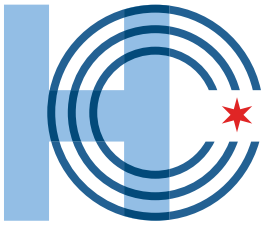
2018-2019

STATE OF CHICAGO HEALTH CARE INDUSTRY



HEALTH CARE COUNCIL

of Chicago

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LETTER FROM THE CO-FOUNDERS

We are pleased to release the Health Care Council of Chicago's third white paper, exclusively focused on the vibrant health care ecosystem in Chicago and outlying areas.

Since the inception of the Health Care Council of Chicago (HC3) we have endeavored to be widely inclusive of the many different stakeholders and entities that constitute our city's health care industry. The range of expertise and skills housed in this city not only do good for its residents, but influence the nation as our innovations, research, and ideas impact the broader system.

HC3 made some important advancements in its third year. First, HC3 made significant progress in conceiving and executing key initiatives that meet its core mission and mandate. These initiatives capture and focus the group's collective genius and resources on areas that are complementary and accretive to other important work happening in the city.

Second, HC3 organized programming to be far more germane to the city's areas of interest, differentiating commentary and analysis from thought leadership. HC3 is making every effort to ensure that opportunities to convene are conducted in a spirit of problem-solving and action rather merely defining problems.

Third, HC3 made a material investment in its infrastructure, primarily by hiring the organization's first executive director, Meghan Phillipp. Meghan is an ardent and passionate supporter of community health and has done exceptional work for our city's underserved through her leadership at CommunityHealth and reimaging their All In™ campaign. Further, HC3 has invested in descriptive materials, technology to support events, office space, and other amenities that will increase the organization's capacity and impact.

Finally, in the spirit of incubation, HC3 took the step to become its own legal entity. MATTER's vigilant housing of HC3 since inception has served a critical role in providing the space and resources required to build the financial foundation to perpetuate a financially self-sustaining model. As an independent entity, HC3 will continue to be supported by both MATTER and Third Horizon Strategies as we work towards building a strong brand identity and further autonomy. HC3 has been organized as a corporation but will abide by the requirements that will allow for a benefits corporation designation, meaning that HC3 exists to achieve its mission and not for the purpose of generating a profit. This decision was made for several reasons, including our aspirations to build a safety-net incubator with partners in the city that can help to capitalize and commercialize grant-funded businesses that have the potential to be self-sustaining.

We enter 2020 as ambitious as ever, seeking to add members, diversify programming, extend the impact of HC3 initiatives, establish governance, and support the development of Chicago-born innovations. We intend to continue reaching deep into the core of our city to operate at the epicenter of economic development and health system transformation and redress the health disparities that continue to plague the city's most vulnerable communities.

We are grateful for the support and commitment of our members, friends, policymakers, and others who continue to see the value of a platform that can convene our diverse ecosystem to advance our common interests for the city we all live, work, and play in.

Steven Collens
Co-Founder

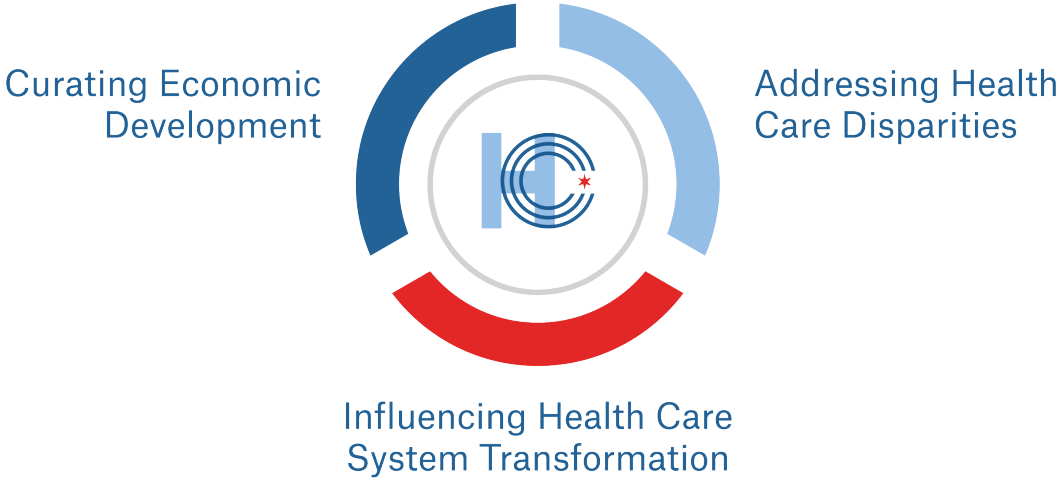
David Smith
Co-Founder

HEALTH CARE COUNCIL OF CHICAGO

Driving real health care change in our community

The **Health Care Council of Chicago** (HC3) is an action-oriented collaborative that brings leaders from across the health care ecosystem to solve our city's most important health-related issues.

HC3 operates at the epicenter **of economic development, health care transformation, and health disparities**. Everything we do is pursued by channeling the diverse and multi-sectoral coalition of health care leaders throughout the city to achieve collective impact.



We seek to achieve this primarily through three fundamental activities:

- **Programming:** Our programs examine Chicago-specific issues, led by Chicago leaders and focused on uniquely Chicago ideation.
- **Initiatives:** Our goal is to strengthen, reinforce, or fill empty space for critical economic and civic objectives to advance the entire community's collective interest in a vibrant, cutting-edge and healthy Chicago.
- **Partnerships & Relationships:** We cultivate uncommon partnerships and relationships to advance efficiency and innovations capable of transforming Chicago's health status.

OUR MISSION

We are Chicago's nationally recognized health care community in action. We harness the collective intelligence and resources of Chicago's health care leaders to drive meaningful change and positively influence the conditions that impact the health of our communities.

OUR VISION

We create uncommon alignment to improve the health and vitality of Chicago.

I. ECONOMIC DEVELOPMENT

GOVERNMENT

In 2019, significant leadership changes at the state and city level impacted many aspects of health care in Chicago. Federally, there was continued debate over the repeal of the Affordable Care Act (ACA) and the submission of waivers addressing Medicaid financing. State administration officials focused on lowering the cost of health care and improving access to care. Notably, the state legislature passed the Medicaid reform bill in August to enhance care, lower costs, and strengthen partnerships with managed care organizations and the state. Feeling the reverberations of federal and state policies, Chicago city officials committed to infusing capital into public health initiatives. Specifically, Mayor Lightfoot focused on standing up a mental health infrastructure to address deficits in neighborhoods across the city. The following section outlines major health care related decisions and events that took place at each level of government in 2019.

FEDERAL

Consistent debate regarding the payer of the U.S. health care system and the fate of the ACA and Medicaid exist at the federal level. The Trump administration focused on public health initiatives such as eradicating AIDS and addressing the opioid epidemic. Many national-level policy decisions have an impact on Illinois and Chicago.

ACA Repeal Efforts In January, 16 states, including Illinois, led by Texas sued the federal government for ruling the ACA unconstitutional.[1] In February, four more states moved to intervene and defend the ACA. The original lawsuit was filed in February 2018, challenging the constitutionality of the ACA after the Tax Cuts and Jobs Act of 2017 which eliminated the individual mandate penalty effective 2019.[2]

Originally, the federal government did not defend the constitutionality of the ACA's individual mandate and agreed with the plaintiff states.[3] However, they argued the protections for individuals with pre-existing conditions, guaranteed issues, and community ratings, should also be considered unconstitutional.[4] In March the federal government reversed it's opinion and stated the entire ACA should be overturned and considered unconstitutional.[5]

In July, the fifth circuit appeal held a hearing to examine the case. Six months later – in December 2019 – the federal appeals judges ruled 2-1 that the ACA's individual mandate is unconstitutional. However, they punted on the question of whether that mandate can be excised from the remainder of the law.[6]

Medicaid: Eligibility, Funding, DSH In 2019 more states sought alternative forms of funding and/or eligibility requirements for Medicaid. For instance, multiple states used the 1115 Waiver to implement work requirements for Medicaid eligibility. As of October, 9 states have submitted waivers, two states have halted work requirements, four states have approved waivers, and three states have waivers blocked.[7] Illinois has not submitted waivers for work requirements or proposals for block grants.

In September, Tennessee released a draft proposal for block grant funding for their Medicaid program, TennCare.[8] If approved, the state would earn more control over Medicaid administration and have fixed federal costs, rather than the open-ended match.[9] Critics state block grants will limit Medicaid eligibility and services leaving the most vulnerable populations exposed.[10] Other states are considering alternative funding opportunities for Medicaid such as Alaska, who has commissioned a study on block grants, and Utah who has requested a per capita cap on Medicaid spending.[11]

The 2020 budget proposal released in March included cuts for the Disproportionate Hospital Share (DSH) add-on to begin on October 1, 2019. During the spring a letter signed by 302 members was circulated through the House to delay the scheduled $12B cuts over the next two years.[12] DSH funding cuts directly impact Cook County Health (CCH) as in FY19 CCH received $157M in DSH funding. If the cuts went into effect 10/1 CCH would have lost $22M this year.[13] In September, the House passed a continuing resolution including a provision to delay the Medicaid DSH payment until November 22 and another resolution in November pushing cuts back

to December 20.[14] On December 19 the Senate passed a $1.4 trillion government spending bill to keep the federal government in operation. Notably, the bill delayed Medicaid DSH payment cuts for five months.[15]

Public Health During the February State of the Union address, President Trump announced an ambitious initiative to end the HIV/AIDS epidemic domestically by 2030.[16] The plan sets out to cut the infection rate by 75 percent in five years and 90 percent in 10 years.[17] The initiative will direct new resources to up to 48 counties, including Cook County, and also improve IT infrastructure for better data management and analytics.

The administration's 2020 budget proposal allocated $291M to support the initiative, including $140M in new funding for the CDC to improve testing and prevention, and another $50M to invest in community health centers for expanded PrEP services.[18] While advocates are supportive of the budget increases, they are wary of the administration's efforts to repeal the ACA also outlined in the budget proposal.[19]

In December, HHS Secretary Alex Azar released the Trump administration's plan to expand access to Gilead Sciences Inc.'s HIV prevention medication for people who have a prescription for pre-exposure prophylaxis drugs but no coverage. The federally funded "Ready, Set, PrEP" program will provide about 200,000 Americans annual access to PrEP and an initial cost of roughly $200 per bottle of a 30- or 60-day prescription. Before the end of March, a new system including CVS Health Corp., Walgreens Boots Alliance Inc., and Rite Aid Corp. will take effect and reduce costs, Azar said.[20,21]

Opioid Crisis The opioid crisis has been a high priority for federal, state, and local governments. In 2017 President Trump deemed the opioid epidemic a public health crisis and subsequently began directing funds and resources to the epidemic. In September the administration announced $1.8B in funding to states to continue to combat the crisis: the CDC wad allocated $900M over a three year period to advance the understanding of the epidemic and improve access to prevention and treatment efforts to states; $932M was furnished to SAMSHA as part of its State Opioid Response grants available to all 50 states.[22]

According to HHS, the administration's efforts have helped nearly 1.27M of the 2M individuals afflicted by the opioids receive medication-assisted treatment services.[23]

Since 2016, Illinois has received four SAMSHA and HHS grants totaling over $110M to address the state's opioid epidemic. Nearly one-third ($33.5M) of the funding was awarded in 2019 to expand medication assisted treatment (MAT) services, increasing public awareness, and initiatives to reduce opioid overdose.[24] As of December 2019, 19,871 individuals with an opioid use disorder have been served through the initiatives funded by the Opioid Crisis Response grants.[25] Three of the four grants expire in 2020, and the state estimates an additional $29M in grant funding in 2020.[26]

