



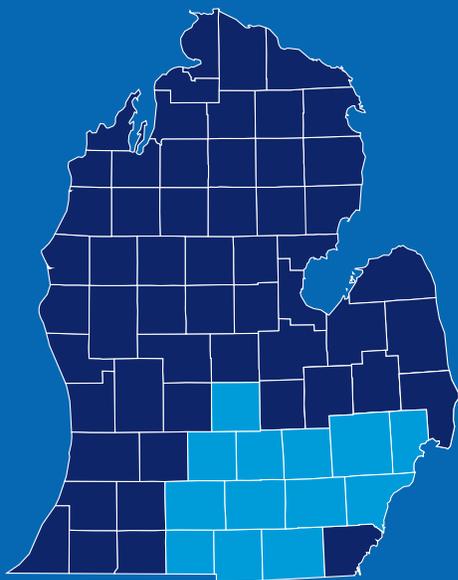
MOSAIC

Clinically Integrated Network

2025 Value Report

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1 Clinical Integration Program

600,000+ Lives Served

Care Locations
Across **13 Counties**

5,000+ Providers,
Including **700+** PCPs



Letter from the President

Mosaic Clinically Integrated Network's (Mosaic CIN's) first full year marks a remarkable beginning for a network built with a clear purpose: to advance the Quintuple Aim through true clinical integration. From the outset, our strategy has centered on improving outcomes, enhancing experience, promoting equity, strengthening care teams and reducing the total cost of care. These principles continue to anchor every part of our work.

We've brought together diverse organizations, aligned cultures and credentialed thousands of providers across specialties and regions. We renegotiated participation requirements and contracts, built shared infrastructure, and supported teams operating in different practice and employment models. These efforts created the foundation of a high-performing network capable of supporting providers and delivering consistent, coordinated care.

The results from our first year demonstrate the strength of that foundation. Mosaic CIN achieved strong performance, delivering meaningful improvements in quality, cost and coordination. These outcomes validate the network's purpose and reflect the deep commitment of our providers and care teams to high-value care.

Partnership has been central to our success. We worked closely with payors, clinical teams and colleagues across the system to strengthen alignment. That shared purpose accelerated performance and allowed us to operate as one network serving our patients.

Mosaic CIN also plays a pivotal role in Henry Ford Health's broader commitment to high-value care. As Henry Ford Health advances a Value-Based Enterprise model, our work provides an essential bridge between provider performance, population health and the experience of patients across the continuum. This year's achievements show that we are well positioned to continue driving that systemwide transformation.

As we look ahead, our focus is on advancing performance, deepening clinical integration and strengthening our ability to deliver measurable, sustainable results. The progress of this first year shows we are moving toward our goal of becoming a national leader in high-value care with clear purpose and momentum.

Thank you for supporting the collaborative work that is strengthening care for people across Michigan.

Sincerely,

Courtland Keteyian, M.D., MBA, MPH
President, Mosaic Clinically Integrated Network



Letter from the Chairman

Henry Ford Health has always been a leader in the evolution to high-value care, and now, more than ever before, we have set a clear course: deliver care that improves outcomes, expands access, and remains affordable for the families and communities we serve. Today, that vision continues to guide our enterprise as we align around a unified, systemwide approach.

Henry Ford Health is one of only a few organizations in the nation that combine world-class care delivery with fully integrated insurance coverage and population health services. This complete continuum of care and coverage includes Henry Ford Medical Group, Michigan State University (MSU) Health Care, partner POs, independent and other providers, Mosaic CIN, Mosaic Accountable Care Organization, Henry Ford Physician Network, The Physician Alliance, Partners in Care, Genesys Physician Hospital Organization, Health Alliance Plan, our network of hospitals including behavioral health, Community Care Services, Populance, and our broader Care Delivery System and Value-Based Enterprise. Together, these assets support our clinicians in becoming the destination for all care and coverage across the entire continuum by leading our nation in high-value care.

Our pluralistic provider community is the foundation of this work. We have deepened collaboration among independent, aligned and employed clinicians and welcomed MSU Health Care, Covenant Health and other partners into a shared clinically integrated environment. This diverse governance model reflects a core belief: coordinated teams, united by purpose, achieve the strongest results.

Our national visibility continues to grow as organizations seek Henry Ford Health's expertise to shape the future of high-value care. With that recognition comes responsibility — to lead with clarity, discipline and a commitment to long-term sustainability.

