Social Security Administration
Fiscal Year 2021
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. This report satisfies that requirement with respect to SSA's activities conducted in fiscal year (FY) 2021 and gives information on SSA's expected activities in this area for FY 2022. BBA 845(a) directs the agency to include in this report the following:

- 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 their own disability or blindness. General tax revenues fund the SSI program.

We pay benefits to about 65 million OASDI beneficiaries (including 2.6 million concurrent beneficiaries also receiving SSI) and almost 8 million SSI recipients on average each month. We paid over $1.1 trillion in FY 2021.

Our Anti-Fraud Efforts

Combatting fraud is an agency priority. We have centralized our anti-fraud efforts to employ data analytics and predictive models to prevent fraud, assess and mitigate fraud risks, 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.

We continue our efforts to review potentially fraudulent eServices transactions to detect and mitigate fraud committed through the mySSA portal. We proceed to develop and refine our business processes to improve the efficiency and effectiveness of our eServices reviews. Additionally, we continue collaborations with several agencies to establish data exchange agreements that will allow us to improve our fraud detection and mitigation efforts.

Our Enterprise Fraud Risk Management (EFRM) strategy establishes a business process and long-term schedule for completing fraud risk assessments across nine major program areas. In accordance with our EFRM strategy, we complete fraud risk assessments annually and develop mitigation strategies to further reduce specific risks identified in those assessments. In FY 2021, we completed two risk assessments and started the pre-planning process for another. By the end of FY 2022, we will have initiated all nine risk assessments. Once we complete all initial fraud risk assessments, we will conduct ongoing reassessments of each area at least every three years. In addition to the pre-planned fraud risk assessments listed in the EFRM strategy, we conduct ad hoc fraud risk assessments at the request of other SSA components.

In FY 2021, we expanded our fraud training offerings for agency employees, developing disability trainings related to identifying exaggerated symptoms and identifying potentially fraudulent medical evidence. We developed comprehensive trainings on administrative sanctions and fraud risk assessments. We expanded our mandatory annual anti-fraud training to provide multiple topics from which employees could choose, including death reporting and processing, procurement fraud, direct deposit fraud blocks, and fraud prosecutions.

In addition, SSA took a comprehensive approach to address the nationwide increase in impersonation scams. We communicated scam awareness information through various social media platforms, our websites, and in media interviews. We sent scam alert emails to 38.2 million *my* Social Security account holders and added scam alert language to the outside of envelopes associated with more than 250 million public notices. We filmed a public service announcement with the Commissioner that was shared in SSA field offices, major retail outlets across the country, and broadcast media, generating 2.8 billion viewing and listening impressions. SSA and the Office of the Inspector General (OIG) partnered for the third year in a row to organize a significant targeted outreach event by designating a highly successful annual National "Slam the Scam" Day, in connection with the Federal Trade Commission's National Consumer Protection Week, to raise public awareness using social media events and news coverage to reach more people.

Our Improper Payment Prevention Initiatives

The Improper Payments Oversight Board provides leadership, oversight, and accountability for the agency's improper payment initiatives. In FY 2021, we collaborated with components to complete the Improper Payments Alignment Strategies (IPAS). The IPAS outlines how we determine underlying causes of errors, develop corrective actions with key stakeholders, and identify cost-effective actions to reduce improper payments. We held discovery sessions with component subject matter experts to identify and explore new mitigation strategies and corrective action plans. We developed a comprehensive approach to prioritize and drive business process, policy, and automation improvements by strategically aligning the new and existing initiatives that will have the most significant impact in the detection and prevention of improper payments to help confirm that SSA is providing the correct benefit amounts only to those who qualify.

In FY 2022, we will develop a framework to measure the effectiveness of the completed corrective actions. By the end of FY 2022 we will identify measurable actions and benchmarks that could be used to demonstrate the progress of the corrective actions in at least three IPASs. We will continue the evaluation process with the remaining IPASs in FY 23 and beyond, and continue to monitor the mitigation strategies and corrective actions to improve effectiveness.

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] Our FY 2021 total operating expense for the Ensure Stewardship strategic goal was $2.695 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 improper payments is challenging, as both are key elements of our PI workloads. Most improper payments we detect do not involve any evidence of intent to commit fraud.

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[1] For more information on our improper payment prevention activities, refer to the Payment Integrity section of the Fiscal Year 2020 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/.

Rather, they involve complex rules about eligibility for program benefits and delays in receiving information about changes in beneficiaries' circumstances.