Public Charge Update In August, the U.S. Department of Homeland Security published the final charge rule with an effective date of October 15. The new policy for "Inadmissibility on Public Charge Grounds" makes it more difficult for immigrants to seek citizenship based on the propensity to need public assistance.[27] The factors that determine the need include if the individual is already using benefits such as food stamps, housing subsidies, or Medicaid. The previous policy only used Medicaid as evidence is the benefit was used for nursing home or long-term care payment.[28]

Cook County Health estimates that 1.7M Illinois residents could drop out or not apply for public benefits due to the rule changes, causing a $30M impact.[29] Numerous health care providers and policy and advocacy groups – including Howard Brown Health, Cook County Health, and Everthrive Illinois – released statements opposing the public charge rule.[30-32]

Nationally, the announcement was met with fierce opposition by states and health care groups.[33] In August 2019, Illinois joined 12 other states in a federal lawsuit opposing the plan.[34] On October 11, days before the rule was supposed to go into effect, three states – New York, California, and Washington – issued temporary injunctions against the public charge rule preventing it from going live.[35] Numerous other states followed suit completing similar filings. On October 15, hours before the rule was supposed to go into effect, a federal judge

in Chicago issued an injunction stopping the rule.[36] In December 2019 and January 2020, three courts – the 2nd U.S. Circuit Court of Appeals in Manhattan, the 4th Circuit in Richmond, and the 9th court in San Francisco – declined the Trump administration's request to lift an injunction on the "public charge" rule.[37]

Despite these legal proceedings, the administration currently has the authority to finish operationalizing the updates to the rule, meaning an extended plurality of documented, non-citizen immigrants, may struggle to gain access to needed medical services. In the short-run, this does not portend any destabilizing effects on communities or the health system at large. However, if left unabated, decreased access to core services could exacerbate health disparities and could have the unintended consequences of further poverty, crime, and socioeconomic erosion.

Costs and Transparency On November 15, the Centers for Medicare & Medicaid Services (CMS) released two rules to carry-out President Trump's Executive Order[38] on Improving Price and Quality Transparency in American Healthcare. The first is a final rule that would require hospitals to publish payer-negotiated prices beginning in January 2021. The second is a proposed rule that would mandate insurers to post online real-time costs to allow patients to get advanced estimates of their out-of-pocket costs before they see a doctor or go to the hospital.

Hospitals and insurers are pushing back on both rules. Some health care groups have argued that the approach could cause prices and premiums to increase. Others have noted that it is not clear if the rules will actually go into effect since earlier this year a federal judge ruled that the administration exceeded its regulatory authority with a similar price transparency rule directed at pharmaceutical companies.[39]

In December, a coalition of hospital groups including the American Hospital Association filed a lawsuit to block the final rule that would mandate hospitals to disclose negotiated rates with insurers. The groups argue such a requirement violates both the First Amendment and the ACA, and that the cost of compliance would exceed the administration's estimates of $38.7M to $39.4M annually.[40]

The federal government has been very active in proposing bills to support lowering drug prices using a myriad of strategies. In July the Senate announced a bipartisan proposal suggesting capping on price increased for Medicare Part B and D and capping patients out-of-pocket costs Medicare Part D costs at $3,100 effective in 2022.[41,42] In September, House Speaker Pelosi announced the "Lower Drug Costs Now Act of 2019" which gives Medicare the ability to negotiate drug prices.[43] The House voted 230-192 to pass Speaker Nancy Pelosi's legislation; however, the bill is all but certain to die in the Republican-controlled Senate.[44]

In November, the Trump administration announced the anticipated release of another plan that would allow states to import cheaper prescription drugs from Canada, known as the International Price Index.[45] The following month (December 2019), the Trump administration released two proposals to lower pharmaceutical prices in the U.S. Collectively, the proposals would effectuate the drug importation action plan released in July.[46] Both parties remain committed to finding a solution before the 2020 elections.

In September, the Illinois Health and Hospitals Assocation (IHA) published comments strongly opposing the proposal to publish hospitals negotiated rates. The IHA cites significant patient confusion and substantial administrative burden for hospitals as reasons for opposing the proposal.[47] They state health plans are best poised to engage in transparency and patient education initiative.[48]

Health Information In February 2019 HHS released two proposed regulations that would give patients increased access to their health records and prevent information blocking. The first rule,[49] issued by the Office of the National Coordinator for Health Information Technology (ONC), would implement key provisions of the 21st Century Cures Act, including provisions designed to advance interoperability; to support the access, exchange, and use of EHI; and address occurrences of information blocking. The second rule,[50] issued by the CMS, outlined opportunities to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats while reducing restrictive burdens on health care providers.

Both rules – still under review by the Office of Management and Budget (OMB) – have been met with mixed industry reactions. In official comments to the ONC, the AMA[51] noted that the proposed rules "may result in a patient's information being shared with third parties—including those under no obligation to keep information private—in a way the patient didn't foresee or want." A few months later (September 23, 2019), seven major provider groups – including the AMA – wrote a letter[52] to Senate and House leaders, urging them to release interim rulemaking to allow agencies to address numerous industry concerns. Vendors, most notably Epic,[53] have also voiced concerns that some of the provisions could limit innovation. Most recently, a group of approximately 40 individuals representing payers, providers, and vendors, met with the OMB to urge the agency to finalize and release the proposed interoperability rules "without further delay."[54]

On July 30, 2019 CMS Administrator Seema Verma announced a pilot program to put claims data directly into the hands of health care providers and clinicians. According to CMS officials, the Data at the Point of Care[55] pilot will fill in the data gaps for providers by giving them access to claims data information (e.g., previous diagnoses, past procedures, and medication lists) via Medicare's Blue Button.[56] Providers can request access to the pilot via the program website. CMS committed to start sending test data to the first few providers in August and start testing with production data in September and October.[57]

The Department of Healthcare and Family Services (HFS) in Illinois spent time in 2019 evaluating the potential of establishing a state-wide ADT (Admission, Discharge, Transfer) system capable of providing basic information to qualified stakeholders regarding core events pertaining to patients. In January 2020, HFS released an RFP seeking a technology solution that could advance this functionality throughout the state.[58]

ILLINOIS STATE

Democratic Governor JB Pritzker was sworn into office on January 14, 2019. Pritzker's major health care campaign promises centered around the preserving Medicaid expansion funding and developing IllinoisCares, a Medicaid buy-in public option ensuring low-cost accessible care for all.[59] At the end of 2019, the public option had still not been announced; however, the state had addressed a multitude of health-related legislation throughout the year.

Budget and Capital Plans In February of 2019, Governor Pritzker delivered his first budget address, proposing re-prioritized and controlled spending in three targeted areas: education, health and human services, and public safety. The governor also proposed, and later signed, a number of provisions to generate $1.1B of new revenue to offset the cost of new programs.[60]

One revenue generator was a proposal to legalize and regulate adult-use cannabis. The governor stated the legalization would bring new jobs and nearly $170M in licensing and other associated fees.[61] On June 25, 2019 Governor Pritzker signed legislation that legalizes cannabis effective January 1, 2020. Another revenue driver is an assessment tax on Medicaid managed care plans, which would yield over $867M in new revenue. These funds will be used to help stabilize the Medicaid budget by reducing the reliance on General Revenue Funds.[62]

Prior to finalizing the proposed budget in May, Governor Pritzker announced a comprehensive $41.5B multiyear capital plan titled "Rebuild Illinois,"[63] of which $465M is allocated to investments in health care and human services.[64] The funding will go towards the following initiatives: construction and rehabilitation of affordable housing ($200M), community health center construction grants for capital improvements to new or existing sites ($50M), hospital and health care transformation grants to help-low income communities with high numbers of Medicaid patients to ensure Illinoisans have access to needed medical care ($200M), and a human services community development infrastructure grant program that focuses on upgrading facilities that provide a range of social services to vulnerable and special needs populations ($15M).[65] The "Rebuild Illinois" bill passed in June placing new taxes in effect July 1.

Public Health and Social Determinants of Health Governor Pritzker made many legislative decrees during his first year in office that impact the public health and

health outcomes of Illinois residents. In February, the governor signed historic legislation making Illinois one of the first states to raise the minimum wage to $15 per hour by 2025.[66] Illinois last raised the minimum wage in 2010 to $8.25.[67] The path to $15 per hour includes a $1 increase in wages below $15 effective January 1, 2020, with subsequent annual $1 increases until achieving $15.[68] Increasing the minimum wage can have important health benefits such as reducing absences due to illness and the prevalence of smoking and low birth weight.[69]

Over the past several years, many Illinois municipalities began increasing the purchase age of tobacco, e-cigarettes, and other nicotine products from 18 to 21. In 2016, Chicago raised the tobacco age, instigating a 5.5 percent (from 15.2 percent to 9.7 percent) decline in cigarette and e-cigarette users among 18-20 year-olds.[70] In March, the Illinois House and Senate passed HB 345, increasing the tobacco purchasing age across the entire state.[71] The law seeks to decrease the overall rate of smoking by 12 percent with the biggest decrease among youth.[72] Governor Pritzker signed the bill in April and the legislation went into effect on July 1.[73] Illinois was the seventh state (of 16) in the U.S. and the first in the Midwest to raise the purchasing age.[74]

In October, Governor Pritzker in conjunction with the Illinois Criminal Justice Information Authority announced $2.8M in grants to support trauma recovery centers statewide.[75] The trauma recovery center model engages patients who have experienced trauma by providing comprehensive clinical, case management, mental health, and advocacy services while addressing underlying tangible social needs as well.[76] Trauma recovery centers outside of Illinois have successfully improved health and functioning for trauma survivors, reduced overall costs of care, and increased self-reported patient satisfaction.[77]

While the federal government has been very active in proposing bills to support lowering drug prices using a myriad of strategies, Illinois has concurrently taken action to rein in high drug costs. In August, Governor Pritzker signed Bill 465, which takes steps to regulate pharmacy benefit managers (PBMs) and lower prices for consumers.[78] The law requires insurers to apply medication discount cards or vouchers to a consumers deductible or copay, prevents clauses that limit pharmacists when advising patients when lower costs alternatives may be available (i.e., when paying cash is cheaper than insurance), protects emergency room medication coverage, and provides greater levels of transparency in the pricing and reimbursement models.[79] The law took effect on January 1, 2020.