Mosaic CIN is a central expression of that leadership. It brings our strategy to life by aligning incentives, strengthening payor partnerships, leveraging technology, and driving measurable improvements in quality and total cost of care. The network is accelerating our progress and enhancing our ability to deliver high-value care at scale.

With the infrastructure we have built, the partnerships we have strengthened and the dedication of our providers, care teams, administrative leaders and team members across Henry Ford Health, we are advancing a sustainable, high-value future — and Mosaic CIN is a vital engine in that journey.

Thank you for your partnership and for supporting our commitment to delivering sustainable, high-value care for the communities we serve and as a model for our nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Jerome Finkel". The signature is fluid and cursive.

Jerome Finkel, M.D., MHA, FACP
Chair, Mosaic CIN Board of Managers
Chief Medical Officer, Value-Based Enterprise
Senior Vice President and Chief Primary Health Officer, Henry Ford Health

What Is Mosaic CIN?

Mosaic CIN is a physician-led organization that connects providers, hospitals and care teams to improve care quality, lower costs and enhance patient experience. The network brings together employed, affiliated and independent physicians to advance care across the communities it serves and lead the nation in high-value care.

Mosaic CIN harnesses data-driven insights and innovative tools to strengthen provider performance and success. Its strong foundation in high-value care supports collaboration that drives and sustains progress, empowers providers and advances health outcomes.

In 2025, more than 5,000 providers served more than 600,000 patients across central and southeastern Michigan.

Commitment to high-value care

This value equation reflects our commitment to helping providers deliver high-quality care and exceptional patient experience while reducing unnecessary costs. When these priorities align, everyone benefits.

At Mosaic CIN, high-value care is more than a goal — it's a formula for success.

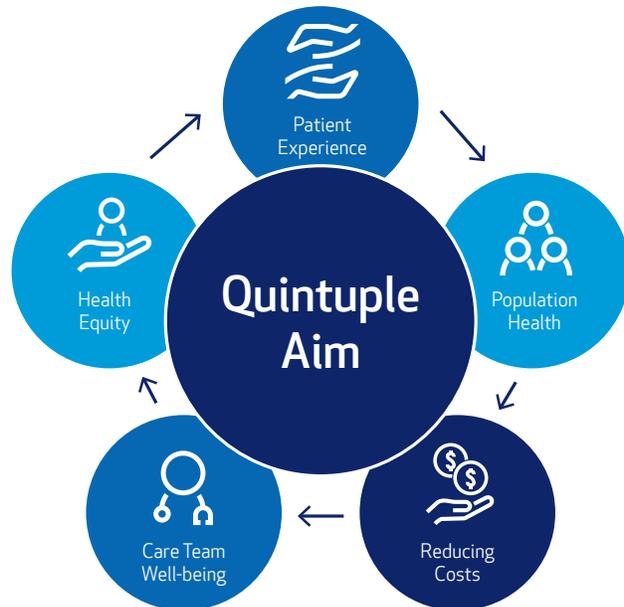
$$\text{Value} = \frac{\text{Quality} \times \text{Experience}}{\text{Cost}}$$

The Quintuple Aim

Healthcare costs continue to rise, increasing the burden for patients, families and communities. Mosaic CIN is working to reverse that trend by delivering high-value care — improving quality, outcomes and experience while reducing total cost of care.

This work is guided by the Quintuple Aim:

- Improve outcomes
- Enhance the patient experience
- Reduce total cost of care
- Support provider and care team well-being
- Advance health equity



Unified approach

The Clinical Integration Program powers Mosaic CIN's high-value care strategy, combining evidence-based practices with a performance-focused model that improves population health and advances the Quintuple Aim.

Key features

- Aligned incentives: Unite goals across patients, providers and payors.
- Clear metrics: Track quality and cost performance.
- Quarterly scorecards: Provide timely insights at the network and physician levels.

This integrated model strengthens Mosaic CIN's ability to secure value-based contracts and recognize providers for delivering high-quality, cost-effective care.

Mosaic CIN also supports performance across multiple value-based arrangements by streamlining credentialing, contracting, analytics, clinical integration and incentive distribution for Mosaic CIN, Mosaic Accountable Care Organization (ACO), and the Henry Ford Physician Network (HFPN).





Practice Performance

The Practice Performance Team advances patient care and clinical integration. In 2025, the team implemented more than 6,000 updates by standardizing Patient Centered Medical Home (PCMH) practices.

