Social Security Administration
Fiscal Year 2019
Bipartisan Budget Act of 2015 Section 845(a) Report

Bipartisan Budget Act Reporting Requirements

Section 845(a) of the Bipartisan Budget Act of 2015 (BBA 845(a)) requires the Social Security Administration (SSA) to include in our annual budget a report on our activities to prevent fraud and improper payments for each fiscal year (FY) from 2016 through 2021. The report must contain:

- The total amount spent on fraud and improper payment prevention activities;
- The amount spent on cooperative disability investigations (CDI) units;
- The number of cases of fraud prevented by CDI units and the amount spent on such cases;
- The number of felony cases prosecuted under section 208 and the amount spent by our agency in supporting the prosecution of such cases;
- The number of such felony cases successfully prosecuted and the amount spent by our agency in supporting the prosecution of such cases;
- The amount spent on and the number of completed:
    - Continuing disability reviews (CDR) conducted by mail;
    - Redeterminations (RZ) conducted by mail;
    - Medical CDRs conducted pursuant to sections 221(i) and 1614(a)(3)(H) of the Social Security Act (Act);
    - RZs conducted pursuant to section 1611(c) of the Act; and
    - Work-related CDRs to determine whether earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity (SGA);
- The number of cases of fraud identified resulting in benefit termination as a result of medical CDRs, work-related CDRs, and RZs, and the amount of resulting savings for each such type of review or RZ; and
- The number of work-related CDRs in which a beneficiary improperly reported earnings derived from services for more than three consecutive months, and the amount of resulting savings.

A brief overview of our programs and anti-fraud activities as well as information required by BBA 845(a) follows.

Overview of Our Programs

Considered one of the most successful large-scale Federal programs in our Nation's history, the Old-Age, Survivors, and Disability Insurance (OASDI) programs provide social insurance for most of our population. Workers earn coverage for retirement, survivors, and disability benefits by working and paying Social Security taxes on their earnings. About 9 out of 10 individuals age 65 and older receive Social Security benefits. The disability insurance (DI) program provides benefits to people who cannot work because they have a medical condition that is expected to last at least one year or result in death. Individuals who have worked long enough and paid Social Security taxes and certain members of their families can qualify for DI benefits.

We also administer the Supplemental Security Income (SSI) program, which provides monthly payments to people with limited income and resources who are aged, blind, or disabled. Adults and children under the age of 18 can receive payments based on disability or blindness. General tax revenues fund the SSI program.

We pay benefits to over 70 million OASDI beneficiaries and SSI recipients on average each month. We paid over $1 trillion in FY 2019.

Our Anti-Fraud Efforts

Combatting fraud is an agency priority, and we take seriously our responsibility to prevent and detect fraud. We have centralized our anti-fraud efforts to take advantage of data analytics and predictive models to prevent fraud, ensure consistent anti-fraud policies, refine employee training, and solidify relationships with other Federal, State, and private partners to identify individuals who wrongfully obtain OASDI and SSI payments.

In FY 2018, we established a deputy commissioner-level organization - the Office of Analytics, Review, and Oversight (OARO). Under OARO, we aligned our anti-fraud programs, quality reviews, audits, appellate operations, business improvements, and advanced data analytics. By realigning our organizational structure, we maximized our resources, streamlined collaborative efforts, and centralized the oversight of the agency's anti-fraud efforts consistent with the Fraud Reduction and Data Analytics Act (FRDAA) of 2015 and the Government Accountability Office's (GAO) report, *A Framework for Managing Fraud Risks in Federal Programs*.

Fraud threats are constantly evolving, and we must continuously enhance our anti-fraud efforts to strengthen our ability to detect, deter, and prevent attempts to defraud agency programs.

In FY 2019, we developed our Enterprise Fraud Risk Management (EFRM) strategy, which establishes a business process and long-term schedule for completing fraud risk assessments across our major program areas. The EFRM strategy meets the FRDAA requirements by

incorporating leading practices for managing fraud risks established in the GAO *Framework*. We will use the results of the fraud risk assessments to identify our most serious fraud risks and determine what, if any, additional controls are needed to further mitigate the risks. Each fraud risk assessment, combined with our tailored plans to mitigate specific risks, will form the fraud risk profile for each program area. Once we complete all initial fraud risk assessments, we will conduct ongoing reassessments of each area at least every three years.