Medicaid Reform As of August 2019, nearly 2.1M of the state's 2.9M Medicaid members were enrolled in an Medicaid Managed Care Organization (MCO).[80] In an effort to strengthen the relationship between MCOs and HFS, the house and senate unanimously passed SB1321, the Medicaid Omnibus Bill, in June and the bill was signed into law in August.[81]

The Medicaid Omnibus Bill is a multi-agency lead, bipartisan effort to expand health care to Illinoisans and reform common Medicaid challenges faced in Illinois.[82] The bill addresses MCO transparency by requiring MCOs to report their Medical Loss Ratio and update their provider roster every 30 days.[83] Greater transparency will support fixing challenges such as the backlog of Medicaid applications that have not been processed within 45 days of their submission. As August 2019, 95,000 applications had not yet been reviewed.[84] The bill aims to improve the medical redetermination process responsible for reviewing eligibility for those whose coverage was discontinued by streamlining the processes.[85]

The bill also addresses the need for greater HFS oversight across the six MCOs offered in Illinois, an issue that hospitals have advocated for, and requires insurers to pay complete claims within thirty days or face a penalty.[86] In an effort to standardize processes and operations to lower denial rates, regulations are also set forth requiring HFS to stand up a new claims clearing house to collect, analyze, and adjudicate medical claims.[87] HFS will also develop a provider communication platform enabling greater transparency and allowing providers to submit complaints, which will help HFS manage conflicts systematically.[88]

In mid-2018, HFS introduced the concept and implementation of an Integrated Health Home (IHH) model for the entire Illinois Medicaid population.[89] This

program outlined principles of a person-centered, fully integrated, financially sustainable model of care.[90] In November of 2018, the auto-enrollment into integrated health homes was delayed until March 2019.[91] The following month, HFS announced a postponement of the entire program until further notice. The announcement also introduced the inclusion of patient choice in the program, allowing beneficiaries to choose their own provider.[92,93] The program was continually delayed throughout 2019. In August, HFS hosted a townhall sharing potential plans for a child and adult focused IHH model. The details shared in August seemed to have fewer restrictions that the original IHH proposed in 2018.[94] As of January 2020, the program is proposed to being April 1, 2020.[95]

In further efforts to expand access to Medicaid, HB72 was introduced in April 2019. The bill expands Medicaid coverage to Deferred Action for Childhood Arrivals (DACA) recipients and Legal Permanent Residents (LPRs) under five years.[96] According to Healthy Illinois, the goal of the HB72 is to "improve health outcomes for tens of thousands of vulnerable, low-income residents, and to increase our economic prosperity by relieving the financial burden of uncompensated care costs on uninsured individuals and health care providers."[97] According to the U.S. census, in 2016 there were approximately 79,000 DACA recipients living in Illinois, 60 percent of which were already insured.[98]

CITY OF CHICAGO

Similar to the state, the city of Chicago saw legislative changes at the beginning of 2019. Early in the year there was a high-profile and crowded race for the seat of Chicago Mayor. The initial election, which took place in February, yielded no majority. A runoff election took place in April between lawyer and activist, Lori Lightfoot and Cook County Board President, Toni Preckwinkle. With nearly 74 percent of the votes, Chicago elected its first African American woman mayor, and first openly LGBTQ+ to lead the city. Mayor Lightfoot was sworn into office on May 20, 2019, making Chicago and nationwide history.

Lightfoot's Campaign Promise Mayor Lightfoot's campaign outlined a seven-point plan prioritizing the health of all Chicagoans. The seven points included:[99]

1. Prioritizing mental health services by expanding capacity with behavioral health providers, increasing access to mental health services and fighting mental health stigma
2. Eliminating lead contamination in the city's drinking water through assisting in the removal and replacement of all remaining lead service pipes, as well as testing and providing resources for children affected by high concentrations of lead
3. Treating violence as a public health crisis and working to both tackle the root causes of violence and prevent it from occurring in the first place
4. Tackling racial disparities among children and adults affected by asthma through inter-agency cooperation and ensuring access to care
5. Addressing Chicago's opioid crisis
6. Reducing maternal morbidity and mortality rates
7. Expanding access to health care through public health clinics.

Mayor Lightfoot's transition committee issued a report outlining the mayor's key focus areas and proposed course of action. In the area of health and human services, the committee included social determinants of health and emphasized the lack of equity across neighborhood lines. The committee recommended a trauma informed and equitable approach to the initiatives the administration should accomplish within the first 100 and long term, in addition to increasing access to housing and home ownership, gun violence prevention, and access to universal pre-k education.[100]

2020 Budget On October 23, 2019, Mayor Lightfoot publicly released her 2020 budget which some criticized was not aligned close enough to campaign promises.[101] Lightfoot's 2020 budget earmarked $9.3M for the Chicago Department of Public Health's, "Framework for Mental Health Equity" to increase mental health care capacity among 20 existing clinics across the city (five CDPH and 15 others publicly funded).[102] The budget proposal did not include re-opening the six mental health centers closed in 2012, a promise Lightfoot made during her campaign.[103] On November 5, 2019, a statement from the mayor's office stated 22 partner organizations had

endorsed the proposed "Framework for Mental Health Equity."[104] According to Crain's, "The framework focuses new investment on mental health care accessibility, ensuring "victims of violence receive mental healthcare in the neighborhoods hardest hit by trauma" and strengthening crisis prevention and response outside of clinics."[105]

The 2020 budget also included funding for community initiatives that impact some of the most pressing social determinants of health. The budget provided $10M to affordable housing and homelessness efforts, increasing the budget for homelessness prevention by 36 percent and the number of affordable units for Chicago's low-income renters by 19 percent. The city has committed a $5M increase in the Flexible Housing Pool and another $5M has been committed from the Low-Income Housing Trust Fund. Altogether, the investments will provide affordable housing to more than 700 new households.[106]

HC3 VIEW: GOVERNMENT'S ROLE

The political turmoil at a national and state level served as an impediment to substantively improving the conditions under which the health system operates. The national focus continued to be firmly rooted in long-standing litigation over the legitimacy of the ACA and key questions of health insurance and access, while less attention was paid to the more fundamental defects in the country's health system in dire need of redress.

For its part, the continued changes made to the state's managed care program have only served to sow discord and administrative lags – as MCOs work to keep up, providers seek to accelerate the pace of payment, and patients continue to see discontinuity of care and inadequate access to other important services. While Chicago has some of the finest safety net resources of any major city in America, our collective failure to appropriately align the interests of the tax payers, policymakers, managed care, delivery institutions, medical professionals, and ultimately the patients serves to exacerbate efficiency and funding gaps that renders our system suboptimal.

There is an emerging consensus that Illinois has an opportunity to abandon the inconsistent policies of the past and advance a bold vision for Chicago and the state that could demonstrate what true health care transformation looks like. Importantly, we believe policymakers should focus on the following key areas in the months and years ahead:

1. Incentivize an accelerated path to alternative payment models under the Medicaid program that would drive shared accountability and financial risk-sharing between appropriate parties
2. Leverage transformation funding to support efforts that seek to rationalize health assets in the community, divesting of unnecessary infrastructure and investing in areas of social, mental, or chronic disease supports capable of elevating the health of a community
3. Establish medical districts that allow for the advent of health utilities that are collectively charged with organizing the biopsychosocial resources of a community in service of improved health
4. Normalize the tax structure to provide for subsidies that would drive ongoing research and development in life sciences, both through academic institutions and the pharmaceutical complex more broadly
5. Establish utility systems – ranging from ADT systems (above) to community referral platforms, primary care capacity management systems, mental health service capacity management systems, etc. – that allow for basic information sharing to better enable coordination between hospitals, medical professionals, community-based organizations, and others
6. Accelerate the operationalization of the IHH program, paying close heed to the admonition of stakeholders articulating the key requirements for economic sustainability required to structurally improve the integration of behavioral health and primary care professionals
7. Mandate performance-based Medicaid payments that incentivize recovery and not relapse to reform the state's addiction treatment and recovery industry
8. Tactically identify key infrastructure gaps that keep vulnerable communities isolated and bereft of the social connectedness and integration that fosters economic opportunity, safe and affordable housing, child care, and access to healthy food.

INDUSTRY TRENDS

Closures, Mergers, Acquisitions, and Openings

Health care providers in every market across the U.S. want to increase their presence in the market they serve. Chicago is no different. As groups like Northwestern Medicine and Advocate-Aurora Health fight for control of Chicago, acquisitions become increasingly appealing, especially when observing national trends. According to U.S. News and World Report, between January 1-April 16, 2019, 17 important mergers or acquisitions happened nationwide: Cleveland Clinic purchased four hospitals, Ascension bought a $50M health plan, and Health Quest and Western Connecticut Health Network combined to form a $2.4B system.[107] Even though important mergers and acquisitions are happening all over the U.S., and many more occurred than just the 17 mentioned in the first quarter of 2019, sin 2019 one of the largest mergers and acquisitions took place in the Chicago area.

CommonSpirit In early 2019, Catholic Health Initiatives (Colorado) and Dignity Health (California) merged to become CommonSpirit, a $29B system that spans 21 states. Although the two systems are not based in the Midwest, they placed CommonSpirit's headquarters in Chicago. The new system will run 142 hospitals and 700 sites of care, employing about 150,000 people, 25,000 of which are clinicians.[108] The system will maintain a dual-CEO system, where the former CEOs from both organizations will essentially continue to run their own company separately. However, the two systems consolidated to better address social determinants and those who are underserved or uninsured. In the midst of these challenging goals, CommonSpirit's first fiscal year was not without difficulty. The health system reported losses amounting to $602M likely exacerbated by the difficulties of such a large merger.[109]

Subsequently CommonSpirit announced a $227M first quarter loss for fiscal 2020, according to Modern Healthcare. This daunting number amounts to four times what the health system saw in the fourth quarter of 2019. The system blames not including California provider fee revenue as the main reason for the staggering loss. However, even in the California revenue is recognized, their losses would be at $119M, which is still double losses recorded the previous year.[110]

Thus far, there is little evidence that CommonSpirit aspires to form a meaningful relationship with the city of Chicago; there are no signs of developing a clinical footprint, nor is there any substantive engagement in the city's health care ecosystem that would portend the entrance of a new value-adding partner.

NorthShore + Swedish Covenant NorthShore University HealthSystem (NorthShore) has shown a clear focus on consolidation over the last few years. The four-hospital system nearly became part of Advocate Healthcare in 2017, before regulators blocked the deal. In July of 2019, NorthShore announced that they had penned a deal to acquire Swedish Covenant Hospital in the Ravenswood neighborhood. Swedish Covenant, a 312-bed hospital, had already been on the brink of a buyout earlier. Rush System for Health attempted to acquire Swedish Covenant, with talks falling through in the Spring. Federal and state regulators approved NorthShore's acquisition last fall and the deal closed on January 1, 2020.[111] Now, Swedish Hospital (formerly Swedish Covenant Health) is officially part of NorthShore University HealthSystem (NorthShore)—complementing the north suburban health provider with a fifth hospital, its first in 11 years and its first-ever hospital in Chicago.

OSF HealthCare + Little Company of Mary OSF HealthCare of Peoria, Illinois will officially move into the Chicagoland hospital market in early 2020. In July OSF announced that they agreed to merge with the heavily sought-after Little Company of Mary. Located in Evergreen Park, Little Company has been involved in consolidation talks with various systems in Illinois. The hospital ended talks with Rush System for Health in 2018 after months of back and forth. Little Company features 12 care sites based around a 298-bed hospital located southwest of Chicago.[112] In early December, the state facilities review board approved the merger.