The team works alongside providers and care teams through:

- **Collaboration:** Practice Transformation Project Specialists (PTPS) partner with each practice or service line, leveraging data analytics to refine workflows and improve outcomes. Monthly meetings with practice leaders help advance progress and maintain momentum.
- **Central support:** The team serves as the central resource for the physician networks and coordinates Henry Ford Health departments to deliver aligned, practice-level support.

In 2025, the team also introduced new tools, including the Compass guidebook as the primary resource. Best practices were shared across the provider networks to improve efficiency and streamline workflows.

Together, these functions strengthen practice performance by pairing hands-on partnership with shared tools, measurable goals and networkwide best practices. The results and priorities below highlight progress to date and the work ahead.

Mosaic CIN Community Scorecard

The community scorecard tracks quarterly performance, highlighting progress on key quality, cost and utilization measures. These charts summarize quarterly results and trends across the network.

2025 Quarter 4 Overall Community Performance					2025 Q4 Community Score	83.61%	
Bundle 1: Preventive Care							
Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
PC.102	Pneumonia Vaccination - age ≥ 65	103,330	146,356	70.60%	69.77%	1	1
PC.103	Immunizations: Birth - 2 years	4,009	6,760	59.30%	55.52%	1	1
PC.106	BMI Activity Nutrition Counseling	201,256	436,540	46.10%	36.42%	1	1
PC.111	Tobacco: Cessation Intervention - age ≥ 9	39,076	61,053	64.00%	50.67%	1	1
PC.121	Adolescent Immunizations Combo 2 'IMA'	2,241	6,519	34.38%	30.92%	1	1
PC.149	Well Child Visits: 3 - 11 years	39,340	60,181	65.37%	64.87%	1	1
PC.150	Well Child Visits: Birth - 15 months	4,481	6,810	65.80%	64.14%	1	1
PC.151	Well Child Visits: 15 - 30 months	4,624	6,825	67.75%	67.63%	1	1
PC.152	Breast Cancer Screening (age 40-74)	106,277	142,816	74.42%	73.48%	1	1
PC.153	Cervical Cancer Screening	106,226	147,951	71.80%	65.19%	1	1
PC.154	Colorectal Cancer Screening (age 45-74)	161,051	231,127	69.68%	65.97%	1	1
PC.157	Low Dose Lung Cancer Screening	7,219	24,222	29.80%	27.11%	1	1
PC.161	Depression Screening: ≥12 years	362,238	506,314	71.54%	70.24%	1	1
PC.166	Blood Lead Screening: Children	3,733	6,763	55.20%	47.17%	1	1
						14	14
Bundle 2: Chronic Disease Care							
Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
CD.212	CVD: Use of Statin Medication	21,628	24,798	87.22%	87.45%	0	1
CD.231	DM: HbA1c < 8.0%	43,378	57,904	74.91%	71.98%	1	1
CD.239	DM: Retinal Eye Exam	31,066	56,883	54.61%	50.18%	1	1
CD.242	DM: Use of Statin Medication	28,827	38,105	75.65%	72.75%	1	1
CD.244	DM: Blood Pressure Controlled	43,049	56,435	76.28%	74.14%	1	1
CD.245	DM: HbA1c ≤ 9.0%	46,767	56,945	82.13%	78.58%	1	1
CD.246	DM: Kidney Health Evaluation	37,155	54,818	67.78%	64.54%	1	1
CD.251	HTN: BP Control	116,863	163,624	71.42%	70.23%	1	1
CD.272	Heart Failure: Use of ACE/ARB/ARNi	7,553	9,880	76.45%	76.27%	1	1
CD.281	COPD Assessment Test (CAT)	14,000	26,395	53.04%	45.45%	1	1
						9	10
Bundle 3: Continuum of Care							
Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
CC.301	PCMH Practice Designation	89	95	93.68%	90.00%	2	2
CC.302	PCMH-N Practice Participation	240	247	97.17%	90.00%	2	2
CC.311	ACO Out of Network 'Leakage'			43.90%	≤50.00%	1	1
CC.317	Access to Care: Outpatient Clinics	301	308	97.73%	90.00%	1	1
CC.318	SDoH Screening	411,759	601,890	68.41%	45.45%	1	1
CC.319	Longitudinal Care Management	12,030	567,068	2.12%	3.30%	0	1
CC.320	ACO HCC RAF Score			1.28	1.13	1	1
CC.321	ACO SNF Admits			28.9	≤33.8	1	1
CC.323	Advance Care Planning	55,322	150,009	36.88%	17.26%	1	1
CC.325	Post Discharge Med Reconciliation	8,987	19,976	44.99%	37.28%	1	1
CC.326	HCC Individual/Cumulative Refresh	237,134	276,393	85.80%	82.72%	1	1
						12	13

