



STATE OF OREGON
Oregon Health Authority (OHA)
POSITION DESCRIPTION

Position Revised Date:
10/12/26

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: Public Service Representative 4
- b. Classification No: C0324 c. REPR code: OAH
- d. Position No: TBD
- e. Working Title: Provider Payment Specialist
- f. Agency No: 44300
- g. Section Title: Provider & Member Services; Provider Services Unit
- h. Employee Name: Vacant
- i. Work Location (City — County): Salem/Marion or Portland/Multnomah; Hybrid
- j. Supervisor Name: CCS2 - Vacant
- k. Position: ☒ Permanent ☐ Seasonal ☐ Limited Duration ☐ Academic Year
☒ Full-Time ☐ Part-Time ☐ Intermittent ☐ Job Share
- l. FLSA: ☐ Exempt If Exempt: ☐ Executive ☐ Professional ☐ Administrative
☒ Non-Exempt
- m. Eligible for Overtime: ☒ Yes ☐ No

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

The Provider and Members Services section includes several specialized units: Provider Enrollment, Provider Services, and Member Services. Specifically, the Provider Services Unit (PSU) 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.

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:

The primary purpose of this position is to assist in-state and out-of-state health care providers in obtaining correct and timely Medicaid reimbursement through a provider-dedicated Customer Service Center environment. Working within the Provider Services Unit (PSU), the position serves as a key customer service and technical support resource, using the statewide Automatic Call Distribution (ACD) phone system, provider web-based tools, email, and written correspondence to respond to complex Medicaid billing inquiries. The position interprets and explains Medicaid rules and Oregon Administrative Rules, researches and resolves provider questions, guides providers through billing and program requirements, and documents interactions to ensure audit readiness, continuity of service, and provider retention. To accomplish this, the position must excel in customer service, de-escalation, and communication, while applying extensive knowledge of Medicaid billing processes, system operations, and administrative requirements.

The primary purpose of this position is also to conduct complex claims payment research and analysis that supports accurate and timely reimbursement and promotes program integrity. The position reviews and evaluates electronic and paper claims, identifies errors and discrepancies, determines corrective actions, and makes payment-impacting decisions in alignment with Medicaid policy and authorized claim-resolution procedures. This includes determining when to independently resolve issues, apply claim edits or MMIS workarounds, or escalate cases involving non-routine, disputed, or policy-sensitive matters. In managing a high-volume workload, the position sets work priorities to meet established timeframes and maintain responsive customer service. Through these activities, the role ensures accurate provider payments, supports OHA program goals, strengthens provider relationships, and maintains the operational integrity of Oregon's Oregon Health Plan Medicaid fee-for-service delivery system.

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.

			• Demonstrate 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 and OHA Graphic Standards Manual.
Always	R	E	Professional Relationships & Professional Development: • Actively collaborate as a team member by coordinating work, utilizing team as a resource, serving as a resource, providing coverage as needed, and engaging in team meetings. • Attend meetings, education, and training sessions as needed; integrating new information, skills, and tools to support continual learning and professional development. • Contribute to and seek to promote team effectiveness and cohesion by enhancing skills in the areas of giving and receiving constructive feedback, generating solutions, and resolving and repairing conflicts.
Always	R	E	Reporting & Quality Assurance: • Meet the customer service and other metric performance expectations for this position, such as logging in and out of the ACD phone system as scheduled and adhering to the established work and break schedule. • Comply with risk management, compliance, and information security program requirements, including accurate and timely reporting of all adverse incidents as described in related policies. Observe principles of data security and client confidentiality. • Utilize Department resources to maintain and develop knowledge of computer systems to gather, compile, and report information as required. • Develop and maintain basic knowledge of the documented Provider Services Resource notebook in order to provide consistent responses to provider inquiries.

