Cleveland Clinic | QualityAlliance

QUALITY ALLIANCE

INSIGHTS & ACHIEVEMENTS

2025

CONTENTS

LETTER FROM OUR BOARD CHAIR

For the Quality Alliance, 2025 was another year of changes. We welcomed additions to our network, advances in our data collection and reporting abilities after the struggles of 2023 and 2024, and significant changes in our contracts and our abilities to affect contract revenue.

At this point we need to note that the ability to contract on upside-only shared savings or pay-for-performance is in the rear-view mirror. The first two shared-risk contracts came into operation in 2025, and another was finalized for 2026. These shared-risk contracts depend on reaching medical loss ratio targets but give us the ability to earn significant portions of any shared savings, which is created by the difference between the payer's premiums collected and the medical claims spent. We are also liable for a portion of any losses from that difference. For now, any immediate downside loss liability to independent providers is being mitigated by the anchor health system and not being passed on to practices. As we move forward from shared losses to shared gains, we expect that revenue enhancements to come will more than repay any current losses incurred, and the balance sheet will end in the positive for the network and for the independent practices.

Unfortunately, due to the contracting shift noted above, we were not able to produce any 2025 incentive payments to independent practices for the first time in many years. We know that is a disappointment, but this was expected to occur during the transition period to shared risk in our Medicare Advantage plans. It is important to note that the Medicare Advantage plan "upside only" contract revenue had in the past provided the majority of incentive funding, and that source is greatly reduced. Again, no independent practices are being asked to cover downside losses at this time. The Medicare ACO, for those providers participating in it, continues to do well and to provide significant shared savings revenue distributed to independent providers with ACO attribution. The learnings from this ACO success are actively being used to drive improvement in the Medicare Advantage contracts.

We are already seeing in 2025 and early 2026 that our focus on cost efficiency, utilization management and shared risk is producing positive results on Star Ratings for the Medicare Advantage contracts as well as steady movement in cost efficiency. These improvements reflect your dedication to providing quality care to patients and our commitment to offering additional services and programs to member practices, including navigation and care coordination programs at no cost. The board has approved the development of a prospective periodic distribution model as a 2026 incentive. We expect to implement these new incentive opportunities to better align with the structure of our priority contracts.

LETTER FROM OUR BOARD CHAIR

Importantly, in addition to the two shared risk Medicare Advantage contracts in 2025, and a single older upside-only MA contract, we have one more new Medicare Advantage contract now operating for 2026. We are working on new commercial contracts that will expand beyond the Cleveland Clinic EHP and the Oscar product. The continued expansion of the Quality Alliance, with total network providers now over 10,700, will assist with maintaining attribution in all contracts.

A hearty thanks to all our Quality Alliance member practices and providers for continuing to provide the highest quality care to hundreds of thousands of patients, and for joining together to produce a leading clinically integrated network in Ohio. Please reach out with any questions or concerns, and a special thank you for the care you provided to tens of thousands of Cleveland Clinics employees and dependents who rely on you for their health care needs!

Sincerely,

Bruce I Rogen MD MPH

Bruce I. Rogen, MD, MPH

OUR MISSION

To transform the delivery of healthcare into a collaborative system where resources are used in a fiscally and socially responsible manner while improving the quality of care and patient experience.

PROGRAM DESCRIPTION

The Quality Alliance is an integrated network comprising independent provider practices and employed Cleveland Clinic providers. We are uniquely positioned to transform patient care by collaborating on assessment, training and education. Our focus is on improving healthcare quality, the provider and patient experience, and patient outcomes while managing costs.

PROGRAM GOVERNANCE

The Quality Alliance is a physician-led organization composed of a board of trustees and various committees. They are responsible for overseeing the program, monitoring member compliance, setting policy and guiding strategic development.

BOARD MEMBERS

Matthew Andresen, MD
Broadview Heights Family Medicine

John Bertsch, MD
Cleveland Clinic

Kenneth Braman, DO
Cleveland Clinic

Brent Burkey, MD
Fisher-Titus Medical Care

Preti Chaturvedi, MD
Kidney Health Group

Keith Fuller, MD
Cleveland Clinic

Aaron Hamilton, MD
Cleveland Clinic

Jessica Hohman, MD
Cleveland Clinic

Christine Jellis, MD
Cleveland Clinic

George Khuri, MD
Lake Point Medical Group

Ahmad Kilani, MD
Cleveland Clinic

Michael Lew, MD
Orthopaedic Associates Inc.