2025 Quarter 4 Overall Community Performance	2025 Q4 Community Score	83.61%
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Bundle 4: Quality, Efficiency & Utilization

Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
EU.401	Length of Stay (LOS) Index	3.43	3.60	0.95	≤1.00	1	1
EU.402	30-Day Readmission COPD	19.04%	17.49%	1.09	≤1.22	1	1
EU.403	30-Day Readmission Pneumonia	13.88%	13.57%	1.02	≤1.05	1	1
EU.404	30-Day Readmission Heart Failure	17.78%	18.04%	0.99	≤1.05	1	1
EU.405	30-Day Readmission AMI	9.06%	10.22%	0.89	≤1.00	1	1
EU.408	30-Day Readmission All Diagnoses	10.83%	11.41%	0.95	≤1.04	1	1
EU.410	ACO ED Visits per 1000			293.5	≤312.83	1	1
EU.416	ACO Total Cost of Care PMPM			1228.30	≤1245.24	1	1
EU.423	ACO Hospital Inpatient Admits per 1000			195.4	≤230.81	1	1
EU.430	PSI-90 CMS HAC Reduction Program			0.97	≤1.00	1	1
						10	10

Bundle 5: Patient Experience

Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
PE.518	Inpatient Experience Satisfaction (HCAHPS) - Service Line Score: Willingness to Recommend	5,507	8,599	64.04%	65.21%	0	2
PE.519	Outpatient Experience Satisfaction (CG CAHPS): Willingness to Recommend	92,625	101,769	91.01%	91.85%	0	2
PE.520	ED Patient Experience (ED CAHPS) - Service Line Score: Willingness to Recommend	7,001	12,034	58.18%	61.60%	0	2
PE.521	Surgery Experience - Anesthesiology (OAS CAHPS)- Service Line Score: Willingness to Recommend	10,302	12,134	84.90%	85.41%	0	2
						0	8

Bundle 6: Citizenship AND Education

Metric ID	Metric Name	Num	Den	Community Score	2025 Target	Points Earned	Max Points
JT.601	Annual Meeting Attendance	1,583	1,936	81.77%	30.00%	2	2
JT.602	Provider Quality Champion	292	464	62.93%	30.00%	2	2
JT.605	Training & Education Sessions	830	2,198	37.76%	30.00%	2	2
						6	6

Notes:

Bundle 1 & 2
 [CC.301, CC.302, CC.317]
 [CC.311] [CC.320] [EU.416]
 [CC.321] [EU.410, EU.423]
 [EU.401 - EU.408]
 [EU.430]
 [Bundle 5]
 [Bundle 6]

Source: Compass. Rolling data to 12/31/2025
 Source: BCBS PCMH Capability [01/01/2025 - 09/30/2025]
 Source: HFHS Premier ACO IS, [09/01/2024 - 08/31/2025]
 Source: HFHS Premier Comparator Report, [10/01/2024 - 09/30/2025]
 Source: Premier Quality Advisor. All payors, Rolling 12-month [12/01/2024 - 11/30/2025]
 Source: Premier Quality Advisor. All payors, Rolling 12-month [12/01/2024 - 11/30/2025]
 Source: Press Ganey Survey. 2025 YTD [01/01/2025 - 12/31/2025]
 New Practices starting after the second PQC of the year will be excluded from JT.602 denominator. Non-incentive specialties (Mid-wife & Optometry) providers/practices will be excluded from N/D

Total Earned Points	Total Max Points
51	61
Q4 Community Score	83.61%

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Accountable Care Organization

As a Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program Accountable Care Organization (ACO), Mosaic ACO unites providers from Covenant HealthCare Partners and Henry Ford Physician Network to deliver high-value care that improves quality, lowers costs, and strengthens outcomes for patients and communities by:

- Managing chronic diseases such as diabetes and hypertension.
- Reducing avoidable readmissions and unnecessary hospital stays.
- Improving preventive care through cancer screenings and immunizations.
- Ensuring accurate HCC coding to reflect patient complexity and support appropriate care.
- Coordinating care across settings to help patients stay healthier and remain at home.

