Social Security Administration
Fiscal Year 2015
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 Act and pursuant to 1614(a)(3)(H);
    - Redeterminations conducted pursuant to section 1611(c); 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. This report also meets the requirements of the FY 2016 Omnibus Appropriations report provisions.

Currently, we do not have the data necessary to track the amount spent on the following:

- Fraud and improper payment prevention activities;
- Cooperative Disability Investigation (CDI) Unit investigations;
- Felony cases prosecuted under section 208 including the amount spent supporting these prosecutions;
- 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

In FY 2016, we will begin discussing how to capture and track the information.

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 2015, we paid a total of more than $931 billion to a monthly average of almost 65 million OASDI and SSI beneficiaries.

Our Anti-Fraud Efforts

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

To efficiently and effectively detect, deter, and mitigate fraud, waste, and abuse in our programs, we established the Office of Anti-Fraud Programs (OAFP) in November 2014 to provide centralized oversight and accountability of our anti-fraud initiatives. This office drives our anti-fraud efforts by sponsoring new initiatives, supporting component anti-fraud efforts,

centralizing anti-fraud analytics capabilities, and supporting the Inspector General's efforts to investigate fraud. OAFP is an integral and critical component in our efforts to implement a 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.

In FY 2015, OAFP had several key accomplishments including: the use of data analytics to enhance fraud detection and the development of analytical tools to determine common characteristics and patterns; the delivery of 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; the coordination of a National Anti-Fraud Conference to bring together stakeholders from across the agency to share best practices and discuss FY 2016 priorities; and the successful partnership with the National Anti-Fraud Committee (NAFC), which is the focal point for SSA's anti-fraud efforts.

Bipartisan Budget Act Reporting Requirements

Total Expenditures on our Fraud and Improper Payment Prevention Activities

In FY 2015, our operating expenses for our strategic goal to "Strengthen the Integrity of Our Programs" were $2.007 billion. The expenditures under this goal include both our program integrity initiatives and our specific anti-fraud efforts. It is difficult to distinguish between specific efforts to reduce fraud and our overall efforts to reduce improper payments. While fraud may cause some improper payments, most improper payments are not fraud related. As a result, we do not currently have the data necessary to compute the expenditures specifically for only our anti-fraud-related activities. In 2016, we will begin discussing how we may track our anti-fraud expenditures and identify resource implications for developing separate tracking metrics. Since all fraud is improper, but not all improper payments is fraud, it is important that we have a clearly defined set of definitions and metrics.

Total Expenditures on Cooperative Disability Investigation (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 fault, and abuse within our disability programs. CDI units, consisting of personnel from our agency as well as the Office of the Inspector General (OIG), disability determination services (DDS), and State and local law enforcement, investigate initial disability claims and post-entitlement events involving suspected fraud. CDI units investigate claimants as well as third parties who are potentially 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. We currently have 37 units, covering 31 States, Washington, DC, and the Commonwealth of Puerto Rico. We plan to open additional units in FY 2016 and more in the following years.

In FY 2015, we spent approximately $28 million[1] on CDI units, which includes personnel costs, training, travel, and equipment. CDI investigations resulted in 6,513 claims ceased or denied in FY 2015 with SSA savings of over $406 million.[2]

We do not track CDI-related costs on a per investigation basis. Consequently, the amount spent on investigations resulting in the cessation or denial of a claim is not available at this time. Tracking such data will require enhancements to OIG's case management system, and we will work with OIG to assess the feasibility of tracking such expense data in the future.

For FY 2016, we plan to spend approximately $31 million[3] 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 often 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 not under section 208 but another Federal Criminal statute applicable to the facts of the OIG investigation. If an OIG investigation is declined for prosecution by the appropriate United States Attorney's Office, it may be prosecuted in the appropriate State Court.