Michelle Medina, MD
Cleveland Clinic

Amy O'Linn, DO
Cleveland Clinic

Christopher Reese, MD
Urology Partners LLC

Bruce Rogen, MD
Cleveland Clinic

Bindu Sehgal, MD
Premier Physicians Centers Inc.

Ranjit Tamaskar, MD
Atrium Medical Group Inc.

FINANCE COMMITTEE

Matthew Andresen, MD
Broadview Heights Family Medicine

John Bertsch, MD
Cleveland Clinic

Preti Chaturvedi, MD
Kidney Health Group

Michelle Haldeman, DPM
Lake Point Medical Group

Erick Kauffman, MD
Neighborhood Family Practice

Ahmad Kilani, MD
Cleveland Clinic

Shelly Senders, MD
Senders Pediatrics

Rajesh Sharma, MD
Cleveland Clinic

Brady Steineck, MD
Community Health Care Inc

Bruce Rogen, MD
Cleveland Clinic

Eric Trattner, DPM
Eric D Trattner DPM Inc

QUALITY COMMITTEE

Chris Babiuch, MD
Cleveland Clinic

Ken Braman, DO
Akron General Partners Physician Group

Susan Clark-Frantz, MD
Generations Women's Healthcare

Adeola Fakolade, MD
Ashtabula Regional Medical Center

Melanie Golembiewski, MD
Neighborhood Family Practice

Jessica Hohman, MD
Cleveland Clinic

Robert Jones, MD
Cleveland Clinic

Michael Kalus, MD
Michael Kalus, MD

Ahmad Kilani, MD|
Cleveland Clinic

Eliot Mostow, MD
Akron Dermatology

Karen Murray, MD
Cleveland Clinic

Amy O'Linn, MD
Cleveland Clinic

Bruce Rogen, MD
Cleveland Clinic

Steven Shook, MD
Cleveland Clinic

Ranjit Tamaskar, MD
Atrium Medical Group Inc.

Terry Wagner, MD
Hudson Family Practice

MEMBERSHIP

The Quality Alliance is composed of physicians and allied health professionals who are employed by, independent of, or affiliated with Cleveland Clinic.

QUALITY ALLIANCE MEMBERS

	2021	2022	2023	2024	2025
Employed					
Cleveland Clinic Medical Group	6,011	6,487	6,820	7,189	7,735
PPG	513	571	652	667	666
Mercy	116	124	153	179	192
Union	68	68	73	89	101
Total Employed *	6,658	7,189	7,640	8,069	8,643
Independent					
Physician Practice	1,141	1,369	1,508	1,697	1,719
ARMC	71	80	69	77	82
FTMC	0	0	0	57	57
Total Independent*	1,162	1,388	1,519	1,776	1,807
% Change	7%	16%	9%	14%	2%
Grand Total*	7,870	8,638	9,217	9,900	10,501