In year four of a five-year contract with the CMS, Mosaic ACO serves over 45,000 Medicare fee-for-service beneficiaries. Managed by the Mosaic CIN administrative team, the ACO delivers strong quality and financial results, generating savings and reinvesting to strengthen care across the network.

Mosaic ACO achieved \$27.2M in shared savings for performance year 2024, reflecting a 4.5% savings rate and surpassing the prior year's results. Of those savings, \$19.9 million was distributed to ACO participants from Henry Ford Physician Network, Mosaic CIN and Covenant HealthCare Partners, with the remainder invested in infrastructure improvements that support the network and future growth.

The ACO also achieved an 87.7% quality performance rating for performance year 2024, its highest rating since launching in 2022. This performance led to invitations to share best practices at forums, including the Patient360 Virtual User Group Meeting, the Premier Quality Webinar and the ACO Quality Panel at Premier's National Fall Conference.

Mosaic ACO continued to grow in 2025 by adding provider groups and expanding support for beneficiaries. Based on our quarterly reports, we are projecting another year of shared savings in 2025.



Henry Ford Physician Network

Henry Ford Physician Network (HFPN) is a collaborative of physicians, hospitals, clinics, labs, and post-acute care providers working together to improve patient outcomes and lower the cost of care.

HFPN includes the Henry Ford Medical Group, physician organizations, and hundreds of independent primary care and specialty physicians.

A key HFPN offering is its direct-to-employer (D2E) plans. D2E plans connect a healthcare organization and its providers with an employer's benefits team to design a medical plan that supports employees and their dependents while managing the company's healthcare spending. Through HFPN, employers can offer a high-value health plan that strengthens quality, enhances employee satisfaction and helps manage overall costs.

Henry Ford Health Self-Funded plans

The contracting team negotiated a new two-year agreement with Henry Ford Health, effective Jan. 1, 2025, covering two D2E products: HFH Advantage Tiered Access plan and CDHP Comprehensive HFH Preferred Network plan.

The agreement integrates legacy HFPN and Jackson Health Network contracts into a single arrangement with terms that expand the program. It also formalizes shared goals and commitments for populations served across the provider networks.



**HENRY
FORD
HEALTH**

GM ConnectedCare

GM ConnectedCare continued to expand access and strengthen performance in 2025, adding chiropractic specialty services and building on strong value-based results. The collaboration also delivered shared savings for HFPN, reinforcing the network's ability to grow partnerships and sustain high-value care.

In August 2025, HFPN and General Motors settled performance year 2024, resulting in approximately \$1.74 million in shared savings for HFPN. Distribution took place in Q4 2025 and Q1 2026.

In 2025, the Practice Performance Team strengthened clinical integration by pairing hands-on practice support with shared tools and clear, measurable goals. This work positions Mosaic CIN, Mosaic ACO and the HFPN to sustain strong performance, expand partnerships and continue delivering high-value care across the network.



Payor Partnerships

Aligned contracting. Shared success.

- ▶ Negotiated professional and facility contracts
- ▶ Improved quality
- ▶ Cost savings
- ▶ Value-based reimbursement
- ▶ Performance incentives
- ▶ Clear performance-based standards
- ▶ Commercial, Medicaid, Medicare, Medicare Advantage, Direct-to-Employer

Mosaic CIN utilizes a networkwide contracting strategy built on clear performance-based targets. Full participating members benefit from negotiated professional and facility contracts that emphasize value-based reimbursement.

Strong payor relationships are essential to sustained performance. Over the past year, the team negotiated key contract changes and new agreements to position the network for success in 2026.