Our Improper Payment Prevention Initiatives

In FY 2019, we implemented a plan to further reduce and prevent improper payments. We established a new Improper Payment Prevention (IPP) team under OARO to focus solely on developing innovative and effective strategies to mitigate the root causes of our improper payments.

We reestablished the Improper Payments Oversight Board (IPOB) and developed the IPOB Charter, establishing Deputy Commissioner-level responsibility for reviewing, approving, and implementing all improper payment initiatives.

We also established a formal Improper Payment Alignment Strategy (IPAS) that we will use to obtain agency-wide engagement and agreement on actions needed to remedy improper payment issues. IPAS outlines how we determine underlying causes of errors, develop corrective actions with key stakeholders, and identify cost-effective actions to reduce improper payments. IPAS will also serve as a template to ensure we considered and evaluated all required factors before implementing a corrective action. We will conduct annual reviews to evaluate the success of our initiatives and as needed, implement new strategies to address the root causes of improper payments.

Bipartisan Budget Act Reporting Requirements

Total Expenditures on Fraud and Improper Payment Prevention Activities[1]

In FY 2018, we issued the Agency Strategic Plan for Fiscal Years 2018-2022[2]. To streamline our focus, we migrated the Fraud and Improper Payment Prevention activities objective from the former goal, Strengthen the Integrity of Our Programs into Strategic Goal 3: Ensure Stewardship. This goal has four objectives:

- 3.1 Improve Program Integrity;
- 3.2 Enhance Fraud Prevention and Detection Activities;
- 3.3 Improve Workforce Performance and Increase Accountability; and

[1] For more information on our improper payment prevention activities, refer to the Payment Integrity section of the Fiscal Year 2019 Agency Financial Report at https://www.ssa.gov/finance/.
[2] For more information on the Agency's Strategic Plan for FY 2018-2022, refer to https://www.ssa.gov/agency/asp/.

- 3.4 Improve Organizational Effectiveness and Reduce Costs.

Our FY 2019 total operating expense for the Ensure Stewardship strategic goal was $2.968 billion. These expenditures included key program integrity (PI) workloads and other stewardship activities, some of which are specific to our anti-fraud efforts. Distinguishing between specific efforts to reduce fraud and our overall efforts to reduce improper payments is challenging, as both are key elements of our program integrity workloads. Most improper payments we detect do not involve any evidence of intent to commit fraud. Rather, they involve complex rules about eligibility for program benefits and delays in receiving information about changes in beneficiaries' circumstances.

Although we lack the level of detailed data necessary to compute the specific expenditures for our anti-fraud-related activities, each year, we verify that we distribute the correct costs to the proper goals. Additionally, during 2017, we modified our process to better track the costs separately for CDI units. We began identifying agency and disability determination services' (DDS) CDI payroll and other object costs through specific/separate common accounting numbers. We determined the proportion of costs already distributed to the PI workloads and removed those costs from the CDI costs to avoid double counting. All PI workloads fall under our strategic goal to Ensure Stewardship.

Total Expenditures on CDI Units, the Number of Cases of Fraud Prevented by CDI Units, and the Amount Spent on Such Cases

The CDI program is a key anti-fraud initiative that plays a vital role in combatting fraud, similar fault, and abuse in our disability programs. CDI units investigate claimants and beneficiaries, as well as third parties who we suspect of committing or facilitating disability fraud. The units consist of personnel from our agency, the Office of the Inspector General (OIG), DDSs, and State and local law enforcement. CDI units investigate initial disability claims and post-entitlement events involving suspected fraud.

We continue to expand our CDI program as resources allow. We currently have 46 units, covering 40 states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands. We are on track to meeting our goal of having CDI units covering all 50 states and U.S. territories by October 1, 2022.

