Click here to link to instructions **All positions in OHA require a Criminal Background Check and an Abuse/Neglect Check. Fingerprints may be required.**

STATE OF OREGON
Oregon Health Authority (OHA)
POSITION DESCRIPTION

Position Revised Date:

This position is:
☒ Classified
☐ Unclassified
☐ Executive Service
☐ Mgmt Svc – Supervisory
☐ Mgmt Svc – Managerial
☐ Mgmt Svc – Confidential

Agency: Oregon Health Authority

Division: Medicaid

☒ New ☐ Revised

SECTION 1. POSITION INFORMATION

a. Classification Title: Program Analyst 1
b. Classification No: C0860 **c.** REPR: OAH
d. Position No: TBD / TBD
e. Working Title: Provider Billing and Compliance
f. Agency No: 44300
g. Section Title: Provider Services
h. Employee Name: Vacant
i. Work Location (City — County): Salem/Marion or Portland/Multnomah; Hybrid
j. Supervisor Name: Arwen Wolf
k. Position: ☒ Permanent ☐ Seasonal ☐ Limited Duration ☐ Academic Year
☒ Full-Time ☐ Part-Time ☐ Intermittent ☐ Job Share
l. FLSA: ☐ Exempt If Exempt: ☐ Executive **m.** Eligible for Overtime: ☒ Yes
☒ Non-Exempt ☐ Professional ☐ No
☐ Administrative

SECTION 2. PROGRAM AND POSITION INFORMATION

a. Describe the program in which this position exists. Include program purpose, who's affected, size and scope. Include relationship to agency mission.

OHA values health equity, service excellence, integrity, leadership, partnership, innovation and transparency. OHA's health equity definition is "Oregon will have established a health system that creates health equity when all people can reach their full potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address: the equitable

distribution or redistributing of resources and power; and recognizing, reconciling, and rectifying historical and contemporary injustices." OHA's 10-year goal is to eliminate health inequities.

The Medicaid Division is aligned with the Oregon Health Authority's core values of partnership, service excellence, leadership, integrity, health equity, innovation, and transparency. In our practice, these values are expressed through:

Health Equity:

- Addressing the clinical and social conditions, as well as the historical and contemporary injustices, which undermine health, so everyone can reach their full health potential.
- Considering the diversity of Oregon's communities as we make decisions about how policy and practice are developed, and how resources are distributed.
- Respecting diverse cultures, populations, histories, and health practices; ensuring a diverse workforce and inclusive work environment.

Service Excellence:

- Exceeding expectations and being committed to delivering responsive, efficient, and effective solutions.

Integrity:

- Being accountable for maintaining the highest standards and outcomes in all aspects of our work; being a good steward of public trust and resources.
- Ensuring decisions are informed, fiscally responsible, open, and easily understood.

Leadership:

- Ensuring every employee has the ability and opportunity to help make changes that improve health and transform health care.
- Leading improvement in health through innovative strategies and creative solutions.

Partnership:

- Seeking out, listening to, and collaborating with partners across diverse communities; respecting internal and external ideas and opinions.
- Working with key invested partners and communities to protect and promote the health of all people in Oregon.

Innovation:

- Not being satisfied with the status quo and seeking new and better ways to meet the needs of the people we serve with creativity and openness.
- Pursuing opportunities to develop new evidence to evolve our practices.

Transparency:

- Communicating honestly and openly, ensuring our actions are upfront and visible.
- Providing open access to information and meaningful opportunities to provide input and participate in our decision-making.

Medicaid Division description:

OHA is home to most of the state's publicly supported health programs. OHA divisions include Behavioral Health, Equity and Inclusion, Fiscal and Operations, Health Policy and Analytics, Medicaid, Public Health, and the Oregon State Hospital.

The Medicaid Division is responsible for the design, development, implementation, monitoring, evaluation, and improvement of publicly funded Medicaid programs and related health programs, which includes the Oregon Health Plan (OHP), Healthier Oregon, the OHP-Bridge Program, and initiatives under 1115 demonstration waivers, state plan authorities, and 1915 home and community-based services waivers. The Division is the Single State Medicaid agency authorized to enter into agreements with the federal government for the state of Oregon. The division defines and manages the Oregon Administrative Rules divisions that govern OHP-covered health care services, eligible fee for service health care providers and participating managed care plans, including Coordinated Care Organizations (CCOs), to ensure programs and services are delivered effectively, equitably, and in compliance with state and federal regulations.

