BENTON COUNTY POSITION DESCRIPTION

CLASSIFICATION	BAND	GRADE	SUBGRADE	FLSA STATUS
Program Manager 3	C	4	3	Exempt

POSITION TITLE:	**Revenue Cycle Optimization Manager**	**POSITION#**:	500744
☐**New** ☒**Revised**	**Date:**	**08/13/2026**	
SERVICE TYPE:	NON-REP MANAGEMENT		

Employee Name:		**Department:**	**Health Services**	**Supervisor:**	**Health Services Business Operations Manager**
FTE:	1.0	**Employment Status:**	Regular Full Time		

Position Summary:

The Revenue Cycle Optimization Manager provides leadership, oversight, and strategic direction for revenue cycle operations across Health Services. The position is responsible for ensuring accurate, timely, compliant, and efficient processes throughout the revenue cycle, including patient registration and eligibility, provider and payer enrollment support, charge capture, coding, claim submission, payment posting, denial and appeal management, accounts receivable, patient billing and collections, reimbursement monitoring, and revenue cycle reporting.

The Revenue Cycle Optimization Manager provides direct leadership and supervision to assigned revenue cycle staff and establishes performance expectations, operational standards, internal controls, and improvement priorities that strengthen financial performance and support sustainable service delivery. The position monitors revenue cycle performance identifies trends and root causes affecting reimbursement, and leads cross-functional improvement efforts with clinical operations, patient access, providers, Finance, Compliance, Health Information Management, Information Technology, and other Health Services teams.

The position serves as the organizational subject matter expert for revenue cycle business systems and reimbursement workflows, including the electronic health record and applicable payer systems. The Revenue Cycle Optimization Manager ensures systems, workflows, fee schedules, payer configurations, and billing processes are appropriately maintained and aligned with payer requirements, regulatory standards, contractual obligations, and organizational policies.

The Revenue Cycle Optimization Manager provides specialized leadership for the unique reimbursement and billing requirements of Federally Qualified Health Centers, CFAA revenue, and other Health Services programs. This includes oversight of applicable Medicare and Medicaid FQHC reimbursement methodologies, alternative payment arrangements, supplemental payment processes, fee schedules, and operational implementation of the Health Center Program Sliding Fee Discount Program and billing and collections requirements.

The position exercises a high degree of independent judgment and serves as a key advisor to Health Services leadership regarding revenue cycle performance, reimbursement strategy, revenue risk, operational improvement, payer trends, and opportunities to maximize appropriate reimbursement for services delivered.

Essential Duties:

No.	Major Functional Area (MFA)	% of Time
1	**MFA**: **Revenue Cycle Operations and Staff Leadership** **Essential Duties**:	30%

	• Provide direct leadership and supervision for all Revenue Cycle functions and staff, including billing, coding, claims, payment posting, denials and appeals, patient accounts, payer eligibility, and other assigned revenue cycle functions. • Hire, onboard, train, coach, supervise, and evaluate assigned staff and address performance or corrective action matters in accordance with County policies. • Establish clear performance expectations, workload priorities, productivity standards, and accountability for revenue cycle staff. • Oversee the day-to-day operations of revenue cycle workflows to ensure timely, accurate, and compliant charge capture, coding, claim submission, payment posting, and patient billing/collections. • Develop, maintain, and implement standardized revenue cycle policies, procedures, workflows, and internal controls. • Assess staffing, workload, processes, and technology needs and recommend changes necessary to maintain effective revenue cycle operations. • Establish mechanisms for routine monitoring of workflow performance and identify operational barriers requiring escalation or corrective action. • Promote a culture of accountability, continuous improvement, customer service, and collaboration within Revenue Cycle operations.	
2	**MFA:** Revenue Performance, Denials & Financial Optimization **Essential Duties**: • Own and monitor revenue cycle performance outcomes across Health Services and establish targets for key performance indicators, including days in accounts receivable, aging distribution, clean claim rate, denial rate, charge lag, payment lag, visit or charge completion, collection rates, write-offs, underpayments, and payer mix. • Lead denial prevention and management activities, including root cause analysis, appeal strategies, trend monitoring, and cross-functional corrective action. • Identify revenue leakage, reimbursement opportunities, systemic billing issues, and process failures and develop corrective strategies. • Monitor payer reimbursement against contracted or established rates and identify payment variances and underpayments. • Partner with Finance to support revenue forecasting, reconciliation, budget development, variance analysis, and evaluation of reimbursement trends. • Evaluate the financial impact of changes in payer policies, reimbursement methodologies, coding requirements, service delivery models, and organizational workflows. • Partner with clinical and operational leaders to improve documentation, coding, charge capture, patient access, eligibility verification, and other upstream processes affecting reimbursement. • Develop and maintain routine revenue cycle reports and dashboards that provide leadership with actionable information regarding financial and operational performance. • Present revenue cycle trends, risks, performance results, and recommended actions to Health Services leadership.	25%
3	**MFA**: **Revenue Cycle Systems, Payer Configuration & Technical Optimization** **Essential Duties**: • Serve as the Health Services subject matter expert for business systems supporting the revenue cycle, including the electronic health record, payer portals, clearinghouses, and other revenue cycle applications. • Lead analysis, configuration, testing, implementation, and optimization of billing-related systems and workflows.	20%