Although we do not have the detailed data necessary to compute the specific expenditures for each of our anti-fraud-related activities, we verify that we distribute the total correct costs to the proper goals. We modified our process to better track the SSA costs separately for CDI units. We identify agency and disability determination services' (DDS) CDI payroll and other object costs through specific and separate common accounting numbers. We determine the proportion of costs already distributed to the PI workloads and remove those costs from the CDI costs to avoid double counting.

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 commit or facilitate disability fraud on initial disability claims and post-entitlement events. CDI units consist of personnel from our agency, OIG, DDSs, and State and local law enforcement.

We continue to expand our CDI program and are on track to meet our goal of providing CDI coverage to all 50 states and U.S. territories by October 1, 2022. We currently have 49 units, covering 47 states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands.

In FY 2021, we spent approximately $41.2 million to operate our CDI units, of which $30.8 million was SSA's cost, and approximately $10.4 million[1] was OIG's cost. These expenditures included personnel costs, training, travel, facilities, and equipment. In FY 2021, CDI investigations resulted in the cessation or denial of 1,078 claims and 74 judicial actions (i.e., sentencing, pre-trial diversion, civil settlement, and civil monetary penalties), which contributed to OIG projecting more than $86 million in savings to SSA programs and monies[2] of over $58 million.

We do not track CDI-related costs on a per-investigation basis. We estimate the average cost per CDI investigation is $19,915 based on 2,072 CDI investigations closed[3] during FY 2021.

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[1] The FY 2021 appropriations language provides that SSA may transfer up to $11.2 million to the SSA OIG for the operation of the CDI units (Pub. L. No. 116-260). This anti-fraud activity is an authorized use of the dedicated program integrity allocation adjustment.

[2] SSA monies include recoveries, restitution, fines, penalties, judgments, and settlements.

[3] In October 2020, we changed how we categorized our open cases to include both full investigations, and preliminary investigations where we took some investigative action but lacked enough information to determine whether the alleged act likely occurred. This approach more accurately reflects our investigative efforts and is consistent with investigative case structure codified in the Attorney General's Guidelines for Domestic Federal Bureau of Investigations Operations. The implementation of this new methodology was undertaken in FY 2021 in connection with the rollout of a new case management system.

For FY 2022, we plan to spend approximately $42.9 million to operate our CDI units, of which approximately $30.8 million is SSA's cost, and $12.1 million[1] will be transferred to OIG pending an annual appropriation.

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[2]

Our employees refer allegations of potential fraud to OIG for investigation. OIG conducts criminal investigations and refers cases to U.S. Attorney's Offices (USAO) within the Department of Justice (DOJ), or to State and local prosecuting authorities, for prosecution.[3] We primarily rely on the USAOs to prosecute Social Security fraud, which is a Federal crime. The federal prosecutors have discretion whether to accept fraud cases for prosecution and what Federal statutes to charge.[4] As an initiative to increase Federal Social Security fraud prosecutions, the Office of the General Counsel has provided DOJ with attorneys who are sworn in and serve as Special Assistant United States Attorneys (SAUSA) in multiple USAOs throughout the country. The SAUSA's focus is solely to prosecute 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 resulted in federal court orders of over $342 million in restitution and more than 2,370 convictions. We ended FY 2021 with 35 SAUSAs in 33 Federal judicial districts. In FY 2021, our SAUSAs successfully prosecuted 262 criminal cases under section 208 of the Act [42 U.S.C. §408] and other statutes.[5] Based on these cases, federal courts ordered payment of over $31.8 million in restitution to the Government, over $17 million of which was to SSA's Trust Funds. The estimated FY 2021 costs of SAUSAs to obtain these convictions was $5.9 million, including the salary and benefit costs of these attorneys.

Program Integrity Expenditures and Numbers

We are committed to ensure eligible individuals receive the benefits to which they are entitled, and to safeguard the integrity of benefit programs to better serve the public. We conduct medical and work CDRs to ensure that only beneficiaries who still qualify to receive benefits under the OASDI and SSI programs continue to receive those benefits. For those receiving SSI, we also

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[1] P.L. 116-260 allows SSA to transfer $11.2 million in FY 2021 from the LAE account to the OIG for the costs associated with jointly operated CDI units. The FY 2022 CR continues this transfer in FY 2022 of up to $11.2 million. The FY 2022 Budget requests a $12.1 million transfer in FY 2022

[2] 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.

[3] This report does not include financial information pertaining to the success of OIG investigations.

[4] 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/semiannual-reports/.

[5] 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.

perform non-medical redeterminations to determine whether recipients continue to meet the program's non-medical eligibility criteria.

