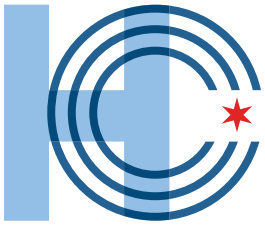
2020

STATE OF CHICAGO HEALTH CARE INDUSTRY



HEALTH CARE COUNCIL

of Chicago

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Information and news documented in this publication were up-to-date as of December 15, 2020. Any information added/updated after December 15 is apparent by the announcement date listed.

LETTER FROM THE CO-FOUNDERS

To say that 2020 was a challenging year would be trite. The highly improbable convergence of a global pandemic, racial justice protests, economic contraction, and political dissonance have profoundly impacted our personal and professional lives.

But as Bob Dylan once said, "the times, they are a-changing." Historically, there is an observable pattern associated with a pandemic that bears similarities to the one we have labored under: everything changes. Our politics, professional norms, economy, and above all, our social compact will forever be changed.

Our industry has been far from exempt to the pressures of this environment. Some of us have been relatively insulated from the broader hardships wrought by 2020. And some of us have been brought to our knees in tearful frustration at the intractability of the world's, this country's, and the city of Chicago's challenges.

The new world we will confront is not changed just because of 2020; but instead by the spark of recent events on a powder keg of significant disruption long simmering under the surface of America's health system.

Over the last year we have seen changes to our industry that heretofore would have taken years, if not decades, to realize. As we emerge from the rubble of 2020, we will be faced with taking what we have learned in recent years and applying those lessons to a landscape irrevocably changed.

Change challenges the foundation of our very nature and brings with it a range of human frailties like anxiety, transition, or unbridled opportunism in a stochastic environment.

But despite any of our individual or collective efforts, change we will.

This is our fourth annual "state of Chicago" paper. While dense, we believe it provides a useful look back at the key events that will shape our tomorrow, for you cannot know where you're going unless you know where you've been.

This year, we have seen "weak signals" abound, providing shreds of evidence for what tomorrow's world holds. We have done our best to share some predictive insights with the full recognition that were we highly skilled fortune tellers, we would certainly have ridden out 2020 on a yacht somewhere in the Pacific.

We believe that 2021 will be a year of building on a new baseline in our industry in how we see historically marginalized communities, how we interface with digital tools, how we organize and access care, and how we move money around our byzantine health system.

Nevertheless, we hold confidence that key trends are readily observable. And when these trends are stitched together, they begin to weave a narrative about where we've been, where we are, and where we are going.

Our ambition is to continue our work with each of our partners while making new friends in 2021 so as to play some small part in that change. A change we believe has the hallmarks and makings of an improved and more inclusive system of health for our city.

David Smith
Co-Founder
Health Care Council of Chicago

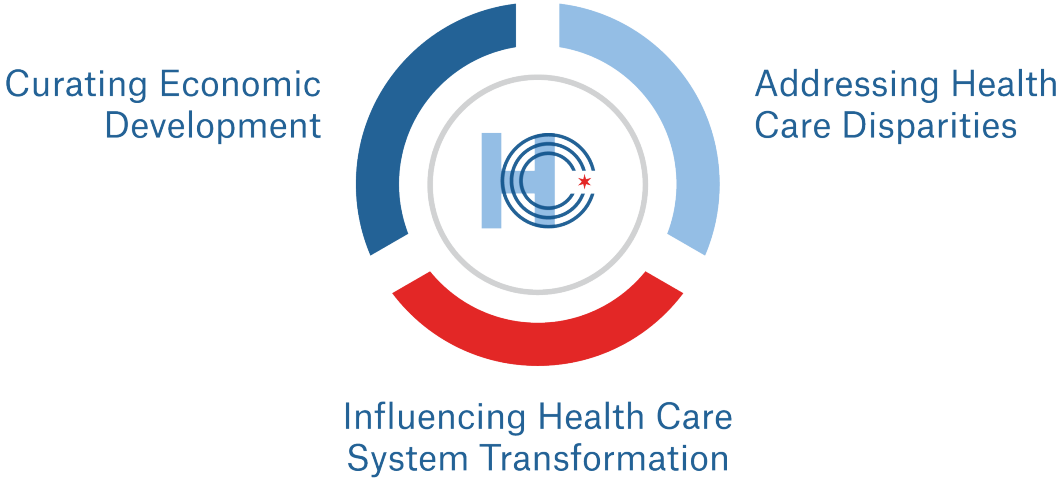
Steve Collens
Co-Founder
Health Care Council of Chicago

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. HEALTH AND SOCIAL DISPARITIES

The term "social determinants of health" was coined a century ago. Key research linking social factors to health was done two decades ago. Industry executives wove it into every talk and every deck two years ago. But we have now lived through the effects of these factors and their explosive effects in watching underserved communities suffer and historically disenfranchised neighbors demand better.

IMPACT OF COVID-19

By the Numbers

Chicago documented its first case of COVID-19 in January. On January 13, a female resident in her 60s returned from Wuhan, China and began to feel symptoms a few days later. On January 24 the woman was diagnosed with COVID-19. Days later, the woman's husband contracted the virus – marking the first documented person-to-person transmission of COVID-19 in the U.S. Although health officials were not surprised the virus was transmitted in close proximity, thus far limited details had been researched or released. This evidence of direct transfer was critical as it illuminated a primary characteristic of COVID-19. Because the virus transfers easily from person-to-person, Chicago quickly became a hotspot for exponential spread of COVID-19.

Consistent with Illinois' varying level of population density, state-wide impact of COVID-19 was widely mixed. Unsurprisingly, the virus spread at a slower pace outside of Chicago. The virus moderately hit the suburbs of Chicago while the rural areas outside of Chicagoland were less affected. By December 10, the Illinois Department of Public Health confirmed 823,531 positive cases, 13,861 deaths, and more than 11.4 million tests performed in the entire state since the beginning of the pandemic.

Fighting the Pandemic and Systemic Issues

Between the beginning of March and early December, Chicago administered 2,077,732 tests and confirmed 176,887 positive cases of COVID-19. The city's goal to perform 4,500 tests per day drove the city to conduct over one million tests by the beginning of October. The city continued to increase the number of tests given daily, reaching 15,000-20,000 tests per day towards the end of November/beginning of December. The city also successfully kept the COVID-19 positivity rate below five percent through September. However, the positivity rate began to climb throughout October, hitting almost 16 percent by the middle of November. The positivity rate entering December was around 13 percent.

With a distinct lack of access to health care on the south and west sides it is not surprising that these communities were (and still are) disproportionately impacted by COVID-19 in contrast to the suburbs, Loop, River North, or the North Side. And, although few things are an exact science with COVID-19, it is scientifically indisputable that individuals with pre-existing conditions suffer more and have a significantly higher probability of mortality.

On August 31, 2020 HC3 held an event including Cathy Dimou, MD, the Midwest Market Medical Executive at Cigna. Dr. Dimou noted, "Prior to COVID-19 we saw inequities. At the start of the pandemic, 70.0 percent of initial deaths were amongst African Americans who make up only one-third of Chicago's population. The second wave we are seeing now is showing less morbidities but affecting more young people (18-29) than the initial wave which was predominantly affecting seniors. The Latinx community represents 44.0 percent of positive COVID-19 cases currently in Chicago, but they only representing 29.0 percent of the current population. (Note: these numbers may be misrepresented being mislabeled Caucasian/white or undefined.) These high rates of infection and morbidities highlight the massive inequities that minority communities are facing in this crisis."

Amid the pandemic, organizations stepped up to address inequality issues. For example, the University of Chicago developed an online resource guide to directly address inequities exacerbated by COVID-19. This accumulation of tools spans a wide range of organizations – including National Public Radio (NPR), Harvard Gazette, Health Affairs, and the American

Medical Association (AMA), to name a few – have all attempted to address issues of health disparities, equity, and social determinants of health.

Sinai Urban Health Institute, Sinai Chicago's research wing, and DePaul University announced a partnership to fight health inequality in Chicago. The memorandum of understanding outlines a focus on community and clinical programs to address social and health inequities. With data science support from DePaul University and the health care delivery expertise of Sinai Chicago, the organizations hope to "develop and apply cutting-edge collective impact evaluation tools and practices to determine the most effective solutions."

In September, Chicago, drafted its first Equitable Transit-Oriented Development (TOD) policy plan to address the basic need of transportation and "advance racial equity, wealth building, public health and climate resilience." In short, the plan hopes to grow housing and retail near transportation hubs, without displacing people affected by the growth.

2020 COVID-19 TIMELINE

JAN 21	CDC confirms first case of the coronavirus in the U.S.
JAN 22	O'Hare begins screening passengers from Wuhan, China
JAN 24	Chicago woman travelling back from China is diagnosed with coronavirus
JAN 30	First U.S. person-to-person case of coronavirus reported in Chicago
FEB 3	Trump declares a public health emergency
FEB 4	FDA issues emergency use authorization for CDC's diagnostic test
MAR 9	Governor Pritzker announces disaster proclamation
MAR 11	WHO declares coronavirus (COVID-19) outbreak a global pandemic
MAR 13	President Trump declares COVID-19 pandemic a National Emergency in the U.S.
MAR 13 – 15	Governor Pritzker announces school closures, orders restaurants and bars to close for sit-in customers, and limits crowds to 50 or less
MAR 17	First COVID-19 death in Illinois is a Chicago resident
	CMS temporarily expands telehealth rules; Medicare to equally cover telehealth and in-person visits
MAR 18	Trump signs Families First Coronavirus Response Act into law
	United States Food and Drug Administration issues an Emergency Use Authorization for Abbott's molecular test for COVID-19
MAR 20	Governor Pritzker announces stay-at-home order from March 21 – April 7 for all "non-essential businesses"
	Work begins to turn McCormick Place into an alternate care facility
MAR 23	Chicago plans to rent thousands of hotel rooms for those exposed to coronavirus and those that think they may have the virus to relieve pressure on hospitals
MAR 25	Illinois extends state tax filing deadline July 15 to match the Fed
MAR 26	Mayor Lightfoot shuts down the 606 and Riverwalk
MAR 27	Trump signs CARES Act into law
	Mayor Lightfoot announces COVID-19 Housing Assistance Program that offers 2,000 grants of $1,000 each for eligible Chicago residents
MAR 31	Governor Pritzker extends the stay-at-home order until April 30

Q1

CASES AND DEATHS

Total confirmed cases:

Chicago - 2,611

Illinois - 5,994

U.S. - 163,359

Total deaths:

Chicago - 26

Illinois - 99

U.S. - 2,860

- Policies
- Mandates/Laws
- Grants/Funding
- Cases
- News

2020 COVID-19 TIMELINE

APR 8 Mayor Lightfoot orders 9 p.m. curfew on liquor sales effective immediately

HHS announces it will provide more than $52 million in federal funding to 45 Illinois health centers (19 in Chicago) to help with the state's COVID-19 response

APR 10 Illinois State officials announce a series of initiatives aimed at increasing testing in the Black community

APR 11 Illinois Department of Aging announces $7 million funding to provide meal assistance to senior residents

APR 13 Mayor Lightfoot announces measures to help the homeless population during the pandemic, including temporary housing and distribution of PPE to shelters

APR 16 Governor Pritzker expands testing to anyone with symptoms, even without a doctor's order; He also announces a partnership with six surrounding Midwest states to coordinate reopening of economies

APR 17 Governor Pritzker announces that all schools will remain closed through the end of the academic year

APR 21 Governor Pritzker announces $112 million additional funding for SNAP recipients with children

APR 23 Governor Pritzker extends the stay-at-home order until May 30, with a few adjustments

APR 27 Governor Pritzker defends his position to maintain restrictions downstate, where cases and deaths are markedly lower, as representatives from the area push backto close for sit-in customers, and limits crowds to 50 or less

APR 29 Mayor Lightfoot announces the Chicago Housing Solidarity Pledge to provide grace periods for mortgage and rent payments and no late fees for missed payments

MAY 1 Illinois modifies stay-at-home order and allows some businesses to reopen fully with social distancing guidelines; Additionally, the state issues a new mandate requiring all residents to wear a face mask in public when social distancing is not an option

MAY 7 HHS awards more than $25 million to Illinois health centers to expand testing

MAY 14 Mayor Lightfoot and BACP award grants to 959 small businesses across 36 low-and-moderate income communities that have been impacted by COVID-19 through the $5 million Microbusiness Recovery Grant Program

MAY 25 New state grant program announced to help expand broadband capacity and digital access

MAY 26 Mayor Lightfoot announces a $56 million request for proposal to expand contact tracing in Chicago

MAY 29 Illinois enters Phase 3 of reopening

JUN 2 Chicago enters Phase 3 of reopening

JUN 8 Chicago receives more than $1.13 billion from the CARES Act

Chicago reopens parks and libraries

JUN 11 ILDPH provides Cook County Public Health Department with $41 million to build a contact tracing program

JUN 15 Millennium Park reopens with restrictions on access and group size

Q2

CASES AND DEATHS

Total confirmed cases:

Chicago - 52,340

Illinois - 143,185

U.S. - 2,581,229

Total deaths:

Chicago - 2,603

Illinois - 6,923

U.S. - 126,739

- Policies
- Mandates/Laws
- Grants/Funding
- Cases
- News

2020 COVID-19 TIMELINE

JUL 9 Mayor Lightfoot unveils the Recovery Task Force Advisory Report, which calls for the city to accelerate investments in neighborhoods on the South and West Sides, calling it a "once in a generation opportunity" to remake Chicago

JUL 16 Cook County Health announces it will support a nationwide effort to test effectiveness of an antibody-based medicine against COVID-19

JUL 20 Chicago halts indoor service at bars and heightens other restrictions as cases rise

JUL 22 Governor Pritzker announces the state will provide more than $150 million to public health departments outside of Cook County to help bolster their contact tracing efforts

JUL 23 Governor Pritzer extends ban on evictions to August 22, previously set to expire July 31

JUL 27 Senate introduces HEALS Act

Mayor Lightfoot announces the second round of rental assistance grants totaling $33 million to prevent evictions and foreclosures

JUL 28 Chicago announces it will be issuing tickets for quarantine violations

JUL 31 Mayor Lightfoot announces $6.2 million in grants to support 1,500 small businesses impacted by the pandemic and civil unrest

AUG 3 Governor Pritzker launches $5 million statewide face mask campaign to raise public awareness

AUG 5 Chicago Public Schools announce remote learning to begin the school year on September 8

AUG 8 Trump bypasses Congress, defers payroll taxes and replaces expired unemployment benefit with lower amount

AUG 10 Governor Pritzker announces the pledged $300 million in rental assistance will not be enough and vows to lobby federal government for additional funds

AUG 31 Mayor Lightfoot announces a $1.2 billion budget shortfall for 2021

SEP 1 CDC issues a temporary halt on evictions until the end of 2020

SEP 8 Final $7.5 million of Illinois COVID-19 Response Fund is distributed to seven nonprofits across the state that serve primarily Black and Latino communities

SEP 16 Trump administration releases vaccine distribution plan, which aims to make vaccine free for all Americans

SEP 28 Mayor Lightfoot lifts restrictions following a drop in confirmed cases

Q3

CASES AND DEATHS

Total confirmed cases:

Chicago - 80,247

Illinois - 293,274

U.S. - 7,168,077

Total deaths:

Chicago - 2,960

Illinois - 8,672

U.S. - 205,372

- Policies
- Mandates/Laws
- Grants/Funding
- Cases
- News

2020 COVID-19 TIMELINE

OCT 5 Cases in Chicago rise 32 percent in a week

OCT 16 Chicago Public Schools announce enrollment has dropped by 15,000 compared to the previous school year amid remote learning

OCT 22 Mayor Lightfoot orders bars to halt indoor service and businesses to close at 10pm

NOV 5 Mayor Lightfoot dedicates $10 million in federal funds to help restaurants and bars threatened by COVID-19

NOV 7 Illinois reports more than 12,000 new cases in a 24-hour period, exceeding previous record by more than 2,000

NOV 12 Mayor Lightfoot urges 30-day stay-at-home advisory

Illinois crosses 600,000 total cases and 11,000 deaths, making COVID-19 the third leading cause of death in the state

NOV 20 Illinois moves to Tier 3 restrictions to curb COVID-19 surge

NOV 25 Pritzker announces the state will borrow $2 billion from the federal government to cover short-term COVID-19 losses

DEC 3 US records over 3,100 COVID-19 deaths in a single day, breaking the previous record of 2,600 on April 15

DEC 10 Chicago's post-Thanksgiving COVID-19 surge increases cases by 30 percent

DEC 11 US allows emergency use of Pfizer COVID-19 vaccine

DEC 14 US health care workers begin receiving COVID-19 vaccine

DEC 15 Health care workers at Loretto Hospital are the first to receive COVID-19 vaccination shots in Chicago

Q4

CASES AND DEATHS

Total confirmed cases:

Chicago - 204,472

Illinois - 963,389

U.S. - 19,346,821

Total deaths:

Chicago - 4,241

Illinois - 16,490

U.S. - 346,039

- Policies
- Mandates/Laws
- Grants/Funding
- Cases
- News

RACISM, UNREST, AND EQUITY

Between 2012 and 2017, life expectancy fell for everyone except for non-Hispanic white Chicagoans. Hispanic Chicagoans experienced an unparalleled decrease of approximately three years from 83.1 to 80.0. The impact of racism on population health is illustrated best through basic epidemiologic indicators. According to the latest data, there is an 8.8-year gap in life expectancy between non-Hispanic Black Chicagoans and their non-Hispanic white counterparts. This translates to more than 3,500 excess deaths for Black people in Chicago every year, with more than half of this burden catalyzed by premature mortality from chronic disease.[1] There are worrying signs that this already dire situation is getting worse. Similar signals emerge from other sensitive population health indicators, including infant mortality and low birth weights for newborn babies. Chicago is one of the few large cities across the U.S. with a widening gap in all-cause mortality between Black and white residents across the last 10 years.[2]

Dr. Camara Jones has advanced four critical mechanisms for understanding the role of racism as a driver of health inequities: structures, policies, practices and norms, and values. According to Dr. Jones, these mechanisms are active throughout society, including in the health care system itself. They lend a narrow focus on the individual (negating and obscuring the structural and social determinants of health), privilege an ahistorical stance (disregarding the deep-rooted structural policies that shape community vitality today), and limit collective capacity to imagine an alternative (depicting health equity as an utopian dream).