** Discreet providers; duplicates suppressed*

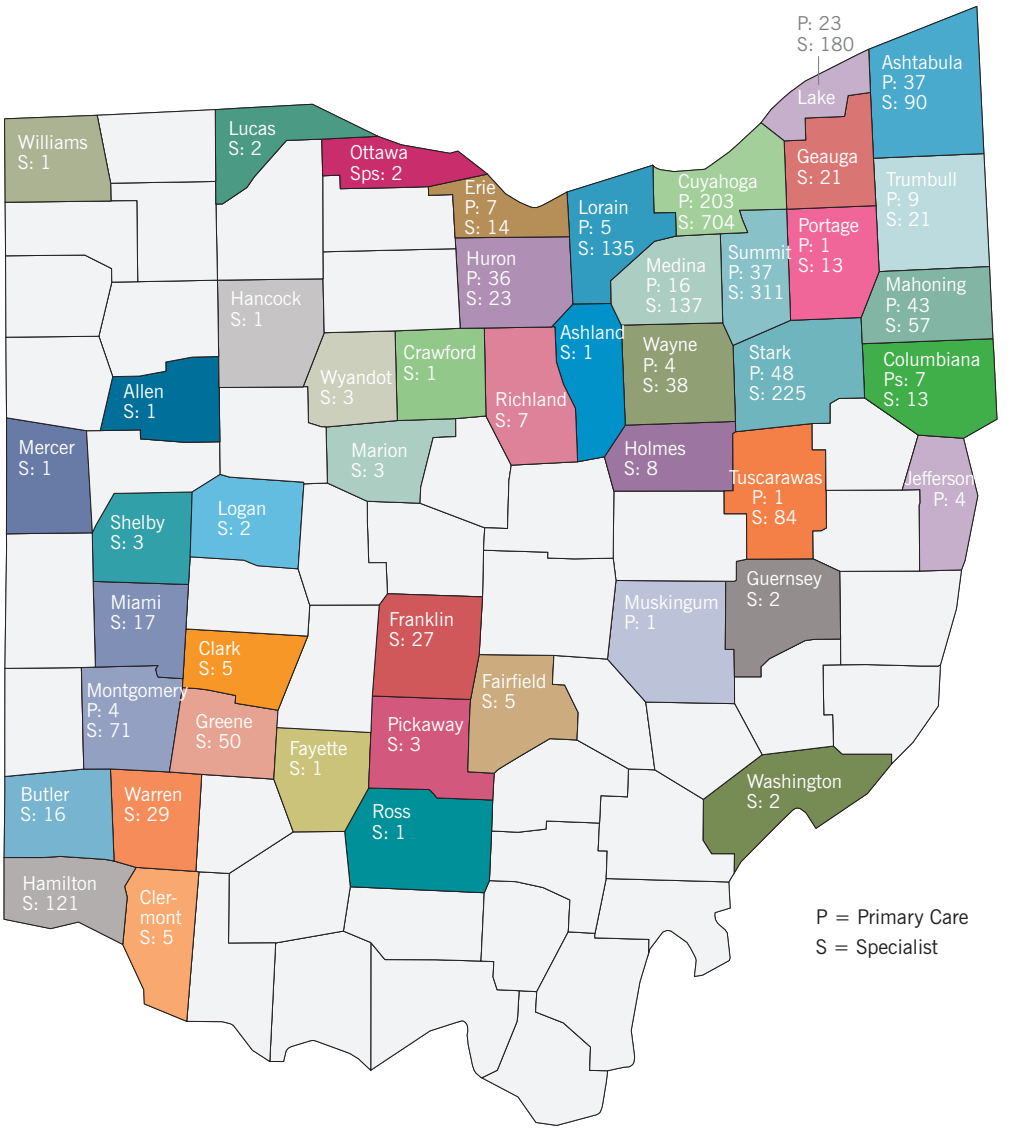
NEW PRACTICES JOINING THE QUALITY ALLIANCE

Beacon Primary Care LLC
Fairlawn
330.665.4488

Chest Disease Associates Inc.
Parma
440.886.2509

Stark Pain Management LLC
North Canton
330.623.7100

GEOGRAPHIC DISTRIBUTION OF PHYSICIANS



Counties

- Allen
- Ashland
- Ashtabula
- Butler
- Clark
- Clermont
- Columbiana
- Crawford
- Cuyahoga
- Erie
- Franklin
- Geauga
- Greene
- Guernsey
- Hamilton
- Hancock
- Holmes
- Huron
- Jefferson
- Lake
- Lucas
- Mahoning
- Marion
- Medina
- Miami
- Montgomery
- Muskingham
- Ottawa
- Pickaway
- Portage
- Stark
- Summit
- Trumbull
- Tuscarawas
- Warren
- Washington
- Wayne
- Williams
- Wyandot

PROFESSIONAL TEAM

The Quality Alliance team is composed of clinical and non-clinical professionals with a broad range of backgrounds and experience.