	• Ensure payer configurations, billing rules, reimbursement rates, provider information, and other revenue cycle system elements are appropriately maintained. • Coordinate revenue cycle-related system upgrades, payer implementations, coding changes, regulatory updates, and workflow changes. • Serve as the lead operational liaison for complex revenue cycle system issues, including OCHIN/EPIC JIRA tickets and vendor escalations. • Translate revenue cycle operational needs into clear system and technical requirements and work collaboratively with IT, OCHIN, vendors, and internal stakeholders to resolve issues. • Conduct validation and user acceptance testing to ensure system changes perform as intended prior to implementation. • Identify system gaps, inefficiencies, automation opportunities, and enhancements that improve accuracy, compliance, staff efficiency, and reimbursement. • Maintain appropriate documentation of revenue cycle system configurations, processes, workflows, payer requirements, and technical changes. • Maintain and oversee revenue cycle reporting tools and data used to monitor revenue cycle performance in partnership with organizational analytics resources. • Ensure appropriate controls exist for changes to payer configuration, fee schedules, billing rules, and other system elements that may materially affect reimbursement**.**	
4	**MFA: Reimbursement, Billing Compliance & Payer Management** **Essential Duties:** • Ensure revenue cycle operations comply with applicable Medicare, Medicaid, commercial payer, contractual, federal, state, and organizational billing requirements. • Provide operational oversight of FQHC-specific billing and reimbursement requirements, including applicable Medicare FQHC Prospective Payment System requirements and Medicaid FQHC payment methodologies. • Oversee applicable Oregon Medicaid FQHC payment processes, including PPS, alternative payment methodologies/APCM, encounter reporting, reconciliation, and supplemental or wraparound payment processes. • Monitor, evaluate, and support implementation of capitated, value-based care, and alternative payment models across Health Services programs, ensuring accurate encounter capture, reconciliation, performance tracking, and alignment with payer requirements and organizational financial goals. • Coordinate implementation and maintenance of the Health Services fee schedule in partnership with Finance, Compliance, clinical leadership, and executive leadership, including periodic evaluation of charges and reimbursement trends. • Ensure operational systems accurately apply approved fee schedules, payer requirements, contractual rates, and applicable patient discounts. • Partner with Compliance and program leadership to implement and monitor the Health Center Program Sliding Fee Discount Program, including eligibility processes, application of approved discounts, nominal charges where applicable, and required operational procedures.	15%

	• Ensure billing and collection practices support Health Center Program requirements regarding patient ability to pay, appropriate collection practices, and approved circumstances for reducing or waiving patient financial obligations. • Support internal and external audits, payer reviews, HRSA operational reviews, and other monitoring activities involving billing, collections, reimbursement, or revenue cycle processes. • Support accurate reporting of revenue, payer, visit, charge, and financial information needed for UDS and other required Health Center Program reporting in partnership with Finance and organizational analytics staff. • Maintain awareness of federal and state FQHC reimbursement requirements and evaluate the operational and financial implications of changes to payment methodologies, including fee-for-service, capitated, value-based, and alternative payment models. • Monitor regulatory and payer changes and ensure timely updates to billing workflows, system configurations, staff education, and policies. • Coordinate with the Compliance & Health Information Management Manager to maintain audit-ready revenue cycle documentation and address identified compliance risks. • Support internal and external audits, payer reviews, HRSA operational reviews, and other monitoring activities involving billing, collections, reimbursement, or revenue cycle processes. •	
5	**MFA**: **Payer Strategy, Cross-Functional Improvement and Training** **Essential Duties**: • Monitor trends in Medicare, Medicaid, coordinated care organization, commercial payer, and other reimbursement models and advise leadership regarding potential operational and financial implications. • Support leadership in evaluating payer agreements, reimbursement terms, alternative payment arrangements, and other revenue opportunities. • Provide revenue cycle and reimbursement expertise in evaluation of value-based, prospective, capitated, alternative, or other payment models while maintaining clear accountability for payment reconciliation and revenue integrity. • Build strong relationships with clinical, operational, Finance, Compliance, IT, and payer partners to resolve revenue cycle issues. • Lead or participate in multidisciplinary workgroups addressing documentation, charge capture, coding, registration, claims, denials, reimbursement, and other revenue cycle improvement opportunities. • Develop and provide training for staff, managers, and providers regarding revenue cycle processes, documentation, coding, payer requirements, system changes, and performance improvement. • Support leaders and managers in understanding revenue cycle performance reports and identifying actions within their areas of responsibility.	10%
Percentages should total 100%		**100%**

Special Requirements

Minimum Qualifications:

HR08.17.11

- Bachelor's degree from an accredited college or university in Healthcare Administration, Business Administration, Health Information Management, Health Informatics, Finance, Accounting, Public Administration, or a closely related field required.