50%	R	E	Provider-Dedicated Customer Service Center Information and Assistance: • Provide front-line, accurate customer service by responding to Oregon Health Plan (OHP) Medicaid billing-related inquiries via phone and email from providers that serve OHP members. • Access and interpret multiple information resources, including several Medicaid Management Information System (MMIS) panels, Oregon Administrative Rules (OARs), and supplemental billing instructions to ensure accurate information is given to providers. Identify and report MMIS and Provider Web Portal system errors affecting provider payments. Communicate complex rules and procedures to fee-for-service providers when clarification is needed or when system, program, or policy changes occur. Verify provider enrollment, OHP member eligibility, claims details, and billing guidelines tied to policy or rate updates. • Conduct claims research, including code-pairing and prior authorization issues, using tools provided and maintained by the Oregon Health Plan (OHP) Provider Clinical Support Services (PCSS) section, and triage issues to clinically staffed PCSS hotlines as needed to ensure accurate and timely reimbursement. • Assist providers in interpreting Medicaid rules, understanding billing expectations tied to program changes, and resolving OHP member eligibility issues from the provider perspective. Coordinate with the Oregon Department of Human Services (ODHS) Virtual Eligibility Center (VEC) team and ODHS district offices as needed, directing providers to appropriate resources to maintain compliance and minimize service disruptions. • Document all provider interactions promptly in the Customer Service System and the Contact Tracking and Maintenance System, noting issues related to billing guidelines, eligibility, code-pairing, and triage activities, ensuring records remain accurate and audit-ready. • Escalate complex issues timely and appropriately. • De-escalate and professionally manage interactions with distressed, frustrated, or irate callers; receive and route complaints, grievances, and reports of potential fraud, following established protocols. • Contribute to process and quality improvement efforts. Communicate routinely with other DHS/OHA entities such as Medicaid Policy, Medical Payment Recovery Unit, Health Insurance Group, Prepaid Health Plan Coordinators, Business Services Unit, Office of Financial Services, and external agencies to coordinate technical support on billing and payments functions. • Lead and coordinate training activities for providers by developing, delivering, and maintaining instructional materials
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			that align with program policies and standards. Offer guidance and support to ensure providers understand requirements, procedures, and best practices. Assist providers who submit claims, adjust claims, request Provider Personal Identification Number (PIN) account resets, or seek additional information via the secure Provider Web Portal.
45%	R	NE	Provider Claims Review & Resolution: - Analyze incoming provider paper or electronic claims, identify errors or discrepancies, determine root causes, and resolve issues using approved workarounds or system edits. - Identify workaround processes when needed and approved by leads or management. - Identify and escalate non-routine or disputed claims involving interpretation of policy or unresolved system issues to higher-level analysis or management. - Track claims in the system to verify correct actions have been taken, ensuring resolution is communicated back to providers. - Bypass edits through the Medicaid Management Information System (MMIS) as appropriate and consistent with Medicaid claim resolution instructions, ensuring claims are processed accurately and timely.
5%	R	E	Performs Other Duties as Assigned: Participate in special projects, serve as member of work groups, attend mandatory unit and section meetings.

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 and/or response to technical and professional material against assigned deadlines. May experience stressful situations due to unchangeable project and program timelines. May experience stressful situations due to high volume of calls, complex technical assistance requests, and heightened emotional intensity of callers and or caller situation needing support. Must be able to respond effectively to verbal instruction and coaching and work collaboratively in a team environment.

Travel, primarily to other OHA work site buildings, as needed. The working conditions include the fulfillment of job essential duties in both in-office and telecommuting settings.

This work may be performed remotely (unless the agency's business and operational needs require in-person) within the defined workweek, utilizing on camera virtual meetings.

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.

Work with Medicaid providers and their representatives to help them understand how to navigate the Oregon Health Plan and resolve any questions or concerns related to their services. Provide clear explanations of rules, policies, and technical procedures so providers can effectively address issues involving member eligibility, billing, reimbursement, and coordination with fee-for-service programs. The majority of time is spent responding to provider calls, conducting follow-up research as needed, and entering accurate, detailed narratives into MMIS to ensure proper documentation and continuity of service.