Periodic Medical Continuing Disability Reviews

The American public expects and deserves outstanding stewardship of the Social Security Trust Funds and general revenues that finance our programs. One of our most important PI tools is the medical CDR. CDRs are periodic reevaluations to determine whether disabled beneficiaries continue to be eligible for benefits because of their medical conditions. We schedule almost all medical CDRs based on a beneficiary's likelihood of experiencing medical improvement (MI) that may make the beneficiary ineligible for benefits 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 an abbreviated review mailer. We decide which method to use after we profile all cases and identify individuals with a higher probability of no longer meeting our standard of disability and the likelihood of MI related to the beneficiary's ability to work. For individuals with a higher likelihood of MI, we send their cases to the DDSs for full medical reviews. For individuals with a lower likelihood of MI, we send a mailer 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. Every 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 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 2023 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 PI funding, including OASDI, SSI, Medicare, and Medicaid program effects.

Work-Related Continuing Disability Reviews

When a disabled OASDI beneficiary is receiving benefits and earning wages, 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 2021.

FY 2021 Actual Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs	170,930	339,580	510,510
CDR Mailers	700,495	404,556	1,105,051
Work CDRs	289,306	-	289,306

Note: The split of full medical CDRs between titles II and XVI for FY 2021 is estimated.

In FY 2021, we spent $569 million[1] on periodic medical CDRs, which included the cost of CDR mailers. We spent an additional $212 million[2] on work CDRs.

We learn about work activity in 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, SSI recipients, and representative payees report work activity through their local field offices, by calling the National 800 Number, or by using the internet reporting application—myWageReport. The application provides a receipt of the report.

We also generate work CDRs through earnings enforcement. The Continuing Disability Review Enforcement Operation (CDREO) uses annual earnings data provided by the Internal Revenue Service (IRS) to identify records likely to have large overpayments. We also initiate work CDRs based on quarterly earnings received by the Office of Childhood Support Enforcement. The quarterly earnings are timelier than IRS data and allow us to learn about unreported work activity sooner.

Section 824 of the BBA also provides us the ability to contract with third party payroll providers to obtain monthly payroll data. We use the monthly earnings obtained from the payroll provider(s) to identify work CDRs. In FY 2022, we plan to enhance automation of wages received from the Payroll Information Exchange by incorporating the monthly wage data into our enforcement operation.

The following table reflects enacted CDR workload volumes for FY 2022.

[1] This figure represents the total workload costs chargeable to PI, CARES Act efforts, and our Information Technology modernization (IT Mod) efforts. The total amount includes $254 million in costs allocated to DI, retirement and survivors insurance (RSI), and hospital insurance/supplementary medical insurance/Part D (HI/SMI/Part D) and $315 million in costs allocated to SSI.

[2] This figure represents the total workload costs chargeable to PI, CARES Act, and IT Modernization. This figure includes about $91 million in costs allocated to DI, $62 million in costs allocated to RSI, and $59 million in costs allocated to HI/SMI.

FY 2022 Estimated Volumes	Title II	Title XVI	TOTAL
Full Medical CDRs	313,708	307,292	621,000
CDR Mailers			1,100,000
Work CDRs year-to-date (YTD)[i]	103,966		103,966

[i] We do not develop official volume projections for work CDRs; therefore, we have included our most recent FY 2022 YTD figures, which are through February.

In FY 2022, we anticipate spending approximately $916 million[1] 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 Non-Medical Redeterminations

Another important PI workload 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. The RZs can identify overpayments, underpayments, or both.

Changes in recipients' living arrangements, 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 scheduled or unscheduled RZs at periodic intervals that vary depending on the likelihood of payment error. We select most scheduled reviews using a predictive statistical model that we implement each year to prioritize 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 result in the initiation of an unscheduled RZ.

RZs are a key workload that ensures the integrity of the SSI program, and maintains and improves payment accuracy. We estimate that non-medical RZs conducted in 2023 will yield a ROI of approximately $3 on average of net Federal program savings over 10 years per $1 budgeted for dedicated PI funding, including SSI and Medicaid program effects.

We do not conduct SSI RZs via mail as we determined they are not cost effective.

In FY 2021, we spent $806 million[2] to conduct 2,367,391 SSI RZs pursuant to section 1611(c) of the Act.

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[1] This figure includes an estimated $463 million in costs allocated to Social Security Disability Insurance, RSI, and HI/SMI/Part D and $453 million in costs allocated to SSI.

[2] This figure represents the total workload costs chargeable to PI, CARES Act efforts, and our IT Modernization efforts.

In FY 2022, we plan to spend $636 million to conduct 1,928,000 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. This data element is on our list of future enhancements to the Allegation Referral Intake System.

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 2021 was 42,484.[1]

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

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