Medicaid, and the related health programs the division oversees, provides coverage for health care and related services for Oregonians with low income. Currently, one out of every three Oregonians receive healthcare through Medicaid programs. These programs play a crucial role in improving health care access, promoting health equity, and reducing disparities across the state. The collective and collaborative effort of division management and staff are essential in helping OHA achieve its vision and aim to produce better and more equitable health outcomes and move closer to our strategic goal to eliminate health inequities by 2030.

Unit/Program Description:

Provider Services offers support to healthcare providers, assisting with claims reviews, payment approvals, and technical inquiries via phone and email, while also addressing billing issues with Medicaid members.

Team Description:

The Provider Billing and Compliance Team (PA1) is responsible for resolving billing complaints submitted by Oregon Health Plan (OHP) members.

This team operates within the Provider Services Unit and is composed of staff who:

- Work independently to review and resolve individual billing cases
- Collaborate with team members when cases require shared expertise or cross-review
- Apply Oregon Administrative Rules (OAR) and Code of Federal Regulations (CFR) to ensure all billing decisions are accurate, compliant, and consistent

The team’s core purpose is to ensure that billing concerns are addressed fairly, accurately and in alignment with state and federal regulations.

b. Describe the primary purpose of this position, and how it functions within this program. Complete this statement. The primary purpose of this position is to:

This position serves as a technical expert in Medicaid member eligibility, provider enrollment, and billing compliance within the Oregon Health Plan (OHP). Its primary purpose is to ensure accurate eligibility determinations, proper provider enrollment, and compliant billing practices in accordance with state and federal laws, Oregon Administrative Rules (OARs), Code of Federal Regulations (CFRs), and agency policy. The role protects program integrity by researching complex eligibility and claims issues, resolving discrepancies, guiding providers, and rendering formal compliance determinations. The work of this position is centered on individual case review and technical support, not program development or administrative leadership.

This position will factor in the perspectives of diverse populations most harmed by social injustice and inequities including communities of color, immigrant groups, the disability and neurodivergent communities, veterans, older adults, individuals identifying as LGBTQIA+ and other communities that have been traditionally marginalized.

SECTION 3. DESCRIPTION OF DUTIES

List the major duties of the position. State the percentage of time for each duty. Mark "N" for new duties, "R" for revised duties or "NC" for no change in duties. Indicate whether the duty is an "Essential" (E) or "Non-Essential" (NE) function.

Note: *If additional rows of the below table are needed, place cursor at end of a row (outside table) and hit "Enter".*

% of Time	N/R/NC	E/NE	DUTIES
At all times	N	E	**Align Conduct with OHA's Values and 2030 Strategic Goal** • Demonstrate awareness, understanding and alignment in service delivery with the OHA Core Values of Health Equity, Service Excellence, Integrity, Leadership, Partnership, Innovation, and Transparency. • In addition to the cultivation of equitable practices across all aspects of the position description, learn and apply knowledge and skills to interrupt systemic racism and oppression of groups most impacted by historical and contemporary racism and social injustices. • Demonstrate recognition of the value of individual and cultural difference; demonstrate evidence of ongoing development of personal cultural awareness and humility; contribute to an inclusive work environment that is respectful and accepting of diversity and where talents and abilities are valued. • Contribute to a positive and productive work environment; maintain regular and punctual attendance; perform all duties in a safe manner; and comply with all policies and procedures.

			• Model professional behavior. Interrupt and report inappropriate behaviors, especially those in violation of policy. • Promote and actively participate in OHA's 2030 goal of eliminating health inequities. • Hold awareness and be attentive to the direct and indirect accountabilities and opportunities within the Medicaid Division to positively impact and influence the goals, strategies, actions, and measures outlined in OHA's strategic plan (2024-2027). • Use language that promotes equity, engagement, asset-framing, and power-sharing; when crafting written content or correspondence, reference and adhere to equity-centered communication guidelines outlined in the OHA/ODHS Writing Style Guide .
15%	R	E	**Member Eligibility, Enrollment & Provider Enrollment Research** • Conduct case specific research of current and past Oregon Health Plan (OHP) member eligibility in MMIS for Open Card (Fee for Service; FFS) and Coordinated Care Organization (CCO) and Medicare enrollment as well as Third Party Liability (TPL) enrollment. • Research provider Medicaid enrollment status to determine provider status. Confirm or clarify validated enrollment information to provider and encourage non-enrolled providers to enroll in MMIS. • Utilize MMIS audit trail to validate OHP member eligibility for the dates of service in question. • Validate changes to OHP member through eligibility systems used across state agencies, including MMIS, DHR, TRACS, ONE and CORMETS. Collaborate on case specific technical issues with internal and external partners. • As identified, refer eligibility issues and discrepancies to CMU, SAT and CES when eligibility errors are discovered for resolution. • Collaborate with other ODHS/OHA entities such as Medical Payment Recovery Unit, Health Insurance Group, Prepaid Health Plan Coordinators and external agencies to coordinate technical support for billing and eligibility issues. •
35%	R	E	**Claims Research and Review** • Review complex OHP billing complaints originating from Client Services, Ombudsmen, the OHA Director's Office, and legislative channels to identify issues, validate billing