LEADERSHIP

Bruce I. Rogen, MD, MPH
Board Chair, Cleveland Clinic Quality Alliance

Ahmad Kilani, MD, MBA, MLS, MSIT, CHCQM-PHYADV, FACP, FACHE
Regional Medical Director; Chair, Quality Committee, Cleveland Clinic Quality Alliance

Thomas Atkinson, MBA, MHA
Senior Director, Cleveland Clinic Quality Alliance

Jeanne Kubiak, MBA
Department Administrator

Patricia Radatz, MBA, CHRC, CPC
Regulatory & Privacy Director

Benjamin Boroway, MSN, MBA, RN, CCM
Director, Population Management

Stephanie Brashear, MBA
Director, Network Relations

PROVIDER ENGAGEMENT TEAM

C. Elizabeth Burley, MSN, MBA, RN, CPHQ, NE-BC
Manager, Provider Engagement

Melissa Brazis
Practice Facilitator

Kathleen Dickson
Practice Facilitator

Chris Stevens
Practice Facilitator

Ashley Taylor
Practice Facilitator

DATA TEAM AND ADMINISTRATION

Garrett Baddorf
Systems Analyst

Belinda Watson
Data Scientist II

Erin Steidel, MBA
Program Manager

Debi Schlegelmilch
Program Coordinator

Jami Balazs
Executive Assistant

POPULATION MANAGEMENT TEAM

Renee Mohr, BSN, RN
Manager, Population Management

Sara Booher, BSN, RN
Care Coordinator

Jill Bunnell, BSN, RN, RN-BC, CCM
Care Coordinator

Tammy Chesser, BSN, RN
Care Coordinator

Colleen Cummins, MSN, BBA, RN, CEN
Care Coordinator

Amy Debevec, BSN, RN
Care Coordinator

Scott Gaydos RN, BSN, CCM
Care Coordinator

Linda Nearhood, RN, CCM
Care Coordinator

Lauren Ranallo
Care Coordinator

Candice Short, BSN, RN
Care Coordinator

Lonnie Weekley, MSN, RN, CAPA
Care Coordinator

POPULATION HEALTH MANAGEMENT

In 2025, the Quality Alliance (QA) expanded its population health management services for QA practices and their patients through targeted program development and technology enhancements.

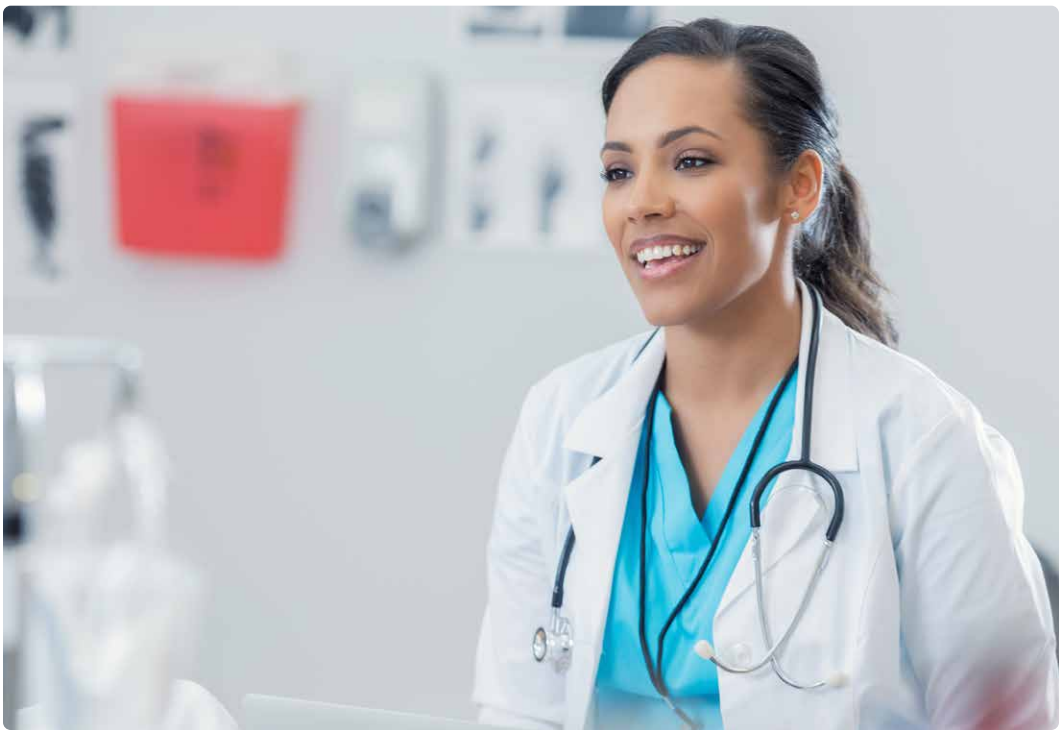
To strengthen patient support and outcomes, programs previously limited to QA-employed providers were extended to independent providers. These expansions included the Post-Acute Care (PAC) and the High-Risk Transitions in Care (HRTIC) programs.