In FY 2019, we spent a total of approximately $36.5 million to operate our CDI units, of which $27.2 million was SSA's cost, and $9.3 million[3] was OIG's cost. These expenditures included personnel costs, training, travel, and equipment. In FY 2019, CDI investigations resulted in the

[3] The FY 2019 appropriations language provides that SSA may transfer up to $10 million to the SSA OIG for the operation of the CDI units (Pub. L. No. 115-245). This anti-fraud activity is an authorized use of the cap adjustment.

cessation or denial of 2,900 claims and 93 judicial actions (i.e., sentencing, pre-trial diversion, civil settlement, and civil monetary penalties*)*, which contributed to OIG projecting more than $177 million in savings to SSA programs and monies[4] of $17.5 million.

We do not track CDI-related costs on a per-investigation basis. We estimate the average cost per CDI investigation is $10,503 based on 3,488 CDI investigations closed during FY 2019.

For FY 2020, we plan to spend a total of approximately $37.2 million to operate our CDI units, of which approximately $27.2 million is SSA's cost, and approximately $10 million[5] is OIG's cost.

The Number of Felony Cases Prosecuted Under Section 208 and the Amount Spent in Supporting the Prosecution of Such Cases; the Amount of Such Felony Cases Successfully Prosecuted and the Amount Spent in Supporting the Prosecution of Such Cases[6]

Our employees refer allegations of potential fraud to OIG for investigation. OIG conducts criminal investigations and refers cases to U.S. Attorney's Offices (USAOs) within the Department of Justice (DOJ), or to State and local prosecuting authorities, for prosecution.[7] We primarily rely on the U.S. attorneys to prosecute Social Security fraud, which is a Federal crime. The U.S. attorneys have discretion whether to accept fraud cases for prosecution and what Federal statutes to charge.[8] As an initiative to increase Federal Social Security fraud prosecutions, the Office of the General Counsel has provided DOJ with attorneys who serve as Special Assistant United States Attorneys (SAUSAs) in multiple USAOs throughout the country and focus solely on prosecuting Social Security fraud. The goal of this initiative is to increase the number of prosecutions for fraud involving Social Security programs.

Since FY 2003, SAUSA prosecutions have led to the order of over $200 million in restitution and more than 1,600 convictions. We ended FY 2019 with 33 SAUSAs in 32 Federal judicial districts. In FY 2019, our SAUSAs successfully prosecuted 319 criminal cases under section 208 of the Act [42 U.S.C. §408] and related fraud statutes.[9] In 249 of those cases, courts ordered payment of over $29.6 million in restitution to the Government, over $16.8 million of which was

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[4] SSA monies include recoveries, restitution, fines, penalties, judgments and settlements.
[5] The FY 2020 appropriations language provides that SSA may transfer up to $10 million to the SSA OIG for the operation of the CDI units (Pub. L. No. 116-94). This anti-fraud activity is an authorized use of the cap adjustment.
[6]Consistent with our 2019 report, this section of our report focuses on how SSA expended funds made available for the prosecution of fraud in the programs and operations of SSA by SAUSAs.
[7] This report does not include financial information pertaining to the success of OIG investigations.
[8] Social Security fraud criminal cases are prosecuted under many different fraud statutes. Because this report is limited to cases prosecuted under section 208 (42 USC 408) and its functional equivalent, 18 USC 641 (theft of public funds), it does not represent the total number of Social Security cases involving fraud against our programs successfully prosecuted. To learn more about OIG's activities and investigations, please see: OIG's *Semiannual Reports to Congress* at https://oig.ssa.gov/newsroom/semiannual-reports.
[9] Our SAUSAs sometimes exercise their discretion to charge 18 USC 641 rather than 42 USC 408 for the same fraudulent conduct to enhance the agency's prospect of obtaining court-ordered restitution, which is mandatory under section 641 and discretionary under section 408.

to SSA's Trust Funds. The estimated FY 2019 costs of SAUSAs to obtain these convictions was $5,557,162, including the salary and benefit costs of these attorneys.