			accuracy, and support resolution. Review billing statements, collection notices, court judgements, wage garnishments, trusts and settlement documents, and payment receipts to establish and document the facts of a billing compliance case. • Review claims and any edits that posted during processing. Based on research and circumstances, determine if billing was appropriate based on State and Federal rules. • Compile and evaluate case information to determine billing compliance outcomes, including assigning liability to either the provider or member, validating billing accuracy, and recommending provider sanctions when providers fail to meet regulatory standards. • Research in MMIS to see if claims have been processed for the services received by the member. Document all relevant paid and denied or suspended claims. Contact provider(s) to request billing statements and information to cross-reference and validate any discrepancies. • Reviews and tracks claim processing steps, documenting actions to ensure compliance, and consulting with agency Policy analysts, MMIS Business Systems Unit (BSU), and Provider Clinical Support Services Unit (PCSU) to resolve policy or system-related questions. • Evaluate data across MMIS panels and other system resources to identify processing errors and reports MMIS and Web Portal issues that result in incorrect provider payments. • Follow up with providers and/or provider agents until billing compliance is reached and cases are closed. Document circumstances and outcomes in FileMaker.
30%	R	E	**Technical Assistance & Quality Monitoring** • Evaluate, clarify, and validate provider billing issues through research, MMIS audit trails, documentation, written and verbal correspondence. • Apply laws (CFRs) and rules (OARs), agency policies and/or precedent rulings to remediate and rectify billing or billing compliance issues. • Notify providers, third party billing services, collection agencies, attorneys and others via telephone and in writing of the billing and billing compliance requirements. • Identify problems where provider training is needed. Provide technical guidance, assistance and training to providers, agency staff (e.g. policy analysts, Ombuds), CCO staff, and other partners.

			• Educate and advise on how to bill according to applicable laws (CFRs) and rules (OARs). Explain technical processing procedures. • Provide technical input and update of OARs. Collaborate with policy to suggest changes and updates needed to comply with current law and technical processing needs.
10%	R	E	**Compliance Determinations** • Identify when rules, laws and policies are violated, or provider is non-compliant. Prepare and draft determination letters citing policies, rules and reasons for outcome. • Propose to manager when a special check is required to make a member, provider or other entity whole. Consult and coordinate with the Office of Financial Services (OFS) when special checks must be included with the determination letter. • Discern need for Cease and Desist order, prepare and draft letter for manager review. • Escalate and defer provider issue to Provider Enrollment and/or to OHA auditors for review due to lack of cooperation and non-compliance. • Consult and coordinate with Provider Enrollment to recommend provider sanctions and/or contract terminations.
5%	NC	E	**Provider Services Phone Coverage** • Answer claims and portal assistance calls when wait times are high or as directed as part of the Provider Services team. The calls consist of claims troubleshooting, claims guidance and provider portal access maintenance.
5%	R	E	**Performs Other Duties as Assigned:** • Participate in special projects, provide informal training to providers, serve as member of work groups, and attend meetings. • Compile information for support in Administrative Hearings and testify in case hearings, when appropriate.

SECTION 4. WORKING CONDITIONS

Describe any on-going working conditions. Include any physical, sensory, and environmental demands. State the frequency of exposure to these conditions.

The person in this position will work a professional work week, Monday through Friday. Occasional overtime may be required to meet the operational needs of the division.

The job requires frequent preparation, presentation, and/or response to technical and professional material against assigned deadlines. May experience stressful situations due to unchangeable project and program timelines. Must be able to respond effectively to verbal instruction and coaching and work collaboratively in a team environment.

This professional collaborative position relies upon positive, productive, and respectful engagement with leadership and subject matter experts within the Division, across the Agency / state agencies, as all as with Oregon Health Plan (OHP) members, providers, and partners.

Occasional in-state travel may be required.

This is a hybrid role that will require occasional in-person time, usually at one of OHA's state office buildings. This work may be performed remotely (unless the agency's business and operational needs require in-person) within the defined workweek.

