

Social Security Administration
Fiscal Year 2016
Bipartisan Budget Act of 2015 Section 845(a) Report

Bipartisan Budget Act Reporting Requirements

Section 845(a) of the Bipartisan Budget Act of 2015 requires us to include in our annual budget a report on our activities to prevent fraud and improper payments for each (FY) fiscal year 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 investigation (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 conducted by mail;
 - Medical CDRs conducted pursuant to section 221(i) of the Social Security (Act) and pursuant to 1614(a)(3)(H) of the Act;
 - Redeterminations 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;
- The number of cases of fraud identified for which benefits were terminated as a result of medical CDRs, work-related CDRs, and redeterminations, and the amount of resulting savings for each such type of review or redetermination; 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.

Below we provide a brief overview of our programs and anti-fraud activities. Then, we provide the information required by section 845(a) of the Bipartisan Budget Act.

Currently, we do not have the data necessary to report on the following:

- Cases of fraud identified by redeterminations, medical and work-related CDRs, including the resulting savings of each; and
- Number of work-related CDRs in which a beneficiary improperly reported earnings for more than three consecutive months, including the resulting savings.

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 the vast majority 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 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.

During FY 2016, we paid over \$960 billion dollars to more than 68 million OASDI and SSI beneficiaries.

Our Anti-Fraud Efforts

As good stewards of our resources and the Social Security trust fund, and SSI program, it is our duty to work aggressively to prevent and detect fraud and recover improper payments whether fraudulent or not.

In 2014, we enhanced our efforts to efficiently and effectively detect, deter, and mitigate fraud, waste, and abuse in our programs through the establishment of the Office of Anti-Fraud Programs (OAFP). OAFP provides centralized oversight and accountability for our anti-fraud program. OAFP leads our anti-fraud activities and works across organizational lines to ensure that employees throughout the agency have the tools to combat fraud. OAFP is an integral and critical component in our efforts to implement the agency Anti-Fraud Strategic Plan that supports a comprehensive approach to fraud prevention and aligns anti-fraud efforts with the United States Government Accountability Office (GAO) report, [*A Framework for Managing Fraud Risks in Federal Programs*](#). The GAO report identifies leading practices for managing fraud risks and identifies control activities to prevent, detect, and respond to fraud in Federal programs. Our agency anti-fraud strategic plan describes how we will develop and implement a comprehensive unified anti-fraud program.

In FY 2016, OAFP had several key accomplishments including:

- Prepared the agency Anti-Fraud Strategic Plan and aligning it with the leading practices identified in the Government Accountability Office (GAO) report [*A Framework for Managing Fraud Risks in Federal Programs*](#);
- Procured the Anti-Fraud Enterprise Solution (AFES) with the intent to replace and expand OAFP’s current anti-fraud systems and processes. AFES will integrate data from multiple sources and use industry-proven predictive analytics software to identify high-risk transactions that require further review;
- Applied predictive and rule-based models to our eServices business processes to determine common characteristics and patterns of potential cases of fraud based on lessons learned from past allegations and known cases of fraud. We currently employ over 20 analytical models to our eServices line of business. With these models, we identify suspicious and evolving patterns of activities in our workloads and prevent fraudulent actions from advancing.
- Delivered two major national training programs: mandatory anti-fraud training and refresher training on fraud or similar fault, which supplemented local and regional anti-fraud initiatives; and
- Coordinated the National Anti-Fraud Conference to bring together stakeholders from across the agency, including the Office of the Inspector General (OIG), to share ideas, best practices, ask questions, and engage in constructive dialogue on how we can work collaboratively to combat fraud in our programs.

Bipartisan Budget Act Reporting Requirements

Total Expenditures on our Fraud and Improper Payment Prevention Activities

In FY 2016, our operating expenses for our strategic goal to “Strengthen the Integrity of Our Programs” were \$2.456 billion. These expenditures included both key program integrity workloads and other stewardship activities, some of which are specific to our anti-fraud efforts. It is difficult to distinguish between specific efforts to reduce fraud and our overall efforts to reduce improper payments, as both are key parts of our program integrity workloads. The vast majority of 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 access to data on beneficiaries’ changing circumstances.

As a result, we do not have the detail level data necessary to compute the expenditures specifically for only our anti-fraud-related activities. Each year we verify that we distribute the correct costs to the proper goals. In 2016, we began discussing how we may track our anti-fraud expenditures. During 2017, we plan to track the costs separately for the CDI. All PI workloads fall under our strategic goal to “Strengthen the Integrity of Our Programs.”

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 combating fraud, similar fraud, and abuse within our disability programs. CDI units consist of personnel from our agency, OIG, disability determination services (DDS), and State and local law enforcement. CDI units investigate initial disability claims and post-entitlement events involving suspected fraud. CDI units investigate claimants as well as third parties who are suspected of committing or facilitating disability fraud.