Program Integrity Expenditures and Numbers

Periodic Continuing Disability Reviews

The American public expects and deserves outstanding stewardship of the Social Security Trust Funds and general revenues that finance our programs. As such, we are committed to ensuring program rules and eligibility standards are fully enforced. One of our most important program integrity tools is the CDR. CDRs are periodic reevaluations to determine whether beneficiaries continue to be eligible for benefits because of their medical conditions. We conduct periodic CDRs to ensure that only those beneficiaries who continue to be disabled, based on our standard of disability, receive monthly benefits. We schedule almost all medical CDRs based on a beneficiary's likelihood of experiencing medical improvement (MI) rather than on suspicion or evidence of fraud. A finding of MI does not mean the beneficiary committed fraud; however, our ability to perform additional CDRs may allow us to detect potentially fraudulent or suspicious activities. There are no improper payments associated with medical CDRs. Benefits for individuals who have medically improved are improper only if the agency fails to suspend payment after we fully complete the CDR appeals process or the individual fails to cooperate with the CDR.

When an adult beneficiary's medical review diary matures, we conduct periodic CDRs using one of two methods: a full medical review or a mailer. We decide which method to use after profiling all cases and identifying individuals with a higher probability of no longer being disabled according to our standard of disability and the likelihood of MI. For individuals with a higher likelihood of no longer being disabled, we send their cases to DDSs for full medical reviews. For individuals with a lower likelihood of no longer being disabled, we send them mailers and use information gathered to determine any indication of MI. If we find an indication of MI, we then send the case to a DDS for a full medical review. If there is no indication of MI, we set a new medical review diary and schedule the case for a future CDR. Each year, we refresh the case priority selections based on the results of a predictive statistical scoring model. We continue to initiate full medical reviews for all SSI child beneficiaries.

We conduct some CDRs outside the centralized process based on events, such as voluntary or third party reports of MI. We send these CDRs to the DDSs for full medical reviews. In addition, there is a subset of cases where the medical review diary matures, but we curtail further development for technical reasons, such as the suspension or termination of benefits for non-medical reasons. Current estimates indicate that CDRs conducted in 2021 will yield a return on investment (ROI) of about $8 on average in net Federal program savings over 10 years per $1 budgeted for dedicated program integrity funding, including OASDI, SSI, Medicare and Medicaid program effects.

Work-Related Continuing Disability Reviews

When a beneficiary is receiving DI benefits, we review his or her case to determine if the beneficiary is performing SGA, and if eligibility for benefits should continue. We commonly refer to this process as a "work CDR".

The table below reflects actual CDR workload volumes for FY 2019.

FY 2019 Actual Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs	271,819	441,337	713,156
CDR Mailers	897,055	328,956	1,226,011
Work CDRs	313,807	-	313,807

In FY 2019, we spent $677 million[10] on periodic CDRs, which included the cost of CDR mailers. We spent an additional $234 million[11] on work CDRs.

We learn about work activity two primary ways: self-reported wages and earnings enforcements. We initiate work CDRs when beneficiaries directly self-report their work or earnings as required by law. DI beneficiaries must report any changes in work activity, and we must determine whether such work constitutes SGA. DI beneficiaries report work activity through their local field offices or by calling the National 800 Number. In September 2017, we expanded the options to report work by creating an Internet reporting application—myWageReport (myWR). The application not only allows DI beneficiaries and representative payees to report wages to us, it also provides a receipt of the report. In June 2018, we began accepting SSI and concurrent (DI/SSI) reports of earnings through myWR.

We also generate work CDRs through earnings enforcement. The Continuing Disability Review Enforcement Operation (CDREO) uses annual Internal Revenue Service (IRS) earnings reports. We also initiate work CDRs based on quarterly earnings received by the Office of Childhood Support Enforcements. The quarterly earnings are timelier than IRS data and allow us to learn about unreported work activity sooner. Section BBA 824 also provides us the ability to contract with third party payroll providers to obtain monthly payroll data. We look forward to incorporating the monthly data into our enforcement operation.