Coming Together to Take Action on Systemic Racism

In 2020, 36 Chicago-area hospitals and community health centers united to name racism as a public health crisis. "We must double down on our efforts. Systemic racism is a real threat to the health of our patients, families and communities. We stand with all of those who have raised their voices to capture the attention of Chicago and the nation with a clear call for action. The health centers and hospitals we represent are deeply woven into the fabric of the communities we serve, live and work in, and we stand united as frontline staff against racism, injustice and inaction," the organizations said in a press release.

A Historical View

Chicago-based health care institutions have been confronting racism since the 1950s. In 1955, the Medical Committee to End Discrimination in Chicago Medical Institutions published the powerful pamphlet, "What color are *your* germs?".[2] It was a powerful rebuke of the state of health care in Chicago at the time – when overt racial discrimination meant that the vast majority of the city's medical capacity (at the time consisting of more than 6,000 doctors and 65 hospitals) was simply denied to Black people. The charge was also raised by the Medical Committee for Human Rights after the passage of the 1964 Civil Rights Act. Again, birth and death data irrevocably showed deep-rooted patterns of discrimination.[3] In the 1980s, the scars of a segregated and unequal system were opened with new data showing the costs and burdens associated with patient dumping of patients from private hospitals to Cook County Hospital. In recent years, structural racism has been at the center of analyses examining Black vs. white inequities in breast cancer mortality.

COVID-19 and the Fault Lines of Inequality

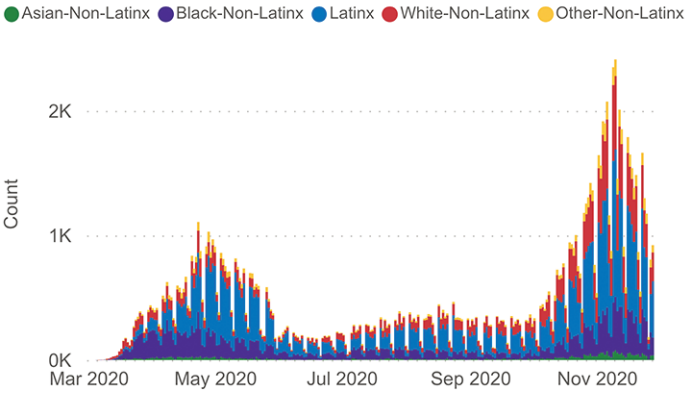
In April, Mayor Lightfoot organized the Chicago Racial Equity Response Team to develop hyperlocal, data-informed strategies to slow the spread of COVID-19 and improve health outcomes among the most hard-hit communities. The city's chief equity officer, the deputy mayor for education and human services, and West Side United co-led the effort with three anchor community organizations: Greater Auburn Gresham Development Corporation, Austin Coming Together, and South Shore Works. Via coalitions, the team brought together expertise form community groups, health care, and academic institutions in the city. The team also prioritized the distribution of tests and personal protective equipment,

1 Benjamins MR, De Maio F, eds. *Unequal Cities: Structural Racism and the Death Gap in America's Largest Cities*. Baltimore, MD: Johns Hopkins University Press; in press.

2 Benjamins MR, Silva A, Saiyed NS, De Maio F. Unequal cities: racial and geographic inequities in all-cause mortality across the 30 biggest U.S. cities. *JAMA Network Open*. in press.

established testing sites in the hardest-hit communities of the city, and provided disaggregated data to the city's COVID-19 data dashboard. According to the dashboard, as of November 30, 41.0 percent of COVID-19 deaths were among Black Chicagoans (see figure below).

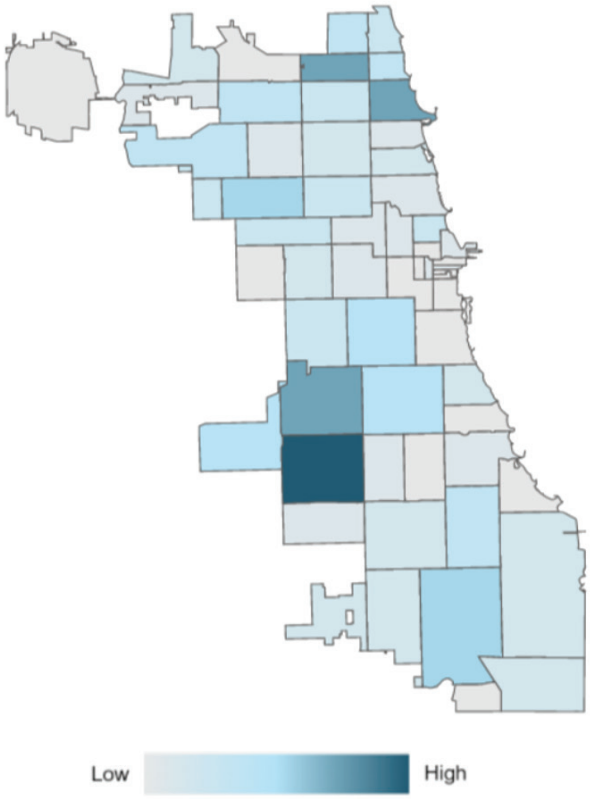
Daily COVID-19 deaths by Race-Ethnicity



Source: Chicago COVID Dashboard (12.15.2020)

The social and economic patterning of COVID-19 deaths are salient, as with other health indicators, through a community-level view. In one of the hardest-hit areas encompassing parts of Brighton Park, South Lawndale, and North Lawndale (zip code 60623), there have been 206 deaths – or 1 in 491 residents. In contrast, a few miles away in the Loop and Near North Side neighborhoods (zip code 60611), there have been 7 deaths – or 1 in 6,485 residents linked to COVID-19. Developing an honest assessment of how racism is operating here entails exploring how the aforementioned mechanisms identified by Dr. Jones shape the patterns depicted in the map.

COVID-19 death rates in Chicago, week ending 12/12/2020



Source: Chicago COVID Dashboard (12.15.2020)

Health Equity Data as Accountability, As Protest

Data for Black Lives advocates for using data to protest against an unfair system that disadvantages some and advantages others. Similarly, the CDPH's Health Chicago 2025 plan asserts, when discussing the racial life expectancy gap in this city: "There is nothing natural or inevitable about these trends. We have the power to change them."

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Needs Assessment

The COVID-19 pandemic highlighted what many in Chicago, especially those tied to the city's health care infrastructure, have known for some time: factors beyond biology play a critical role in determining the outcome of one's health. A substantial amount of data worldwide has illuminated how COVID-19 has disproportionately impacted communities of color, populations living at or below the poverty level, and those with other challenges in addressing their non-biological needs. Earlier this year, Marynia Kolak, a health geographer, and her team at UChicago Health released the U.S. COVID Atlas, which, "identifies and tracks [COVID-19] hotspots at the county and state levels to help communities predict the trajectory of the pandemic." In addition to census data, the team looked at social determinants of health (SDoH) including age, education level, family structure, minority status, and access to health insurance. According to their analysis, SDoH accounted for more than 65.0 percent of the variation in premature deaths, leading them to conclude that, "social factors, rather than the built or natural environment, as the most important determinants of health outcomes."

These findings, while perhaps not to the same extreme, rang true for other conditions plaguing the city's residents. A team at the University of Illinois at Chicago, led by Samuel Harford, a PhD candidate in the department of mechanical and industrial engineering, built a machine-learning algorithm to predict the survival rates of out-of-hospital cardiac arrests. The algorithm combines data from the Cardiac Arrest Registry to Enhance Survival (CARES) database with SDoH information (e.g., crime rates, access to health care, education) from the Chicago Health Atlas. Once clinical and SDoH simplified data were combined, the team found that the average recall of out-of-hospital cardiac arrests survival predictions made by the algorithm increased; this led the team to conclude there is wide potential utility in leveraging social determinants data to more accurately predict clinical outcomes of patients.

Regardless of the health concern of focus, how SDoH are identified and addressed will lay the groundwork for how well the city of Chicago, Cook County, the state of Illinois, and the country will rebound from the pandemic, prevent or address destabilizing health emergencies, and elevate the overall health and wellbeing of its citizens. With the release of Healthy Chicago 2025, Chicago established a framework for how it will address SDoH for at least the next five years. The vision of the Healthy Chicago 2025 initiative is, "a city where all people and all communities have power, are free from oppression and are strengthened by equitable access to resources, environments and opportunities that promote optimal health and well-being." *More information on the Healthy Chicago 2025 initiative can be found on page 28*.

But the city cannot act alone. There is a movement in the insurance industry to collect and analyze this data. Federally, the Centers for Medicare and Medicaid Services (CMS) has been pushing for both publicly funded programs to improve their capacities to identify and address the social determinant needs of covered beneficiaries. Illinois has made some headway here, at least in Medicaid: Managed care organizations (MCOs) in the state that are contractually obligated to both screen and make referrals for the social needs of their attributed beneficiaries. On the commercial side, a review of publicly available information from eight insurance carriers showed that there is increased investment by the carriers to address social determinants of health. These investments, however, are predominantly funded through carriers' philanthropic bodies, and do not necessarily come with any associated changes in coverage or benefits.

Despite the source of movement, there is a time-sensitive need to continue and accelerate activity. Interviews with stakeholders of the Illinois Medicaid program indicated that in 2021 they would like to see a program focused on addressing SDoH. As activity around the Healthy Chicago 2025 initiative increases and city and state budget pressures mount, insurance carriers will be pressured to address SDoH overall or at a minimum help with data collection across all products.

2020 Census

In October the Supreme Court ruled in favor of moving up the deadline for the 2020 Census, cutting the once-in-a-decade count short by two weeks. The order passed with one dissent from Justice Sonia Sotomayor, who argued that the accuracy of the census would suffer and cause harmful impacts that could last for the next 10 years.

By mid-October of this year's census, only 60.5 percent of Chicagoans had responded, well below the city's goal to reach a 75.0 percent response rate and the 66 percent response rate in 2010. The state is at risk of losing $195 million per year for each 1.0 percent of the population that is undercounted and could also lose two congressional seats to the census-based redistricting.

HC3 View: Health and Social Determinants

Our health system's financial mechanics are not directly compatible with incorporating the sometimes-opaque nature of a social factor that could be detrimental to a person's health. But at close to 20.0 percent of our national GDP, dispassionate economics and strong social dissonance will increasingly drive our industry deeper down the rabbit hole of untangling those things we know and those things we do not.

We anticipate social factors related to housing and transportation will become more of a focus while we continue to better understand a range of other issues such as food security, violence, early childhood education and the like.

II. ECONOMIC DEVELOPMENT

GOVERNMENT

Federal

Medicaid

Eligibility, Funding, and DSH

Across the country, states are continuously recalibrating budget and enrollment projections for their Medicaid programs. Low unemployment and an almost decade-long period of revenue growth had states at the beginning of the 2020 looking at increased revenue with level, or decreased, Medicaid enrollment. However, as has been consistently reported throughout the COVIV-19 pandemic, states are anticipating significant budget shortfalls at a time when they are seeing and/or anticipating a strong growth in Medicaid enrollment on the horizon. While the federal government has intervened with an increased the federal match rate by 6.2 percent through the Families First Coronavirus Response Act, states anticipate this will be insufficient, "fully offset state revenue declines and fully address state budget shortfalls." In the FY 2021 budget, Illinois has allocated $8.01 billion in general funds for the Department of Healthcare and Family Services (DHFS), which, "maintains all eligibility and benefit levels in the Medicaid program to ensure individuals retain their healthcare coverage."

In response to the COVID-19 pandemic, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 (P.L. 116-136) on March 27, 2020. One component of the CARES Act was to eliminate any planned disproportionate share hospital (DSH) payment reductions during FY 2020. Additionally, the CARES Act proposed reducing DSH payments by one-half (to $4.0 billion) for FY 2021 (which began July 1, 2020, though cuts were delayed until December 1, 2020), and resuming the originally planned reductions by $8.0 billion a year for FY 2022 through FY 2025.

While states will have to factor these reductions into their upcoming budgets, they will not have to change how they calculate DSH payments overall. In November 2020, a ruling by a federal appeals court upheld that DSH payment calculations can include, "Medicaid patients as well as patients eligible for treatment under experimental Medicaid 'demonstration projects' approved by the Department of Health and Human Services."

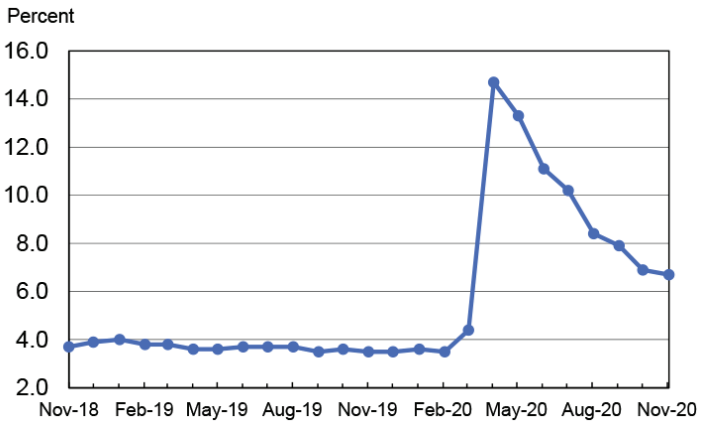
Public Health

Unemployment and Coverage

The COVID-19-induced shutdown caused a rapid and massive spike in unemployment and resulted in economic disruption that may persist for years. The pre-COVID unemployment rate in February was about 3.8 percent nationally. At the initial peak of the pandemic in April, the unemployment rate was nearly 15.0 percent, up more than 11.0 percent compared to the rate in February and at the end of 2019. Although the unemployment

rate continued to decline every month since April, the unemployment rate by the end of November was still nearly 7.0 percent, more than 3.0 percent higher than February levels with economists commenting that this rebounded number would be obscuring the true impacts because of those that have dropped from the workforce. Furthermore, the U-6 unemployment rate, which accounts for underemployment and individuals who gave up searching, stood at 11.6 percent in November, almost double the rate as the same time last year (6.5 percent). Existing racial disparities in unemployment rates persisted through the pandemic. In April, the unemployment rate was 16.7 percent among Black workers and 18.9 percent among Hispanic workers, compared to 14.2 percent among white workers. The ratio of unemployment among Black and white workers has historically been two to one, so the gap seemed to be closing at the height of nationwide unemployment in 2020. However, the unemployment rate dropped at different rates for each racial group throughout the remainder of the year. By November, unemployment stood at 10.3 percent for Black workers and 5.9 percent for white workers, indicating the disparity in unemployment rates between the two groups is on track to returning to pre-pandemic levels. Hispanic workers had the largest drop in unemployment, hitting 8.3 percent by November, a drop of nearly 11.0 percent since April.

