will be an extremely challenging goal, because we will not have fully integrated financial systems until the Department's Unified Financial Management System (UFMS) (discussed below) is operational across all of the component agencies, scheduled for FY 2007.

Furthermore, OMB directed federal agencies to prepare quarterly financial statements for the first time in FY 2003, in essence challenging HHS to produce more financial reports within compressed timeframes.

After reviewing various alternatives to meeting the November 15 reporting date, HHS has decided to embark on a "Top Down" approach to the audit. This approach will reduce the number of OPDIV-entity full scope audits, without sacrificing the financial integrity of the Department-level statements. It calls for specialized audit work on various accounts that are material to the Department-level financial statements which will be tested on a random basis, and enable us to meet the November 15 target reporting

date. See Appendix C for a comparison of the new "Top Down" approach to the "Bottom Up" approach used in prior years. In order to implement this new approach, representatives from the OPDIVs are participating in committees formed to address specific aspects of accelerated reporting such as: audit coordination, performance reporting, use of estimations, etc.

Challenges to the accelerated reporting include: 1) determining a list of "do-able" milestone steps and dates with across-the-board buy-in; 2) resolving new issues quickly, such as the increased usage of estimation techniques for material account balances; 3) reporting with limited availability of recent GPRA program performance data; and 4) learning and adapting to changes in the audit approach including responding to requests for appropriate audit evidence needed to support the new approach.

In addition to re-engineering departmental reporting and auditing processes to accommodate accelerated reporting, HHS is also working to resolve audit findings (material weaknesses and reportable conditions) at both the Department and the component agency levels.

HHS has been submitting quarterly Corrective Action Plans (CAPs) to OMB since March 2002. These CAPs address findings from the Department's financial statement audits, the FMFIA, and FFMIA reports in an integrated manner, to reduce redundant reporting and tracking procedures. Quarterly progress is detailed in order to support OMB's quarterly scorecard rating for HHS on financial management. It is important to note that the annual audits of each OPDIV will no longer be available (except as explained in Appendix C) to determine the existence or resolution of OPDIV-level material weaknesses and reportable conditions. However, HHS will continue to report on all previous findings in the quarterly CAPs until management and/or the auditors believes they have been resolved.

The HHS Office of Finance has begun developing a quality assurance strategy which will measure the effectiveness of corrective actions cited in the Corrective Action Plan (CAP), that are being implemented to resolve audit findings.

Developing and Implementing a Unified Financial Management System

Over the last few years, HHS financial auditors have cited the Department's lack of an integrated accounting system as a material weakness and a specific impediment in preparing timely financial reports and statements. Secretary Thompson has directed a "One HHS" approach to managing the Department. One of the major tenets of the Secretary's approach is the development and implementation of a Unified Financial Management System (UFMS) for the Department. In accordance with Secretary Thompson's June 2001 direction, the UFMS is to be composed of two primary components—one component for the Centers for Medicare & Medicaid (CMS) and another component for the rest of the Department. The two components will be integrated to provide for Department-wide financial reporting. The unified system is to generate interim and annual financial statements, as well as other

required external and internal financial reports. Effective design and implementation of the UFMS should resolve the Office of the Inspector General audit finding regarding current financial system weaknesses. We believe that in FY 2005, UFMS will be substantially implemented and that the material weakness for financial systems and reporting will be eliminated. However, until the system is fully operational across the Department in FY 2007, HHS will continue to confront significant challenges in meeting accelerated financial reporting dates established by OMB.

HHS management has defined a number of strategic objectives related to the UFMS initiative:

- Eliminate redundant and outdated financial systems by implementing a modern integrated HHS-wide system.
- Produce reliable, timely and relevant financial information to help HHS managers make fact-based decisions to improve service to customers.
- Comply with federal financial management system requirements, as well as accounting standards and financial reporting requirements.
- Strengthen internal controls by instituting business rules, data standards and accounting policies across HHS.
- Continue to achieve unqualified audit opinions on annual financial statements.

HHS also identified the following Critical Success Factors for the UFMS:

- Sustaining commitment from HHS top leadership;
- Developing and articulating a clearly-defined scope;
- Obtaining dedicated staffing resources (Departmental and contractor) with the knowledge, skills and abilities to successfully accomplish program objectives;
- Defining and meeting HHS business requirements;
- Securing adequate funding to sustain the project;
- Coordinating with other Department-wide initiatives;
- Creating a unified team comprised of highly qualified representatives from HHS component agencies;
- Developing and executing a comprehensive implementation plan, to include:
    - Acquisition Planning,
    - Change/Communication Management,
    - Financial Management,
    - Performance Management,
    - Quality Control, and
    - Risk Management.