[10] This figure represents the total workload costs chargeable to both Program Integrity and our Information Technology modernization (IT Mod) efforts. The total amount includes $315 million in costs allocated to DI, retirement and survivors insurance (RSI), and hospital insurance/supplementary medical insurance/Part D (HI/SMI/Part D) and $362 million in costs allocated to SSI.

[11] This figure represents the total workload costs chargeable to both PI and IT Mod. This figure includes about $104 million in costs allocated to DI, $66 million in costs allocated to RSI, and $64 million in costs allocated to HI/SMI.

The following table reflects enacted CDR workload volumes for FY 2020.

FY 2020 Estimated Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs	265,000	438,000	703,000
CDR Mailers			1,100,000
Work CDRs year-to-date (YTD)[i]	70,061		70,061

i/We do not develop official volume projections for work CDRs; therefore, we have included our most recent FY 2020 YTD figures, which are through December 2019.

In FY 2020, we anticipate spending a total of $917 million[12] on full medical CDRs, CDR mailers, and work CDRs. Since work CDRs are not an agency-controlled workload, we do not develop official volume projections for that workload in a given fiscal year. Historically, work CDR volumes are consistently 250,000–300,000 annually.

In formulating the budget, we fully incorporate the projected costs of work CDRs into the total projected costs for CDRs.

Supplemental Security Income Redeterminations (RZ)

Another important program integrity tool is the SSI RZ, conducted under section 1611(c) of the Act, which is a periodic review of non-medical eligibility factors, such as income and resources.

Changes in recipients' living arrangements or the amount of their income and resources can affect both their eligibility for SSI and the amount of their payments. To ensure the accuracy of SSI payments, we conduct RZs. These reviews can be scheduled or unscheduled. We select most scheduled reviews using a predictive statistical model that we implement each year to prioritize these RZs and focus on reviews with the highest expected overpayment amount. We conduct other scheduled RZs as a limited review of a certain aspect of eligibility, resulting primarily from a computer match against other data sources. Typically, information reported by recipients, representative payees, or other third parties may cause an SSA employee to initiate an unscheduled RZ. RZs can result in the identification of overpayments, underpayments, or both.

RZs are a key activity in ensuring the integrity of the SSI program and maintaining and improving payment accuracy. SSA estimates indicate that non-medical RZs conducted in 2021 will yield a ROI of approximately $3 on average of net Federal program savings over 10 years

[12] This figure includes an estimated $346 million in costs allocated to DI, RSI, and HI/SMI/Part D and $571 million in costs allocated to SSI.

per $1 budgeted for dedicated program integrity funding, including SSI and Medicaid program effects.

Effective October 2008, we ceased conducting SSI RZs via mail, as we determined they were not cost effective.

In FY 2019, we spent $772 million to conduct 2,666,287 SSI RZs pursuant to section 1611(c) of the Act.

In FY 2020, we plan to spend $635 million to conduct 2,150,000 SSI RZs.

The Number of Cases of Fraud Identified for Which Benefits Terminated Due to Medical CDRs, Work-Related CDRs, and Redeterminations, and the Amount of Resulting Savings for Each Such Type of Review or Redetermination

We do not track the number of instances of identified fraud where we terminated benefits because of medical CDRs, work CDRs, or RZs. Neither our fraud referral form nor our case management systems capture these specific events. We are currently developing a replacement for our fraud referral process and will include this data element on our list of future enhancements.

The Number of Work-Related CDRs in Which a Beneficiary Improperly Reported Earnings Derived from Services for More Than Three Consecutive Months and the Amount of Resulting Savings

Since DI beneficiaries are not required to report earnings monthly, we define "improperly reports earnings" to mean a DI beneficiary who reports inaccurate information or does not report a change in work activity. We identify non-reporters through our IRS earnings match, commonly referred to as CDREO. The number of cases alerted through CDREO in FY 2019 was 238,372.[13]

Other Report of Interest

Below is an additional agency report of interest.

- Annual Performance Report Fiscal Years 2017-2019 (https://www.ssa.gov/agency/performance/)

[13] Historically, about 40 percent of these alerted cases result in completed work CDRs.