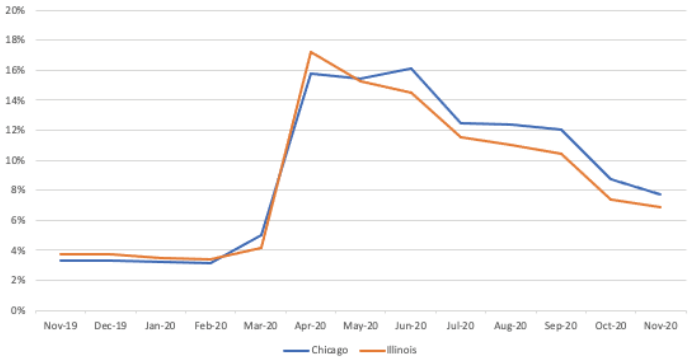
Unemployment rate, seasonally adjusted (November 2018-November 2020)



Source: Bureau of Labor Statistics, U.S. Department of Labor

Chicago (Chicago-Naperville-Arlington Heights, IL Metropolitan Division) and Illinois trends mirrored national findings as well. Unemployment rates from November 2019 through February 2020 remained consistently near 3.3 percent for both regions. The steepest increases for both Chicago and Illinois simultaneously occurred in April through September. Chicago's rate increased to a high of 16.1 percent in June and the state reached a high of 17.2 percent in April. The rates decreased to 8.7 percent and 7.4 percent, respectively, in October. While a dramatic decrease from the spring and summer highs, the rates are still incredibly higher than the prior two years' rates.

Seasonally Adjusted Unemployment Rate



Source: Illinois Department of Employment Security, Economic Information and Analysis
Revised 2010-2019 estimates published in April 2020

A survey conducted by The Conference Board in October revealed that nearly one in 10 U.S. businesses planned to lay off workers during the final three months of the year because of the COVID-19 pandemic. Nine percent of companies cutting employees in the fourth quarter avoided layoffs earlier in the health crisis, when 29.0 percent of firms eliminated staff. Another 13.0 percent of firms plan major restructurings in the last quarter that could include some layoffs not already counted in the 9.0 percent, according to the principal researcher in human capital for The Conference Board. Milliman predicts that there will be a -13.0 percent to a -5.0 percent net reduction in employment in 2021.

Prior to COVID-19, about 48.0 percent of Americans received employee sponsored insurance, 27.0 percent received subsidized Patient Protection and Affordable Care Act (ACA) or Medicaid coverage, 16.0 percent had

other coverage (i.e., VHA, non-dual Medicare), and 9.0 percent were uninsured. The rise in unemployment was expected to result in significant declines in employee-sponsored insurance (ESI) coverage and an increase in the number of uninsured individuals. However, thus far, declines in ESI have not because of cobra mirrored declines in employment, and the national uninsured rate has remained relatively flat. Enrollment in the fully-insured group market decreased by only 1.5 percent between March and September, compared to a 6.2 percent decrease in employment during the same period. Enrollment in Medicaid increased by more than six percent between February and July 2020, suggesting that loss of ESI was partially offset by enrollment in Medicaid. While Medicaid served as a safety net for some patients who lost employer-based coverage, individuals living in non-expansion states are less likely to qualify for Medicaid. Also, shifts in coverage may still present challenges or disrupt continuity of care. Only 71.0 percent of physicians accept Medicaid for new patients, posing an access barrier for patients newly shifting into Medicaid enrollment. Patients may no longer be able to see their established providers if they are not in network of their new plan.

Thus far, data submitted by insurance companies to the NAIC show that employers have actually kept coverage rates steady. Employers and benefit consultants say one of the reasons the rate has held steady could be due to employers electing to keep furloughed workers enrolled in health coverage. As the pandemic continues it's unclear how long this can continue. Data from BLS show that temporarily laid-off workers made up the vast majority of the unemployed in the spring and early summer. However, temporary lay-offs have decreased, while the number of permanent job losses has increased. If this trend continues as the survey suggests and Congress fails to pass meaningful new stimulus legislation in the lame duck session, the employer market could see larger coverage losses in Q1 of 2021.

Housing

The COVID-19 pandemic will have a significant and long-lasting impact on the housing sector. At the beginning of 2019, there were an estimated 561,715 homeless individuals in the U.S. More than 96,000 were chronically homeless, and more than 35,000 were unaccompanied youth. The COVID-19 pandemic exposed the severity of the homelessness crisis. When stay-at-home orders were put into place, homeless individuals had no place to go and were already at a higher risk of exposure to COVID-19 and serious cases of COVID-19 because of poor health status and pre-existing conditions.

The CARES Act provided $4 billion provided to help state and local agencies expand shelter options and help people remain housed. A federal eviction moratorium was also enacted to prevent a spike in evictions early on in the pandemic. The moratorium helped lower eviction rates in (March and?) April, but the number surged well above average rates by June as some localities lifted their respective moratoria were lifted. Analysts believe an additional $11.5 billion is needed to continue these efforts throughout the pandemic. Without additional relief funding the pandemic could backtrack the progress made in previous years and lead to an estimated 45 percent increase in overall homelessness in a single year.

Shifts in Care Delivery and Utilization

The COVID-19 pandemic had a dramatic impact on health care delivery and utilization. The CMS released recommendations on March 18 urging providers to postpone or cancel elective, non-essential medical, surgical, and dental procedures to preserve equipment and staff for COVID-19 patients. Not only did most providers defer elective and preventive care visits following the recommendation, but most patients also avoided in-person care due to fear of exposure to the virus. The federal government also loosened previous requirements, including HIPAA compliance and licensing restrictions, and expanded telehealth reimbursement guidelines for a more seamless transition to virtual care. As a result, the shift towards care delivery via telehealth accelerated, and telehealth replaced in-person visits where possible. The number of telehealth visits increased rapidly following the onset of the pandemic, from virtually zero percent in February to nearly 14.0 percent of all visits by mid-April. Telehealth visits began to decline slightly in May to approximately 12.0 percent of all visits and continued to decline further through the summer. By October, telehealth made up 6.3 percent of all visits, which remained above pre-pandemic levels. Utilization

of telehealth varies significantly across specialties as well. In October, telehealth was used for 41.0 percent of all behavioral health visits, 9.0 percent of adult primary care visits, and only 3.0 percent of obstetrics/gynecology and dermatology visits. Telehealth played an important role in expanding access to care for millions of patients during the pandemic, and it will likely be a source of care delivery beyond the pandemic. However, health care delivery will need to be a hybrid of both in-person and virtual care because telehealth still has its limitations. It also exposed, and may have exacerbated, the health disparities that already existed among vulnerable populations. The most significant barriers to telehealth utilization among low-income and rural communities is broadband access and lack of appropriate technology to access services.

In early April, visits to ambulatory care providers dropped by 60.0 percent compared to the pre-pandemic period. In May, the number of visits began to rebound but remained about a third of the number of visits pre-pandemic. By June 14, visits to ambulatory practices remained 11.0 percent lower than the baseline, which is a significant rebound from the April count. However, the cumulative visit deficit between March 15 and June 20 was still nearly 40.0 percent. The decline in visits varied by states; states that had early surges in COVID-19 cases saw a 17.0 percent decline compared to an eight percent decline for states with low COVID-19 activity. By October, outpatient practices and patients had adapted to the "new normal." Ambulatory care visits returned to pre-pandemic levels and visits to some specialties exceeded pre-pandemic levels, including dermatology (up 17.0 percent), adult primary care (up 13.0 percent), and surgery (up three percent). However, providers in some parts of the country were still battling surges in COVID-19 that made it challenging to keep patients and providers safe while also ensuring a stream of revenue. Pulmonology visits were down 20.0 percent, overall behavioral health visits were down 14.0 percent, and cardiology visits were down 10.0 percent ("visits" are reflective of all types, in-person and via telehealth, for each specialty). The rebound to outpatient varies by payer type. Visits by Medicare patients are three percent above baseline, compared to 1.0 percent for commercial and negative one percent for Medicaid patients. Smaller health care organizations had a harder time rebounding visits to pre-pandemic levels compared to larger organizations. Organizations with one to five providers had a six percent decrease in visits by October, compared to an increase of 14.0 percent for organizations with more than six providers.

Elective patient volume across U.S. hospitals declined by 30.0 to 55.0 percent during the first wave of the pandemic. The deferral of elective surgeries during the pandemic cost the U.S. hospital system an estimated $16.3 to $17.7 billion per month in reimbursement and $4 to $5.4 billion per month in net income. Previous deferrals of elective procedures caused an average 30.0 to 40.0 percent drop in revenue for nonprofit hospitals across the nation, so hospitals are reluctant to defer elective care again despite an uptick in COVID-19 cases. Because many states have not mandated broad shutdowns, hospitals are left with the decision of whether or not to allow elective procedures. Elective procedures are likely to continue because hospitals are better prepared following the first wave of the pandemic. Not only do executives have insight on how to better manage capacity and safety guidelines, there has been an increase in production of personal protective equipment to prevent another shortage, even with the continuation of elective procedures.

Although most operations and procedures are defined as "elective" in the health care system, elective care is not necessarily optional; it can range from vital preventatives measures, like a screening colonoscopy, to essential surgery, such as cataract removal. The deferral of elective care caused disruptions in care for many people and have resulted in worse patient outcomes and higher costs. Even as hospitals begin to allow elective procedures again, it is estimated that there will be a cumulative backlog of more than one million surgical cases for two years after deferments ended. It may take seven to 16 months until the U.S. health system can perform 90.0 percent of the pre-pandemic volume of surgery depending on various scenarios.

The impact of the pandemic on health care utilization and costs throughout 2021 is subject to significant uncertainty and depends on the vaccine timeline, social distancing guidelines and adherence, and patient fear surrounding return of elective care. Towards the end of the third quarter of 2020, Willis Towers Watson outlined

projected impacts on medical costs depending on a few possible scenarios:

Scenario A: Early control

- This scenario assumes there will not be another wave like the one seen in March and April, and COVID-19 remains at a manageable level. Care deferred during the first wave will resume at the end of 2020 and the beginning of 2021.

Scenario B: Variable hot spots

- There will be some level of COVID-19 infection that will appear and disappear within certain geographies, but the national infection rate remains flat so there is not another wave similar to the one in March and April.

Scenario C: Widespread new infections

- COVID-19 infections are at manageable levels through the summer, but a second wave emerges in late 2020 that is similar to the first wave or worse.

Scenario D: Widespread new infections with multiple peaks

- The first wave will be small compared to a second wave that will emerge in the winter of 2020 and an additional wave in the spring of 2021.

As infection rates increase across the country in November and December, scenarios A and B have been debunked. The most likely scenario is C because the country is in a second wave that is similar in severity to the first wave and may become worse. In this scenario, COVID-19 is projected to decrease 2020 health care costs by 5.8 percent and increase 2021 health care costs by 2.7 percent. The two-year net impact is a 3.1 percent decrease in health care costs. Because the COVID vaccine has been approved, it is unlikely that there will be another wave in the spring like scenario D suggests. However, if a third wave does occur in the spring, health care costs are projected to decrease by 8.8 percent in 2020 and increase by five percent in 2021. The two-year net impact on health care costs is a decrease of 3.8 percent.

Behavioral Health and Opioid Crisis

COVID-19 had a devastating toll on Americans' behavioral health and those suffering with substance use disorders. According to CDC data released on December 17, over 81,000 drug overdose deaths occurred in the U.S. between May 2019 and May 2020, the highest number of overdose deaths ever recorded in a 12-month period. "The disruption to daily life due to the COVID-19 pandemic has hit those with substance use disorder hard," said CDC Director Robert Redfield, M.D. "As we continue the fight to end this pandemic, it's important to not lose sight of different groups being affected in other ways. We need to take care of people suffering from unintended consequences." An earlier report revealed that in June, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19.

Recognizing the need to support individual's behavioral health needs, providers started taking steps to integrate behavioral and mental health services into primary health care settings and ensuring primary care physicians are equipped to provide services. In October, the AMA announced the formation of the Behavioral Health Integration Collaborative, a new effort that will provide best-in-class support to physicians working to combine mental and physical health services in their medical practices in an effort to make behavioral health more accessible. Around the came time CommonSpirit Health also announced it Is partnering with Concert Health, a leading behavioral health medical group, to offer patients increased access to support for depression and anxiety within the primary care setting.

At the beginning of 2019, Chicago and Illinois launched several initiatives to address mental health and substance use. With the onset of the COVID-19 pandemic, these initiatives grew in scope as the associated impact, prevalence, and severity of the pandemic intensified.

In January, Illinois Governor JB Pritzker signed an Executive Order establishing two committees to address the opioid crisis in the state: The Governor's Overdose Prevention and Recovery Steering Committee to oversee the State Opioid Action Plan (SOAP) and the Opioid Social Equity Committee to address the social and racial disparities of the opioid epidemic. The governor also announced additional initiatives and investments including making 50,000 new doses of naloxone available, expending provider capacity for MAT, creating a rapid response system to notify physicians when their patients experience an overdose, and piloting a study of safe consumption sites.

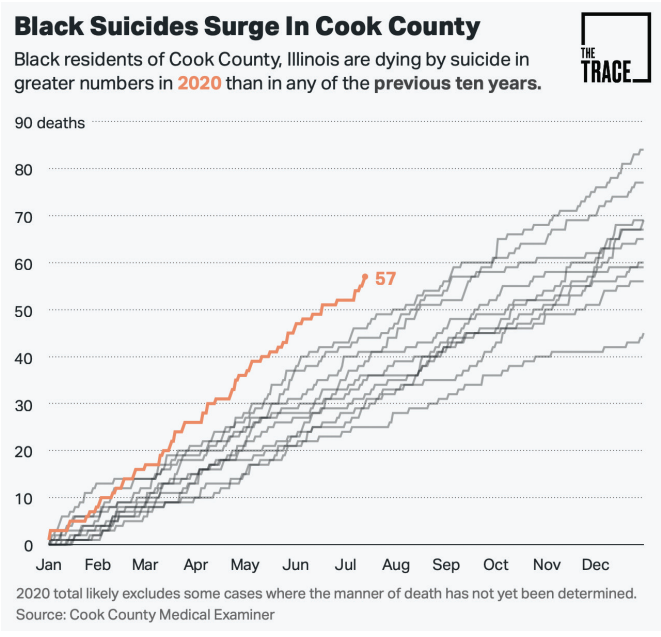
At the end of 2019, the Behavioral Health Workforce Education Center Task Force presented its findings to the Illinois Assembly. The report outlines the evidence of work shortages, such as the unmet need for behavioral health services across the state and proposes additional models and calls for the creation of an Illinois Behavioral Health Workforce Education Center to foster and build workforce capacity. In February of 2020, Senator Heather Sterns introduced a bill to establish the center. In March, the state took two additional steps to address behavioral health. First, a senate committee approved legislation for more immediate access to mental health treatment. The legislation specifically encourages parity in insurance network adequacy requirements and amends insurance code requiring insurers to have a wait time no longer than ten business days between a patient requesting an appointment and being seen for mental health care. Second, the senate addressed the behavioral health workforce capacity shortages, as called for in the Behavioral Health Workforce Education Center Task Force Report.

Once COVID-19 struck the city and state, all efforts focused on mitigating the pandemic, pushing many prior health care initiatives to the backburner. Like physical health conditions, the state acted quickly to ensure mental health care was available via telehealth. On March 19, Governor Pritzker released an Executive Order expanding telepsychiatry and other behavioral health services. Many health insurers also implemented cost sharing waivers for behavioral health services, some extending through the end of 2020.