PAC provides coordinated follow-up for patients in preferred-network skilled nursing facilities (SNF). Length-of-stay facilitators improve the patient's transition home, reduce the risk of readmission and ensure an appropriate SNF stay duration.

HRTIC delivers additional support for patients at a highest risk of readmission by offering advanced practice provider home visits that complement transitional care management from the primary care provider.

The QA also implemented new technologies to improve communication with patients and practices. The addition of the Doximity texting platform allows care coordinators to send text reminders, share educational materials and increase call answer rates. A new centralized telephone hotline for the care coordination team further improved availability and responsiveness of the team for patients and providers.

Finally, the QA's core population health management teams, Care Coordination and Population Health Navigation, achieved notable successes and operational improvements throughout 2025, which are detailed in the following sections.



CARE COORDINATION

The Quality Alliance Care Coordination team, composed of 10 registered nurse care coordinators, provides essential support to independent primary care physicians and their practices. In 2025, this support was delivered through five key initiatives.

Transitional Care Management

To reduce hospital readmissions and improve patient outcomes, the team continued its Transitional Care Management (TCM) efforts, reaching out to all payer priority patients and any high-risk patients following hospital or skilled nursing facility stays. The team conducted outreach to over 6,000 patients for TCM. During these calls, care coordinators reviewed discharge instructions, follow-up appointments, home health care contact information, and medication changes — critical factors influencing patient recovery.

A key focus remained on ensuring post-discharge appointment completion, a strategy proven to lower readmission rates. Coordinators assisted patients in scheduling appointments, provided timely reminders, and addressed social drivers of health issues when needed.

Chronic Disease Management

The Chronic Disease Management program utilizes structured goals and targeted interventions based on patients' chronic conditions. Care coordinators focus on priority populations, particularly those covered under Medicare Advantage (MA) and the Cleveland Clinic Accountable Care Organization. The team is committed to chronic disease education, optimizing healthcare utilization, addressing social drivers of health and securing necessary resources for patients. Outreaches were placed to over 800 patients for enrollment.

Complex Care Management

In 2025, the Complex Care Management (CCM) program was initiated to make significant strides in transforming the way we approach patient care for individuals with multifaceted health needs. This long-term program was designed to assist patients in navigating the complexities of healthcare systems while addressing their overall health and well-being. Through continuous support, the program focuses on managing diseases that are complex and multifaceted, providing tailored solutions for social determinants of health concerns, including financial insecurities, caregiver support and mental health needs. By prioritizing holistic care and fostering seamless coordination, CCM empowers patients and caregivers alike, ensuring they receive the resources and assistance necessary to improve their quality of life.

Actionable Finding Support

The care coordination team played a vital role in ensuring follow-up on incidental radiology findings by reviewing imaging recommendations and collaborating with providers and patients. In 2025, the team averaged 400 encounters per month, which included notifying providers of findings, obtaining necessary orders and assisting patients with scheduling follow-ups. Over the course of the year, more than 3,000 findings were addressed and successfully closed, ensuring timely and appropriate care.

Value-Based Agreement Support

In 2025, the care coordination team continued its efforts to improve medication adherence and overall patient outcomes under value-based agreements. This initiative included reviewing payer-generated lists and proactively reaching out to patients to ensure timely medication refills. Coordinators worked closely with local pharmacies and provider offices to facilitate prescription refills while also reminding patients about the importance of medication adherence.