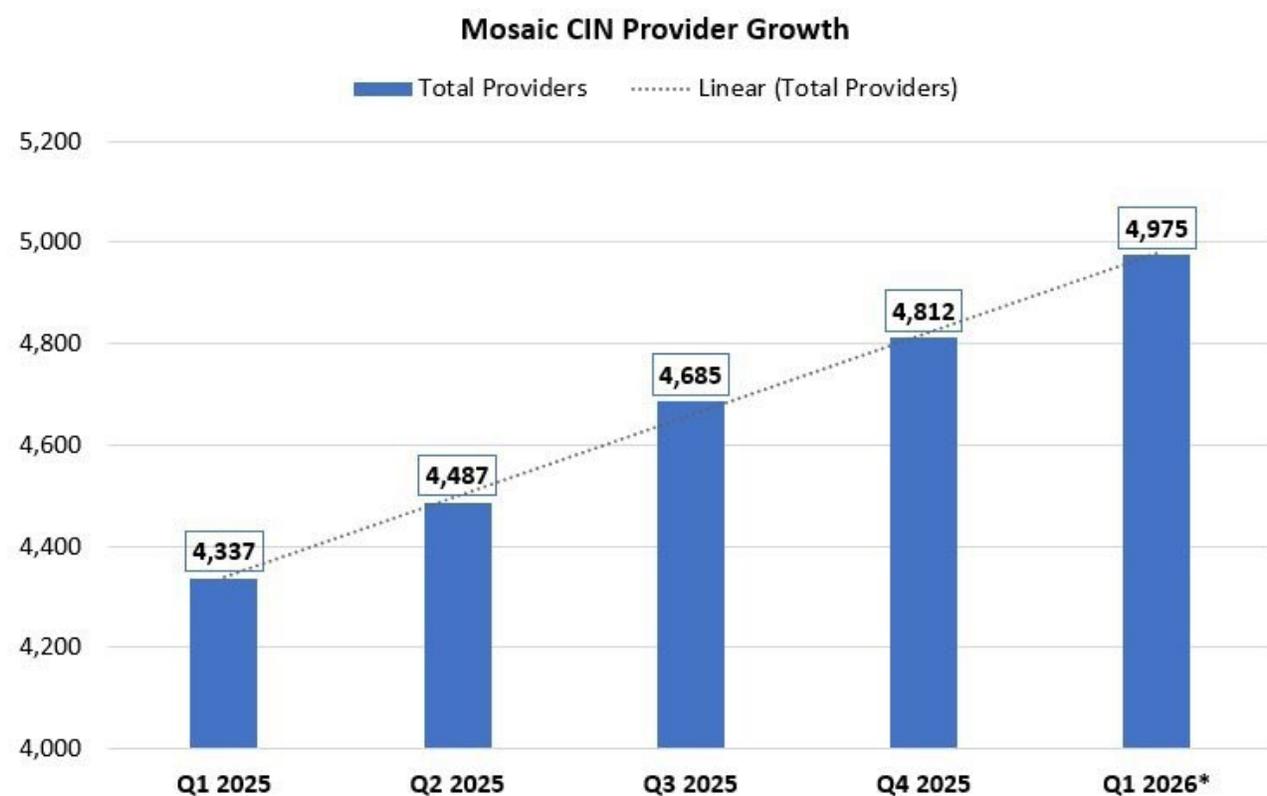


Growth & Partnerships

In 2025, the network experienced significant growth in both patients and providers. The strategic effort to build Mosaic CIN with the highest caliber providers to serve a growing patient footprint gained significant momentum, adding 10,762 patient lives and 638 providers.

The commitment to high-value care and providers remains central. By reducing administrative complexity and equipping care teams with practical tools, Mosaic CIN is strengthening performance across the Quintuple Aim: better quality and health outcomes, enhanced patient experience, lower total cost of care, improved provider and staff well-being and greater equity.

This progress reflects the impact of aligned providers working together toward a healthier, more connected Michigan.



*As of January 2026

Financial Performance

Mosaic CIN partners with health plans and other payors to advance a healthcare system focused on better outcomes, improved patient experiences and sustainable affordability. The network negotiates payment arrangements that align incentives across patients, providers and payors, supporting care models built on clinical integration, proactive population health management and continuous improvement.

These value-based arrangements give participating providers the resources and accountability to deliver coordinated, patient-centered care while helping payors achieve durable cost and quality performance.

Mosaic CIN views each payor relationship as a long-term partnership focused on transforming care delivery and creating lasting value for the communities it serves.

In 2025, the total value of these payment terms was nearly \$50 million.

Value-based care payment models

Value-based care payment models align financial incentives with improved health outcomes, a better patient experience and lower total cost-of-care.

Unlike traditional fee-for-service reimbursement, these models combine prospective support payments with performance-based incentives to enable and reward high-value care.

Core payment components typically include:

- Administrative Infrastructure per member per month (PMPM) payments
- Care Management PMPM payments
- Shared Savings
- Quality Incentives

Together, these elements provide the financial foundation and accountability to support effective population health management.