Making Progress in Estimating Improper Payment Rates/Amounts

The Department is at different stages in developing erroneous payment rates for seven of its programs listed in OMB Circular A-11 -- Medicare, Medicaid, SCHIP, TANF, Child Care, Foster Care and Head Start -- which account for close to 90 percent of outlays. For the Medicare program, HHS has been a leader in the area of monitoring and mitigating improper payments. We began measuring errors in Medicare in 1996 and have made progressive strides in reducing errors. The FY 2002 rate of 6.3 percent is less than half the 13.8 percent estimated in fiscal year 1996. Building upon Medicare's success in measuring errors, the Department is well into the process of creating a payment accuracy measure in the Medicaid program, and will soon start applying the payment accuracy measure to the SCHIP program as well. Further, work is progressing in establishing payment error rates for TANF, Child Care, Foster Care and Head Start.

The recently enacted Improper Payment Information Act of 2002 (IPIA) requires agencies to estimate the annual amount of erroneous payments for certain programs susceptible to more than $10 million in erroneous payments and report in the PAR for the fiscal years ending on or after September 30, 2004: a) the estimated amount of erroneous payments; b) the causes of the erroneous payments identified; c) the actions taken to correct causes; and, d) other related information. Related OMB Guidance requires that agencies conduct risk assessments and report on programs that have estimated annual erroneous payments exceeding both 2.5% of program payments and $10 million. OPDIV CFOs have been directed by ASBTF/Finance in recent months to conduct risk assessments of their programs and to provide their results to ASBTF. ASBTF is in the process of reviewing information provided by the OPDIVs and will be determining which of the Department's programs will be covered under the IPIA/OMB Guidance.

Further, a new mandate under Section 831 of the Defense Authorization Act for Fiscal Year 2002 requires that agencies institute a recovery audit program to identify and recover amounts erroneously paid to contractors. OPDIV CFOs have been directed by ASBTF/Finance to provide: a description of their programs for identifying errors made in paying contractors and for recovering amounts erroneously paid to the contractors; and, on those actions needed to comply with the mandate. ASBTF will be working with the OPDIVs in the coming months to implement audit programs which comply with the recovery auditing mandate.

Both the IPIA requirement and recovery auditing mandate are related to the PMA initiative to reduce improper payments in Federal programs that falls under improved financial management. The Department's progress related to the IPIA initiatives is factored in by OMB in determining HHS' quarterly progress scorecard ratings in the area of improved financial management.

Ensuring Quality Awardee Audit and Oversight

HHS works closely with its partners including states, local governments, and tribes, to ensure they understand Federal regulation, requirement, policy, etc. Since all are accountable to taxpayers for use of the federal funds, audits of the use of those funds are conducted at the partner level as well as the HHS level. In addition to the other grants management improvements discussed above, HHS has committed to timely audit resolution in the HHS ASBTF GPRA plan. Also, HHS provides assurance of the quality of audits performed by non-federal auditors via a multi-tiered approach as follows:

- Quality Control Reviews performed by the Office of Inspector General's (OIG) National External Audit Review (NEAR) Center, discussed below,
- Maintenance of an up-to-date HHS Audit Compliance Supplement providing complete coverage of major programs and guidance to the auditor,
- Referral of non-federal auditors to the NEAR center and/or state societies for disciplinary review as a result of findings during the normal audit resolution process, and
- Technical assistance provided at various association meetings, state societies, internet-posted questions and answers, and individual discussion.

The OIG's NEAR center performs desk reviews on all single audit reports received from the Census Bureau. The findings and recommendations are summarized and identified by federal department officials responsible for the resolution. A written response to the HHS resolution official is requested within 30 days from the date the letter was sent out by NEAR. In addition, quality control reviews (QCR's) of states, local governments, and non-profit organizations audits under OMB Circular A-133, are performed during the year.

Improving Other Financial Performance

In addition to the key priorities highlighted above, HHS is also committed to monitoring and improving debt collection, referral, and credit reform activities. In fact, HRSA has diligently been taking steps to improve oversight of credit programs. Specifically, HRSA is working in concert with OMB and has or is in the process of establishing procedures and processes to assure:

- Timely submission of apportion requests for Credit Program Accounts,

- Annual re-estimates of HRSA Credit Programs,
- OMB understanding of the operation of HRSA Credit Programs,
- Continuing education of HRSA program staff in Credit Reform Requirements,
- Distribution of credit program workload among financial management staff, and
- Credit program management requirements are included in the new Unified Financial Management System.