Beyond medication adherence, the team contributed to broader quality measure initiatives to enhance performance under the Anthem, Humana and Aetna MA agreements. Key areas of focus included:

- Osteoporosis management for women with a fracture
- Statin use in individuals with cardiovascular disease/diabetes
- Blood sugar control
- Follow-up after emergency department visits
- Blood pressure control

By addressing these quality measures, the team helped improve patient outcomes while supporting the success of value-based agreements.

Team Changes

Lauren Ranallo and Scott Gaydos joined the care coordination team.

Renee Mohr was promoted to manager of care coordination.

Ben Boroway was promoted to director of population management.

The care coordination team remains dedicated to putting patients first, delivering high-quality care and driving positive outcomes for the Quality Alliance.

2025 HIGHLIGHTS

Network Status

After experiencing double digit growth percentages for several years, owing to the successive addition of very large groups, 2025 saw a moderate increase in membership of 1.3%. This was the result of adding two primary care and two specialty care practices. We maintain an attractive mix of pediatric and adult PCPs and specialists and continue to expand our geographic footprint in our primary service area.

Incentive Programs

For the second consecutive year, value-based revenues received in 2025 did not cover operating expenses and therefore there were no excess funds for a 2024 performance year incentive program. The Board of Trustees did authorize a modest program for PCPs in recognition of the engagement and effort they had expended and that was executed in mid-year. For QA members in the ACO, 2024 results were very strong. Those results were finalized with distributions calculated at the end of 2025 and distribution in January of 2026.

The drivers of our financial performance during the transition from legacy to future contracting models is nicely described in the letter from our chair that opens this document. What is important to note is the divergent results in the ACO and our legacy contracts. We do have the capability to succeed in shared-risk contracts and have proven so on many occasions in the MSSP ACO.

Value Contracting Strategy

To be successful in shared risk contracts we need to focus on four primary domains:

1. Attribution
2. Documentation
3. Quality
4. Utilization

Furthermore, we need to target our activities and limited resources to the patients who can most benefit from our interventions. We are evolving from an approach that could be characterized as “one-size fits all” to a very measured and patient-centric set of programs. To support this approach, we have continued to invest in more refined risk-modeling and reporting. These refined capabilities are now in use and drive the work of our population management teams. We are extremely pleased that we have been able to offer programs and services to the patients of our members that had previously only been available to Cleveland Clinic employed physicians. Notably, the Post Acute Care (PAC) program now uses its SNF-based LOS facilitators to assist the patients of QA members in safe and timely transitions to home. We also began providing the services of the High Risk Transitions of Care (HRTIC) to the patients of our members.

Long standing programs have evolved. Care coordination workflows have been refined and customized to support the needs of our patients in a more tailored way. Our navigation team has been expanded to four dedicated individuals and saw a 249% increase in patient outreach in 2025.

To create better awareness of the drivers of contract performance our provider engagement and data teams adjusted workflows and processes. Measures in Arcadia were streamlined to reflect those that are meaningful in our contracts. Our provider engagement team provided individualized instruction on new measures and new tools such as pre-visit planning and other custom dashboards. We offered several educational sessions to reinforce these teachings that were well-attended and received positive feedback.

In total, the changes implemented in 2025 have begun to demonstrate their effectiveness. We already see how quality scores are trending more positively in our target populations than in our general populations. In 2025 these included the ACO, Humana MA and Aetna MA. As more MA plans enter shared risk partnerships with us, we will continue to expand our abilities to bring current and future program offerings to these populations. We expect dedicated social work resources to be available to us in 2026 and continue to discuss how our value-based pharmacy teams can be leveraged to benefit the QA membership.

These are challenging times in our industry and we are confident in our strategy to create mutually beneficial relationships with our payer partners and to elevate the health status of their plan members while rewarding those that make this possible. You, the members of the Quality Alliance, make this possible and we are grateful for your continued engagement and efforts.

Staffing Changes

The year 2025 saw some notable changes to our staffing. We welcomed a new director of population management in Ben Boroway and a new director of network relations in Stephanie Brashear. At the manager level, Renee Mohr was selected to oversee our care coordination team, and Elizabeth Burley was selected to manage our provider engagement team. In all four cases, these individuals were chosen from within our team. This is a testament to the depth and quality of our staff and is gratifying as an example of our commitment to life-long learning and the professional development of talented individuals.