- Five (5) years of progressively responsible professional experience in healthcare revenue cycle, healthcare finance, reimbursement, billing operations, healthcare business systems, or a closely related area, including at least three (3) years of management or supervisory experience.

- An equivalent combination of education, training, and experience that demonstrates the required knowledge, skills, and abilities may be considered.

Knowledge, Skills, & Abilities:

Demonstrated knowledge of:

- Healthcare revenue cycle operations, including registration, eligibility, charge capture, coding, billing, claims processing, payment posting, denials, appeals, accounts receivable, and collections.
- Medicare, Medicaid, commercial payer, and managed care reimbursement requirements.
- Healthcare coding and billing principles, including ICD-10, CPT, HCPCS, modifiers, claim forms, and payer-specific billing requirements.
- Electronic Health Records and healthcare revenue cycle information systems.
- Revenue cycle performance indicators and methods for monitoring and improving financial performance.
- Payer enrollment, credentialing interfaces, reimbursement configuration, fee schedules, and payer contract implementation.
- Healthcare regulatory and compliance requirements affecting billing and reimbursement.
- Principles of operational improvement, project management, root cause analysis, and process redesign.
- Budgeting, forecasting, revenue analysis, and financial performance measurement.
- FQHC reimbursement models, including Medicare FQHC PPS and Medicaid FQHC payment methodologies.
- Health Center Program requirements related to fee schedules, Sliding Fee Discount Programs, billing and collections, and patient financial responsibility.
- Alternative payment methodologies, supplemental payment processes, managed care reimbursement, and value-based payment arrangements applicable to safety-net healthcare organizations.
- Principles of revenue integrity, reimbursement reconciliation, payment variance analysis, and prevention of revenue leakage.

Preferred Experience:

Preference may be given to candidates with experience in one or more of the following:

- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Programs (CMHPs)
- Public Health
- County or local government healthcare systems

- EPIC/OCHIN revenue cycle systems
- Medicare and Medicaid billing and reimbursement
- Managed care or Coordinated Care Organization reimbursement
- Revenue cycle management in a multi-site healthcare organization
- Denial prevention and accounts receivable improvement
- Payer enrollment and reimbursement configuration
- Healthcare financial analysis and forecasting
- Value-based or alternative payment arrangements
- FQHC PPS, Medicaid alternative payment methodologies, and supplemental/wraparound payment reconciliation
- HRSA Health Center Program billing, collections, fee schedule, and Sliding Fee Discount Program requirements
- Revenue cycle audit readiness and implementation of corrective action plans

Physical Requirements:

Physical Demands

While performing the duties of this job, the employee is frequently required to use hands to finger, handle or feel; talk; or hear. The employee is occasionally required to stand; walk; sit; reach with hands and arms; and stoop; kneel; or crouch The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, depth perception and ability to adjust focus.

Work Environment

The employee works in well-lighted, clean environments. The noise level in the work environment is quiet to moderate. **Check the following that applies to this position:** The employee may occasionally: ☒ work with angry or hostile clients or members of the public, ☐ work with toxic substances and biohazards, and ☒ exposure to infectious illnesses.

Emergency Preparedness:

Benton County is committed to emergency preparedness planning and implementation, and disaster recovery. In the case of a Health Department, County, State, Federal or other emergency or disaster, this position may be called upon to assist in responding. This may require the assignment of additional responsibilities, depending on the circumstances. These responsibilities could include unscheduled temporary changes in work schedule and/or work duties, including evenings and weekends, work relocation, overtime, working with other community agencies such as the local Fire Department, hospitals, the Red Cross and other emergency responders. The ability to be flexible is critical in our overall response to the emergency or disaster. Under Emergency situations this position may be called in to work, supporting Administration in regular duties or other work as assigned. Per County personnel policy, this position may be included in the agency's essential personnel for emergency/disaster response.

Quality Improvement Participation:

Employees are expected to participate in improving BHS' performance, processes, and programs through quality improvement activities, use of the PDSA model and participating on QI teams as assigned.

NOTE: The above job description is intended to represent only the key areas of responsibilities; specific position assignments will vary depending on the business needs of the department.

Employee:_____Date:_____

Immediate Supervisor:_____Date:_____