In May, the city took specific action to increase access to behavioral health care for residents which were aligned with Mayor Lightfoot's Framework for Mental Health Equity released in 2019. The CDPH announced a partnership with four community mental health organizations, each with deep community ties, to increase behavioral health care access: Friend Health, Healthcare Alternative Systems, Thresholds, and Trilogy Behavioral Healthcare. The department provided $1.2 million to the organizations to expand initiatives that target persons living with serious mental illnesses such as schizophrenia, bi-polar disorder, or other co-occurring disorders. The city purchased and implemented a HIPAA compliant telemedicine platform, called doxy.me, to expand telehealth capabilities in community mental health centers in Bronzeville, Englewood, West Elsdon, Lawndale, and North River. The city also partnered with ten percent happier to release a free wellness website called Windy City Wellness to offer free guided medications.

In October the city announced a second wave of behavioral health funding via an $8 million grant awarded to 32 mental health care organizations in the city's west and south sides. More than half ($5.3 million) of the grant came from 2020 budget funds earmarked for mental health services, the remaining funds were from the federal government for COVID-19 Support. Block Club Chicago reported "The city's grant will help Healthcare Alternative Systems bridge those gaps and improve service for uninsured people, who comprise about 30 percent of the group's patients." The city also announced $1.6 million in federal funds to provide mental health services for individuals experiencing homelessness.

Anecdotally, Chicago behavioral health clinics are corroborating the increased demand. Cityscape Counseling located in the loop, reported their new case load jumped from 95 to 148 over the course of two months pushing their 17 therapists to see 500 clients per week. Data supports Chicago's increase rates of mental health disorders as well. Particularly, Black residents of Cook County are seeing a spike in suicide rates higher than any of the last 10 years.



Source: InjusticeWatch.org; Cook County Medical Examiner

COVID-19 has also exacerbated substance use and the opioid epidemic within the city. The state-based initiatives at the beginning of the year provided infrastructure for interventions and solutions, however, as of June, the city still saw a dramatic year over year increase. A mid-year report released by the city found a 55.0 percent increase in opioid related overdoses in the city from 2019 to 2020 with 80.0 percent of those deaths involving fentanyl. The report noted that Black males experienced the highest number of opioid overdose deaths (60.0 percent).

Opioid-Related Overdose, Chicago		
	Counts	2019 to 2020 % Change
January-June		
EMS Runs[1]	7,3016	0.5%
Naloxone doses administered[2]	8,8785	7.5%
Opioid-R elated Overdose Death[3]	5735	4.9%

Source: Chicago Opioid Update: Mid Year, Chicago Department of Public Health

Organizations such as Well Being Trust created a framework for excellence in mental health and well-being offering strategies and policies for promotion, prevention, treatment, and maintenance of these conditions that can be tailored for unique population needs. In response to the continued increase, the CDPH announced new initiatives in August focused on overdose prevention and linkage to treatment and services, including:

- Funding for:
  - the Illinois Public Health Institute (IPHI) to convene a cross-sector learning collaborative to expand evidenced based approach to prevention and treatment of opioid use disorder
  - increased partnerships between mobile units and medication for opioid use providers for greater street outreach engagement
  - the formation of a cross-sector group to develop partnerships between community organizations and high-volume overdose emergency rooms
- Forming a South Side Opioid Task Force and greater guidance to harm reduction organizations
- Consistent tracking of monthly opioid-related EMS responses with data sharing to providers and other service organization through the cities Health Alert Network System (HAN).

Cost and Transparency

Price transparency: Hospitals and Pharmaceuticals

At the end of 2019, the Trump administration released its final rule requiring hospitals to disclose the prices negotiated with health insurers so that consumers can compare prices for a wide range of services. The hospital industry responded by suing the CMS, stating that the rule exceeded the agency's statutory authority. On June 23, 2020, Federal Judge Carl Nichol upheld the rule, saying that it will advance the agency's interest in informing patients about the cost of care and thus help tamp down the cost of care. The next day, the American Hospital Association (AHA) and three other hospital groups filed an appeal and urged the Trump administration to delay the rule, set to go into effective on January 1, 2021. During the remaining months of Trump's presidency, the administration showed no intent to do so. In early September, the CMS released its Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule (CMS-1735-F), confirming that the agency will collect data on hospital median payer-specific negotiated charges and use that information to set relative Medicare payment rates. The agency stated that the provisions will, "introduce the influences of market competition into hospital payment and help advance CMS's goal of utilizing market-based pricing strategies in the Medicare FFS program."

Rise in Premiums

According to Kaiser Family Foundation's 2020 benchmark Employer Health Benefits Survey, annual family premiums for employer-sponsored health insurance rose 4.0 percent to average $21,342 this year. Amid the COVID-19 pandemic, the CMS allowed health insurers to offer premium reductions to individual and small group market members until the end of the year to help ensure that consumers can continue to be covered during COVID-19. Simultaneously, utilization of health care services fell so dramatically that numerous insurers

– including Anthem; Blue Cross and Blue Shield plans in Illinois, Massachusetts, Michigan, Minnesota, Rhode Island; Priority Health, UnitedHealth Group – announced premium credits under the ACA's Medical Loss Ratio (MLR) rebate rule.

Despite dramatic decreases in health care utilization during COVID-19 yielding savings for health plans, health coverage premiums and costs are still projected to rise in 2021. According to The Business Group on Health annual "Large Employers' Health Care Strategy and Plan Design Survey," companies anticipate that average cost of coverage will reach roughly $15,550 in 2021, a 5.3 percent increase compared to the estimated $14,769 in 2020. A limited analysis of proposed 2021 rates in the exchanges of 10 states and D.C. showed a median increase of 2.4 percent, with changes ranging from a hike of 31.8 percent by a health plan in New Mexico to a cut of 12.0 percent in Maryland. A more robust analysis from the Kaiser Family Foundation found that overall proposed rate changes on the ACA exchanges for 2021 range from a 12.0 percent decrease to a 31.8 percent increase, with more than half falling between a 2.0 percent decrease and 6.0 percent increase. Twenty-seven of the 63 filings reviewed for the analysis (43.0 percent) elected not to factor in potential coronavirus-related costs to their initial proposed premiums due to uncertainty, citing a lack of information and the evolving nature of the pandemic. A report from the American Academy of Actuaries predicts that COVID-19 will cause more volatility in the individual market next year as new enrollees could cause adverse selection. The actuaries noted that even a small change in enrollment could significantly affect the morbidity level on the exchanges, which will affect the risk pools.

Towards the end of the year, the Trump administration announced that Medicare Advantage premiums are set to decline 11.0 percent in 2021 compared to plan year 2020, decreasing from $23.63 to an estimated $21.00 per month on average.

According to CMS data, as of October 16, 2020 insurers nationwide paid out nearly $2.5 billion in MLR rebates. More than 11.2 million Americans will be eligible for a rebate across the individual, small group, and large group markets, with an average rebate of $219 per person. Close to 5.2 million people enrolled in individual market plans will receive rebates. The average rebate for individual market plans is $322 per person, for a total of more than $1.7 billion in rebates.

HC3 View: Coverage and Utilization

There are a few things to consider about the data that CMS released. First, a number of insurers waived costs for telehealth visits and COVID-19 tests and treatments to lower the MLR rebates they could owe. Second, the CMS data is based on reports filed through October 16, so technically additional rebates could be sent during the last 10 weeks of the year. Third, CMS calculates MLR rebates based on a three-year average of insurers' spending; the data reflects 2017, 2018, and 2019 spending. We anticipate that payers who are running a sub-80 percent MLR will continue to issue refunds through the remainder of 2020 to stay complaint with the ACA provision. Furthermore, MLR rebates next year could likely be substantially more (even if utilization returns to pre-pandemic rates) because they will be based on 2018, 2019, and 2020 financial data.

Judicial Activity

The 2020 calendar year covered parts of two Supreme Court terms: the 2019-2020 and 2020-2021 terms. During these two terms, the Court's health-related cases focused on components of the ACA (three cases), access to abortion services (one case), and the ability of states to regulate pharmacy benefit managers' operations.

At the end of last year (December 2019) the fifth circuit court of 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. In mid-August the Supreme Court released its list of October term arguments, revealing that the court would hear arguments on the ACA on November 10, one week after the presidential election. On September 18, Supreme Court Justice Ruth Bader Ginsburg died due to complications of metastatic pancreas cancer. Barely one week after her death, President Trump nominated Amy Coney Barrett, a conservative leaning federal appeals court judge, to succeed the late Ginsburg on the U.S.

Supreme Court. The Senate officially confirmed Judge Amy Coney Barrett as a U.S. Supreme Court justice on October 26 by a vote of 52-48. Every GOP senator voted for Barrett's confirmation except Senator Susan Collins clearing the way for Barrett to weigh-in on the ACA case. After oral arguments regarding the law's individual mandate on November 10, it appeared that most of the ACA could survive. Chief Justice John Roberts and Justice Brett Kavanaugh suggested they are unlikely to throw out the entire health care law. "Here, Congress left the rest of the law intact. … That seems to be compelling evidence that Congress did not intend to repeal the rest of the law," Roberts said.

On July 8, 2020, the Court issued its decision on Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania. The decision before the Court was whether or not the Trump administration acted properly in adding exemptions to regulations that require contraceptive coverage to be included in employee health plans. In their ruling, the Court reversed a decision by the Third Circuit Court of Appeals by deciding that the Departments of Health and Human Services, Labor, and Treasury had the, "authority to provide exemptions from the regulatory contraceptive requirements for employers with religious and conscientious objections." In her dissent, Justice Ginsberg noted that this decision by the Court would cause between 70,500 and 126,400 women an immediate loss of access to no-cost contraceptive services.

On April 27, 2020 the Supreme Court decided its ruling in Maine Community Health Options v. United States (argued in December 2019), concluding that under the "Risk Corridors" statute of the ACA, "petitioners [insurance carriers] may seek to collect payment through a damages action in the Court of Federal Claims" from the federal government. This ruling, though relevant to only the first three years during which risk corridors are in effect, indicate the Court will not allow the federal government to not abide by its own statutory obligation. However, this decision will not resurrect Illinois Co-Op, Land of Lincoln, which cited non-payment of risk corridors as reason for insolvency.

The Supreme Court's ruling in June Medical Services LLC v. Russo, decided on June 29, 2020, indicates that the fight around access to legal abortion services is still at-play in the United States. In 2014, the State of Louisiana passed Act 620, requiring physicians who perform or induce abortions to have active admitting privileges at a hospital that is no further than thirty miles from where the abortion is performed or induced. At issue before the Supreme Court was whether a ruling by the U.S. Court of Appeals for the Fifth Circuit, deciding that Act 620 did not pose undue burden on providers, should be upheld, despite a law similar to Act 620 being struck down in Texas (Whole Women's Health v. Hellerstedt). In a slim 5-4 majority, the Court ruled that the similarity between Louisiana's Act 620 and Texas' House Bill 2 were too great to treat them differently in the eyes of the law. As a result, the Fifth Circuit's ruling was reversed and Act 620 was deemed unconstitutional. Chief Justice Roberts joined in the narrow majority in supporting the concept of stare decisis, though wrote in his concurrence that he, "joined the dissent in Whole Women's Health and continue to believe the case was wrongly decided." This ruling can be seen as providing an opening for ongoing future challenges to access to abortion services by indicating the potential support of the Court.

On December 10, 2020, the Supreme Court ruled on Rutledge v. Pharmaceutical Care Management Association. This case prompted the Arkansas Act 900 which attempted to regulate how pharmacy benefit managers operate within the state, including implementing a maximum allowable cost list regarding the reimbursement costs for pharmacies dispensing generic drugs, in an effort to address the state's low number of rural and independent pharmacies. The question before the Court was whether or not Arkansas Act 900 is preempted by the Employee Retirement Income Security Act (ERISA), aligning this case with the recent flurry of attention and activity at the federal level regarding drug pricing. In an 8-0 ruling (Justice Coney-Barrett was not seated when the Court heard the case on October 6, 2020), the Court ruled that Arkansas Act 900 neither, "has an impermissible connection with an ERISA plan" nor is reliant on ERISA plans to be operationalized. The ruling, authored by Justice Sotomayor, thus concluded that Arkansas Act 900 is not preempted by ERISA.

Medicaid Expansion

To date, 38 states and the District of Columbia have adopted the Medicaid expansion and 12 states have not adopted the expansion. In the past year, voters in two states approved ballot measures for expansion. On June 30, Oklahoma voters approved a ballot measure on June 30, 2020 which adds Medicaid expansion to the state's Constitution. The amendment requires the Oklahoma Health Care Authority to submit a SPA and other necessary documents to CMS within 90 days of the ballot measure's approval, and for expansion coverage to begin no later than July 1, 2021. On August 4, Missouri voters voted to add Medicaid expansion to the state's constitution. The amendment requires the state to submit all SPAs necessary to implement expansion to CMS no later than March 1, 2021 and for expansion coverage to begin July 1, 2021.

On March 13, 2020 President Trump signed an executive order declaring a public health emergency concerning the COVID-19 pandemic. The declaration triggered Section 1135 of the Social Security Act; allowing states to modify or waive certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure beneficiaries of such programs have their health care needs met during the public health emergency. All 50 states, D.C., and three territories have requested, and CMS approved, Section 1135 waivers.

COVID-19 has caused serious economic strain to most states. Multiple analyses have indicated that anywhere between 10 and 30 million people will lose employer-sponsored coverage by the end of 2020. In a majority of states – especially those who have expanded Medicaid – many will be able to transition to Medicaid. The National Association of Counties estimates an overall $144 billion budgetary impact across all U.S. counties through fiscal 2020-21—$114 billion in lost revenue and $30 billion in additional expenditures.

Illinois State Budget and Capital Plan

Governor Pritzker's 2020 budget included $127 million in revenue from recreational cannabis sales. In January, 41 dispensaries sold nearly $40 million in recreational marijuana which generated more than $10 million in tax revenue for the state ($7.3 million in cannabis tax revenue and more than $3.1 million in sales tax revenue). As of September 2020, Illinois collected $86 million in taxes. To promote equitable practices of dispensaries the Illinois Cannabis Regulation and Tax Act requires 25 percent of revenue "to be reinvested through the Restore, Reinvest and Renew (R3) Program in communities that have been disproportionately impacted by the justice system, directed to address substance abuse and prevention and mental health concerns, or allocated to local governments to support their own crime prevention programs." There is limited evidence that any behavioral health or substance use disorder interventions are funded from this revenue.

In February, Governor Pritzker released a $42 billion spending plan for FY 2021. Part of the budget placed $1.4 billion on reserve in the event the state votes to amend the constitution in November allowing a graduated income tax rate. The reserve included $482 million in funding for health and human services that will increase Medicaid reimbursement rates ($42 million), increase funds to the Department of Aging community care program ($40 million), and increase contributions to the state employee group insurance costs ($400 million). The graduated income tax amendment did not garner enough support in the election and therefore, the reserve will not be accessed.

Because the graduated income tax (known as the "fair tax") was not passed, the governor warned of painful funding cuts as the alternative to the increased 15.0 percent across the board to cut to discretionary spending. Of the proposed (which included the proposed reserve) $7.4 billion budget allocated for health care and human services, below are some of the notable initiatives as outlined by Health News Illinois.

- Full funding of $500 million for the Integrated Health Homes program. The program, which is set to launch in July, will receive a 90 percent federal match for the first two years but was not suspended.
- $118.5 million for the Department of Human Services to provide services for people with developmental disabilities in support of the Ligas consent decree.

- $15 million in revenues from the legalization of cannabis will be used to expand substance use disorder and mental health treatment services.
- $4.5 million for the Department of Public Health to reinstate a marketplace navigator program to help consumers navigate the insurance marketplace.
- An additional $29 million for HIV/AIDS programs, which will help the Department of Public Health serve approximately 14,000 clients.