The mission of the CDI program is to investigate questionable statements and activities of claimants, medical providers, and other third parties to obtain material evidence that is sufficient to resolve questions of potential fraud in the agency's disability programs.

We continue to expand our CDI program as resources allow and as state and local partners become available. We currently have 39 units covering 33 States, Washington, DC, and the Commonwealth of Puerto Rico.

In FY 2016, we spent approximately \$32 million¹ on CDI units, which includes personnel costs, training, travel, and equipment. CDI investigations resulted in 5,033 claims ceased or denied in FY 2016 with projected SSA savings of more than \$268 million and scheduled SSA recoveries in excess of \$4.7 million.

We do not track CDI-related costs on a per investigation basis. We estimate the average cost per CDI investigation is \$5,426.50, based on 5,903 CDI investigations closed during FY 2016.

For FY 2017, we plan to spend approximately \$32 million² on CDI units.

The Number of Felony Cases Prosecuted Under Section 208 and the Amount Spent by the Social Security Administration in Supporting the Prosecution of Such Cases; the Amount of Such Felony Cases Successfully Prosecuted and the Amount Spent by the Social Security Administration in Supporting the Prosecution of Such Cases

Our OIG examines and investigates allegations of fraud, waste, abuse, and mismanagement in our programs and operations. These allegations may involve issues such as benefit fraud, Social Security Number misuse, violations by our employees, or fraud related to grants and contracts. OIG's investigations may result in criminal or civil prosecutions or the imposition of civil monetary penalties (CMP) against offenders. These investigative efforts improve our program integrity by recovering funds and deterring those contemplating fraud against the agency in the future.

The determination as to whether to proceed with a criminal prosecution under section 208 of the Social Security Act [42 U.S.C. 408] based upon an OIG investigation rests with the appropriate United States Attorney's Office. The United States Attorney may decide to prosecute the case

¹ This figure includes OIG funds.

² This figure includes OIG funds.

not under section 208, but another Federal criminal statute applicable to the facts of the OIG investigation. If an OIG investigation is declined for Federal prosecution, it may be prosecuted in the appropriate State court.

In FY 2016, OIG investigations resulted in the successful felony prosecution of 150 subjects under section 208, resulting in approximately \$9 million in restitution ordered to our agency. In FY 2016, OIG investigations also resulted in successful prosecution of 1,012 subjects under other statutes, such as 42 U.S.C. 1383a (establishing penalties for SSI fraud, 18 U.S.C. 641 (crimes involving Theft of Government Property, and 18 U.S.C. 1001 (crimes involving False Statements, resulting in more than \$60.9 million in additional restitution ordered to our agency).

Limiting the reporting of cases to those prosecuted under section 208 underrepresents the number of OIG cases involving fraud against our programs that resulted in a successful prosecution,³ as the prosecuting attorney has discretion when seeking criminal charges. In many investigations involving fraud against our programs, which a prosecutor could have charged under section 208, the subjects were convicted under other criminal statutes as noted above. Furthermore, OIG may seek other remedies related to Social Security fraud, such as CMPs or civil actions.

In total, OIG efforts during FY 2016 resulted in more than \$484 million in investigative accomplishments, including more than \$128.7 million⁴ in recoveries, restitution, fines, settlements, and judgments,⁵; and more than \$355 million in projected savings from investigations resulting in the suspension or termination of benefits. The timeframe used to determine projected savings is based on the type of investigation, and whether the claimant was in pay status at the time of the investigation.

The Department of Justice (DOJ) is the Federal agency responsible for prosecuting defendants who have violated Federal law. However, due in part to a lack of prosecutorial resources, DOJ declines many cases for prosecution. For more than a decade, the Office of the General Counsel (OGC) has worked with OIG to develop the Fraud Prosecution Project. The goal of this initiative is to increase the number of prosecutions for crimes involving Social Security matters. To support this project, OGC has provided attorneys to serve as Special Assistant United States Attorneys (fraud prosecutors) to help prosecute Social Security fraud cases.

Since FY 2003, our fraud prosecutors have secured over \$60 million in restitution and more than 1,000 convictions. Although we began FY 2016 with 24 fraud prosecutors, ongoing attrition, coupled with the hiring freeze, has reduced this to 16 SAUSAs as of March 2017. Nonetheless,

³ A successful prosecution is a prosecution that results in a conviction or pretrial diversion.

⁴ This includes the \$9 million in restitution for section 208 prosecutions and the \$60.9 million in restitution for prosecutions under other statutes.