When working remote, the current structure relies upon Division issued equipment, utilizing the employee's internet network and activation of secure network software to connect to OHA's Virtual Private Network, and utilizing on camera virtual meetings.

Works with providers and their representatives to navigate Oregon Health Plan (OHP) processes, resolve questions or concerns, and ensure understanding of applicable rules, policies, and technical procedures. Provides guidance on billing requirements, compliance expectations, and interactions with fee-for-service programs or Coordinated Care Organizations (CCOs). Spends the majority of time responding to provider inquiries, conducting follow-up research, and entering accurate case narratives across multiple databases.

Open office environment or virtual environment with frequent interruptions while working on multiple projects simultaneously. Continuous use of computer and communication devices/ applications. Multiple communication streams including email, instant message, and cell phone. These are daily conditions.

SECTION 5. GUIDELINES

a. List any established guidelines used in this position, such as state or federal laws or regulations, policies, manuals, or desk procedures:

- Federal Regulations (including but not limited to Medicare and Medicaid regulations and Health Insurance Portability and Privacy Act)
- Oregon Revised Statues
- Oregon Administrative Rules
- Medical manuals including ICD-10, HCPCS and CPT
- ICD Diagnosis Code Books
- Program budget, expenditure and utilization reports, program operations claim status and error reports related to assigned medical program and service areas
- MMIS Computer Guide
- State laws, rules, and contract requirements relating to Medicaid services

- OHA/ODHS Human Resource policies and procedures
- Oregon Department of Administrative Services (DAS) policies and procedures
- Departmental and office policies and procedures
- Collective Bargaining Agreement
- Local requirements as appropriate
- Continuous Improvement strategies

b. How are these guidelines used?

All review activities and determinations are grounded in expert interpretation of OHP billing rules, coverage guidelines, and payment policies. Professional judgement is applied to evaluate documentation, identify unique billing scenarios, and ensure that claims and prior authorization requests align with required criteria.

Serves as a billing and compliance reviewer and provides subject-matter input for administrative rule development and implementation. Utilizes OHP guidelines to verify that services meet medical necessity, coding, and documentation standards necessary for correct payment. Ensures all approvals and denials are issued within the intent of the Oregon Administrative Rules (OARs), established coverage limitations, and the scope of allowable reimbursement.

SECTION 6. WORK CONTACTS

With whom, outside of co-workers in this work unit, must the employee in this position regularly come in contact?

Note: *If additional rows of the below table are needed, place cursor at end of a row (outside table) and hit "Enter".*

Who Contacted	How	Purpose	How Often?
OHA Senior Management; Other State Agency Senior Management (ODHS, OYA, ODE, etc.)	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report); Phone	Collect, provide and discuss information and data; collaborate and coordinate on policies and programs; provide and receive direction or consultation; answer questions; gather input; enforce policies, regulations and contracts; negotiate agreements	Daily, as needed
OHA Staff; Medicaid Policy, Business Services Unit (BSU), Office of Financial Services (OFS)	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report); Phone	Collect, provide and discuss information and data; collaborate and coordinate on policies and programs; provide and receive direction or consultation; provide technical assistance; answer questions; gather input; enforce policies, regulations and contracts; negotiate agreements	Weekly, as needed

Department of Justice (DOJ)	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report); Phone	Collect, provide and discuss information and data; provide and receive direction or consultation as it relates to regulations, rules, contracts and the implications of policy or program actions or activities	As needed
OHP recipients and persons with lived experience	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report)	Listen and engage to identify opportunities, co-design solutions, reconcile concerns with commitment to improve services, supports, programs and policies	Weekly, as needed
OHP Providers	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report)	Listen and engage to identify opportunities, co-design solutions, reconcile concerns with commitment to improve services, supports, programs and policies	Daily, as needed

SECTION 7. POSITION-RELATED DECISION MAKING

Describe the typical decisions of this position. Explain the direct effect of these decisions:

Always determine the impact of programs, policies, operations, budgets, and all other aspects of the program on health equity.

Ensure decisions prioritize the equitable distribution or redistribution of resources and power and recognize, reconcile and rectify historical and contemporary injustices.

Determine OHP member eligibility status and resolve discrepancies by analyzing MMIS audit trails, cross-system data (MMIS, DHR, TRACS, ONE, CORMETS), and coordinating with program units (HIG, CSU, CMU, SAT, CES) to ensure accurate enrollment and coverage determinations.

Determine provider billing compliance by reviewing claims, edits, documentation, billing histories, and applicable federal and state regulations (CFRs, OARs).