Despite the state receiving federal funds for COVID-19, and new revenue from recreational marijuana sales, the state was still left with a multibillion-dollar budget revenue shortfall. In April, Governor Pritzker announced a potential shortfall of at least $7.3 billion over the next two years. The estimate stated a $2.7 billion in FY 2020 and $4.6 billion in FY 2021 with potential to increase to $7.4 billion pending the passing of the graduated tax amendment in November. In May, the state released an updated FY2021 spending plan, decreasing the total amount by $1 billion (for a total of $41 billion) and relying heavily on federal financial aid to support COVID-19 shortfalls. The federal stimulus of $3.7 billion includes the following priorities as summarized by Health News Illinois:

- $385 million to provide support to providers of long-term care services, excluding specialized mental health rehabilitation facilities. An additional $50 million will be given to support providers offering long-term care services to disproportionately impacted areas, based on positive COVID-19 cases.
- $150 million to support federally qualified health centers. An additional $40 million will support federally qualified health centers that serve disproportionately impacted areas, based on positive COVID-19 cases.
- $190 million to support ambulance providers, medical assistance providers, excluding specialized mental health rehabilitation facilities.
- $14.6 million to support specialized mental health rehabilitation facilities.
- $30 million for services including mental health, substance abuse and other counseling services and assistance for individuals and families impacted by the COVID-19 pandemic.

The budget includes a dedicated $19.8 million to nine specific, highly-Medicaid-dependent providers:

Hospital	Amount
South Shore Hospital – Chicago	$3.2M
Roseland Community Hospital – Chicago	$3.2M
West Suburban Medical Center – Chicago	$3.2M
Loretto Hospital – Chicago	$3.2M
Javon Bea Hospital – Rockford	$2M
Mount Sinai Hospital – Chicago	$2M
Touchette Regional Hospital – Chicago	$1M
Jackson Park Hospital – Chicago	$1M
St. Bernard Hospital and Health Care Center - Chicago	$1M

The FY2021 budget also renewed the hospital assessment program at $3.5 billion, an increase of $250 million, effective July 1, 2020 through 2022 and approved the annual transformation funding pool of $150 million to support hospitals and providers engage in specific transformation efforts.

In an attempt to fill the $3.9 billion budget gap for the 2020 fiscal year, on December 15 Governor Pritzker announced $711 million in spending cuts. More than $200 million was cut from health care and human services, including $126 million in DHS cuts through hiring freezes, reduced overtime, and decreased grants. "These cuts reflect the first phase of our path forward, doing what is within my powers, unilaterally and without the Legislature. This is going to be tough, and as my ongoing conversations with General Assembly leaders would indicate, there is a great deal of work the Legislature must do when it convenes next month," Pritzker said.

In September, Mayor Lightfoot released the 2021 budget forecast. Similar to the state, the results of COVID-19 and continued social unrest caused a $1.2 billion shortfall for

the coming year and an $800 million shortfall in the $4.4 billion 2020 budget. This is the largest budget gap in the city's history and the shortfall is expected to continue and grow through at least 2023.

2020 CORPORATE FUND YEAR-END ESTIMATES

2020 Year-end estimates	
Revenues	$3,532.6M
Expenditures	$4,331.4M
Surplus/(Deficit)	*($798.8M)*

2021 CORPORATE FUND PROJECTIONS

2021 Year-end estimates	
Revenues	$3,636.0M
Expenditures	$4,840.5M
Surplus/(Deficit)	*($1,204.5M)*

Source: City of Chicago 2021 Budget Forecast

To address the shortfall, the city is considering solutions such as debt refinancing, CARES Act reimbursement for eligible unbudgeted COVID expenses, services efficiencies, and slowing hiring. Proposed solutions to close the future shortfalls in 2021 include increasing department efficiencies, workforce reforms, exploring new revenue sources, and financial reforms.

Public Health and Social Determinants of Health

The state of Illinois and city of Chicago have each spent much of 2020 fighting COVID-19, as referenced on page 26. While most of the state's and city's major executive orders and laws have been related to COVID-19, there have been a few substantial public health-related actions from local and state government.

Tobacco was a hot-button topic nationwide and in Illinois. In response to community outcry, Chicago began talking about a new ban on flavored tobacco products in July. Just two months later, the city council passed a new ordinance that prevents the sale of flavored tobacco.

In tandem with the new ordinance aimed to protect youth against tobacco use, the CDPH performed a study to measure youth tobacco use in the city. On one hand, the rate of those smoking cigarettes was down nearly 4.0 percent. However, on the other, nearly 17.0 percent of high school respondents said they use tobacco products, up from 12.0 percent in 2017. Interestingly, the rate of cigarette and vape usage in Chicago is still lower than averages for each in Illinois and the U.S. as whole.

Mayor Lightfoot and the Department of Family & Support Services (DFSS) received $35 million in CARES Act dollars to invest in housing for people without housing. In tandem with a $1.3 million donation from Chicago Funders Together to End Homelessness (CFTEH), an organization called All Chicago Making Homelessness History (All Chicago) will use the CARES Act money to enact the Expedited Housing Initiative (EHI). This project dismantles standard barriers that folks unfortunately go through when attempting to regain permanent housing. From inability to secure subsidies to income verification, EHI removes procedural roadblocks that draw out the process of gaining access to housing.

Mayor Lightfoot also announced an innovative partnership between Chicago, Uber, and Lyft that collectively raised over $20,000 for Chicago people who are experiencing domestic violence and need transportation. The Illinois Domestic Violence Hotline will use the funds to coordinate those in need with free rides from Uber and Lyft.

On Friday, December 11 DHFS unveiled its health care transformation plan aimed at addressing social and structural determinants of health. "It's time we looked beyond the four walls of a hospital or doctor's office and reorient the entire system around people and communities," department director Theresa Eagleson said in a statement. "We need to reimagine care delivery and focus on what it takes to truly improve health and wellness for the most vulnerable Illinois residents. Public policy and funding should focus more on integration of services and social factors that have the greatest impact on individuals and communities, in addition to inpatient hospital care or specific providers." According to an article in Health News Illinois, the plan will require legislative approval to fund pilot projects and planning grants that emphasize

collaboration with community-based organizations plus an unrelated health care provider. Criteria for each project must also be measurable and centered around health equity. DHFS wants to use the $150 million that is set aside annually for transformation in the hospital assessment program to fund the plan.

Medicaid

DHFS reported an 18.9 percent increase in the number of HealthChoice Illinois enrollees between January and October 2020. During the same time period, Cook County reported an 18.4 percent increase in the number of enrollees. At the plan level, Blue Cross/Blue Shield of Illinois saw the largest growth in enrollment from January to October (30.4 percent), with Molina Healthcare seeing the second-largest growth (28.7 percent). Even with distribution of a COVID-19 vaccine,[3] there is speculation that Medicaid programs across the country will continue to see increases in enrollment as the pandemic continues to impact the economic vitality of the country.

In addition to increasing enrollment in the state's Medicaid program, the COVID-19 pandemic also caused NextLevel Health, one of Illinois' Medicaid Managed Care Plans, to shut its doors. In July 2020, the plan's roughly 55,000 members were transitioned to one of the five remaining MCOs covering Medicaid services in Cook County. Based on analyses of monthly enrollments for the five plans between June and July 2020, Meridian likely absorbed the majority of NextLevel Health's beneficiaries, given their outlying 29.4 percent increase in enrollment during that time. The closure of the MCO player in Illinois was unanticipated. Molina Healthcare, another MCO player in Illinois, announced in January 2020 plans to acquire NextLevel Health as part of the company's growth strategy; however, four months later, the MCO announced they were pulling back from the deal. NextLevel Health refused to abandon its commitment continuing its search for capital partners to "positively impact our communities and save lives."

YouthCare HealthChoice Illinois (YouthCare), the Centene-based Medicaid Managed Care plan for the state's children in care with the Department of Child and Family Services (DCFS), launched on September 1, 2020 and those formerly in care with DCFS transitioned to the program in February 2020. The transition was delayed multiple times, due primarily to child advocates voicing concerns that the DCFS-managed provider network is inadequate to meet the needs of YouthCare-eligible youth and that a Managed Care model will only further limit access. During a hearing with the Illinois Senate Human Services Committee on October 23, 2020, ACLU Illinois called to light access barriers experienced by YouthCare beneficiaries since the program's date. A day after the hearing, Committee Chairwoman Julie Morrison (D-Lake Forest), issued a statement saying that, "Together, through communication and a willingness to put children's health first, Illinois can soon have some of the most robust care for children in need."

Part of this "willingness" is the collection and assessment of quality data related to services provided to the estimated 18,000 and 19,000 youth enrolled in YouthCare. DCFS, in partnership with DHFS, will examine data related to the provision of services for YouthCare-eligible youth that occurred between February 1, 2020 and January 31, 2021 to set benchmarks for future quality assessments. Under the program's implementation plan, YouthCare will be eligible for incentives, or be on the hook for penalties, related to the quality of the care they provide beginning March 1, 2021.

The Integrated Health Home (IHH) initiative, another component of the Illinois Medicaid program, was indefinitely put-on hold in November 2020. This indefinite hiatus is not the first delay experienced by the program: initially slated to begin in January 2020, the initiative has since had anticipated start dates of April 2020, July 2020, and January 2021. While officials within DHFS shared that the IHH delay was part of a larger, "transformation proposal" to help the Illinois Medicaid program better address social determinants of health, improve access to services, and foster collaboration among providers and community services, DHFS has not yet shared a timeline when they anticipate the proposal to take effect and, therefore, when IHH could theoretically be implemented.

3 On December 11, the United States Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for the first SARS-CoV-2 mRNA vaccine, BNT162b2, manufactured by the Pfizer.

There are two areas where subject matter experts on Illinois Medicaid hope to see DHFS bring the program in 2021: addressing social determinants of health and strengthening collaborations between partners and others serving HealthChoice Illinois beneficiaries. (THS interviews with Subject Matter Experts (November 2020). Therefore, this "transformation proposal" will potentially receive high levels of scrutiny next year as stakeholders examine if the plan actually addresses the priorities that the program's stakeholders identified.

City of Chicago

Lightfoot's Campaign Promise and the 2020-21 Budget

In her 2019 campaign, Mayor Lightfoot promised to execute on a seven-point plan prioritizing the health of all Chicagoans. The plan focused on mental health services, lead contamination in city water, addressing violence, racial disparities among people with asthma, Chicago's opioid crisis, maternal morbidity and mortality rates, and access to health care through public health clinics. In 2020, Mayor Lightfoot continued to execute on the plan. Lightfoot formed the Racial Equity Rapid Response Team which focuses on overcoming disparities including chronic illnesses like asthma. In September, Mayor Lightfoot announced an inaugural plan to replace lead lines in the city. She said her team is still gathering information on how much the replacement program will cost but estimates it will run about $8.5 billion. The city will depend on a Community Block Grant for replacing lead lines for low-income residents and federal grants for much of the rest of it, but Lightfoot acknowledged that the money for the program doesn't currently exist.

Lightfoot's 2020 budget earmarked $9.3 million for the CDPH's "Framework for Mental Health Equity" to increase mental health care capacity among 20 existing clinics across the city. The 2020 budget also included funding for community initiatives like affordable housing and homelessness efforts. In October, Lightfoot delivered on these budget plans when she announced that the city would award over $9 million in grant funding to 32 mental health services organizations to:

- Grow the city's "mental health safety net" with $8 million a year in spending on new facilities offering trauma-informed mental health services, particularly on the south and west sides
- Address homelessness and related issues with an additional $1.6 million in programs
- Launch a public awareness campaign to reduce stigma around mental health care

Mayor Lightfoot has stated that the COVID-19 pandemic has caused the city to lose approximately $780 million in revenue, and she projects an $800 million budget shortfall for 2020 and a $1.2 billion deficit for 2021. Mayor Lightfoot has not given specifics on how she plans to close the 2020 budget gap, but she has indicated that her budget team is looking at a personal property tax on computer leases as a potential new revenue source for the city. She also said that the city will utilize a significant surplus in tax increment financing that was intended to be set aside for development projects. Other proposed solutions include a $94 million property tax increase and layoffs of hundreds of city workers.

Recovery Task Force

In April, the city of Chicago launched a COVID-19 Recovery Taskforce (RTF) to advise the city's strategic health and economic response to the unique challenges and financial turmoil presented by the COVID-19 pandemic. Co-chaired by Mayor Lightfoot and former White House Chief of Staff Sam Skinner, the RTF is organized into five core committees that each include a range of industry experts, regional government leaders, community-based partners, and policymakers. The task force proposed 17 recommendations across five core priorities:

Build on our region's strengths	* Expand the region's transportation, distribution, and logistics sector by leveraging new trends in the localization of supply chains * Strengthen Chicago's healthcare and life-sciences ecosystem * Build on the region's assets in food and agriculture
Capture opportunities created by COVID-19	* Build on the region's historic strength in manufacturing * Prepare the region to capture HQ2s and corporate development and specialty centers * Capture film and TV production opportunities
Reignite activity throughout Chicago by sharing our story	* Introduce Chicago's master brand * Lead the re-imagination of regional tourism, travel, and hospitality * Develop new and existing neighborhood hubs to encourage tourism in neighborhoods * Show the world Chicago is open for business

Source: Recovery Task Force Advisory Report, Forward Together: Building a Stronger Chicago (July 9, 2020)

The recommendations span over a multi-year journey with explicit timing for different phases to implement interventions across the city. The near-term initiatives planned for 2021 aims to increase access to mental and emotional health resources via a dedicated 211 line for individuals to access community resources, a digital one-stop shop website for wellness and self-care resources and leveraging and expanding telehealth investments that were made due to COVID-19.

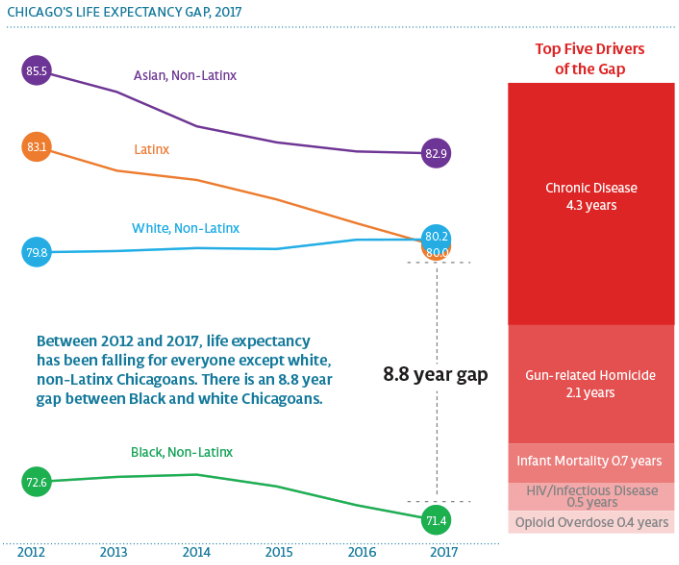
In a city survey, roughly 85 percent of respondents indicated that funding from the police budget should be redirected to other public health and other social services. Despite these demands from some residents, Mayor Lightfoot said that she will not be making major cuts to the Police Department. Her plan budgets nearly $1.7 billion for the Police Department, which is a reduction of about $59 million, or 3.3 percent, from what the department received for 2020. Lightfoot said, "I've been very clear that I do not support defunding the police…Our police officers are not our enemies."

Two-and-a-half months after announcing the task force, Mayor Lightfoot unveiled the Recovery Task Force Advisory Report presenting the city's COVID-19 economic recovery plan. The report also provides substantial guidance on addressing racial inequities in Chicago, taking advantage of what Mayor Lightfoot called a "once-in-a-generation opportunity" to address poverty and entrenched racism in communities that have been hit especially hard COVID-19.

The report also highlights four initiatives that the city has already implemented, one of which is INVEST South/West – a community improvement project that directs resources from various city departments to 10 communities of Chicago's South and West Sides – Auburn Gresham, Austin, Bronzeville, Greater Englewood, New City, North Lawndale, Humboldt Park, Greater Roseland, South Chicago, and South Shore. In June, Mayor Lightfoot announced $11 million in grant funding for two critical developments in the Auburn Gresham and North Lawndale neighborhoods. One development is the Auburn Gresham Healthy Lifestyle Hub and the other is the North Lawndale Surgical and Ambulatory Care Center. The city expects that the two projects will serve as a framework for additional investment in these and other community areas.