Loyola Medicine + Palos Health After a non-binding letter of intent to merge in January, Loyola Medicine and Palos Health decided against a merger in May. Loyola and Palos are working together on a number of other projects and will continue to do so regardless of their inability to complete a merger. Loyola Medicine, a three-hospital system based in Maywood, is part of the notable Trinity Health based in Michigan and one of the largest Catholic

health systems in the country. Palos Health is centered around their 528-bed hospital in Palos Heights and boasts a number of other impressive ambulatory facilities.[113]

Cook County Health The state granted Cook County Health approval to build an eight-story replacement of Provident Hospital. Estimated at $240M, the new space will be built adjacent the current hospital located in the Bronzeville neighborhood on the South Side of Chicago. The new hospital will have 42 beds, compared to 79 at the current site, but will have 70 outpatient exam rooms in an effort to stay with the trend of outpatient over inpatient care. The project is expected to be finished around April of 2023 with plans to demolish the old hospital once the new facility is completed.[114]

Blue Cross and Blue Shield of Illinois (BCBSIL On April 27, 2019, Blue Cross and Blue Shield of Illinois (subsidiary of Healthcare Services Corporation) opened their first community center in the Pullman neighborhood on the South Side of Chicago. Entitled the Blue Door Neighborhood Center, the center's goal is to engage all members of the community, BCBSIL clientele or not, in health and wellness activities. Specifically, the center will have classes and programs centered around chronic disease (such as diabetes and heart disease), behavioral health, fitness, and wellness. The center also aims to educate people about the need for health insurance and community involvement in resources, which can provide necessities like food and transportation.[115]

BCBSIL broke ground on a second facility on the South Side in Morgan Park, much like the first community center in Pullman. The project, which involves repurposing a recently-closed Target, will be done around the middle of 2020 and add up to 550 jobs. The center will have similar programs to those available at the Pullman location but will also include other BCBSIL employees related to the health insurance side of the business.[116]

Westlake Hospital + Pipeline Health The for-profit health care providers were increasingly challenged in the Chicago market throughout 2019. In January, for-profit health care giant Tenet Health officially relinquished their remaining three Chicago hospitals to another for-profit company, Pipeline Health. The three hospitals – Westlake Hospital in Melrose Park, Louis A. Weiss Memorial Hospital in the Uptown neighborhood, and West Suburban Medical Center in Oak Park – were to be kept open regardless of poor financial outlooks for each hospital. In light of Pipeline's stated goal to keep the hospitals open, the CEO, Jim Edwards, said, "We feel strongly with our resources, our finances, our experience we can come in and make a difference, and, for lack of a better way to put it, save these hospitals."[117] Three weeks later, Pipeline announced they would be closing Westlake Hospital in the second quarter of 2019. Months after the hospital closed, the city of Melrose Park, Pipeline Health, area legislators, and citizens are still at odds. Regardless of Pipeline Health's continued presence in the area through their two remaining hospitals, their failure to deliver on their promise to keep Westlake Hospital open is a prime example of a for-profit health company's inability to successfully maintain its presence in the Chicago area.

Metro South Medical Center + Quorum Health MetroSouth Medical Center is a hospital in the south suburb of Chicago, Blue Island. Similar to Westlake Hospital, MetroSouth is owned by a for-profit health care organization, Quorum Health, and closed its doors in a move that has shocked the community. Quorum Health announced in June that if they did not find a buyer by the end of the year, they would shut down the hospital. Immediately, employees, citizens, and politicians spoke out against the proposed shut down. However, before the state review board could authorize the closure, as is necessary, Quorum announced that the hospital would close at the end of September instead of the end of the calendar year. Hospital closures hit communities hard. They result in a lack of necessary health care, especially in emergency instances when ambulances would have gone to MetroSouth but will now have to drive further to another hospital. Closures also resulted in huge employment losses (MetroSouth had over 800 employees) and business that comes to the community through hospital-related traffic. The MetroSouth closure is an occurrence that is sadly becoming more frequent. Instead of abruptly closing facilities and abandoning communities, health care providers need to be smarter about adapting care that is sustainable. The future of health care is not the hospital; however, the irresponsibility involved in closing facilities without pause or solutions is dangerous.

HC3 VIEW: SYSTEM TRANSFORMATION

Last year we said it was unlikely that we would see any other blockbuster M&A activity and we continue to hold to that assertion. We believe that over the next five years, hospitals will evolve their growth through the following three patterns:

- Acquire other remaining stand-alone facilities whose profitability and performance could be improved by achieving certain economics of scale or efficiencies with a larger system
- Expand beyond the core clinical footprint to other regions and states
- Aggregate safety-net institutions to close the efficiency gap in underserved communities

For the last point, we believe the underlying economics of safety-net institutions threaten to create a situation of unfunded liabilities that policymakers will be increasingly loathed to satisfy. Recently, there has been activity seeking to consolidate certain entities in pursuit of ensuring hospitals remain open while right sizing assets in the community.

However, the broader markets accelerated creation of niche solutions and technology advents may carry equal disruptive power, as an increasing number of entities have isolated attractive economics to keeping patients out of hospitals and focused on longer-term improved care.

For managed care, we anticipate that CountyCare will seek some key strategic partnership or may end up transferring or selling its assets to another party as a means of securing needed financial resources that could be applied to the broader stability of the system. Under the second scenario, it's possible that we may see the entrance of a new managed care entity. Rumors are swirling that CareSource, a regional Managed Care Organization based in Dayton, OH, may well enter the market. Centene's acquisition of Wellcare will make the organization formidable in its influence over the Medicaid program, despite its sale of IlliniCare to CVS Aetna.

We anticipate Medicare Advantage will continue to grow on two fronts. First, Chicago's comparatively lower penetration and adoption of Medicare Advantage by its seniors is poised to change as community organizations and technologists are increasingly driving messaging intended to catalyze increased adoption. Secondly, there is an emerging trend of specialty programs (called special needs plans or SNPs) that can yield higher margins and potentially deliver better care. Niche and locally sourced players are likely to quickly move into these areas as a means of staking land that has not been claimed by the larger, national Medicare Advantage firms.

EXECUTIVE LEADERSHIP MOVEMENT

As mergers and acquisitions in the Chicago health care market continue to increase, a related spike in movement among executives at those institutions is natural given duplicative roles. Although mergers and acquisitions seem to have a been a driving force behind many executives leaving last year, as exampled below, there are other common threads which underline much of the executive movement.

Amita Health Chief Executive Officer Mark Frey stepped down in late August of 2019. Founded in 2015, Amita is a joint venture between Ascension's Alexian Brothers Health System and Adventist Midwest Health. After the merger, Amita became the largest hospital system in Illinois with 19 hospitals. The system also boasts 230 outpatient sites and 900 providers. In addition to running the joint venture, Frey was focused on integrating Presence Health into Amita, after Ascension bought the struggling health system.[118]

Along with the loss of their system CEO, Amita lost five other regional chief executive officers between February and September of 2019, according to Crain's. The five CEOs were responsible for eight of the system's 19 hospitals. Ultimately, because Amita is a relatively new health system attempting to integrate 19 hospitals and all that comes with those facilities, such a significant loss in hospital-level leadership in a short period of time speaks to their ongoing struggle.[119]

The Rush University System for Health president, Michael Dandorph, announced in late September that he would be stepping down from his role to pursue other interests. Dandorph was the president for about

two years, building up Rush's outpatient presence and completing a new $450M center for cancer and neurosciences.[120] His resignation came in the wake of the retirement of longtime Rush CEO, Larry Goodman. Because Goodman was responsible for such a large array of work, his duties were assumed by two people. The dean of Rush Medical College and senior vice president of the Medical Center, Dr. Ranga Krishnan, filled one of those roles as CEO of the Rush University System for Health. Dr. Omar Lateef, the former medical officer for the system and the medical center, absorbed the other half of Goodman's former duties and was given the title of CEO of Rush University Medical Center.[121]

AdvocateAurora Health system dropped their co-CEO model approximately one year after their merger was finalized. The system announced that Jim Skogsbergh, former CEO of Advocate Healthcare, would take over full responsibility from his counterpart and former co-CEO, Nick Turkal, MD.[122]

Dr. Richard Gilfillan announced his resignation as CEO of Michigan-based Trinity Health, a three-hospital system (Loyola Medicine in the west suburbs of Chicago and Mercy Hospital & Medical Center in Chicago are owned and operated by Trinity Health). Gilfillan was named CEO a month after Trinity Health merged with Catholic Health East. Tasked with integrating two large systems, he was responsible for leading Trinity Health to both clinical and financial success. In 2018, Trinity Health had a revenue increase of 4.1 percent, resulting in a total revenue of $18.3B. Gilfillan was replaced by former president and chief operating officer for the system, Michael Slubowski.[123]

In late July, Healthcare Services Corporation (HCSC) CEO Paula Steiner abruptly announced her resignation. Only days later, the company's CFO, Eric Feldstein, resigned as well. Both Steiner and Feldstein had served in their roles for about three years, leaving on private and uncertain terms. However, not long after, it became public that the HCSC board was tired of Steiner's cautiousness in the face of rampant consolidation in the commercial insurance sector. Consolidations are quickly changing the market landscape (e.g. Aetna and CVS merged in a deal worth $70B). Steiner and Feldstein clearly did not see the same need for aggressive recourse as the board did and there was a mutual severance. Chief Information Officer Steve Betts, Chief Human Resources Officer Nazneen Razi, and long-serving board member M. Ray Perryman, all stepped down since the exodus of Steiner and Feldstein. Betts and Razi served in their roles for five and eight years, respectively. Perryman had been a board member since 2002, capping off the long list of puzzling departures at HCSC. Because the commercial insurance provider has been trending strongly, many will be waiting anxiously for future news and 2019 financials, in light of recent changes.

In late November of 2019, only one day after the County Board approved a $6.2B spending plan,[124] Dr. John Jay Shannon's contract as Cook County Health CEO was not renewed. According to sources, leadership unanimously voted on the decision during the executive session of hospital's board meeting on November 22.[125] Over his five-plus year tenure as CEO, Shannon led the hospital system through a transformative time; spearheaded County Care, the largest Medicaid health plan in the county; and diligently worked to fulfill the county's mission of providing care to all residents, regardless of their status. Despite his reduction of reliance on taxpayer dollars,[126] he faced tremendous financial pressures to relieve the financial burdens on the system, specifically around charity care. He publicly addressed the dramatic increase in charity care coverage of the Cook County Health at a City Club event in October, calling out the private hospital leadership teams on their regular "dumping" practices of uninsured or underinsured patients in need of complex treatment or care.[127] County Commissioner Larry Suffredin stated, "The system is in better shape than when he started, there will be an opportunity for others to look at it and meet the challenge of growing uncompensated care that the system face." During the transition and search for new leadership, Debra Carey will serve as the interim CEO of operations for Cook County Health starting on January 1, 2020.

HC3 VIEW: LEADERSHIP EVOLUTION

In 2019, some incredible leaders left the city's system in favor of a newer generation. Notably, a couple of key leadership changes were not planned events, but the result of political tensions or philosophical disagreements. Regardless, installing a new leader requires an organization to undergo the significant process of adapting to the new leader's vision or operating edict.

We are concerned about the long-term veracity of the Cook County Health as it seeks to navigate a highly complex environment with a disproportionate volume of charity care and the absence of a long-term CEO to chart a path.

We remain optimistic that Rush's new leadership will pick up the mantle left behind by Dr. Goodman and Mr. Dandorph in their efforts to extend Rush assets and resources to have impact on the vulnerabilities felt by west side neighborhoods.

Finally, the leadership transition at HCSC represents an opportunity to select a new slate of leaders that can successfully marshal the firm's resources for growth while also taking a bold leadership position in the emerging sciences of health that demonstrate the converging values of social supports, mental health, and improved chronic disease management for improving the health and vitality of communities.

INSURANCE COVERAGE

In 2019, the Illinois state exchange, known as Get Covered Illinois, involved five health plans: Celtic, Health Alliance Medical Plans (HAMP), HCSC (BCBSIL), Cigna, and Quartz (newcomer, Wisconsin-based). Although Get Covered Illinois has seen large cuts to funding and number of employees, 312,380 were enrolled in 2019 according to the CMS.[128] Upon finalizing rates for 2019, three of the five insurers offering exchange plans increased their rates. Celtic was the only insurer to average a decrease in rates by about four percent from 2018.