Issue formal determinations by drafting decision letters citing relevant rules, identifying non-compliance, recommending sanctions or escalations when necessary, and proposing special check issuance when warranted to resolve provider or member impacts.

Direct provider engagement and compliance remediation by evaluating billing issues, guiding providers through required corrective steps, coordinating training or technical assistance, and deciding when to escalate cases to auditors or Provider Enrollment for further action.

SECTION 8. REVIEW OF WORK

Who reviews the work of the position?

Note: *If additional rows of the below table are needed, place cursor at end of a row (outside table) and hit "Enter".*

Classification Title	Position Number	How	How Often	Purpose of Review
Contact Center Manager 1 (CCM1)	1003473	Virtually, In person, Phone, Email, written form	Daily to Weekly, and as needed	Communicate updates on progress of major tasks and projects; Ensure project and program decisions meet federal, agency and user requirements; Promote quality assurance, strategic plan alignment, and equitable outcomes; Discuss and review goals, performance, expectations and training needs; Promote problem-solving and solution-seeking

SECTION 9. OVERSIGHT FUNCTIONS

a. How many employees are directly supervised by this position? 0

How many employees are supervised through a subordinate supervisor? 0

b. Which of the following activities does this position do?

- ☐ Plan work
- ☐ Assigns work
- ☐ Approves work
- ☐ Responds to grievances
- ☐ Disciplines and rewards
- ☐ Coordinates schedules
- ☐ Hires and discharges
- ☐ Recommends hiring
- ☐ Gives input for performance evaluations
- ☐ Prepares and signs performance evaluations

SECTION 10. ADDITIONAL POSITION-RELATED INFORMATION

ADDITIONAL REQUIREMENTS: List any knowledge and skills needed at time of hire that are not already required in the classification specification.

All positions in OHA require a Criminal Background Check and an Abuse/Neglect Check. Fingerprints may be required.

Desired Attributes

- Evidence of ongoing development of personal cultural awareness and humility, and knowledge of social determinants of health and their impacts on health outcomes.
- Experience factoring in the perspectives of diverse populations most harmed by social injustice and inequities including communities of color, immigrant groups, the disability and neurodivergent communities, veterans, older adults, individuals identifying as LGBTQIA+ and other communities that have been traditionally marginalized.

- Knowledge of federal requirements, state rules and program requirements for the Oregon Medicaid Program.
- Knowledge of Oregon Administrative Rules and Oregon Revised Statutes, other applicable regulations, and program requirements.
- Knowledge of health services delivery systems, particularly the Oregon Health Plan/ Medicaid administration in Oregon, and experience in working with Community Mental Health Programs, Behavioral Health Service Providers, Coordinated Care Organizations or other managed care entities.
- Experience in working with Coordinated Care Organizations or other managed care entities, especially as it relates to equitable access to supports and services.
- Experience within the context of healthcare claims processing.
- Experience analyzing complex, detail problems within the context of an extremely automated, highly complex Information System, such as the Medicaid Management Information System (MMIS).
- Knowledge of policies, process, and procedures related to managed care services, enrollment, and eligibility.
- Ability to explain and offer expert level technical assistance on rules, policy, and procedures.
- Experience developing and providing planning tools, documents, data, and meeting coordination to facilitate collaboration and decision-making.
- Ability to demonstrate advanced Microsoft Excel, Word, Outlook, and use of collaboration tools such as Microsoft Teams, SharePoint and Smartsheet.
- Demonstrates skills in the following areas:
    - Community and Partner Engagement
    - Constructive and Collaborative Working Relationships
    - Customer Service and Person-centered Engagement
    - Critical Decision-making and Problem-solving
    - Issue Identification and Resolution
    - Data Synthesis, Analysis and Reporting
    - Workload Planning & Prioritization
    - Team Collaboration & Group Facilitation
    - Expert level Technical Assistance
- Written and oral communication, including preparation of reports and presentations.

BUDGET AUTHORITY: If this position has authority to commit agency operating money, indicate the following:

Note: *If additional rows of the below table are needed, place cursor at end of a row (outside table) and hit "Enter".*

Operating Area	Biennial Amount ($00,000.00)	Fund Type

SECTION 11. ORGANIZATIONAL CHART

Attach a current organizational chart. Be sure the following information is shown on the chart for each position: classification title, classification number, salary range, employee name and position number.

SECTION 12. SIGNATURES

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Minnie McCloud-Walker LL
Minnie McCloud-Walker LL (Jul 2, 2026 11:06:32 PDT)
Appointing Authority Signature

Jul 2, 2026
Date