Incentives that reward what matters

At Mosaic CIN, value-based care means shared purpose and shared reward.



Clinical Transformation

Clinical Transformation advances Mosaic CIN's mission through two core functions: performance scorecards and innovation.

Performance scorecards benchmark provider performance against peers and payor measures using evidence-based metrics. They also help allocate payor incentives across service lines, specialties and providers to drive improvement.

Innovation partners with clinical teams to design, refine and implement measures for primary and specialty care.

Focus area

Clinical Transformation strengthens consistent, high-value care delivery by improving performance, alignment and day-to-day workflows. Priorities include:

- Improving care quality, patient outcomes and cost performance.
- Aligning practices with evidence-based standards and value-based care expectations.
- Optimizing workflows, leverage actionable analytics and support continuous improvement.

This work advances Mosaic CIN's population health goals by reducing unwarranted variation and strengthening care coordination aligned with the Quintuple Aim.

Partnerships power progress

- Stronger care coordination
- Improved outcomes
- Better patient experience
- Support for providers
- Lower cost of care
- Healthier communities



Key achievements

In 2025, the team expanded network capabilities and improved performance visibility through stronger analytics, refined measures and broader specialty engagement.

- Developed, refined and supported specialty-specific scorecards across 45 network specialties.
- Aligned Epic Care Gaps with Compass and CIN Scorecard logic, including BMI counseling, advanced directives and a new lung cancer screening metric.
- Added MSU Health Care physicians and other practices to the network, including integrating them into Community and Individual Scorecards and preparing for integration with Henry Ford Health's Epic instance.
- Enhanced the Compass tool with predictive analytics, earning national recognition and resolving attribution issues via provider feedback.
- Advanced 16 metric proposals to the Clinical Performance Committee, resulting in eight metric revisions and eight newly approved measures.
- Established Clinical Transformation subcommittees to prioritize system-wide and regional clinical improvements.
- Added eight specialty types to the Mosaic CIN scorecard structure and attribution table.

Future goals

In 2026, the team will build on this strong foundation by scaling proven best practices, strengthening integration and using data-driven insights to accelerate improvement across the network.

- Optimize preventive care and care transitions.
- Leverage innovation and analytics to drive continuous transformation.
- Achieve top-tier performance on the Mosaic CIN scorecard.
- Deliver patient-centered care while supporting physician growth and development.
- Advance Mosaic CIN's position as a national leader.



Population Health

In 2025, Mosaic CIN advanced population health by strengthening care management, expanding community-based support, and scaling programs that improve outcomes and address patients' social needs.

Key achievements include:

- Optimized care management and community health worker workflows, along with performance tracking, to improve efficiency as the network continued to scale.
- Launched the first embedded community health worker pilot to support patients with social drivers of health (SDOH) needs.

These efforts come to life when barriers are removed that keep patients from accessing care. The story below shows that impact in action.

A community health worker supported an individual experiencing homelessness who lacked stable housing and routinely missed appointments due to transportation barriers. The client also faced reduced Supplemental Security Income benefits and trouble applying for food assistance.

The worker connected the client with housing resources through the Community Action Agency, shared available housing options, and provided bus passes and transportation resources. The support helped address housing, transportation and basic needs.

Ambulatory Care Management

Ambulatory care management improves outcomes, strengthens care coordination and enhances the patient experience while helping reduce costs through evidence-based interventions. The program supports patients with chronic conditions and addresses risks and barriers early, before they become costly or harmful. It also tracks annual payor target performance at the practice and network levels and progress toward Clinical Integration Program targets. Mosaic CIN works alongside practices, payors and Populance to ensure patients receive effective, coordinated care management.

These efforts are most visible in individual lives, when care teams coordinate clinical support and connect patients to resources.

A patient experienced a left middle cerebral artery stroke, with no lasting physical deficits but ongoing memory and word-finding challenges.

Working closely with the patient's primary care physician (PCP), the care manager coordinated referrals to speech therapy and Collaborative Care. The patient completed both and later underwent left internal carotid artery stent placement.

During a follow-up call, the patient reported his leg had given out. He denied pain and did not plan to seek care. The care manager, upon further assessment, identified symptoms consistent with another stroke and urged the patient to go to the hospital. Testing confirmed a second stroke, but he luckily did not sustain lasting deficits.

At follow-up, the care manager and PCP reviewed warning signs, when to seek care and prevention strategies with the patient. He is now doing well and is more proactive in managing his health.

