Steffani C. Gray, BS, AHFI

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Forward-thinking Investigations Specialist with 10+ years of fraud operational experience with healthcare insurance. Extensive experience in fraud, waste, and abuse data analytics, with demonstrated ability to successfully develop and remediate cases in a timely manner. Possesses excellent report-writing skills combined with an acute attention to detail.

Professional Experience

Blue Cross Blue Shield of MI | Detroit, MI **October 2007 - Current**

Fraud Investigator, Government Programs | January 2024- Present

- Experienced in collaborating with law enforcement agencies, regulatory bodies, and legal teams to build cases against individuals or organizations suspected of healthcare fraud
- Knowledgeable about relevant laws, regulations, and industry standards governing healthcare fraud, including the False Claims Act, Anti-Kickback Statute, and HIPAA
- Excellent communication skills, with the ability to effectively interview witnesses, testify in court, and present findings in a clear and concise manner
- Interview patients, healthcare providers, insurers, and other relevant parties to gather information and evidence related to suspected fraudulent activities, ensuring confidentiality and adherence to legal protocols
- Collaborate with law enforcement agencies, such as the FBI, Department of Health and Human Services, Office of Inspector General (HHS/OIG), and other investigative bodies, to share information, provide support for criminal investigations, and facilitate prosecution of fraud cases
- Conduct surveillance operations when necessary to gather evidence of fraudulent activities, such as monitoring provider practices, patient behavior, or billing practices to detect fraudulent patterns
- Interface with regulatory agencies such as the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS), and state regulatory bodies to report findings, share intelligence, and collaborate on fraud prevention initiatives
- Educate providers on fraud, waste, and abuse, using extensive knowledge of fraud to promote fraud literacy, mitigating financial loss while staying in contact with BCBSM members to ensure comfortability in safety of healthcare benefits contributing to STARS rating

Sr. Special Investigative Analyst, Government Programs | January 2022 – January 2024

- Gather and compile data to be used in fraud investigations and referred to various Law Enforcement agencies, using extensive database experience along with detail-oriented nature to assure accurate data input
- Assist with reporting of compiled data for compliance purposes, using data analytics to report findings to multiple government anti-fraud agencies including CMS
- Review data and attend Credentialing Committee meetings to provide input on behalf of the Special Investigations Unit for consideration of provider recredentialing
- Investigate a caseload of fraud allegations that require review of data and accuracy of claims that has resulted in over $200K cost avoidance in 1 year
- Triage fraud allegations reported from many different internal BCBSM areas and determine the necessity of a fraud investigation
- In 2022, testified in a Federal fraud case with over $13M financial exposure regarding claims data I provided
- Respond to inquiries from employees across the corporation as well as law enforcement entities with analytical results

- Use fraud investigative experience to provide valuable input for software development, assuring a functional system
- Educate providers on fraud, waste, and abuse, using extensive knowledge of fraud to promote fraud literacy, mitigating financial loss while staying in contact with BCBSM members to ensure comfortability in safety of healthcare benefits contributing to STARS rating
- Ensure compliance in reporting FWA allegations within Health Plan Business including Emerging Markets and all government sponsored programs
- Perform investigative strategies utilizing industrywide best practices
- Prepare detailed reports of all investigative findings and present to BCBSM leadership for review

Senior Investigative Data Analyst | April 2018 – December 2021

- Conducted proactive data analytics to develop cases for investigation, using database navigation skills to locate relevant data leading to over 25 new investigative cases annually
- Reviewed information requests, using strong problem-solving skills to quickly review requests and create new cases accordingly
- Researched healthcare fraud research trends, using ability to learn rapidly to begin applying knowledge to everyday work processes, helping to more readily identify new patterns of fraudulent behavior
- Coordinated with cross-functional team, using strong communication skills and flawless English language skills to develop positive working relationships, allowing for improved collaboration
- Educated providers on fraud, waste, and abuse, using extensive knowledge of fraud to promote fraud literacy, mitigating financial loss
- Aided investigators in resolving up to 50 cases annually, using impeccable critical thinking skills and strong attention to detail to exceed the outstanding threshold for founded case closures by 23% for FY 2021

Compliance Reporting Analyst | December 2015 - April 2018

- Reported up to 10 cases daily using FIMS or FSTS system, using extensive FEP knowledge to streamline the reporting process
- Served as a liaison among organizations, using flawless English writing and speaking skills to clearly and professionally communicate, ensuring compliance with rules and regulations
- Created and updated department policies, using strong attention to detail to ensure compliance with all Medicare regulatory policies

Blue Cross Blue Shield of MI | Detroit, MI
Special Investigative Analyst | July 2012 - December 2015

- Gathered and compiled data to be used in fraud investigations, using extensive database experience along with detail-oriented nature to assure accurate data input
- Assisted with reporting of compiled data for compliance purposes, using strong report-writing skills to help produce over 10 accurate and clear reports monthly
- Participated in user testing for new alert system, using fraud investigative experience to provide valuable input to software developers, assuring a functional system

Fraud Hotline Technician | February 2011 - July 2012

- Completed intake for over 100 allegations of fraud from internal and external parties on a monthly basis, using strong prioritization skills and ability to work under pressure to ensure on-time resolutions
- Inputted required information for each allegation of fraud into internal system and forwarded for investigation, using strong attention to detail to assure accuracy
- Consistently exceeded case input requirement by 3 days
- Assisted investigator with an internal case by working undercover as a professional service client and provided a written report describing the experience

Core Competencies

Fraud Investigation, Data Analysis, Report Writing, Databases, Financial Services, Training, Problem-Solving Skills, Attention to Detail, Process Improvement, Financial Recoveries, Project Management, Management

Technical Skills

SAS, SAS Fraud Framework, SAS Visual Analytics, Alation, Microsoft Office (Word, Access, Excel, PowerPoint, OneNote, Teams), NHCAA SIRIS, TLO, Accurint, CLEAR, Healthcare Fraud Shield

Education/Certifications

Bachelor of Science in Project Management, Colorado Technical University
Master of Business Administration, Colorado Technical University expected March 2026
Medicare and Medicaid Fraud Training, Centers for Medicare & Medicaid Services (CMS) Outreach Program
Accredited Healthcare Fraud Investigator, NHCAA, 2021
Open-Source Intelligence and Social Media Training, JAG Investigations Inc., 2018 & 2023
Sankofa Leadership Training- Tier 1, Blue Cross Blue Shield of MI, 2023
Sankofa Leadership Training- Tier 2, Blue Cross Blue Shield of MI, 2024

Professional Affiliations

Member, National Management Association, BCBSM Chapter, 5 years affiliated
Member, National Health Care Anti-Fraud Association

- Completed over 100 continuing education credits in healthcare fraud prevention and reduction

Member, Healthcare Fraud Prevention Partnership