Healthy Chicago 2025

On September 17, the CDPH launched Health Chicago 2025, a new community health improvement plan focused on reducing racially driven life expectancy gaps. According to a report CDPH released, the life expectancy in Chicago has fallen between 2012 and 2017 for everyone except white, non-Latinx Chicagoans. The largest contributors to the life-expectancy gap are chronic disease, opioid overdoes, gun-related homicide, infant mortality, and HIV/infectious disease.



Source: https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/HC2025_917_FINAL.pdf

Healthy Chicago 2025 aims to close this 8.8-year gap by focusing on four assessment themes and seven priority areas. The four themes include:

1. Transform policies and processes to foster anti-racist, multicultural systems
2. Strengthen community capacity and youth leadership
3. Improve systems of care for populations most affected by inequities
4. Further the health and vibrancy of neighborhoods

The priority areas are: Housing, food access, environment, public safety, neighborhood planning and development, health and human services, and public health system organizations.

During the livestream launch event for Health Chicago 2025, Health Commissioner Allison Arwady, MD said that CDPH is "being even more explicit in the work and the planning than ever before. We certainly recognize that racism is at the heart of many of these inequities that we are talking about."

HC3 View: Government's Role

The political strife seen in 2020 is unlikely to abate. A deeper societal schism remains unresolved, even through the pain experienced by our political and economic systems over the year.

At the federal level, areas related to price transparency, clinical interoperability, behavioral health, and accountable care will remain high priorities for the federal government. Despite the outcome of the Georgia Senatorial run off, we are likely to see a veritable strengthening of the ACA and a growing number of small group and mid-market employers shift health coverage to Health Reimbursement Accounts, which will in turn markedly increase the size of the exchanges.

The political climate in Illinois we will remain tense as well-intended efforts clamor for scarce dollars, transformation efforts rise and fall, and the state prepares for an upcoming electoral cycle. Thus far, we have failed to make the difficult tradeoffs required for long-term budget sustainability and remain focused on perpetuating a narrow view of health care's role in underserved communities.

Reforming the state's system will require bold and decisive action. The safety net policies of the past will not carry us into the future. We have an abundance of evidence, resources, and well-intentioned professionals that collectively can solve the problems inflicting pain today and address the challenges that will inflict pain tomorrow.

INDUSTRY TRENDS

Closures, Mergers, Openings, Acquisitions

Amid COVID-19, M&A general activity for hospitals and health systems did not slow down. According to a report from Kaufman Hall, there were 19 health care transactions in Q3 of 2020. This number is not only on trend with past Q3 reports, but also marks a 35 percent jump from Q2 (14 to 19).

Advocate Aurora Health, one of the largest health systems in Illinois, was part of many of the biggest deals in 2020. First, the system revealed that they were part of an ambitious plan to bring together four hospitals on the South Side of Chicago. Advocate Trinity Hospital, in partnership with Mercy Hospital & Medical Center, South Shore Hospital and St. Bernard Hospital, revealed a plan to consolidate the four facilities under a new entity with one leadership team in a deal worth an estimated $1.1 billion. However, the deal relied heavily on assistance from the state of Illinois, which never came. In late May, the four hospitals announced they would no longer be pursuing a merger and would likely need to cut services as a result. The effects of COVID-19, the lack of a deal between counterparts, and other contributing factors left Mercy Hospital & Medical Center with no choice but to declare their closure. Pending State approval, the hospital planned to close for good between February 1 and May 31 of 2021. Mercy revealed that they were losing about four million dollars a month and could clearly not sustain their current rate of loss. In mid-December, the Illinois Health Facilities and Services Review Board unanimously rejected the plan by Trinity Health to close Mercy Hospital & Medical Center. The Board expressed concerns prior to the vote about the impact that closing the facility would have on the south side of Chicago. Mercy Hospital officials have shared a commitment to transformation and have made plans to go before the board again in 2021 in order to discontinue inpatient services and transition to an outpatient model to continue to serve south side residents.

Health News Illinois announced in January that Advocate Aurora Health is planning a $63.5 million expansion of the Advocate Condell Medical Center in Libertyville, Illinois. The building application filed with the Illinois Health Facilities and Services Review Board highlighted a focus on modernizing the intensive care unit of the facility. Advocate was exploring the possibility of merging with Beaumont Health in June. However, the two large systems called off the merger in October. If the two systems had merged, their combined revenue would be around $17 billion, making them one of the largest health systems in the U.S.

On the North Side of Chicago, NorthShore University HealthSystem had a busy 2020. As announced in 2019, Swedish Hospital (formerly Swedish Covenant Hospital) officially became part of NorthShore at the beginning of 2020. Also on the merger front, NorthShore and Northwest Community Healthcare (NCH) based in Arlington Heights, revealed a plan to merge into "a regional, community-focused health care hub." Although the merger is not yet official, if the two join together, then the new organization would have an annual revenue around four billion dollars.

Moving south, OSF Healthcare and Carle Health System made substantial acquisitions. As recorded in HC3's 2018-2019 State of Chicago Health Care, Little Company of Mary, in Evergreen Park, officially joined the Peoria-based system OSF Healthcare. Central Illinois also saw a big acquisition between Advocate Aurora Health and Carle Health System. Carle, which is based in Urbana, Illinois, purchased Advocate BroMenn in Normal, Illinois and Advocate Eureka Hospital in Eureka, Illinois for a total of $190 million.

Executive Leadership Movement

HC3's 2018-2019 State of Chicago Health Care documented a large movement in executives across Chicagoland and the U.S. Significant organizations like the Health Care Service Corporation went through a bout of resignations and general executive movement. However, with a small nod towards COVID-19, a study by the American College of Healthcare Executives (ACHE) found a small decrease in health care executive movement in 2020. Although the turnover rate only dropped minimally, the rate had not dropped or increased since 2014.

Nationally, the Blue Cross Blue Shield Association (BCBSA) named a new president and chief executive officer (CEO) in 2020. Kim Keck, who arrived at BCBSA from Blue Cross Blue Shield of Rhode Island, also held a number of significant positions at Aetna before her time in the Blue Cross Blue Shield family. With plans in every state, new leadership for the BCBSA affects all corners of the U.S. Keck is the first woman to hold the role of president and CEO of BCBSA, marking an important step for the BCBSA at a time when new leadership will be important to move the organization forward.

In 2020, Chicago witnessed a handful of executive moves which will certainly shape the local health care landscape. Last year, Catholic Health Initiatives (CHI) merged with Dignity Health and moved the new organization, CommonSpirit Health, to Chicago. Until June 30 of 2020, Kevin Lofton and Lloyd Dean, the previous chief executives of CHI and Dignity, were co-leaders of the new organization. However, after Lofton stepped down this summer, Dean became the sole CEO of CommonSpirit Health. The University of Chicago Medicine brought in Thomas Jackiewicz to take over as system chief operating officer and the University of Chicago Medical Center president. Jackiewicz arrives in Chicago after serving as CEO of Keck Medicine of the University of Southern California. However, there is no evidence of any significant operating activities sourced in Chicago, or that we are aware of plans.

AMITA Health and DuPage Medical Group (DMG), two of largest health care providers in the suburbs of Chicago, hired new chief executive officers in 2020. AMITA Health experienced significant executive resignations and movement as the organization attempted to deal with post-merger woes. With the announcement in 2019 that Mark Frey was to step down as CEO, AMITA tapped Keith Parrott from Tenet Health to start in January 2020. Parrott formerly oversaw Tenet's Alabama and Tennessee Group and was CEO of Brookwood Baptist Health before that. Because AMITA has 19 hospitals and approximately $4 billion in annual revenue, Parrott could have great effect on health care in Chicagoland.

DMG hired Steve Nelson, formerly the CEO of UnitedHealthcare. On the provider side, Nelson held numerous executive roles at Henry Ford Health System

and Intermountain Healthcare. DMG has over 100 locations and 750 primary and specialty care physicians across the Chicago suburbs.

HC3 View: M&A

COVID-19 relief funding provided some safety net institutions long-needed liquidity that will aide in extending their solvency runway. However, recovery will not come quickly. Many of the better endowed stakeholders have watched liquidity and solvency erode at an unprecedented rate and statewide, institutions are still facing a changing economic structure that can inflict significant pain over time.

Critically, such entities must find new ways to integrate in the system by demonstrating value and constructing business relationships accordingly. We believe most of the M&A in the managed care ecosystem has played out for the short term and, as we've stated in previous papers, there are boundaries to how much horizontal consolidation can occur with providers in our state.

Thus, value capture will occur as the number of independent practices wane, complementary biopsychosocial competencies are acquired, and the digital services market begins a long journey of consolidation.

Insurance Coverage

In 2020, the Illinois exchange had 292,945 people enrolled in private individual market plans, a drop of more than 24.0 percent from 2016 and the lowest enrollment rate since 2014. Besides Quarts, which expanded into three additional counties for 2020, most insurers in the Illinois exchange maintained the same coverage areas. Health Care Service Corporation (HCSC, Blue Cross Blue Shield of Illinois) continues to be the only statewide insurer. The five participating insurers in the Illinois exchange had the following average rate changes for 2020:

- Celtic Insurance Co. (Ambetter) had an overall average rate **decrease** of 7.4 percent
- Health Alliance Medical Plans Inc. (HAMP) had an overall average rate **decrease** of 4.0 percent
  - 7.9 percent **decrease** for HMO plans
  - 2.3 percent **decrease** for POS plans
- HCSC (Blue Cross Blue Shield of Illinois) had an overall average rate **increase** of 0.4 percent
- Cigna had an average rate **decrease** of 0.6 percent
- Quartz Health Benefit Plans Corporation had an overall average rate **increase** of 5.5 percent

Three new insurers joined the exchange in Illinois for 2021:

- Bright Health, which previously only offered Medicare Advantage plans in Illinois, will be offering plans in the Chicago area
- MercyCare HMO expanded its plans outside of Wisconsin to the Rockford area
- SSM Health Plan (WellFirst Health) expanded its plan into Illinois to cover the full St. Louis area

In 2019, Health Alliance which was the only insurer offering Small Business Health Options (SHOP) plans for small businesses in some areas of the state. The insurer exited the exchange in 2020, forcing small business to purchase plans directly from insurers or through a broker.

Brokers across the nation have their sights on the fast-growing Medicare Advantage (MA) market, which is projected to reach 47.0 percent penetration by 2025 and began to strengthen their Medicare presence in 2020. One-fourth of Medicare beneficiaries in Illinois are enrolled in MA plans as of 2020. This summer, Walmart announced its new insurance agent subsidiary called Walmart Insurance Services and rolled out two new Walmart Health clinics in Georgia and Arkansas, with plans to expand into Florida and Illinois.

Effective January 2020, SB162 required health plans in the state to expand mammography coverage beyond the federal preventive care mandate, which only requires insurers to coverage screening mammograms. Illinois insurers now have to fully cover diagnostic mammograms, as well as breast ultrasounds and MRIs for women with dense breast tissue or women who are advised by their doctor that these services are medically necessary.

In September, Blue Cross insurers reached a tentative $2.7 billion settlement in an antitrust federal lawsuit that claims the group has allegedly engaged in a conspiracy to curb competition and essentially divide the health insurance market among themselves. Under the proposed terms, the Blue Cross plans would no longer have to adhere to rules developed by the association that prevent the plans, which operate independently, from engaging

in head-to-head competition. The plans would be able to compete for business from national employers and in areas where they do not use the Blue Cross name. The proposed settlement will still need to be approved by Judge R. David Proctor of the U.S. District Court for the Northern District of Alabama, who is overseeing the case, as well as all of the three dozen Blue Cross insurers that make up BCBSA.

Digital Health and Health Innovation

Within days of the World Health Organization declaring the COVID-19 a pandemic, the digital health industry sprang into action to ensure that health care delivery didn't grind to a halt. The surge in telemedicine and pivoting existing technologies helped make care accessible while so much else was in question. The federal government relaxed regulations that have long thwarted telemedicine companies and eliminated barriers to address the unprecedented urgencies to advance and invest in health care technology.

At the end of March, some of Chicago's leading innovation hubs – mHub, MATTER, and 1871 – joined forces to mobilize the tech ecosystem to help develop solutions to support the fight against COVID-19. "In this unprecedented time, one thing is certain: technology and innovation are more important than ever. Our health system is straining, and there is an important role for technology to play in the short- and long-term," said Steven Collens CEO of MATTER and Co-Founder of HC3. mHUB, 1871, and MATTER developed a website, seeking opens calls from stakeholders, along with opportunities for innovators to share their solutions. Throughout the year, the collective efforts of these innovation hubs was able to leverage resources and assemble knowledge-sharing opportunities to address complex issues facing the health care industry. The team has also engaged hospitals and regional leaders to connect to startups, focusing on solutions for personal protective equipment, such as ventilators, respirators, and masks, as well as temporary medical facilities.

The team at P33 explored several priorities at the intersection of P33's strategy and the crisis, including a solution to coordinate regional hospital data that would build on P33's health care analytics work over the past six months to mobilize a comprehensive approach to data and analytics for the Covid-19 response. On August 5, P33 announced a collaboration with the OCC – a builder of data commons and data-sharing ecosystems, and MATTER to create the Chicagoland COVID-19 Data Commons (CCC) to understand the pandemic, measure Chicagoland's regional response, and build a helpful decision-making tool for local government. The CCC uses open APIs, and the data that it contains is available without restriction, except for those restrictions required to protect data derived from human subjects, or the privacy restrictions required by consumer apps that collect the data.

Digital Health Funding

The pandemic has exposed the fragility of our current health care ecosystem, leaving the entire system with no choice but to evolve and survive or remaining stagnant and risking failure. The growth in the digital health space has partly driven the transformation of health care. Digital health is on track to have its largest funding year ever in 2020, setting records for overall funding, number of deals, and average deal size. In the U.S., digital health companies raised $5.4 billion in venture funding in the first half of 2020 ($3 billion in Q1 and $2.4 billion in Q2) across nearly 550 deals averaging $25.1 million per deal. Digital health startups raised $4.0 billion in Q3, putting the year's total funding so far at $9.4 billion, exceeding total venture funding of $7.4 billion in 2019. It is estimated that total venture funding will reach $12 billion by the end of 2020. The average deal size across 311 deals this year is $30.2 million, compared to the previous record average of $21.5 million in 2018. The COVID-19 pandemic stunted digital health investment in April, but investors hit the ground running in the digital health space in May.

On-demand health care services, which includes telemedicine services and prescription delivery, were the most funded value propositions. These services alone raised $2.0 billion across 48 deals at an average size of $42.1 million per deal through Q3 2020. The deals that had the largest investments include:

- Alto Pharmacy, a free prescription delivery service, raised $250 million
- Ro, a virtual consultation platform for home-delivered prescriptions, raised $200 million

- Amwell, a telemedicine platform, raised $194 million initially. It later raised $742 million after going public in September, which is higher than they had projected.

The second most funded value proposition this year is research and development (R&D) catalysts, which includes drug discovery and clinical trial management, with $1.32 billion invested across 25 deals at an average size of $52.7 million per deal. Fitness and wellness trails closely behind with $1.26 billion in total investment this year across 21 deals.

Teladoc + Livongo Merger

Teladoc announced in early August that it is buying digital chronic disease management company, Livongo. This merger may be the starting pistol for further M&A activity in the digital health space. This is the country's first digital health megamerger, suggesting there is untapped potential of the nascent market. The deal will make up 41.0 percent of the total $45 billion in venture capital funding for digital health since 2011. The combined company expects 2020 revenue of $1.3 billion, an 85 percent growth compared to last year. They also estimate additional revenue growth of 30 to 40 percent over the next two to three years. Funding in digital health is at an all-time high, and this Teladoc-Livongo deal signals more investment by employers, as well as more consolidation on the horizon as employers look to get a broader variety of services from one vendor and provide a single-access point to digital care.