Additionally, OMB and Treasury are developing a number of financial performance measures intended to be used by Federal agencies. Some of these measures are already in use at HHS, such as prompt pay, and others would need to be implemented. When OMB and Treasury finalize the complete list of measures, HHS will incorporate them into our data collection and performance measurement activities.

Finally, HHS is working to improve efficiencies of administrative operations by analyzing and developing plans for moving to a shared services environment for finance functions, including aligning those services with UFMS. The concept is under development.

Measure	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	Performance/Comments
HHS Performance and Accountability Report and audited financial statements for CMS are submitted to OMB by Nov. 15	Yes - Pilot	Yes	Yes	Yes	Yes	Yes	Baseline: No for the FY 1996 audited financial statements. More recently, the FY 2002 HHS and CMS statements were submitted timely on 1/29, two days ahead of the OMB deadline of 1/31.
Number of department-level material weaknesses	2	1	0	0	0	0	Baseline: FY 1997 - 5 material weaknesses were cited in the HHS audit opinion. More recently, in FY 2002, the audit opinion cited 2 material weaknesses: financial systems/processes and Medicare contractor EDP controls. The material weakness for Medicare EDP controls is expected to be resolved in FY 2004. The material weakness for financial systems and processes will be substantially resolved in 2005 with the partial implementation of the Unified Financial Management System (UFMS), along with HIGLAS being implemented at 10 contractors equating to 75**%** of outstanding Medicare receivables.
Number of department-level reportable conditions	1 (Info. Sys. Controls)	1 (Info. Sys. Controls)	0	0	0	0	Baseline: FY 1997 - 3 reportable conditions. More recently, in FY 2002, there was 1 reportable condition Departmental Information Systems Controls. We believe this issue will be substantially resolved with the partial implementation of UFMS in 2005.

Measure	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	Performance/Comments
OMB's PMA assessment rating for financial management progress	Green	Green	Green	Green	Green	Green	New Performance Measure for the Five Year Plan. (Quarterly ratings)
OMB's PMA assessment rating for financial management status			Yellow	Yellow	Green	Green	New Performance Measure for the Five Year Plan. (Annual rating)
Number of department-level instances of FFMIA non-compliance	2	1	0	0	0	0	Baseline: FY 1997 – 4 instances of non-compliance. More recently, in FY 2002, HHS had 2 non-compliances with the Federal Financial Management Improvement Act. These two items are duplicates of the financial statement audit material weaknesses: financial systems and processes and Medicare EDP controls. The material weakness for Medicare EDP controls is expected to be resolved in FY 2004. Plans call for achieving substantial compliance on financial systems and processes in 2005. Note: Assumes 75**%** of Medicare receivables are in HIGLAS in 2005. (See quarterly Corrective Action Plan.)
Percentage of Medicare contractors that will be subjected to a SAS 70	33%	33%	33%	33%	33%	33%	Baseline: FY 2000 - 26 of 50 contractors had SAS-70 reviews; 19 of the contractor's SAS 70 reviews covered Part A; 16 covered Part B. Statement of Accounting Standard No 70 (SAS 70) is intended for all entities that outsource tasks for conducting accounting transactions and related services. It requires accountability and internal control assessments. Based on the results of the SAS 70s (Type I) performed in FY 2000, CMS will continue SAS 70s of Medicare contractors using a more detailed approach (Type II). CMS plans to review all Medicare contractors remaining in the program at least once in a three-year period.

Measure	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	Performance/Comments
Number of OIG/NEAR Quality Control Reviews-OIG Lead Agency	6	TBD	TBD	TBD	TBD	TBD	In FY 1999 and FY 2000, 14 reviews were completed. On FY 2002, 7 reviews were completed.
Number of OIG/NEAR Quality Control Reviews-OIG Supporting Agency	6	TBD	TBD	TBD	TBD	TBD	In FY 1999, 3 reviews were completed, and 1 was completed in FY 2000. In FY 2002, 7 reviews were completed.
Number of Quality Control Reviews-Contractor Personnel	0	TBD	TBD	TBD	TBD	TBD	In FY 1999, 7 reviews were completed, and 0 were completed in FY 2000. In FY 2002, 3 reviews were completed.
Percentage increase of collections over prior year	10% increase	10% increase	10% increase	10% increase	10% increase	10% increase	Baseline: FY 1998: $13.3 billion. More recently, in FY 2002, $14.4 billion in debts was collected, the same amount collected in FY 2001. Basis for measure/target: The target is to have an increase of 10% in total dollars collected over the prior year. CMS's performance is critical to achieving this target. While FY 2002 collections did not increase in dollar amounts, it did represent a stable pro rata share (51.6%) of total receivables of $27.9 billion in both FY 2001 and FY 2002. Measure to be reviewed in 2004 to identify potentially more effective measure/target. (See Appendix D)
Percentage of eligible delinquent debt referred for cross-servicing to Treasury	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 0% referred as we were anticipating designation as a government-wide Debt Collection Center. More recently, in FY 2002, 93.5% of eligible debt was referred to Treasury for cross-servicing. Targets of 100% are in accordance with law (DCIA of 1996). CMS is a key HHS component in achieving these targets.