Diabetes Care Connection

Through Populance, Mosaic CIN partners to deliver Diabetes Care Connect, supporting practices with targeted outreach and services that strengthen diabetes self-management, improve diabetes control and expand access to medical nutrition therapy. The program tracks patient engagement and outcomes across Diabetes Self-Management Education, Diabetes in Active Control and Medical Nutritional Therapy.

Here's one example of the program's impact:

A 59-year-old male with type 2 diabetes, hypertension and dyslipidemia was referred to the Diabetes Education Center with a hemoglobin A1c of 10.5%, well above the typical goal of less than 7%. Assessment showed inconsistent medication use, a high-carbohydrate diet and continued smoking.

Through diabetes education, he learned strategies to improve medication adherence, reduce carbohydrate intake and lower risk, including through foot care. He was also referred to Tobacco Treatment Services.

After completing his education plan, his A1c dropped to 6.5% and has remained there for six months. He lost 15 pounds, improved his blood pressure, quit smoking and added regular exercise.

Social Drivers of Health

SDOH work identifies nonmedical needs, connects patients to resources and tracks follow-through to ensure support is delivered. In 2025, 38.6% of successfully contacted patients completed SDOH assessments and received an intervention. Of those, 88.8% were closed loop, meaning the outcome was known or three follow-up attempts were completed and documented as unable to contact. Among closed-loop interventions, 34.2% resulted in a successful intervention with a documented disposition.

Collaborative Care

Collaborative Care tracks the total number of patients served across the program at the network level. In 2025, the program served 5292 patients.

This network-level reach translates into individual outcomes — like this patient's experience:

A behavioral health care manager worked with a 36-year-old woman with depression, anxiety and premenstrual dysphoric disorder who had taken Paxil for 20 years. As she considered pregnancy, she raised concerns about medication risk and said Paxil was no longer controlling her symptoms, which was affecting her work and further increasing her anxiety.

The care manager provided evidenced-based support, and a psychiatric consultant counseled the patient and her primary care physician on pregnancy-related risks and alternatives. The patient chose to transition to a new medication. Despite early side effects during the cross-taper, ongoing follow-up helped her stay on track and improve: Her PHQ-9 score dropped from 12 to 3, and her GAD-7 score from 12 to 4.

"I am really happy," the patient said. "I feel like life is back in my control, and the coping tricks I've learned are effective again. Thank you!"

High-value care

Best possible outcomes at the lowest total cost of care

Mosaic CIN improves lives, including connecting patients to timely clinical support, behavioral health services, education and community resources to help close care gaps, prevent avoidable complications and strengthen self-management.



2026 and Beyond

Mosaic CIN enters 2026 with strong momentum, serving more than 600,000 covered lives and supported by over 5,000 employed and independent clinicians. Together, we are advancing high-value care across Michigan and demonstrating what aligned providers, payors and health systems can achieve.

Mosaic CIN delivers consistent, scalable and measurable results across more than 20 value-based arrangements. Advanced analytics, unified contracting and a pluralistic governance model strengthen performance today while positioning the network to influence the direction of high-value care.

Looking ahead, Mosaic CIN is focused on targeted investments that strengthen performance, sustainability and growth. In 2026, priorities include advancing coding technology to support accuracy and completeness, expanding analytics that illuminate cost and utilization trends to inform contract performance, and growing membership through strategic partnerships that extend access while preserving continuity of care.

This next chapter centers on deepening provider engagement, advancing integrated workflows, improving reliability in quality performance, and expanding in ways that strengthen access for patients and communities. In a complex healthcare environment, Mosaic CIN is designed to deliver both stability and innovation.

The future of our network is about more than growth. It is about strengthening a connected ecosystem where providers can thrive, patients experience affordable, seamless, coordinated care, and communities benefit from better health. Mosaic CIN is not simply participating in value-based care — it is helping shape how it evolves.



Appreciation for our leaders

We extend sincere appreciation to the leaders and partner organizations who guided Mosaic CIN throughout 2025. Your expertise, collaboration and commitment keep the network strong, adaptable and aligned with the needs of the people we serve.

Special thanks to the Mosaic CIN Board of Managers for their steady leadership and clear vision. Your dedication continues to strengthen our foundation and advance the delivery of high-value, patient-centered care across Michigan.

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Celebrating Our Vision

*Our Network will transform care
across the communities we serve,
leading the nation in high-value care.*

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