Teladoc has already announced two major acquisitions this year: InTouch Health (a $600 million deal) and Livongo. These acquisitions may establish the company as the only digital health care provider covering the full range of acuity, from critical to chronic to everyday care, positioning Teladoc to become the partner of choice for health systems seeking a single solution for their entire digital care strategy. In H1 2020, Teladoc reported:

- Visits tripled to 2.8 million in Q2
- Sixty percent of its visits were new customers in the first months of the pandemic
- $241 million in H1 revenue, an 85 percent increase year over year

Other notable acquisitions this year include:

- Unite Us, a data analytics company that leads in its sector, acquired Staple Health, which provides detailed and predictive analytics regarding social determinants of health to drive the move towards value-based care.
- Lululemon athletica, an exercise apparel company, acquired Mirror, an in-home fitness content streaming platform, for $500 million in a plan to expand its scope in the fitness arena beyond apparel.
- Omada, a digital chronic disease management platform, acquired Physera, a platform for remote consultations with physical therapists, for $30 million.

HC3 View: Digital revolution is here (again)

Okay, we *really* mean it this time. It is a tradition to begin the year in our industry by convening in San Francisco to say things like "this is the year of the consumer" and "digital revolution is here." But this time, there is increasing cause to believe it.

By necessity, digital health's baseline of adoption massively shifted upward over 2020. And then downward as service suspensions abated. Yet our society's increased use of these services for care (and everything else) will set a new hallmark for how health systems, managed care, and other stakeholders approach various services.

Digital health is not the monolithic synchronous clinical encounter our imaginations often conjure up. It ranges from capacity management, ADT systems, clinical intelligence wrought by interoperability, cognitive behavioral therapies, asynchronous functions for triage and imaging, and, and, and.

Each of these competencies have found significant use case demand as our system quickly pivoted our way of working.

If 2020 was the year of determining our new baseline, 2021 will finish determining our new vector by indicating how fast the industry will move. Valuations will remain irrationally high while venture investors will seek their exit. Consolidation in digital health will abound.

Life Sciences and Pharmaceuticals

The Chicagoland area hosts some of the world's leading pharmaceutical and biotechnology companies including

Astellas, Abbvie, and Horizon Therapeutics. It is also home to medical device and diagnostics companies such as Abbott and Baxter. Along with industry presence, Chicago is an incubator market with life sciences startups being cultivated in university research and think tanks. Chicago's market has seen a rise in investment to create better infrastructure for start-ups and development plans for facilities to support this work. Local developers have been creating plans for districts focused on biomedical research and life sciences in order to attract a more companies, startups and labs, and substantially expand Chicagoland's life sciences real estate footprint. Life sciences districts are being planned for Bronzeville, Fulton Market, Illinois Medical District, Lincoln Park, and near the University of Chicago in Hyde Park. Chicago developer Sterling Bay created a new investment arm, Prysm Life Sciences, that plans to put millions of dollars into emerging life sciences companies. In early March, GRIT – a joint venture of Farpoint Development, Bronzeville Community Development Partnership, Chicago Neighborhood Initiatives, Draper & Kramer, Loop Capital and McLaurin Development – announced a partnership with Kaleidoscope Health Ventures to create a first-of-its kind "healthy neighborhood of the future" targeting the former Michael Reese Hospital site in Bronzeville. A memorandum for the first tenant was signed to cultivate a global health and wellness innovation hub in the first phase of the 100-acre mixed-use development.

At the start of 2020, there was a lot of buzz around lower-cost drug pricing at both the state and federal levels of government. In 2019, the Illinois State Legislature created the Prescription Drug Affordability & Accessibility Committee to take on the challenge of prescription drug pricing. The committee has had some early success in 2020 with the passage of IL's SB667, which caps the price of insulin in Illinois being signed into law by Governor Pritzker on January 24.

Senator Andy Manar (D-Bunker Hill) and Representative Will Guzzardi (D-Chicago) introduced HB3493, which would have created the Prescription Drug Affordability Board and required all payers in the state to use a single upper payment limit when negotiating with drug manufacturers to purchase drugs. The bill received only eight yes votes on the 18-member committee reviewing it, two votes short of the majority needed.

In June, Illinois joined a third lawsuit alleging that generic drug-makers are conspiring to raise prices. "This is yet another layer of the pervasive conspiracy by generic drug companies to increase drug prices and their profits at the expense of Americans who rely on these vital medications," Attorney General Kwame Raoul said in a statement. "This conduct is illegal and immoral." Nationally, about one-third of U.S. states are experimenting with price-control measures for prescription drugs. But it is still not clear as to whether the controls will hold up to legal challenges, according to a first-of-its-kind survey on the state efforts. The controls revolve around state-created drug affordability boards - similar to the one Illinois was trying to develop - which are tasked with reining in state spending on prescription drugs. According to a Manatt Health survey, to date, 17 states have established or are considering legislation to establish such boards.

President-elect Joe Biden vowed to reduce drug costs and to allow Medicare to negotiate drug prices. He has support from Congressional Democrats to pass such legislation, which the Congressional Budget Office estimates could cost the industry more than $300 billion by 2029.

Pharma and MedTech companies quickly became front and center as they worked to scale-up production of vitally important medical products (e.g., personal protective equipment) and sprinted to develop new tests, therapeutics, and vaccines to diagnose and treat COVID-19. Two Chicago-based organizations in particular supported testing and prevention needs. On March 18, the U.S. Food and Drug Administration (FDA) issued an Emergency Authorization for Abbott's molecular COVID-19 test And in late August, the FDA issued Emergency Use Authorization for Abbott's BinaxNOW™ COVID-19 Ag card rapid test. In mid-December, the University of Illinois Urbana-Champaign announced the development of a statewide lab network to expand their COVID-19 saliva-based testing and tracing initiative. One of the key benefit of this advanced testing is the quick-turnround rate of test results within hours.

Looking Ahead

The COVID-19 pandemic has challenged community pharmacists to perform under difficult circumstances.

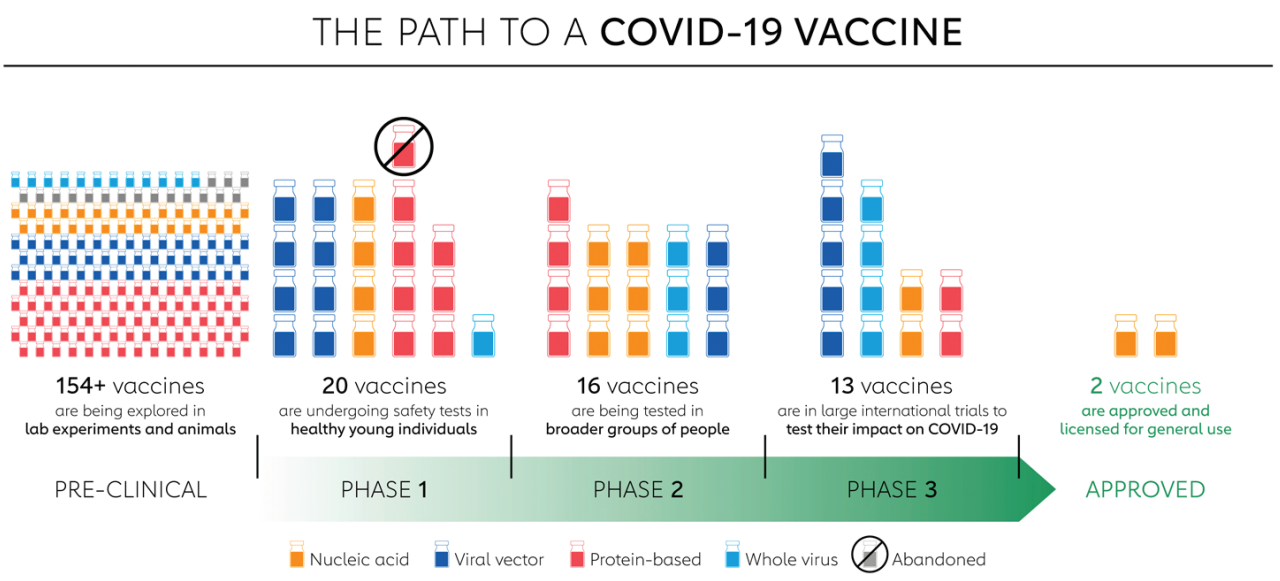
The pandemic has also highlighted the key public health functions community pharmacists play in medication therapy, chronic disease management, self-care recommendations, vaccinations, point-of-care screening and testing services, and adherence support. Although the role of pharmacists in chronic disease prevention and management is well established, the COVID-19 pandemic has accentuated the critical contributions community pharmacists make during an infectious disease outbreak. In early April, HHS issued guidance under the Public Readiness and Emergency Preparedness Act to authorize licensed pharmacists to order and administer COVID-19 tests that the U.S. FDA authorized. The accessibility and distribution of retail and independent community-based pharmacies enabled faster distribution and alleviated work for healthcare workers and first responders.

Across the globe, scientists have worked faster than ever to find vaccines to stop the spread of COVID-19. As of early December, approximately a year from the start of the pandemic, there are several promising vaccines on the brink of going through regulatory approval to be rolled out. Moncef Slaoui, the head of Operation Warp Speed, told reporters that the U.S. is hoping to give a COVID-19 vaccine to 100 million people by the end of February. That number essentially represents all of the nation's front-line health workers, the elderly, and people with underlying conditions. Slaoui noted that his calculation is based on the number of vaccines that could be available from Moderna and from Pfizer and BioNTech.

COVID -19 has had an uneven economic impact on the life sciences industry. There has been strong growth for companies with COVID-19-specific products, but there has also been a disruption to research and development and clinical studies. This in turn has dampened demand for products other than COVID -19 specific products. The interruption in research and clinical trials due to COVID-19 may jeopardize non-COVID-19 grant-funded research. New non-COVID-19 grants may be harder to find as money is focused on COVID-19, and government and non-profit budgets are stressed due to the recession. Prior to COVID-19, concerns about privacy may have slowed the growth of machine learning in the health care industry, but it looks like those concerns took a backseat amid the pandemic.

Vaccine Race and Distribution

Vaccines usually take years to create. However, in 2020, a new initiative appropriately called Operation Warp Speed instigated a race to produce an effective and safe coronavirus vaccine as quickly as circumstances would allow. According to the New York Times tracker, as of December 15, researchers were testing 59 vaccines in clinical trials on humans, and 16 have reached the final stages of testing. At least 86 preclinical vaccines are under active investigation in animals. On December 11, the FDA issued an Emergency Use Authorization (EUA) for the first SARS-CoV-2 mRNA vaccine, BNT162b2, manufactured by Pfizer. One week later, the FDA issued its second EUA



Source: https://www.gavi.org/vaccineswork/covid-19-vaccine-race

for the Moderna vaccine. The vaccine which uses similar technology to the Pfizer's vaccine; however, it can be stored in normal freezers and does not require a super-cold transportation network, making it more accessible for smaller facilities and local communities.

On Tuesday, December 15 Chicago's first front-line health care workers received the first round of COVID-19 vaccinations. Injections were given that morning at Loretto Hospital in the Austin community, where the death rate exceeds the citywide average. "This is, I fully believe, the beginning of what will be the end of COVID-19 here in Chicago," said Dr. Allison Arwady, CDPH Commissioner. Illinois is expecting to receive roughly 109,000 doses of the vaccine developed by Pfizer to start. Of that total from Pfizer, 23,000 doses will go to Chicago. In Illinois, the vaccine is being administered first to health care workers. There are roughly 655,000 health care workers so it will take months to vaccinate health care workers in Illinois. As we move into 2021, Illinois state will continue to look for guidance from the CDC to continue to roll out vaccine distribution.

On December 23, HHS announced that it reached a $1.95 billion deal with Pfizer to deliver another 100 million doses of its COVID-19 vaccine in the U.S. In exchange for the doses, the government will invoke the Defense Production Act to give Pfizer better access to roughly nine specialized products it needs to make the vaccine. Pfizer, which will be paid $4 billion in total by the federal government for this order and its previous 100 million dosage commitment, will team up with its partner BioNTech SE to deliver at least 70 million vaccine doses by June 30, with the deadline for the full 100 million supply set for July 31.

III. SYSTEM TRANSFORMATION

MARKET SCAN

Value Based Care and Alternative Payment Models

There were also some notable partnerships with value-based care organizations headquartered in Chicago. In January, Advocate Aurora announced a partnership with Oak Street Health to manage the senior population in Elgin, IL. Advocate hopes to learn from the expertise Oak Street Health has gained from managing fully capitated Medicare patients to grow savings and improve outcomes in their MA contracts. In September, Oak Street Health also announced a partnership with Walmart to offer its primary care services in select Walmart stores in Texas. If successful, this type of partnership could scale across the country as Oak Street continues to grow. Lastly, Deerfield-based Walgreens and Chicago-based VillageMD in July announced a partnership to open as many as 700 doctors' offices in Walgreens stores.

In March, Premiere Inc. released survey results of 245 health care providers finding that 82.0 percent of APM participants leveraged care management support to manage patients during COVID-19, as opposed to 51.0 percent of those not in APMs. Eighty-five percent of respondents reported declines in fee-for-service revenues of 30.0 percent or more due to canceled or delayed ambulatory care visits and elective or diagnostic procedures resulting in lost revenue. Provider did state they are concerned about financial losses from downside risk arrangements due to COVID-19, however, they have hope CMS will grant relief in these programs. The results indicate the "head start" providers in APMs had on managing care for patient during unprecedented times and may re-ignite interest in providers shifting to value.

Medicare

Nationally, there remains a strong commitment to a shift to value. In September, CMS Administrator Seema Verma announced that the 2019 revised Medicare Shared Savings Program generated a net total savings of $1.19 billion, representing the largest annual savings for the program to date. The announcement, revealed that 205 of the 541 ACOs participated in the Pathways to Success Program for the first time, achieving an average net savings of $169 per Medicare beneficiary. Meanwhile, the remaining 336 ACOs that participated in the legacy tracks achieved an average of $106 in savings. A total of 150, or 27.7 percent, were in a downside risk track last year – up from 17.0 percent (95 of the participating 548 ACOs) in 2018. Medicare ACOs serving parts of IL recouped $151 million in shared savings in 2019 reported this year. The 40 ACOs operating in the stated contributed $304 million of the nearly $1.2 billion saved by the program nationally.

Medicare Advantage

As of September 2020, 30.0 percent of Cook County's Medicare population was enrolled in a Medicare Advantage (MA) plan. Despite a slight 2.0-percent increase over the same time last year, the number remains below the national average of 36.0 percent.

In 2019, there was an increase in new MA plans including MoreCare and Zing Health. MoreCare had nearly 300 enrollees entering 2020, slightly above the anticipated numbers for the year. MoreCare's goal is to have 1,250 members by the end of the year. Zing Health announced plans for expansion in October. While the number of enrollees has not been released publicly, the company announced plans to move into six additional counties in Illinois, three in Indiana, and three in Michigan starting in 2021. Zing is also expanding its product line by offering a Point of Service HMO (POS-HMO), Chronic Special Needs HMO plan (C-SNP) covering cardiovascular disease, diabetes, and chronic heart failure, and an Employer Group Wavier Plan (EGWP) to select retiree groups.

As existing plans grow, there continues to be new players in this space. Blue Cross and Blue Shield of Illinois and Advocate Health Care announced a partnership to enroll members into a co-branded Medicare Advantage plan for January 1, 2021. Plan enrollees will have access to over 400 sites of care, nine hospitals, and one of the region's largest medical groups across Cook, DuPage, Lake, Kane, Kendall, McHenry and Will counties. This arrangement is not surprising as the two companies have partnered in the past on an ACO in 2011 and an HMO network in 2015.

Medicaid

At the beginning of the year, DHFS reported to the Illinois General Assembly, as required by Public Act 101-0209, findings from stakeholder discussions in 2019 on how to develop alternative value-based payment models for behavioral health providers in an attempt to transition them away from fee-for-service reimbursement. DHFS developed five recommendations with the following considerations in mind: (i) there is inequality in how ready providers feel to take on value-based arrangements; and (ii) there are myriad examples of value-based arrangements active in the Illinois market to learn from. The recommendations are as follows:

1. "No specific value-based arrangement should be mandated by the State at this time.
2. Value based arrangements should be encouraged and rewarded by DHFS through the MCOs.
3. By including the number and quality of value-based arrangements as part of the auto assignment algorithm, DHFS will best incentivize these arrangements while allowing managed care and provider creativity.
4. DHFS will strongly encourage some of the examples demonstrated particularly around full-term deliveries, non-medical interventions for asthma, and behavioral health.
5. There were some examples around waivers that are not included in managed care. DHFS will review with providers some of these examples for potential implementation in pilots."