Measure	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	Performance/Comments
Percentage of eligible delinquent debt referred to the Department of the Treasury for offset	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 20.2% (2nd quarter baseline established in FY 1998 Plan). More recently, in FY 2002, 72.4% was referred to Treasury. Targets of 100% are in accordance with law (DCIA of 1996). CMS is a key HHS component in meeting these targets.
Number of Department level FMFIA material weaknesses/non-conformances pending at year end							Baseline: FY 1997: 7; FY 2002: 2.
Section 2	1 (Food Safety)	1	0	0	0	0	FDA has identified 2005 as the target date for resolving the food safety material weakness.
Section 4	1 (Fin. Sys & Processes/EDP Controls)	1 (Fin. Sys & Processes)	0	0	0	0	Financial systems and processes is expected to be substantially resolved in 2005, assuming 75% of Medicare contractors accounts receivable are on HIGLAS. The Medicare EDP controls citing is expected to be resolved in FY 2004.
Percentage of vendor payments made on time	96%	97%	97%	97%	97%	97%	Baseline: FY 1998: 91%. More recently, in FY 2002, 98.3% was achieved. Because of the volume of their activities, NIH, IHS, and PSC are the HHS components that have a critical impact on meeting these targets.

Appendix A

HHS AND HHS OPDIV AUDIT OPINION HISTORY

Entity	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
ACF	Qualified	Qualified	Split	Clean	Clean	Clean	Clean
AHRQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AoA	N/A	N/A	N/A	N/A	N/A	Clean	N/A
CDC	Mgt Rpt-I/C Assess	Qualified	Clean	Clean	Clean	Clean	Clean
CMS	Disclaim	Qualified	Qualified	Clean	Clean	Clean	Clean
FDA	Qualified	Qualified	Clean	Clean	Clean	Clean	Clean
HHS	Disclaim	Qualified	Qualified	Clean	Clean	Clean	Clean
HRSA	Qualified	Qualified	Split	Clean	Clean	Clean	Clean
IHS	Qualified	Qualified	Split	Qualified	Qualified	Clean	TBD
NIH	Mgt Rpt-I/C Assess	Qualified	Split	Clean	Clean	Clean	Clean
OS	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PSC	N/A	N/A	N/A	Clean	Clean	Clean	Clean
SAMHSA	Qualified	Qualified	Split	Clean	Clean	Clean	Clean

Split=Statements of Custodial Activity, Budgetary Resources and/or Financing Disclaimed
N/A=Not Applicable

Appendix B

SUMMARY OF FY 2002 AUDIT FINDINGS BY HHS COMPONENT

Area	HHS	ACF	CDC	FDA	CMS	HRSA	IHS	NIH	PSC	SAMHSA	AoA	Total
							TBD				**N/A**	
Financial systems and processes	1 MW	1 RC	1 RC		1 MW	1 RC		1 MW	2 RC	1 RC		
Medicare Information Systems Controls	1 MW				1 MW							
Medicare regional office oversight												
Medicaid error rate												
Information Systems Controls	1 RC	1 RC	1 RC	1 RC		1 RC		1 RC	1 RC	1 RC		
Property								1 RC				
Fund balance with Treasury								1 RC				
Grant financial management								1 RC				
Reimbursable agreements						1 RC				1 RC		
Controls over grants			1 RC									
Accounts payable and unliquidated obligations								1 RC				
HEAL Allowance for Uncollectible Accounts						1 RC						
Accounting for litigation claims						1 RC						
Accounts receivable								1 RC				
FFMIA	2 CLR		1 CLR	1 CLR	1 CLR	1 CLR		1 CLR		1 CLR		
TOTAL	2 MW 1 RC 2 CLR	2 RC	3 RC 1 CLR	1 RC 1 CLR	2 MW 1 CLR	5 RC 1 CLR	TBD	1 MW 6 RC 1CLR	3 RC	3 RC 1 CLR		TBD