Enrollment for 2020 plans began November 1, 2019 and ended mid-December, with plans becoming effective at the beginning of the new year. Just as for 2019, Celtic, HAMP, HCSC, Cigna, and Quartz are all participating in the state exchange. Celtic and HCSC both introduced a minor decrease in average rates (<1 percent), while HAMP offered an average decrease in rates around four percent. On the other hand, Cigna plans increased 5.8 percent on average, and Quartz rates went up an average of 5.3 percent.[129]

HCSC, based in Chicago, is one of the largest health insurance providers in the country. As a licensee of Blue Cross and Blue Shield, they sell Blues products exclusively to residents of Illinois, Montana, New Mexico, Oklahoma, and Texas. After modest gains from 2014-2016 (between $65 and $282M), HCSC boasted $1.3B in net income in 2017, followed by a $4.1B gain in 2018. Even though the $4.1B is largely due to a tax refund, the company did increase revenue by 10 percent, indicating a steady trend over the last four years. However, as previously noted, major leadership changes in the latter half of 2019 undoubtedly shook the company.[130]

Centene, WellCare, and IlliniCare In late March, Centene and WellCare announced that they would merge in a deal estimated at $17.3B. Their merged headquarters would be in St. Louis, Missouri, with current Centene CEO Michael Neidorff serving as chairman and CEO. The new entity would be 71 percent owned by Centene, with WellCare responsible for the remaining 29 percent.[131]

In a pointed effort to win over the state, Centene sold IlliniCare to CVS Health. According to Modern Healthcare, IlliniCare served about 20 percent of all Illinois managed Medicaid program. However, if Centene-WellCare did not sell IlliniCare, they would have controlled about 54 percent of the Illinois Medicaid market, making the merger unappealing before the IlliniCare divesture.[132]

Just after Centene announced they would be selling IlliniCare, the Illinois Department of Insurance approved the merger. Following approval from New Jersey, Centene and WellCare secured all of the necessary state approvals. The deal is currently pending final approval from the Department of Justice.[133]

Blue Cross and Blue Shield of Illinois Beginning in 2020, Blue Cross and Blue Shield of Illinois (BCBSIL) will add Northwestern Medicine to their provider network. Those enrolled in the Blue Choice Preferred PPO, which is available on the ACA's exchange, and their Medicare Advantage HMO will be included. Because BCBSIL is the state's largest commercial insurance provider and Northwestern is both large and consistently high-ranking in quality metrics, this relationship will likely lead to an increased level of access to quality care.[134]

HEALTH INNOVATION AND DIGITAL HEALTH

The digital health maturity continues to evolve as we enter the next decade. Cultivating the right conditions and environments to harness cutting-edge health innovation still remains challenging for the Chicago market compared to some of its coastal city counterparts like Boston and San Francisco.[135] In recent years, collaboration has been a key factor in the evolution of technologies and innovation in Chicago's health care ecosystem.

In February 2015, MATTER was founded with support from the city of Chicago and local businesses as a premier health care incubator and co-working space.[136] Over the past five years they have built a community of 200+ health care related startups and 60+ corporate partners from across the globe. In late September of 2019, MATTER announced an expansion to New York. According to Steven Collens, CEO of MATTER, the expansion will "create east coast opportunities for Chicago-based companies."[137] A large percentage of MATTER members are not Chicago-based, but the nexus of their efforts rooted in Chicago over the past five years combined with this extension to the east coast will potentially drive new investments to the Chicago's hub and by extension the local market.

Fueled by a shared vision to reinvigorate Chicago's tech community, P33 is an initiative that was launched two years ago, going live September of 2019.[138] Founded by Penny Pritzker and Chris Gladwin to foster better connections between Chicago stakeholders and the global tech and innovation community for better economic vitality. The mission of P33 is to capitalize on Chicago's greatest strengths and attract and keep capital in Chicago. According to Michelle Hoffman, P33 Senior Vice President of Life Sciences, the company's success in 5-10 years would include: more businesses headquartered in Chicago – specifically data analytics and engineering hubs; increased attraction of the best and the brightest talent in the tech workforce for the future; and, Chicago continuing to evolve into a place that incubates great ideas.

Chicago's health tech innovators and entrepreneurs can also expect some new-found support via the Pritzker Administration, which has already shown strong interest in new platform for government in health care. We expect to see more policy alignment to support system transparency and transformation, as well as investment in technology.

As health care costs continue to rise, everyone from payers to providers are looking for innovative ways to simplify processes to improve health outcomes. In the health care sector, technological advancements have generally lagged behind other fields. The most discernable path for health care industry advancement is to continue to cultivate digital solutions. Over the past decade, activity in the digital health space has traditionally been centered around the electronic health record market. In 2019, there was a noticeable rise in investments, as well as IPOs for digital health solutions.

Private health-tech companies have had high valuations, but few have gone public. Prior to 2019, the last IPO of a U.S. digital health company was in 2016. Six digital health platforms across the U.S. debuted IPOs last year, including Livongo which is headquartered in Mountain View, California, but has offices in Chicago and is funded by local investor, Seven Wire Ventures. Livongo was valued at $3.4B by the end of its trading debut in July.[139]

AVIA, a digital health solutions consulting firm founded by Abundant Venture partners and based in Chicago, is leading the Medicaid Transformation Project – a collective of 50+ health systems across the nation dedicated to digitally deployed transformational change to improve health care needs, while reducing overall cost of care.

HC3 VIEW: DIGITAL CHANGE IS COMING

The impact of digital solutions as a means of extending scarce resources in health care, improving workflow efficiency, enabling improved information sharing, and supporting key decision making, cannot be overstated. The sheer volume of point solutions in the digital market is disorienting. Certain categories have become quite mature and advanced, giving way to consolidation of key players. Under-developed categories continue to strive for proof-points and use cases necessary to achieve scale.

As these solutions continue to develop and proliferate, we anticipate strategic aggregators or platform entities will emerge to harness the collective power of these digital resources and apply these assets in modular ways to address core business and clinical objectives.

LIFE SCIENCES AND PHARMACEUTICALS

Life Sciences, and especially pharmaceutical, companies have a long history in the Chicagoland area. Although Chicago is lagging behind in optimal lab space for biomedical startups, the city and surrounding suburbs are ripe with pharmaceutical companies.[140] From startups like AveXis, which was sold last year for over $8B, to AbbVie, a North Chicago company that is has an annual revenue over $30B, Chicago is certainly ripe with players in the life sciences space.

North Chicago-based AbbVie Inc. is one of the largest pharmaceutical companies in the world. For years, they have relied on their flagship drug commonly known as Humira (adalimumab). In 2018, the drug was responsible for 61 percent of their $32B revenue.[141] AbbVie has relentlessly protected the drug, which is used to treat arthritis and other similar ailments, from potential generic versions via their patent. However, their ability to depend on the Humira is dwindling as a generic competitor has already been released in Europe, with U.S. versions coming in 2023 when their patent expires. In the meantime, AbbVie has been working hard with research and development in attempts to cover the billions that will be lost when their Humira (adalimumab) patent ends. In the past year they have received FDA approval for two new drugs: one to treat rheumatoid arthritis and another for plaque psoriasis.[142]

Although AbbVie expects to cover half of potential losses from Humira through new drug rollouts over the next five years, many experts saw a merger or acquisition as the company's best option for maintaining their status quo. In June, realizing the pressure they were under because of Humira's downward spiral, AbbVie acquired Irish drug maker Allergan. AbbVie announced that they would be selling $30B in bonds to cover a little less than half of the total $63B price tag on Allergan.[143] Allergan, who is also one of the largest pharmaceutical companies in the world before the merger, is best known for their wrinkle reducing solution, Botox. Allergan's Botox, along with a few other successful drugs, will likely boost AbbVie's bottom line but whether the North Chicago-based pharma giant's long-term security is yet to determined.[144]

In conjunction with the $350M AbbVie pledged last year in charitable contributions; they have donated $40M to rebuild the Neal Math & Science Academy in North Chicago.[145]

Astellas Pharma US Inc. (Astellas) and Amgen Inc. (Amgen) came to an agreement with the Department of Justice in April. Both pharma giants were accused of violating the False Claims Act by covering Medicare copays for their own products through independent companies. Astellas is responsible for a $100M fine. Amgen will cover the remaining $24.5M.[146] Both companies have offices in the Chicagoland area.

Chicago-based pharmaceutical company Novum Pharma filed for bankruptcy. As of February, the once notorious pharma company who raised prices of their eczema skin gel from $226 to $7,968 in 2016, is now defunct.[147]

AptarGroup Inc. of Crystal Lake, IL bolstered their pharma division through two acquisitions worth about $50M total.[148] The first company is Nanopharm, which specializes in drug delivery systems for respiratory issues. The second, Gateway Analytical, supports injectable medicine manufacturers with particulate detection services. AptarGroup is a health care and beauty product packing company; however, acquisitions such as these mark a focus on pharmaceutical-industry development.

II. SYSTEM TRANSFORMATION

MARKET FINDINGS

Alternative Payment Models

There is expectation among the payer community that movement into Alternative Payment Models (APMs), and therefore the transition to value-based care, will continue to increase.[149] In fact, a 2019 study (based on 2018 data) found that 91 percent of payers think as activity within Category 3 and 4, the more advanced of the categories, will increase.[150] This increase in APM activity, however, is also linked to provider consolidation: 56 percent of payers believe that adopting APMs will result in ever more consolidation among health care

providers.[151] Despite this expectation, the survey found that more than one-third (39.1 percent) of health care payments in 2018 had no link to quality and/or value.[152] While respondents (who were all payers) identified health plan interest and readiness as the top facilitator to APM adoption, they called out provider characteristics (e.g., willingness to take on financial risk, ability to operational APMs, and interest and readiness for APMs) as the top barriers to adopting APMs.[153]

While payers are looking towards the increase in APM activity, 2019 gave providers reason to pause. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), providers were given the opportunity to participate in APMs and receive bonus payments based on their performance. In 2017, the first eligible performance year, 99,000 providers were participating in MACRA-eligible APMs; CMS anticipates this number to grow to 403,306 (a 307 percent increase) for the 2020 performance year. However, as of October 2019, no provider who had participated in a MACRA-eligible APM during the 2017 performance year had received their bonus payments; providers who participated in quality programs under the Merit Based Incentive Payments System (MIPS) during the same performance year saw no interruption in their planned payment adjustment on January 1, 2019. The delay in incentive payments to APM-participating providers is raising concern among industry leaders: "If these payments are not made soon, we fear clinicians could be dissuaded from participating in Advanced APMs in the future, or worse, be forced to make difficult budgetary choices in the short-term that could hinder patient care or inhibit their ability to succeed in APMs."

There is also growing concern that APMs as they exist today are not benefitting the country's most vulnerable and high-risk patients. Two Chicago-based health care entities took steps in 2019 to start addressing this concern. During its Annual Meeting in June, the American Medical Association (AMA) adopted three policies to support its Health Equity Center's goal of, "enabling optimal health for all." Two of the policies focus specifically on APMs: linking quality measures to clinical outcomes most prevalent in high-risk and vulnerable populations and developing and implementing APMs utilizing these new linkages. The third policy commits the AMA to advocate for a redesign of risk adjustment methodologies used in APMs, ensuring that relevant clinical outcomes and social determinants of health are utilized when models are used around high-risk and vulnerable populations.[154] In September, The Alliance for Addiction Payment Reform (The Alliance), an initiative of Chicago-based Third Horizon Strategies, announced six pilots for its Addiction Recovery Medical Home – Alternative Payment Model (ARMH-APM). The ARMH-APM framework transitions addiction treatment away from an isolated model of acute care into an integrated chronic care model based on a system of bundled payments correlated to patient outcomes.[155] The Alliance will utilize findings from the initial pilots to understand how to best scale the model and which markets are most primed for its implementation.

