Non-Union Exempt Position Summary

JOB CODE: 3

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<th>POSITION TITLE:</th>
<th>Provider Network Contract Manager</th>
<th>DATE:</th>
<th>June 2020</th>
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<td>DIVISIONS:</td>
<td>Operations</td>
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<td>REPORTS DIRECTLY TO:</td>
<td>Sr. Director of Network Management</td>
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POSITION PURPOSE:
The Network Manager is responsible for maintaining compliance with policies and procedures, as well as, regulatory and customer requirements for day-to-day network management activities. To facilitate accomplishment of goals, management of these functions include, but are not limited to, coordination and interface with Clinical & Service Operations, Compliance, IT, Data Analytics, Communications, Delegated Vendor(s), and Health Plan customers. Provides assistance, as needed with the management and coordination of a variety of processes and projects in order to achieve consistent and effective execution of the company’s obligations and priorities that support the overall corporate Mission, Vision and Values.

ACCOUNTABILITIES:
- Ensures compliance to organizational and departmental policies and procedures
- Participates in the successful development, implementation, management and evaluation of strategic business and service goals for network management functions
- Support program strategy development to ensure organizational capabilities designed to serve members are translated into products and services appealing to group purchasers
- Manage provider recruitment, contracting and termination functions
- Participate in the development and distribution of provider communications
- Manage development and maintenance of administrative procedure materials and tools (i.e., provider manual, provider billing training, etc.)
- Prepare audit samples of the network for health plan customer(s)
- Respond to provider educational needs, inquiries and complaints
- Produce network evaluations with regard to access and availability requirements
- Assist with the development and maintenance of network management related work instructions and policies and procedures
- Complete daily core business functions of co-workers as needed in their absence, including but not limited to credentialing functions
- Member of Fulcrum Operations Committee
- Other tasks, projects, and functions as assigned that support the development and maintenance of the provider network.
REQUIRED QUALIFICATIONS:

• Bachelor’s degree in business, health care administration or related field
• Skilled at establishing and maintaining effective interpersonal relationships with all level of leaders, providers, employees and members/customers
• Experience in working in a matrix organization with shared service models
• Demonstrated success in developing business strategy, and critical decision making
• Five (5) or more years of experience in a health care Network Management, Provider Services, Operations, Compliance or Quality Improvement/Management department within a health care organization
• Working knowledge of performance improvement processes and team processes/collaborative team management
• Well-developed organizational skills with the ability to prioritize multiple assignments
• Understanding of business processes and audit functions
• Strong skills using Microsoft Office (primarily Word, Excel, Power Point and Outlook) and willing to learn other software applications
• Travel – up to 30%

PREFERRED QUALIFICATIONS:

• Masters degree in business or health care administration.
• Seven (7) years experience within a health plan strongly preferred.

DIRECT/INDIRECT REPORTS:

Number of direct reports and titles: 0
Number of indirect reports: 0