TBD=To Be Determined MW = Material Weakness CLR = Compliance with Laws and Regulations citing RC = Reportable Condition

Changes since 2001 audit results:

HHS - Reportable conditions decreased from three to one, as Medicaid Improper Payments and Mgt Systems Planning & Div. were not cited.
ACF - Grant Financial Management reportable condition and one EDP reportable condition were dropped, decreasing reportable conditions from 4 to 2.
CDC - Reimbursable agreements reportable condition was dropped.
CMS - Medicaid error rate and grant financial management reportable conditions were dropped, decreasing reportable conditions from 2 to 0.
HRSA - Grant Financial Management reportable condition was dropped.
IHS - Audit NOT completed on time for this report.
NIH - Investments in management systems material weakness was dropped. Reportable conditions decreased from 11 to 6.
PSC - Trading partner information and reconciliation of transactions requiring elimination reportable condition was added.
SAMHSA - Grant Financial Management reportable condition and one EDP reportable condition were dropped, decreasing reportable conditions from 5 to 3.
AoA - No audit in FY 2002.

Appendix C

TOP DOWN AUDIT APPROACH: COMPARISON WITH HISTORICAL AUDIT METHOD

Entity	FY 2002: "Bottom Up Approach" Subject to Audit?	FY 2003: "Top Down Approach" Subject to Audit?
ACF	Yes, Full Scope	Yes, subject to random testing in “top down”
AHRQ	No	Yes, subject to random testing in “top down”
AoA	No	Yes, subject to random testing in “top down”
CDC	Yes, Full Scope	Yes, subject to random testing in “top down”
CMS	Yes, Full Scope	Yes, Full Scope
FDA	Yes, Full Scope	Yes, Full Scope
HHS	Yes, Full Scope	Yes, Full Scope
HRSA	Yes, Full Scope	Yes, subject to random testing in “top down”
IHS	Yes, Full Scope	Yes, subject to random testing in “top down”
NIH	Yes, Full Scope	Yes, Service and Supply Fund subject to Full Scope. Yes, Other NIH subject to random testing in "top down"
OS	No	Yes, subject to random testing in “top down”
PSC	Yes, Full Scope	Yes, Full Scope
SAMHSA	Yes, Full Scope	Yes, subject to random testing in “top down”

Appendix D

HHS RECEIVABLES MANAGEMENT PERFORMANCE TRENDS *(Dollars in Billions)*

	FY 1999	FY 2000	FY 2001	FY 2002
Beginning Receivables	$10.3	$9.8	$10.2	$10.8
New Receivables	$18.6	$18.7	$17.0	$16.6
Accruals	$0.5	$0.7	$0.7	$0.5
Total Receivables	**$29.4**	**$29.2**	**$27.9**	**$27.9**
Less:				
Collections	$14.3	$15.3	$14.4	$14.4
Adjustments	$2.3	$3.1	$2.1	$2.4
Write-offs	$3.0	$0.6	$0.6	$1.0
Ending Receivables	**$9.8**	**$10.2**	**$10.8**	**$10.1**
Collections as a % of:				
Total Receivables	48.6%	52.4%	51.6%	51.6%
Beginning & New	49.5%	53.7%	52.9%	52.6%
Collections+Adjustments+Write-Offs as a % of:				
Total Receivables	66.7%	65.1%	61.3%	63.8%
Beginning & New	67.8%	66.7%	62.9%	65.0%
Write-Offs as a % of:				
Total Receivables	10.2%	2.1%	2.2%	3.6%
Beginning & New	10.4%	2.1%	2.2%	3.7%
Collections	15.3%	3.2%	3.5%	5.6%
Delinquencies:				
1 to 90 Days	$1.0	$0.7	$0.5	$0.4
91 to 180 Days	$0.5	$0.5	$0.2	$0.2
181 Days to Over 10 Years	$3.3	$4.9	$5.0	$4.6
Total Delinquent	$4.8	$6.1	$5.7	$5.2
Delinquencies as a % of Total Receivables:				
1 to 90 Days	3.4%	2.4%	1.8%	1.4%
91 to 180 Days	1.7%	1.7%	0.7%	0.7%
181 Days to Over 10 Years	11.2%	16.8%	17.9%	16.5%
Total Delinquent	16.3%	20.9%	20.4%	18.6%

Source: Treasury Reports on Receivables (Fourth Quarter)