⁵ The [OIG 2016 Fall Semiannual Report to Congress](#) provides individual figures for recoveries, restitution, fines, settlements, and judgments. See SSA OIG, *Semiannual Report to Congress April 1, 2016 – September 30, 2016*, Fall Edition, p. 50 (November 30, 2016), at <http://oig.ssa.gov/semiannual-reports/fall-2016>.

in FY 2016, we achieved 196 convictions and over \$25.2 million in restitution to the government, including \$14.7 million to SSA's Trust Funds. The estimated FY 2016 costs of our Special Assistant United States Attorneys to obtain these convictions was \$2,981,004, which includes the salary and benefit costs of these attorneys.

In FY 2016, OGC's fraud prosecutors obtained 196 convictions and \$24,525,962⁶ in total restitution. The estimated FY 2016 costs of our Special Assistant United States Attorneys to obtain these convictions was \$2,981,004, which includes the salary and benefit costs of these attorneys.

Program Integrity Expenditures and Numbers

Periodic Continuing Disability Reviews

The American public expects and deserves for us to be outstanding stewards of the Social Security Trust Funds and general revenues that finance our programs – and as such, we are committed to ensuring that program rules and eligibility standards are fully enforced. One of our most important program integrity tools are CDRs, which are periodic reevaluations to determine whether beneficiaries still qualify to receive benefits. We conduct periodic CDRs to ensure that only those beneficiaries, who continue to be disabled, based on our strict standard of disability, continue to receive monthly benefits. Almost all medical CDRs are scheduled based on a beneficiary's likelihood of experiencing medical improvement rather than on suspicion or evidence of fraud. The primary purpose of a CDR is to determine if a beneficiary continues to be entitled to benefits because of his or her medical condition; a finding of medical improvement does not mean that the beneficiary committed fraud. However, our ability to perform additional CDRs may allow us to detect potentially fraudulent or suspicious activities. It should also be noted that there are no improper payments associated with the medical CDR process. Benefits for individuals who have medically improved are only improper if the agency fails to suspend payment after the CDR appeals process has been fully completed, or the individual had failed to cooperate with the CDR.

For case reviews that we initiate centrally when a medical review diary matures, we conduct periodic CDRs using one of two methods. We send some cases to the DDS for a full medical review; we complete others using the mailer process. We decide whether to initiate a full medical review or send a mailer after profiling all cases to identify the likelihood of medical improvement. We send cases with a higher likelihood of medical improvement to DDSs for full medical reviews. For those cases with a lower likelihood of medical improvement, we send mailers to obtain more information from the beneficiaries, which we evaluate to determine if there is any indication of medical improvement. If we find an indication of medical improvement, we send the case to a DDS for a full medical review. Otherwise, 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.

⁶ During the first half of FY 2017, our SAUSAs successfully obtained at least 119 guilty pleas and convictions. This led to over \$10.3 million in restitution, including more than \$6.3 million in restitution to SSA.

We conduct some CDRs outside the centralized process based on events such as voluntary or third party reports of medical improvement. We always send these CDRs to the DDSs for a full medical review. 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. SSA estimates that continuing disability reviews conducted in FY 2018 will yield net Federal program savings over the next ten years of roughly \$8 on average per \$1 budgeted for dedicated program integrity funding, including OASDI, SSI, Medicare and Medicaid effects.

Work-Related Continuing Disability Reviews

We use the term “substantial gainful activity” (SGA) to describe a level of work activity and earnings that precludes initial eligibility for DI benefits. When a beneficiary is receiving disability benefits from the DI program, 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.”

We learn about work activity through two primary ways. Some work CDRs are initiated when beneficiaries 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. We are planning to expand the options for a DI beneficiary to report work activity by creating an internet reporting process. Currently DI beneficiaries generally report work activity through the local field office or by calling the National 800 Number. An internet reporting application called myWageReport will also assist us by conveniently loading information about work activity directly into our work CDR systems and generating a receipt to the beneficiary. Providing a more convenient method for beneficiaries to report work will also reduce the burden on SSA staff to take reports and manually enter the data. Development is on track with initial implementation targeted for September 23, 2017. Our initial release will allow both (Title II) self-reporting beneficiary and representative payee the option to report wages behind the mySSA application.

Other work CDRs are generated through the Continuing Disability Review Enforcement Operation (CDREO). The CDREO is an automated process that identifies work activity by matching earnings reported to the Internal Revenue Service (IRS) and posted to our Master Earnings File with the information in our other records. We are working on a business process to incorporate more earnings data sources into the CDREO process. We can contract with third party payroll providers to obtain payroll data, which is timelier than IRS data and allows us to learn about unreported work activity more quickly.