VALUE-BASED CARE

Across the county, value-based health care contracts are growing in the commercial market; however, the amount of risk included is not substantial enough to implicate a movement away from fee-for-service. Some of the deterrents in moving providers to value-based care include a lack of transparency, poor data, and the use of generic quality metrics that vary based on commercial insurance payer.[157] One industry expert in Chicago emphasized another challenge: providers are increasingly challenged to make up their margins if they are unable to manage costs under the proliferating number of value-based contracts with Medicare. Commercial payer fee-for-service (FFS) contracts help providers remain "whole" when providers experience losses under Medicare contracts as they transition into value-based models. The ability for patients to self-refer to providers under commercial payer FFS contracts help providers in making up their margins; however, it prevents them from being able to truly manage the dollars associated with their patients' care, and thus poses challenges to successful performance under some value-based care models.

Chicago is particularly challenging for commercial value-based care contracts for two main reasons: 1) the

market has an abundance of providers for consumers to choose from when selecting their care and 2) HCSC is the dominant payer in the market. In 2019, HCSC had 71 percent of market share for commercial lives statewide.[158] With the lack of competition, HCSC has the negotiating power to establish contracting terms more in favor of the carrier over the patient and/or provider.

Despite these challenges, there is still movement towards value-based care in the Chicago commercial payer market. Last year the Blue Cross Blue Shield Association (BCBSA) announced a new nationwide high-performance network for 2021.[159] Launching in markets across the country, including Chicago,[160] the Blue High-Performance Network (Blue HPN) aims to drive beneficiaries to providers who consistently offer high-quality care at low cost. According to the BCBSA, existing value-based care contracts in the individual market yield the payer an average 10 percent of total cost savings on top of their current networks (Blue PPO, BlueCard, etc.).[161] The BCBSA sees the addition of the Blue HPN to its portfolio of plans as a way to expand value-based care outside of the individual market[162] and grow savings even further.[163] We will continue to watch how the Chicago market and associated players adapt to new value-based care initiatives.

MEDICARE

In 2018, the 47 Medicare ACOs represented across the state generated $91M in savings, a 14 percent increase from 2017.[164] While an increase, critics say there is an opportunity for much more savings and that hospitals have not fully embraced the transition to value and continue to benefit from traditional payment models. Models, such as Oak Street Health, that are taking full risk on Medicare patients are seeing significant clinical outcomes. In July, Oak Street Health reported 50 percent reduction in hospital admissions, 52 percent reduction in emergency department visits, 35 percent reduction in 30-day readmission rate, and a 90 percent retention rate with its patients.[165] Oak Street Health has not publicly shared their financial metrics.

Medicare ACOs will face operational changes in the new year. In July 2019, CMS announced the *Pathways to Success*, a redesign of the Medicare Shared Savings Program (MSSP) intended to, "encourage Accountable Care Organizations to transition to performance based risk more quickly."[166] Medicare ACOs in the program's BASIC track will begin under a one-sided model that automatically phases-in higher levels of risk over the five-year contract period; the highest level in the track will qualify as an Advanced APM as defined by the Quality Payment Program. The program's ENHANCED track is based on Track 3 under MSSP with added flexibility and resources to assist ACO's in optimizing their performance. While CMS sees Pathways to Success as integral in moving ACOs to risk and therefore helping the program realize savings promised under the original MSSP model, provider networks are hesitant: 2019 saw the first drop in ACO participation since 2012.[167]

In addition to changes in the Medicare ACO system, the federal government also looked to entice providers to assume financial risk through four additional value-based programs: Primary Care First-General, Primary Care First-High Needs Populations, Kidney Care First, and Comprehensive Kidney Care Contracting. The four voluntary programs included combinations of pay-for-performance and shared savings/risk models. However, in October 2019, the federal government announced a delay in the roll-out of these value-based models.[168] Despite a potential two-year delay in implementation, CMS is still encouraging providers to participate, with applications expected to be accepted in January 2020.[169]

MEDICARE ADVANTAGE

As of December 2019, 28 percent of Cook County's Medicare population was enrolled in a Medicare Advantage plan.[170] Despite a 1.4 percent increase over the same time last year,[171] the number is still below the national average of 34 percent.[172] According to Cook County Health, the top five plans in the market represent 77 percent of Medicare Advantage enrollees with no dominant player.[173] The low penetration, and therefore potential financial opportunities in the MA space, have attracted new entrants to the market.

For the 2020 coverage year, these new entrants include:

Ascension Complete Illinois AMITA Health announced the formation of Ascension Complete Health, which became available for communities served by AMITA Health

in Illinois January 1, 2020. The plan offering will initially rollout in four states with intentions to expand to all communities served by Ascension providers in the future. Ascension Complete Medicare Advantage was established as a joint venture by Centene Corporation and Ascension and will offer beneficiaries, "excellent care with predictable, affordable costs, and a simple, personalized experience."[174]

MoreCare a fully owned subsidiary of Medical Home Network, has collaborated with Cook County Health to bring more coordinated, individualized care to Cook County beneficiaries. The program also offers the first HIV-specific chronic condition special needs (C-SNP) plan for Medicare-eligible Cook County residents living with HIV. MoreCare's focus in the market will be to deliver whole-person care by integrating physical, behavioral, and social health.[175]

Zing Health The AMA's innovation arm, Health2047, has provided seed funding to Drs. Eric Whitaker and Ken Alleyne to develop the Medicare Advantage offering Zing Health. Available to Cook County residents beginning January 1, 2020, Zing Health promises to centralize care and improve patient outcomes through local care teams (rather than call centers) that are dedicated to addressing social determinants of health and care coordination efforts.

MEDICAID

2019 Enrollment and MCOs In 2019, there were six MCOs operating in Illinois, of which only two were exclusively offered to Cook County Residents. As of October, Cook County had slightly over one million residents enrolled in an MCO, nearly the same as October of 2018.[176,177]

Value-Based Initiatives Outcomes Medical Home Network (MHN), a Medicaid ACO operating in Chicago, published a case study in April outlining their program results. Findings show the MHN ACO participants decreased their utilization and had lower utilization when compared to the external network (See figures below).[178]

Outside of the MHN ACO, there is limited publicly-available resources on value-based care efforts for Medicaid in Chicago. Over the past few years, the focus has been on implementing and establishing a strong managed care network for Medicaid patients and we anticipate this will remain a focus as the Medicaid reform kicks off in 2020. However, we also hope to see more transparency on how value-based efforts in Illinois' Medicaid program is impacting its beneficiaries.

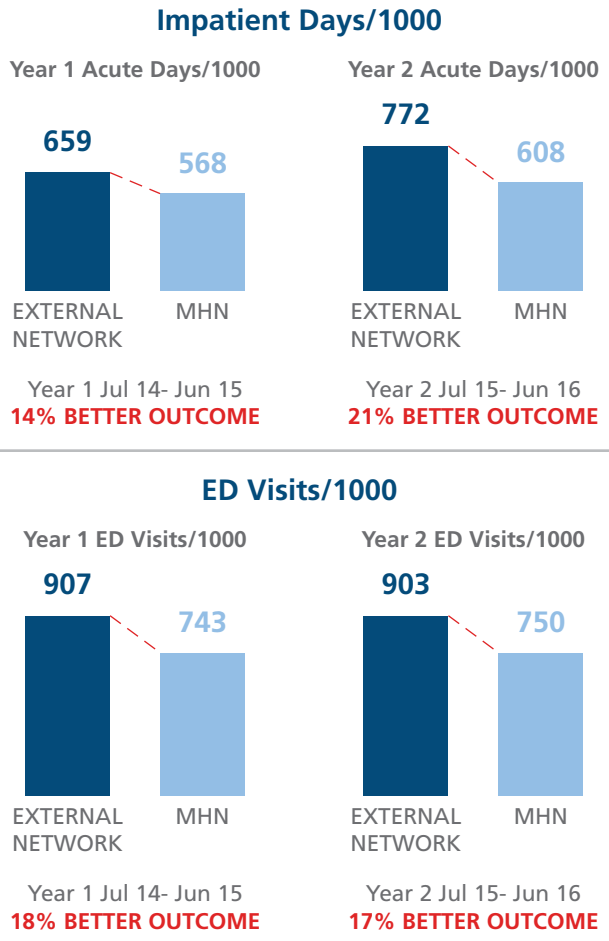
Figure 1: 2019 Medicaid Enrollment by MCO

MCO	Enrollment as of October 19	Market Share
BCBS Illinois	241,143	24%
IlliniCare Health Plan	107,769	11%
Meridian Health Plan	225,637	22%
Molina Healthcare	65,143	6%
County Care Health Plan	319,471	32%
Next Level Health Partners	54,554	5%

Figure 2: MNH ACO Performance Outcome (2012-2013) Versus a Baseline Year (2011)

Outcomes Measure	% Change Year 1	% Change Year 2
30-day Hospital Readmissions	-12.4%	-24.5%
Inpatient Hospital Days	-3.7%	-24.5%
Average Length of Stay	-5.1%	-20.2%
Cost of Care PMPM	-3.3%	-5.0&

Figure 3: Comparison of MHN and non-MHN Inpatient Days and ED Visits



Despite this focus, there was still movement in 2019 at the state level to help move Illinois' Medicaid program more into the value-based arena. In August, the Illinois General Assembly passed Public Act 101-0209, which amends the Illinois Public Aid code by adding a section on value-based purchasing within the Medicaid program. Per the new language, the state HFS and Department of Human Services (DHS) are to, "confer with stakeholders to discuss development of alternative value-based payment models that move away from fee-for-service and reward health outcomes and improve quality…"[179] Public Act 101-0209 also requires the HFS and DHS to present a relevant value-based purchasing model for behavioral health providers to the Illinois General Assembly by January 31, 2020, including "projections of the funding necessary for the model."[180]

In addition to legislation, the Illinois health care community began participating in a collaborative effort to move Medicaid towards value through a national learning collaborative. The Advancing Health Equity Learning Collaborative will support its seven state teams in, "designing or refining VBP [value-based purchasing] models that incentivize healthcare delivery transformation to reduce and eliminate disparities…"[181] Each state team will include representation from the state Medicaid agency, a Medicaid MCO, and at least one provider organization or system with a contract with the represented Medicaid MCO.[182] Illinois' team consists of HealthChoice Illinois, CountyCare Health Plan, Cook County Health, and Access Community Health Network. The Robert Wood Johnson Foundation-backed learning collaborative launched in October 2019.

HC3 VIEW: SYSTEM TRANSFORMATION

Currently there is seemingly one core catalyst to accelerated APM adoption in Chicago through the emergent exigent situation of the safety net itself. We believe that risk-bearing organizations will begin to move into underserved areas and seek to capture value by assuming a form of capitated risk in these markets.

Other examples of value-based care may emerge through select diseases or populations in bundles driven by commercial entities and patterned, in whole or in part, on programs similarly executed by CMS.

For it's part, the Center for Medicare and Medicaid Innovation (CMMI) will continue to operationalize changes to the ACO programs and specialty payment innovations (such as Community Paramedicine and CKD/ESRD models) while concurrently advancing transparency and information rules that accelerate conditions for improved clinical intelligence.

At the moment, there doesn't seem to be an accelerated path by the state to drive payment reforms. Further, the broader delivery ecosystem is geographically fragmented with certain local concentrations that market powers and factors are unlikely to motivate larger risk sharing arrangements in commercial settings.