In FY 2015, OIG investigations resulted in the successful felony prosecution of 178 subjects under section 208, resulting in approximately $8.2 million in restitution ordered to our agency. In FY 2015, OIG investigations also resulted in successful prosecution of 1,064 subjects under

[1] This figure includes OIG funds.

[2] The 6,513 claims ceased or denied do not represent the number of cases of fraud prevented by CDI units as defined by statute.

[3] This figure includes OIG funds.

other statutes such as 42 U.S.C. 1383 – SSI fraud; 18 U.S.C. 641 – Theft of Government Property; and 18 U.S.C. 1001 – False Statements resulting in over $44.7 million in additional restitution ordered to our agency.

Limiting the reporting of cases prosecuted to section 208 likely underrepresents the number of OIG cases involving fraud against our programs that resulted in a successful prosecution, as the prosecuting attorney has discretion when seeking criminal charges. A successful prosecution is prosecution that results in a conviction including pretrial diversions. 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 2015 resulted in over $224 million in investigative accomplishments, including over $63 million (this figure includes the $8.2 million in restitution stated above) in recoveries, restitution, fines, settlements, and judgments; and over $167 million in projected savings from investigations resulting in the suspension or termination of benefits. The timeframe for savings are based on the type of investigation and whether the claim was in pay at the time of the investigation. We use a calculation of the monthly benefit amount or amount of reduction in benefits multiplied by 60 months for Title II and Title XVI program savings. For Title II and Title XVI initial claim disability cases, we use a set figure based on the program affected. For Title II and Title XVI in-pay disability cases, we use a calculation of the monthly benefit amount multiplied by 61.6.

Since the determination as to whether to proceed with a criminal prosecution based upon an OIG investigation rests with the appropriate United States Attorney's Office, we cannot quantify how many cases will be prosecuted and their resulting restitution.

In FY 2016, we will begin discussing the feasibility of capturing this information in the future. As noted previously, since all fraud is improper, but not all improper payments are fraud, it is important that we have a clearly defined set of definitions and metrics.

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, 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) in many of the Federal districts where we have regional offices and at our Headquarters in Baltimore, MD.

By early 2015, OGC hired fraud prosecutors in the new locations reflected in the chart below. Seattle, Puerto Rico, and Chicago were existing locations where we had to backfill. Kansas City was a part-time position that we converted to full-time and hired accordingly. With previously existing sites, OGC now has fraud prosecutors in 24 locations.

Location	Start Date / Entry on Duty
Alexandria, Virginia	Internal Hire – No Start Date Necessary
Chicago, Illinois	Internal Hire – No Start Date Necessary
Concord, New Hampshire	Internal Hire – No Start Date Necessary
San Juan, Puerto Rico	09/08/14
Boise, Idaho	09/21/14
Kansas City, Kansas	09/21/14
Los Angeles, California	09/21/14
Richmond, Virginia	09/21/14
Salt Lake City, Utah	09/21/14
San Antonio, Texas	09/21/14
San Diego, California	09/26/14
Detroit, Michigan	09/29/14
Baltimore, Maryland	10/27/14
Seattle, Washington	10/27/14
Albany, New York	11/03/14
Cleveland, Ohio	01/26/15

By early 2015, OGC accomplished all the hires provided. This effort doubled the number of fraud attorneys that were available at the start of 2014. With the new locations and new attorneys on board, OGC attorneys secured 171 convictions in FY 2015 resulting in total restitution of $16,469,595. The estimated FY 2015 costs of these 25 Special Assistant United States Attorneys prosecuting fraud was $3,953,000, which includes the salary and benefit costs of these attorneys. As the attorneys gain experience, the return on this investment will increase.

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 if beneficiaries still qualify to receive benefits. We conduct periodic CDRs to ensure that only those beneficiaries who remain 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.

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. Our current estimates indicate that medical CDRs conducted in FY 2017 will yield a return of investment (ROI) of about $8 on average in net Federal program savings over 10 years per $1 budgeted for dedicated program integrity funding, including Old-Age, Survivors, and Disability Insurance (OASDI), SSI, Medicare and Medicaid program effects.