When we learn of work activity, we analyze the work activity to determine if we must investigate. After we review the earnings, we may screen out many work reports and CDREO alerts because they do not meet the requirements for a work CDR. In addition, many CDREO alerts may identify payments that are not earnings from work activity (e.g., sick pay or long-term disability benefits); these payments also do not require a work CDR.

Please see the below table for actual CDR workload volumes for FY 2016:

| FY 2016 Actual Volumes | Title II | Title XVI | TOTAL |
|-----------------------------------|-----------------|------------------|--------------|
| Full Medical CDRs | 293,016 | 560,738 | 853,754 |
| CDR Mailers | 974,948 | 278,437 | 1,253,385 |
| Work-Related CDRs | 279,711 | - | 279,711 |

In FY 2016, we spent \$669 million⁷ on Periodic CDRs, which includes the cost of CDR Mailers. We spent an additional \$231 million⁸ on Work-Related CDRs.

Please see the below table for estimated CDR workload volumes for FY 2017:

| FY 2017 Estimated Volumes | Title II | Title XVI | TOTAL |
|---------------------------------------|-----------------|------------------|--------------|
| Full Medical CDRs ⁱ | 299,000 | 551,000 | 850,000 |
| CDR Mailers | 1,100,000 | | 1,100,000 |
| Work-Related CDRs (YTD) ⁱⁱ | 160,146 | | 160,146 |

i/ Volumes above are based upon CDRs available to process. We have the authority to reallocate funds based upon Section 201(g) of the Social Security Act.

ii/ We do not develop official volume projections for Work-Related CDRs, therefore we have included our most recent FY 2017 YTD figures, which are through March.

In FY 2017, we anticipate spending a total of \$825 million⁹ on Full Medical CDRs, CDR Mailers, and Work-Related CDRs. Since Work-Related 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 incorporated the projected costs of Work-Related CDRs into the total projected costs for CDRs.

SSI Redeterminations

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

⁷ Includes \$328 million in costs allocated to DI, retirement and survivors insurance (RSI), and hospital insurance/supplementary medical insurance (HI/SMI) and \$341 million in costs allocated to SSI

⁸ Includes about \$109 million in costs allocated to DI, \$65 million in costs allocated to RSI, and \$57 million in costs allocated to HI/SMI

⁹ Includes \$291 million in costs allocated to DI, RSI, and HI/SMI and \$535 million in costs allocated to SSI

Changes in beneficiaries' 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 redeterminations. To select redeterminations, we use a predictive statistical model, which we implement each year to prioritize redeterminations to focus on reviews most likely to result in the correction of improper payments. Redeterminations are a key activity in ensuring the integrity of the SSI program and maintaining and improving payment accuracy. SSA estimates indicate that non-medical redeterminations conducted in FY 2018 will yield a return on investment of about \$3 on average of net Federal program savings over ten years per \$1 budgeted for dedicated program integrity funding, including SSI and Medicaid program effects.

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

In FY 2016, we spent \$664 million to conduct 2,530,446 SSI redeterminations pursuant to section 1611(c).

In FY 2017, we plan to spend \$701 million to conduct 2.522 million SSI redeterminations pursuant to section 1611(c).

The Number of Cases of Fraud Identified for which Benefits were Terminated as a result of Medical CDRs, Work-Related CDRs, and Redeterminations, and the Amount of Resulting Savings for Each Such Type of Review or Redetermination

OIG does not track the number of instances of fraud identified where benefits were terminated because of a medical CDR. In addition, the agency does not track the number of instances of fraud identified where benefits were terminated because of a work-related CDR or redetermination. Neither our fraud referral form, nor OIG or SSA case management systems, capture these specific events.

We plan to work with OIG to obtain a list of all FY 2016 DI cases terminated because of a medical CDR, work-related CDR, or redetermination to attempt to meet the requirements to answer the above question.

In addition, we plan to work with OIG and other stakeholder components to propose revisions to the referral intake process, including the e8551 referral form. During this time, we will continue to determine if the tracking of such data is feasible by assessing our policies and procedures.

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 inaccurately or not all when there is a change in work activity. We identify non-reporters through our IRS earnings match commonly referred to as the CDREO.

Section 826 of the Bipartisan Budget Act (BBA) of 2015 enables us to create an internet tool to expand our beneficiaries' options for reporting work activity. As part of our implementation of this provision, we will expand the management information used to identify DI beneficiaries who self-report earnings to allow us to compare overpayment totals for beneficiaries who reported earnings with beneficiaries identified through CDREO.

The internet tool should be effective September 30, 2017.

Other Reports of Interest

We have provided below additional agency reports of interest.

- Fiscal Year 2016 Agency Financial Report
(<https://www.socialsecurity.gov/finance/>)
- Annual Performance Report 2015 - 2017
(<https://www.socialsecurity.gov/agency/performance/>)