We also bid farewell to our long-serving friend, colleague and medicald director, Ahmad Kilani, MD. Dr. Kilani served the Quality Alliance with passion for over a decade. His experiences and relationships gleaned from his own private practice background made him a tireless advocate for our members. Ahmad's knowledge of, and connections within, Cleveland Clinic allowed Dr. Kilani to turn that advocacy into action on many occasions and we thank him for his service.

Looking Forward

We expect 2026 to be another year of ongoing evolution and transition. To further support our collective success in the future we expect to modify our approach to our long-standing model for incentive programs. As our new contracts provide for some concurrent and predictable revenues, we will begin to pivot from an exclusively retrospective approach to a blended model of prospective/concurrent elements that are reinforced with trailing performance recognition.

We will continue to unlock resources and programs previously available only to Cleveland Clinic employed physicians to all Quality Alliance members. We will also continue to refine our analytics and reporting capabilities to enable QA members' access to actionable and meaningful data and insights with greater efficiency and timeliness.

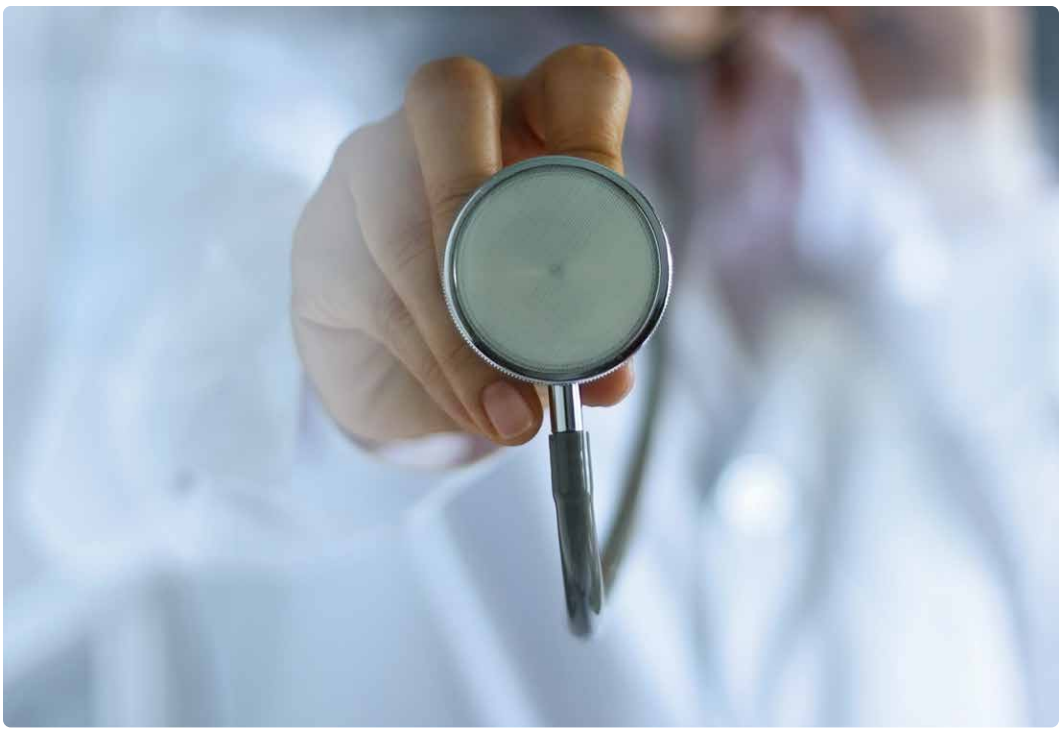
At the core of the Quality Alliance's mission is the improvement of the quality of care received by the patients of our members. We have been hindered in recent years from executing our well-developed Performance Improvement program due to our data vendor transition. In 2026 we will sreturn to actively engaging with our members through this program to continue delivering on our mission of improved quality of care for all patients.

Most importantly, to all of you, our Quality Alliance members, we will in 2026 continue to be your advocate and partner so that you can continue to deliver high quality compassionate care to your patients.