Work-Related Continuing Disability Reviews

We use the term "substantial gainful activity" (SGA) to describe a level of work activity and earnings. When a beneficiary is receiving disabled worker benefits from the SSDI 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 triggered when beneficiaries report their work or earnings as required by law. SSDI 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 SSDI beneficiary to report work activity by creating an internet reporting process. Currently SSDI beneficiaries generally report work activity through the local field office or by calling the national 800 number. An internet reporting application 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.

Other work CDRs are triggered 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. The recent Bipartisan Budget Act provides us the opportunity to contract with third party payroll providers to obtain payroll data. Third party payroll data is timelier than IRS data, and will allow 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 2015:

FY 2015 Actual Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs	301,317	497,696	799,013
CDR Mailers	983,332	189,467	1,172,799
Work-Related CDRs	247,772	-	247,772

In FY 2015, we spent $560 million[4] on Periodic CDRs, which includes the cost of CDR Mailers. We spent an additional $215 million[5] on Work-Related CDRs.

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

[4] Includes $278 million in costs allocated to DI, retirement and survivors insurance (RSI), and hospital insurance/supplementary medical insurance (HI/SMI) and $282 million in costs allocated to SSI

[5] Includes about $105 million in costs allocated to DI, $61 million in costs allocated to RSI, and $49 million in costs allocated to HI/SMI

FY 2016 Enacted Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs[i]	500,000	350,000	850,000
CDR Mailers	800,000	300,000	1,100,000
Work-Related CDRs (YTD)[ii]	55,569	-	55,569

i/ Volumes above are based upon the funding provided in our FY 2016 appropriation (PL-114-113). The FY 2016 workload estimates are 350,000 Title II CDRs and 500,000 Title XVI CDRs. 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 2016 YTD figures, which are through December

In FY 2016, we anticipate spending a total of $825 million[6] 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. However, in formulating the budget, we fully incorporated the projected costs of Work-Related CDRs into the total projected costs for CDRs.

Redeterminations

Another important program integrity tool is SSI redeterminations, which are periodic reviews of non-medical eligibility factors such as income and resources.

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. Our estimates indicate that non-medical redeterminations conducted in 2017 will yield a ROI of about $3 on average of net Federal program savings over 10 years per $1 budgeted for dedicated program integrity funding, including SSI and Medicaid program effects.

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

In FY 2015, we spent $630 million to conduct 2,266,993 redeterminations pursuant to section 1611(c).

In FY 2016, we plan to spend $701 million to conduct 2,522,000 redeterminations pursuant to section 1611(c).

[6] Includes $496 million in costs allocated to DI, RSI, and HI/SMI and $329 million in costs allocated to SSI

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

For 2015, OIG reported overall savings of $475 million from all investigations resulting in the suspension or termination of benefits. This figure is reported in its Semiannual Report to Congress. However, OIG does not track the number of instances of fraud where benefits were terminated because of a medical CDR, work-related CDR, or redetermination. Neither our fraud referral form nor the OIG case management system captures this specific event. Therefore, we cannot provide FY 2015 volumes or resulting savings.

We plan to work with the OIG to assess our policies and procedures to determine if the tracking of such data is feasible and what requisite systems modifications would be needed.

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

Because SSDI beneficiaries are not required to report monthly, the only way an SSDI beneficiary can "improperly" report earnings is to not report at all when there is a change in work activity. We use the CDREO process to learn of unreported work activity. As mentioned earlier, we plan to expand options for beneficiaries to report earnings electronically and pursue new sources of earnings data for the enforcement process.

Other Reports of Interest

We have provided below additional agency reports of interest.

- Fiscal Year 2015 Agency Financial Report (https://www.socialsecurity.gov/finance/)
- Annual Performance Report 2014 - 2016 (https://www.socialsecurity.gov/agency/performance/)