HEALTH CARE WORK FORCE

Clinician Burnout

Recently the health care industry has taken a deeper look at burnout amongst providers. In 2016, a collaboration of 10 health system CEOs identified burnout among physicians as a "national health crisis."[183] This sentiment was echoed, and scaled up to a public health crisis, in the 2018 *A Crisis in Healthcare: A Call to Action on Physician Burnout* report.[184] In 2019, a *Medscape* report found 44 percent of physicians experiencing burnout.[185] The *Clinician Burnout in Healthcare* reported a 70 percent prevalence of burnout among a range of clinical staff.[186]

In the 2019 *Medscape* report, female physicians were found to experience burnout at a higher prevalence than their male counterparts: 50 percent to 39 percent, respectively. Additionally, *Medscape* identified that burnout does not impact physicians within 29 different specialties equally. Urology, Neurology, and Physical Medicine and Rehabilitation had the highest levels of burnout, while Public Health & Preventive Medicine, Nephrology, and Pathology had the lowest levels. Physicians focused on primary care specialties fell in the middle of the ranking: Internal Medicine (4th), Family Medicine (6th), and Pediatrics (17th).[187]

In addition to the longer-term impact provider burnout may have in the industry's transition to value-based models, there are direct and immediate consequences of a workforce feeling losses in satisfaction and efficacy in their jobs. A 2010 Mayo Clinic study found a strong relationship between burnout and number of "major medical errors" made by surgeons.[188] In 2015, research done among 1,425 intensive care physicians and nurses found that patient mortality was predicted by emotional exhaustion;[189] "emotional exhaustion" is one of the three subscales used to measure burnout through the Maslach Burnout Inventory (MBI).[190] More than one-quarter (26 percent) of physicians have reported that their experiences of burnout have lowered their motivation to, "be careful while taking patient notes."[191]

Patients are taking note of burnout as well. A 2019 Harris Poll, done on behalf of the American Society for Health-System Pharmacists, found that 74 percent of surveyed adults expressed concern about burnout among health care professionals. This concern was found to be based in the respondents' understanding that burnout can, "can lead to impaired attention and decreased functioning that threatens to cause medical errors and reduce safety."[192] Additionally, at least for the last decade, patients have been reporting lower rates of satisfaction because of physician burnout.[193] The myriad impacts burnout can have on patients resulted in the ECRI Institute naming physician burnout on their top ten list of Patient Safety Concerns for 2019.[194]

Burnout also has financial implications. As physicians and all health care staff continue to experience the impacts of burnout, they will also continue to exit their employment. This employment churn costs health care institutions both in recruitment dollars, as well as lost hours of productivity. In the middle of 2019, the Annals of Internal Medicine published a study that looked to estimate the costs related to physician turnover due to burnout. The study's authors concluded that, on a conservative base-case model, burnout-associated physician turnover (as well as reduction in clinical hours) costs the U.S. $4.6B (approximate) on an annual basis.[195] For an organization, this approximated cost equated to $7,600 per year per employed physician. One local institution, the University of Chicago, found they spent $250,000 to replace and make up lost revenue from each physician who retired or resigned due to burnout over a five-year period.[196]

III. HEALTH AND SOCIAL DISPARITIES

Chicago is replete with individuals and institutions collectively focused on improving the lives of our underserved neighbors. There are significant government and philanthropic resources committed to ensuring access to transportation, food, housing, education, and the other core social elements that we know are correlated to improved health.

Despite the incredible work being done and assets deployed, Chicago, like most American cities, continues to live far below its potential. We should be aspiring to have a well-coordinated, integrated system that is serving the ultimate objective of improving a person's life and health. Instead, we find isolation and fragmentation that fails to

adequately optimize the resources we are investing. This is not a tenable situation as additional funding sources are scarce and we continue to fail in materially moving the needle in certain neighborhoods.

There is sufficient evidence that improving the lives and platforms of individuals in underserved communities can act as a long-term, inter-generational catalyst for improved health, which leads to improved economic development. However, this does not happen with a simple 90-day whole-person focused model (such as the Camden Coalition), it requires sustained investment, commitment, and performance management.

Our aspiration in this section is to detail key activities occurring in our city and to put those in context of critical areas we have a collective opportunity to solve for.

ADDRESSING HEALTH CONDITIONS

Equal Hope (formerly the Metropolitan Chicago Breast Cancer Task Force) The Metropolitan Chicago Breast Cancer Task Force (the Task Force) is a not-for-profit organization founded in 2008 to fight racial disparities in breast cancer mortality in Chicago. Research done by the Sinai Urban Health Institute from 2005 and 2007 found that 62 percent more black women died from breast cancer than white women in Chicago and that black women were being diagnosed less often than white women.[197] Because this rate was unique to Chicago in comparison of other large metropolitan issues, the founders of the Task Force concluded that health care in Chicago was systemically racist and began holding brainstorm sessions and town hall meetings. In October 2007, their efforts were documented in a report titled "Improving Quality and Reducing Disparities in Breast Cancer Mortality in Metropolitan Chicago" and the Task Force was established. In a 2017 report, the organization reported that the breast cancer mortality gap between black and white women decreased from 62 percent to 39 percent.

In 2019 the Task Force changed their name to Equal Hope and expanded their mission to eliminating health disparities in Illinois to save women's lives, rather than focusing solely on breast cancer mortality. Specifically, Equal Hope addresses "women's health holistically by helping women establish medical homes with the goal of eliminating in inequities in prevention, screening, diagnosis, treatment, and survivorship for all women."

Chicago HEAL Initiative In October 2018 U.S. Senator Dick Durbin announced the Chicago HEAL (Hospital Engagement, Action, and Leadership) Initiative – a collaboration between 10 of the largest hospitals in Chicago aimed at reducing violence and improving health in Chicago's most underserved neighborhoods.[198] The initiative, which is convened and supported by Durbin, seeks to make tangible commitments to reduce gun violence, heal the physical and mental trauma that violence inflicts on victims, increase well-paying jobs, and create other economic opportunities in the neighborhoods they serve.

The Chicago HEAL Initiative is a three-year project to make a measurable difference in the well-being of Chicago residents and specifically in 18 of Chicago's neighborhoods with the highest rates of violence, poverty, and inequality. Recognizing their roles as the leading employers, the hospitals have made 16 tangible commitments on actions – outside of their traditional health care roles – to uplift their communities, including through local hiring and procurement, job training and mentorship, housing, and mental health activities.

Chicago HEAL's interim report released in October 2019 shows that initial progress being made on three priorities:[199]

- increase local workforce commitment to reduce economic hardship
- support community partnerships to improve health and safety of public environments
- prioritize key in-hospital clinical practices to address unmet needs

Together, the 10 hospitals have employed nearly 15,000 individuals from 18 of the most underserved neighborhoods, screened more than 75,000 patients for trauma and social determinants of health needs, and provided nearly 5,000 local students with career development programs.[200]

Innovation Center at Albany Park (ICAP) Heartland Health Centers in partnership with AllianceChicago, introduced the Innovation Center at Albany Park (ICAP) on February 1, 2019. ICAP is a new kind of clinic established to create space, time, and expertise to collaborate and further develop a relationship-based care model and enhance innovative health information technology as part of the pathway towards a consumer-centric care model of the future. The relationship-based model is built around an advanced team care model, with an emphasis on the role of a care team coordinator as part of the practice. ICAP's FQHC-based innovation model provides a mechanism to advance patient and consumer-centric relationship-based care models and innovative health information technology.[201]

PrEP4Love The PrEP4Love campaign was founded in 2016 by the Chicago PrEP Working Group (since changed to Illinois PrEP Working Group). The goal of the initiative was to increase awareness of the daily HIV prevention pill, pre-exposure prophylaxis (PrEP), which is up to 99 percent effective. The project attempted to appeal to their intended audience through a campaign focused on intimacy, based on 2015 research that increased intimacy was correlated with PrEP use. PrEP4Love used an array of intimate photos of Chicago residents to highlight three particularly vulnerable populations – black transgender women, gay men and other MSM of color, and cisgender heterosexual women of color – in a public advertisement campaign. The campaign was built on $250K from the Alphawood Foundation, $100K from private citizens of Chicago, and pro bono creative support from firms like Leo Burnett and Starcom.

In June of 2019, the PrEP4Love campaign received well-deserved validation. The Chicago Center for HIV Elimination at the University of Chicago had evaluated the campaign with the knowledge that PrEP is heavily underutilized. Researchers at the Chicago Center for HIV Elimination tracked viewership to better understand the level of viewership and engagement with the sex-positive PrEP campaign. Measuring the project's inaugural four months from February to May 2016, researchers found that nearly 41M uniquely-viewed campaign advertisements while almost 25,000 individuals visited the website. Although these numbers are simply viewership and do not give direct evidence to any change in PrEP usage or general stigma, the campaign was properly called a success. To reiterate, in four months almost 41M people viewed their content. As the John Peller said, President and CEO of the AIDS Foundation of Chicago, the results were "astounding."[202]

ADDRESSING INEQUITIES IN CHICAGO COMMUNITIES

All In Chicago CommunityHealth is the largest free clinic in the country serving over 8.500 low-income, uninsured population each year.[203] After the rollout of the ACA in 2014, CommunityHealth convened stakeholders and community leaders to explore the remaining gaps in coverage, to identify barriers to care that still remain for some Chicagoans, and to discuss ways we can work together to overcome them at the inaugural All In Chicago thought leadership breakfast in November of 2015.

In the spring of 2019, the All In™ campaign was reimagined into a series of thought-provoking events and programs hosted across the city to discuss and generate solutions for providing accessible health care to local communities. The mission and purpose of CommunityHealth's All In™ campaign is to make Chicago the first major metropolitan city to have a fully functioning system in place ensuring that everyone has access to the right care, at the right time, in the right place.[204]

West Side United West Side United is a coalition of Chicago-based institutions that have united to address certain issues to improve the community around them, specifically on the West Side of the city.[205] The group came together after research was published by the Sinai Institute for Health that detailed the life expectancy gap when comparing the West Side of Chicago with the Loop. Other sources reveal that Streeterville, a neighborhood just north of the Loop, had a life expectancy of 90, which is 30 years more than an even larger discrepancy when comparing life expectancy with the West Side. In response, six hospitals joined forces to begin to shorten this gap: Amita Health, Ann & Robert H. Lurie Children's Hospital of Chicago, Cook County Health, Rush University Medical Center, Sinai Health System, and the University of Illinois Hospital & Health Sciences System.

The organization is also comprised of a number of other general financers (Ballmer Group and Michael Reese Health Trust) and contributing members (AMA, Catholic Charities, and the Greater Chicago Food Depository, among many others).

In conjunction with their one-year anniversary in early 2019, West Side United announced goals for the coming year that include an emphasis on inequality in health care, education, economic vitality, and environment. In terms of tangible work in the community, West Side United added funding to six new and existing community improvement projects. They provided $1.7M to businesses that are helping to bolster affordable housing and encourage youth to get involved in resources available locally. The group has set the goal of donating an additional $250,000 in small business grants by 2021. West Side United has also created a program that provides a pathway for non-clinical, entry-level employees in four West Side hospitals to gain the education to be medical assistants. Through this and other programs, West Side United has set a goal of hiring 3,500 new individuals across their partner organizations by 2021.[206]

Payers supporting the community BCBSIL pledged to donate $1M to finding housing for those without it in Chicago. The $1M grant will be provided to Chicago's Flexible Housing Pool over the course of two years as a part of BCBSIL's overall health strategy. As one of the original investors of Chicago's FHP, BCBSIL continues its dedication to the organization that coordinates care for those without homes, including finding housing and other associated services. The program is modeled after a Los Angeles-based model which found that every $1 spent found $1.20 in health care savings.