PROVIDER ENGAGEMENT

Independent providers in the Quality Alliance deliver exceptional patient care across our community, within Cleveland Clinic hospitals, and through value-based contracts alongside Cleveland Clinic–employed clinicians. Each independent practice is supported by a dedicated provider engagement (PE) team member who serves practices in member success and alignment within the clinically integrated network. The PE team fosters collaboration across the care continuum, engages independent providers in system-wide transformation efforts, collaborates with member practices toward individualized solutions and delivers education on quality metrics using the third-party data aggregator Arcadia to strengthen performance and population health management.

The PE team led efforts to align quality metrics more closely with value-based payer requirements and provided individualized education with practices in 2025. As the QA welcomed new team members with specialized skill sets, the PE team leveraged existing and new areas of expertise to create tools and educational guides supporting performance improvement and strengthening provider engagement. In addition, the team delivered priority care gap education, reaching more than 90% of eligible PCP practices through Arcadia in Q4 2025, further supporting readiness for payer expectations and timely interventions impacting patient and population health. The PE team extends its appreciation to all QA practices for their continued engagement throughout our transition to risk-based contracting and enhanced population health, which served as an important learning year for the network.



POPULATION HEALTH

The population health navigation team supports practices by focusing on quality measures for Quality Alliance value-based contracts. The team works to resolve open quality measures such as gaps in care and health maintenance.

Population health navigators help align patients with Quality Alliance providers and, unless otherwise requested, to help close care gaps in areas such as:

- Annual wellness visits
- Colorectal cancer screening
- Breast cancer screening
- Diabetes eye exams
- HbA1C testing for patients with diabetes
- Kidney/nephropathy monitoring for patients with diabetes
- Controlling blood pressure

POPULATION HEALTH *continued*

In 2025, the population health navigation team:

› Provided support for pending orders for colonoscopies, mammograms, HbA1C testing, albumin testing and eGFR testing.

- Called patients, sent MyChart messages and/or mailed letters reminding patients of care gaps.
- Mailed letters for health maintenance items due.
- Called patients and mailed letters for Fidelity (primary care provider).
- Uploaded Epic medical records to payer portals.
- Secured care gap documentation.

Mallory Reinking
Assistant Director, Care Management Operations

Patrick Iafelice
Navigation Manager

Kristy Owens
Navigator

Danielle Duhaime
Navigator

Mesa Elkin-Reho
Navigator

CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

Highlights and Celebrations

The Cleveland Clinic Medicare Accountable Care Organization (CCMACO) is the organization's participating entity in the Medicare Shared Savings Program. Last year brought exciting changes to CCMACO, including the addition of four ACO pharmacists — Courtney Fornwald, Sarah Milkovich, Lauren Schulz and Alayna Wagner. In December, CCMACO welcomed a new leadership team to support its initiatives moving into 2026.

Daniel Allan, MD
CCMACO President/ACO Executive

Kenneth Braman, DO
CCMACO Medical Director

Albert Civitarese, DO
CCMACO Associate Medical Director

Jessica Marzulli, MA
ACO Program Manager

With over $200,000 in external grant funding to support our care model innovation, significant work was dedicated toward disease state care continuums as well as post-acute care programmatic enhancements. CCMACO also continued its collaboration with the West Health Institute Learning Action Network and the Duke Margolis Institute of Health Policy, examining opportunities to improve Medicare value-based care models.

2025 Performance

We are thankful for the tremendous innovation and collaboration, internally and externally, supporting our ACO patients. We will not see data on the final settlement for PY2025 until late summer, but performance trends were notable for reductions in post-acute care settings, specifically skilled nursing facilities, and small reduction in inpatient admission rates as well as significant (and targeted) increases in ambulatory visits.

Final 2024 Medicare Shared Savings Program Results

The final PY2024 MSSP Accountable Care Organization performance results were released in August 2025. For the fifth year in a row, CCMACO generated savings to Medicare by outperforming its benchmark. For PY2024, $33.6M in savings were generated for CMS.

CCMACO's quality measure performance also continued to be strong across disease management and prevention/screening.

Thank you to everyone who has contributed to the ongoing success of our ACO.

26-FIN-7955558