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 Accountability Act)
- Oregon Revised Statutes
- Oregon Administrative Rules
- State laws, rules, and contract requirements relating to Medicaid services
- Oregon Health Plan Provider Guides
- Medical manuals including ICD-10, HCPCS and CPT
- OHA/ODHS Human Resource policies and procedures
- Departmental and office policies and procedures (including Provider Services Unit Desk Procedures and Policies)
- Collective Bargaining Agreement
- Local requirements as appropriate
- Microsoft suite guidelines
- MMIS Computer Guide

b. How are these guidelines used?

Must utilize the guidelines to ensure appropriate criteria is met and rules are followed to ensure appropriate payment and/or prior authorization review. Must make approvals or denials within the intent of the OARs and scope of payment coverage and limitations.

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?
Treatment Service Providers and Professionals	In-person; Virtual (e.g. MS Teams, Zoom); Written (e.g. email, letter/memo, report); Phone	Answer payment questions and explain procedures and policy, share information	Daily
Central Office and Operations Staff	Telephone, written correspondence, in person	Research special claim issues and clarify Medicaid policy	Daily
OHA Staff; Other State Agency Staff	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	Daily
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

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 the correct interpretation and application of Medicaid rules, Oregon Administrative Rules, billing guidelines, and Medicaid Management Information System (MMIS) information when resolving provider inquiries or clarifying complex fee-for-service billing requirements.

Assess provider claims, documentation, system information, and identified discrepancies to make payment decisions that support program integrity and ensure accurate reimbursement.

Decide when to resolve issues independently, initiate claim edits or MMIS bypasses using approved processes, apply workarounds, or escalate non-routine, disputed, or policy-sensitive issues to higher-level analysis or management.

Evaluate provider complaints, grievances, eligibility conflicts, and indicators of potential fraud to determine correct routing, documentation, and follow-up actions in alignment with established protocols and risk-management standards.

Set work priorities for personal caseload and deskwork to ensure tasks are completed within required timeframes, promoting timely customer service, continuity of operations, and provider retention.

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 Supervisor 2 (CCS2)	1026375	Virtually, In person, Phone, Email, written form	Daily to Weekly, and as needed	Ensure high-quality customer service is being performed; Communicate updates on progress of major tasks and projects; Discuss and review goals, performance, expectations and training needs; Promote problem-solving and solution-seeking

Program Analyst 1 (PA1)	Lead worker	Virtually, In person, Phone, Email, written form	Daily to Weekly, and as needed	Monitor and strengthen the quality of customer service by guiding staff through questions, offering timely feedback, and ensuring work meets established standards. This review also helps identify individual training needs and supports continuous skill development across the team
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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 | ☐ Coordinates schedules |
| ☐ Assigns work | ☐ Hires and discharges |
| ☐ Approves work | ☐ Recommends hiring |
| ☐ Responds to grievances | ☐ Gives input for performance evaluations |
| ☐ Disciplines and rewards | ☐ 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.

- Evidence of ongoing development of personal cultural awareness and humility, and knowledge of social determinants of health and their impacts on health outcomes.
- Experience supporting the implementation of policies, projects and programs at the community, state, and/or national level that promote equity and inclusion and address systemic health disparities, with an emphasis on integrating the voice of consumers with lived experience.
- Experience explaining to the public (in person, on the telephone, or in writing) laws, rules or policies relating to a particular program, operation, or service.
- Experience researching and reviewing rules, regulations, and program requirements for daily decision making; knowledge of relevant federal and state requirements specific to Medicaid preferred.
- Experience within the context of healthcare application or healthcare claims processing.
- Ability to demonstrate advanced Microsoft Excel, Word, Outlook, and use of collaboration tools such as Microsoft Teams and SharePoint.
- Demonstrates skills in the following areas:

- Constructive and Collaborative Working Relationships
- Critical Decision-making and Problem-solving
- Customer Service and Person-centered Engagement
- Data Entry Accuracy and Productivity
- Data Synthesis, Analysis and Reporting
- Strong Oral and Written Communication, including preparation of reports
- Training and technical Assistance
- Workload Planning & Prioritization

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



Appointing Authority

Oct 14, 2026

Date

Vacant_PSR4 Provider Payment Specialist_HOT - CCS2

Final Audit Report

2026-10-14

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