HC3 YEAR IN REVIEW

2019 HC3 MEMBERSHIP

Creating change is more than meetings and networking. It's action. HC3 members drive action. HC3 members represent a variety of stakeholders from the health care industry in Chicago, ranging from hospitals and providers to investors and marketers. Together, we're making an impact and driving real health care change in our local communities.

Founding Members

LEAVITT PARTNERS

MATTER

THIRD HORIZON STRATEGIES

HC3 Member Organizations

4Sight Health
AbbVie
Advocate Aurora
Aligned Modern Health
Allscripts
American Dental Association (ADA)
American Hospital Association (AHA)
AMITA Health
Anne and Robert H. Lurie Children's Hospital of Chicago
Astellas
AVIA
BlueCross & BlueShield of Illinois
Canary Telehealth
Chicago Pacific Founders
Cigna
CommunityHealth
Cressey & Co.
Drinker Biddle & Reath
Edelman
Erie Family Health Centers
Healthcare Financial Management Association (HFMA)
Health Law Consultancy
Horizon Therapeutics
Illinois Health and Hospital Association (IHA)
Illinois Medical District
Illinois Primary Health Care Association (IPHCA)
Infant Welfare Society
Jarrard, Phillips, Cate & Hancock
Kaizen Health
L.E.K. Consulting
McDermott Will & Emery
Medical Home Network
Mutare
Now Pow
Oak Street Health
OSF Healthcare
Pareto Intelligence
physIQ
Primo Health Center for Women and Children
Radiology Partners
Rush University Medical Center
Sandbox
Sidley Austin
Takeda
Terry Group
Waller Helms Advisors
Weber Shandwick
YearUP
Ziegler
Ziprad

HC3 Membership is open to organizations and companies that maintain a physical presence in Chicago and are invested in building a healthier local community.

2019 HC3 EVENTS

In 2019, HC3 hosted 10 thought leadership events, including our first ever half-day forum.

10 Events • 30+ speakers • 800+ attendees

JANUARY 18, 2019

The Role of Retail in Healthcare

Marcus Osborn, Walmart

FEBRUARY 19, 2019

Venture Capital and Investing in Chicago

Senator Bill Frist, Cressey & Co
Chris Booker, Cressey & Co

MARCH 18, 2019

2019 Expectations on Illinois Policy Reform

AJ Wilhelmi, Illinois Hospital Association
Jordan Powell, Illinois Primary Health Care Association
Samantha Olds Frey, Illinois Association of Medicaid Health Plans

APRIL 2, 2019

Federal Health Care Agenda Update

Clay Alspach, Leavitt Partners

MAY 15, 2019

The State of Value-Based Care

Dave Johnson, 4Sight Health

MAY 28, 2019

The Next Critical Phase of HIT

Aneesh Chopra
Steve Lalonde, Allscripts
Harold Wolf, HIMSS
Mary Tolan, Chicago Pacific Founders

JUNE 18, 2019

The Digital Imperative for Health care

Amy Stevens, AVIA
Lisa Dykstra, Lurie Children's Hospital

SEPTEMBER 16, 2019

The Future of the MA Program and It's Role in Chicago

Chris Hendrickson, Ziegler
Rob Hitchcock, HCSC
Regan Murphy, Oak Street Health
Eric E. Whitaker, MD, Zing Health Inc

DECEMBER 16, 2019

Chicago's Community Violence as a Public Health Focus

Clarisol Duque, U.S. Senator Durbin's Office
Sheila Regan, Acclivus
LeVon Stone, Acclivus
Mamta Swaroop, MD, Northwestern Medicine
Karen Teitelbaum, Sinai Health System

THOUGHT LEADERSHIP FORUM 11/25

Reimagining Chicago's Safety Net: A Community Leadership Forum

KEYNOTE ADDRESS:

Reimagining the System and Forging a Path to Safety Net Reform for Uncommon Alignment

David Smith, Founder and CEO, Third Horizon Strategies

Charting A Path to Safety Net Reform Speakers

Eric Hargarten, Associate, Blue Venture Fund

Ayesha Jaco, MAM, Executive Director, West Side United

Mindi Knebel, CEO, Kaizen Health

Karen Lee, MS, Executive Director, ECHO Chicago

Fred Rachman, MD, CEO, AllianceChicago

Jay Shannon, MD, CEO, Cook County Health

Featured Guest Speakers

Sol Flores, Deputy Governor, State of Illinois

David Munar, CEO, Howard Brown Health

Greg Harris, Majority Leader & State Representative of the 13th District of Illinois

2019 INITIATIVES

HC3 is developing strategies and setting measurable goals to impact local health and then decisively executing – in policy, in board rooms, and in neighborhoods – all in the spirit of building healthier communities. In 2019, HC3 executed five key initiatives:

- Community Violence as a Public Health Focus
- Clinician Burnout Assessment
- Health Care Work Force Program
- Reimaging the Safety Net
- State-Wide ADT Initiative

Each initiative is described below.

Community Violence as a Public Health Focus

America is in the midst of a gun epidemic that can be examined from two very different lenses. Through one lens, we see a general and systemic decline in urban violence across key American cities that were once viewed as unsustainable epicenters of violence and trauma. Such declines are a testament to coordinate public support, police reforms, community collaboratives, and highly deliberate public policy. However, the second lens tells the bleak story of a country that still has the highest number of gun-related homicides per-capita of any other developed economy. While mass-shootings and calls for gun reform dominate the debate, there remains significant and causal factors that continue to perpetuate this national challenge.

Addressing primary prevention opportunities is critical to addressing the fundamental core of the issue. But there is a certain political fortitude and private sector collaboration required to make such overtures and cities are in a constant state of flux and fluidity regarding serious, sober reforms.

However, secondary prevention opportunities introduce a new locus of players further downstream with some (selectively) economic incentives to take action. The ultimate ideal of any public policy to address policy would be in the reduction of secondary prevention needs. Nevertheless, in the face of political intransigence, secondary prevention can be a means of organizing an infrastructure to treat and re-direct victims, perpetrators, and families to resources that can remediate and lessen violence.

In 2019, HC3 developed an initiative for secondary violence prevention provided by Acclivus, a Chicago-based organization dedicated to breaking the cycle of violence to enable pathways to safety, self-esteem, and systematic change.

The next phase of this initiative will continue in 2020 with a partnership cultivated by HC3 between Acclivus, Forward Health Group, and NowPow to augment Acclivus' current platform, creating a unique city-wide trauma informed population health tool for understanding and managing the public health epidemic of community violence in Chicago. This health information technology will house data that will highlight critical opportunities for advocacy geared towards healthy equity and economic development of marginalized communities in partnership with critical community stakeholders.

ABOUT ACCLIVUS

Acclivus supports community health and well-being for Chicago area populations at risk for violence and other negative health outcomes. Acclivus uses a multi-disciplinary public health approach that draws upon the lived experience of its staff to provide health and well-being services to Chicago area communities at most risk for violence. Through its trusted grassroots community network, partnerships with Level 1 trauma centers and grounded by proven methods, Acclivus helps break the cycle of violence to enable pathways to safety, self-esteem and systemic change. Learn more at www.acclivusinc.org.

HC3 MEMBERS

McDermott Will & Emery

WEBER SHANDWICK

NOWPOW

HC3 PARTNERS

Acclivus

MICHAEL REESE

FORWARD HEALTH GROUP

CLINICIAN BURNOUT ASSESSMENT

Collaborating with the AMA and local provider associations, HC3 is working to disseminate a burnout assessment to facility leaders throughout the city and state. Data will be managed and tracked through a proprietary system that will allow facilities to benchmark their results against other in the city. The results will provide us with a composite view of key areas of opportunity throughout the market, supporting technology development and investment, policy-driven efforts and more to address this issue.

HC3 MEMBERS

Illinois Health and Hospital Association

IPHCA Illinois Primary Health Care Association

FORWARD HEALTH GROUP

AMA AMERICAN MEDICAL ASSOCIATION

HEALTH CARE WORK FORCE PROGRAM

HC3 has convened a taskforce to explore community partnerships and programs that focus on education and work force development. Currently, this initiative has three main objectives:

- create an educated workforce
- drive interest in the health care industry
    - o empower youth – specifically the underprivileged and underserved youth that would potentially not have easy access to these types of professional opportunities – to access new career paths and do meaningful work

The goal is for HC3 to foster the future of the health care community. In 2020, we hope to develop a structure of connecting HC3 Members and partners to community and educational institutions to spark an interest in non-traditional health care careers, and offer foster the future of the health care community.

HC3 MEMBERS

McDermott Will & Emery

Cigna

Canary Telehealth

radiology partners

yearup

WEBER SHANDWICK

HC3 PARTNERS

MICHAEL REESE

Chicago Public Schools

REIMAGING THE SAFETY NET

Chicago's safety net system plays an indispensable role in supporting the health of our most vulnerable communities. The system is uniquely engineered for supporting the health and well-being of our neighborhoods, but without a significant effort of coordinated, thoughtful, and deliberate action, it is bound for significant decline in five years. HC3 is exploring opportunities through policy, systemic restructuring and community engagement to disrupt the system to better serve our local communities.

On November 25, over one hundred community, government and corporate leaders convened for HC3's Safety Net Forum. The purpose of this event was to explore and develop opportunities to create a fundamentally new approach to Chicago health care's safety net system.

News Coverage of the Event

WHAT'S HAPPENING TO CHICAGO'S SAFETY-NET HOSPITALS?

Crain's Chicago Business, November 25, 2019

LINK TO ARTICLE

SMITH: COLLABORATIVE EFFORT NEEDED TO BOLSTER CHICAGO'S SAFETY NET SYSTEM

Health News Illinois, November 26, 2019

LINK TO ARTICLE

PANEL DISCUSSES FIXES FOR CHICAGO'S SAFETY NETS

Health News Illinois, December 2, 2019

LINK TO ARTICLE

In 2020, HC3 will convene a Safety Net Alliance, as well as continue researching and developing ideologies with supportive data to drive new ideas and alignment to address health inequities in our most vulnerable communities.

STATE-WIDE ADT INITIATIVE

As Illinois looks to continue improving the efficiency of its health system and organizing resources in a way that promote improved outcomes, lower cost, and higher health capital in communities, there are key advantages to improved information sharing. While establishing an HIE throughout the state may be politically challenging, enabling an ADT system that can be leveraged by different stakeholders in different ways is increasingly appealing.

HC3 has convened a taskforce of leadership from local health systems and community health centers that have agreed to collaborate on establishing principles, technology characteristics, and funding solutions that would support a statewide ADT system. This is in partnership with AVIA's Medicaid Transformation Project.

HC3 MEMBERS

AllianceChicago
Innovating for better health

IPHCA
Illinois Primary Health Care Association

Centros de Salud erie Family Health Centers

DrinkerBiddle

IHA Illinois Health and Hospital Association

Advocate Aurora Health

HC3 PARTNERS

AllianceChicago
Innovating for better health

COOK COUNTY HEALTH

ABOUT HC3

The Health Care Council of Chicago (HC3) is an action- oriented collaborative that brings leaders from across the health care ecosystem together to help support business growth and solve our city's most important health-related issues.

We exist in response to our members' desire to impact health related issues and are a vehicle for our city's health care leaders to create true change and impact the conditions that determine health in our city

Founded by Leavitt Partners and MATTER, HC3 is growing into an independent, dynamic and member-led organization that's being shaped by the leaders of some of Chicago's most impressive and well-known healthcare organizations.

THANK YOU TO OUR MEMBERS FOR THEIR CONTINUED SUPPORT OF HC3'S MISSION AND VISION.

HEALTH CARE COUNCIL
of Chicago

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