Also in January, Illinois, through the Ann & Robert H. Lurie Children's Hospital of Chicago and the Egyptian Public & Mental Health Department and six other states, started the two-year pre-implementation period for Integrated Care for Kids (InCK) model. This $126 million federal program aims to: (i) improve child health; (ii) reduce avoidable inpatient stays and out-of-home placement; and (iii) create sustainable Alternative Payment Models (APMs). The state partnerships – consisting of a Lead Agency, the state Medicaid Agency, and a Partnership Council – will focus on implementing three activities to achieve the goals of the program:

- Early identification and treatment of children with co-occurring physical, behavioral, and other health-related needs;
- Integrated services, through care coordination and case management, to address identified co-occurring needs; and
- Development of APMs specific to state contexts.

Each funded partnership is awarded up to $3 million for each of the two pre-implementation years, with $2 million for each of the following five years of program

implementation. In Chicago, the Ann & Robert H. Lurie Children's Hospital of Chicago will run the program, with a focus on serving approximately 42,000 Medicaid beneficiaries in the 60639 and 60651 zip codes. The APM model for the Lurie program will have a fee-for-service foundation with quality-based incentives focused on services related to primary care, community services, and care teams. The program was written to be modeled after the state's IHH program, the indefinite hiatus of which will require a redesign of the hospital's InCK implementation.

In October, Blue Cross and Blue Shield of Illinois (BCBSIL) announced its Health Equity Hospital Quality Incentive Program. The program is anticipated to provide $100 million in funding to participating hospitals who commit to, "pursuing health equity and reducing health disparities for BCBSIL members" over a three-year period. The program will hone on such areas of quality as maternal health care and telehealth implementation. BCBSIL will invite hospitals to participate in the program, with the first two hospitals to join being University of Illinois Hospital on Chicago's Near West Side and Springfield's Memorial Health System.

HC3 View: Market Scan

Everything described thus far in this paper portends a pattern of digital over physical, integration over isolation, and better-served communities no longer over underserved communities.

We are beginning to enter a multi-year period that will change the function of the American hospital. In order to survive, hospitals will need to implement one or several of the following options: 1) considerably reduce asset investments, 2) repurpose other brick and mortar assets, 3) increase M&A activity, and 4) share or participate in accountable arrangements that penalize/reward their institution in comparison to other hospitals.

"Transformation" is at a terrible risk of being a commodity word. Yet its meaning has never had more importance. Our system simply won't bear the status quo. Economics, life physics, are immutable. There is no more money to do all the things we wish we could do. Our system is going to be pressured to make do with what we have. The bright side is that we have a lot in Chicago. If we can get out of our own way, we are more than capable of building a transformed system of care that meets every one of our expectations, rich or poor. If you're a leader in this industry, you have work to do in the new year lifting where you stand and fostering an abundance mentality as you seek to collaborate or as others seek to collaborate with you.

Health is seminal to economic development. Thus, health is seminal to our city's future and prosperity.

HEALTH CARE WORKFORCE

COVID-19 Workforce Challenges

COVID-19 exacerbated problems that existed prior to the pandemic. The compounding challenges posed by providing care for patients have a strong correlation with the economic ripple effect of the ever-changing environment in health care institutions throughout 2020. Higher expenses (e.g., purchasing PPE, hazard pay for front-line workers, purchasing devices and investing in telehealth and health IT, setting up forward triaging infrastructure,) coupled with lower revenue (e.g., declines in non-COVID outpatient visits, the postponing of non-time sensitive procedures, restrictions on providing non-urgent care due to COVID-19 precautions, or use of "social distancing" to limit the number of outpatient appointments per unit time) have contributed to Illinois hospitals losing as much as $1.4 billion a month, putting aside CARES Act or other federal relief. COVID-19 has eroded revenues for hospitals and some institutional providers across the state have furloughed workers or cut pay. Additionally, Illinois hospitals are facing staffing shortages. According to Doris Carroll, the President of the Illinois Nurses Association, "Approximately half of the nurses in Illinois are 55 and older, and I'm one of them. We will be retiring soon and so the concern is there won't be enough people to take care of our patients." In order to meet the growing needs across the nation, legislation or executive orders were made to help meet the needs in different states; however, as Carroll noted, " they need to fix this long-term problem of chronic staffing, so we are prepared because we will have more pandemics."

The COVID-19 pandemic has also intensified preexisting fiscal issues for some of the state's hospitals that typically see large numbers of uninsured or underinsured patients.

The downstream effect for health care workforce is especially challenging with nearly one in 15 health care workers lacking health insurance. Employees that are not providers and working on the frontlines in roles such as janitorial staff are being put at risk in their job without the security of benefits if they fall ill. Illinois' health care workforce across all levels is going to continue to be challenged as they deal with the direct health risks of providing care for COVID-19 patients with the mental and physical burdens placed on them.

Physician Burnout

The overwhelming impact of COVID-19 burnout has been felt by all, but especially amongst the health care industry's frontline workers. Workers are caring for increasing numbers of critically ill and dying patients with depleted resources – resources that are needed both to treat patients and to protect workers from infection. At the same time, they also face emotional and mental health consequences including exhaustion, stress, post-traumatic stress disorder, depression, anxiety, suicidality, domestic violence, and substance abuse. However, factors that contribute to physician burnout such as workflow challenges, reducing administrative burden and cultivating innovative care models to address person-centered care and care team coordination were present prior to the pandemic.

Early on in the pandemic, CMS rapidly made policy and payment changes to "help healthcare providers contain the spread of the 2019 Novel Coronavirus Disease" since the onset of COVID-19. One of the most impactful changes for providers was the CMS waiver of policies regarding verbal orders. Prior to this waiver, there was no concrete evidence that the majority of orders could not be safely conveyed by verbal or team order, when a member of the care team transcribes the order indicated by the physician into the EHR (electronic health record). Some crisis-related policy and practice changes should revert to the way things were before the crisis, however there are some opportunities for reshaping the way we practice medicine in the post-COVID world. In a Health Affairs article co-written by Dr. Christine Sinsky, Vice President of Professional Satisfaction at the American Medical Association and Dr. Mark Linzer, Division Director, General Internal Medicine at Hennepin County Medical Center outlined some guiding principles to consider post-crisis which include: more focus on evidence-based policy and regulation, loosening of documentation requirements of practitioners, policy and punishment are not the only levers to drive quality and safety, and the responsibility of health care outcomes should be assigned appropriately.

And while the rapid advancements in health IT and the pivot to telemedicine were helpful in reaching patients throughout these uncertain times, IT can also be a hindrance, and actually lead to burnout. Clumsy or ineffective EHRs and tools have been a complaint of physicians for some time. Design and personalization on this front have come a long way, but there is still much to be done in streamlining and easing the burden. Access has improved with innovations during this time but creates different challenges when meeting the needs of more vulnerable populations. "Implementing telemedicine, which we all have done during the pandemic, is not by any mean going to change how we address the digital divide and literacy-related challenges for our most vulnerable population" said Dr. Druhmil Shah of Compass Medical.

HC3 View: Our Health Care Workforce is Hanging by a Thread

In the opening chapters of 2020, we celebrated our front-line health workers as "heroes" and venerated their contributions to our community's well-being. By the holidays, we had all but forgotten the hours of turmoil and sacrifice these professionals rendered to continually heal others. The truth is, our nation should have done far better than we did during this period. The social complexities surrounding our cultural view of the pandemic will be a subject of fascination for years. As we navigate the changes in the system, the men and women that do the hard work of healing must be at the top of our minds so the next time we come to depend on them, they will be safer, more balanced, and more equipped than ever before.

CARE DELIVERY

Primary Care

In 2020, more attention shifted to keeping patients healthy via preventive screenings and counseling, causing a number of players to announce partnership with

primary care providers to increase access to services. Walgreens took the plunge—with a $1 billion investment in VillageMD, the retail pharmacy giant plans to open as many as 700 doctors' offices in its stores. Medicare-focused primary care startup Oak Street Health filed its S-1 and Amazon announced it will collaborate with Crossover Health to offer primary care services to its employees in five cities. CommonSpirit Health and Paladina Health also partnered to offer a direct-to-employer primary care offering to employers in regions served by CommonSpirit.

The focus on preventive services and primary care became even more important during the first few months of the COVID-19 pandemic, as utilization of primary and specialty services rapidly declined. A series of analyses conducted by the Commonwealth Fund illustrate that outpatient visits fell by 60.0 percent in April and slowly started to return to pre-pandemic levels thereafter. In June, overall visits were still down with a "cumulative deficit" of nearly 40.0 percent. By October, outpatient visits had returned to their pre-pandemic levels, with visits varying by age, provider specialty, and insurance type. While dermatology and adult primary care visits are substantially up, visits by young children in addition to behavioral health and cardiology visits remained down.

The COVID-19 pandemic caused a recalibration towards earlier interventions through more convenient channels of delivery and a greater importance of primary care. The "no wrong door" approach will be a main driver in the development of emerging care models to enable individuals to access the right primary care services at the right time and for the right reasons. There will always be a need for some facility-based care but if it can be done digitally, it will be delivered digitally. If it can be done in the home, at the workplace, or in a retailer such as Walgreens or CVS, it will be.

In mid-March, Medical Home Network (MHN) developed a predictive health risk screening tool in partnership with CloosedLoop.ai to identify Medicaid patients at the most risk of contracting COVID-19. "Medical Home Network is using our health risk data which includes social determinants of health powered by AI predictive models to prioritize resources in our communities," said Cheryl Lulias, President and CEO, Medical Home Network. MHN's ACO, includes 10 FQHCs, three hospital systems, and their physician practices. As fewer patients sought care, Cook County Health's Medicaid plan (CountyCare) entered into a new reimbursement agreement with Medical Home Network (MHN). Under the agreement, doctors will receive a set amount per patient per month, rather than fee-for-service. The payment model was made applicable to approximately 37.0 percent of CountyCare Medicaid members part of the MHN ACO.

Home Health Care

Between 2018 and 2019, the number of home health care agencies declined 3.6 percent. Industry experts anticipated that the home health care industry would shrink even in 2020, partially due to the Patient-Driven Groupings Model (PDGM) going into effect and CMS's phaseout of Requests for Anticipated Payment (RAPs). However, consolidation slowed due to the COVID-19 pandemic and the associated relief measures the Trump administration introduced to support health care providers. COVID-19 and an aging population also substantiated the need to provide care, treatment, and preventive services in an out-patient setting. As such, public and private health care providers took additional steps to ensure more home-based health care options are available. According to a survey of National Association of ACOs (NAACOS) members, 51.0 percent of all ACOs deliver home-based care to their patients and another 17.0 percent have a home-visit program in the works.

On July 6, CMS released a rule aimed at increasing access to home dialysis for beneficiaries with end-stage renal disease (ESRD) an further advancing the administration's Advancing American Kidney Health initiative. The rule proposes new payment changes to expand the transitional add-on payment adjustment for the Medicare ESRD Prospective Payment System (PPS) to cover additional new and innovative home dialysis machines. The agency said the need for more at-home care has never been more urgent, especially for those with underlying health conditions like ESRD. In October, CMMI Director Brad Smith also signaled that the agency was looking at expanding the Home Health Value-Based Purchasing Model nationally, noting that it is one of the models that has shown significant cost savings and improvement on key quality metrics. Originally implemented in 2016, the

model was designed to pay home health providers in nine states – Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington – based on outcomes and the value of services delivered. Home health providers in participating states have mostly supported the value-base model, with many calling for a national expansion.

Reimbursing innovative at-home treatments will allow patients to mitigate barriers that prevent them from receiving the right level of care, thus improving the patient's overall health and reducing the downstream impact and cost of non-compliance to the health system. Home health services will continue to expand as payers recognize the cost effectiveness of home health services and providers experience the impact at-home care has on the quality of care and patient lives.

FUTURE OF THE SAFETY NET

Many safety net hospitals already had thin margins with little cash-on-hand prior to the pandemic. Hospitals with a higher proportion of patients with Medicaid or don't have health insurance will be disproportionately impacted financially. Chicago's safety net status quo has run out of runway. Chicago's west and south side most important safety net hospitals are projected to reach a compounded operating loss of $1.76 billion.

Based on historical financial trends and our longitudinal modeling, the seven primary safety net hospitals on Chicago's south side (Advocate Trinity), Roseland Community, St. Bernard, Holy Cross, Mercy, Jackson Park, and South Shore) are projected to endure a total loss of $1.34 billion by 2024.

The safety net hospital cohort to the city's west (consisting of Mount Sinai, Loretto, St. Anthony, AMITA Health Saints Mary and Elizabeth Medical Center - Saint Mary Campus, and Norwegian) will bear $421 million in compounded operating losses over the same period.

These projections may prove conservative, given that they do not account for the financial duress of the COVID-19 pandemic, the deepening recession, and any other substantial changes to volumes or costs since 2018 (the period through which our modeling is based).

Despite the significant cost the Illinois taxpayer bears to underwrite the state's portion of the Medicaid program and the related subsidies intended to maintain the financial vitality of the safety net, health outcomes have not generally improved, access to important health services have maintained a staggering disparity with the rest of the city, and the structural integrity of the institutions that provide thousands of jobs stand at a fracturing point.

Without meaningful transformative action from the market and policy makers, already scarce health services for south and west side residents are at risk of further erosion.

The *Challenging Future of the Chicago Safety Net*, a report developed in collaboration with HC3, Medical Home Network, and Sinai Chicago will be available in 2021. The report analyzes retrospective financial data to illustrate the financial situation of Chicago's safety net hospitals, highlights the key health and social outcomes that have remained stuck, and comments on the persistent health disparities despite significant investments. The publication will also offer considerations to policy makers and market leaders as they contemplate the highest and best use of the city and state's scarce resources through government funding, corporation giving, philanthropic contributions, and tax-payer dollars.

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HC3 YEAR IN REVIEW

2020 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

MATTER

THIRD HORIZON STRATEGIES

HC3 Member Organizations

Civic Organization
Illinois Medical District
Infant Welfare Society
Now Pow
YearUP

Communications & Marketing
Edelman
Jarrard, Phillips, Cate & Hancock
Weber Shandwick

Financial Services & Investment Banking
Terry Group
Ziegler

Healthcare Payer
Blue Cross and Blue Shield of Illinois / Health Care Service Corporation
Cigna

Healthcare Provider
Advocate Aurora
AMITA Health
Ann and Robert H. Lurie Children's Hospital of Chicago
Christian Community Health Center
CommunityHealth
Erie Family Health Centers
Oak Street Health
Primo Health Center for Women and Children
Radiology Partners
Rush University Medical Center
Sinai Chicago
OSF Healthcare

Innovation & Technology
Advocatia
Alliance Chicago
AVIA
Kaizen Health
PCCI
Medical Home Network
Ziprad

Law Firm
Health Law Consultancy
McDermott Will & Emery LLP
Sidley Austin

Life Sciences & Pharmaceuticals
AbbVie
Astellas
Horizon Therapeutics

Management Consulting
4Sight Health
Cressey & Co.
KPMG
Leavitt Partners
Pareto Intelligence

Professional Association
American College of Surgeons (ACS)
American Dental Association (ADA)
Illinois Health and Hospital Association (IHA)
Illinois Primary Health Care Association (IPHCA)

Venture Capital & Private Equity
Chicago Pacific Founders
Sandbox Industries

2020 HC3 EVENTS

In 2020, HC3 hosted fourteen different events in-person and virtually with over a dozen different collaborative partners and sponsors.

14 Events • 35+ Speakers • 800+ Participants

FEBRUARY 25, 2020

2018-2019 HC3 State of Chicago Health Care White Paper Release

★ **HC3 Thought Leadership** | In-Person at MATTER

Cristal Gary, Principal, Leavitt Partners

Michelle Hoffman, Senior Vice President of Health & Life Sciences, P33 Chicago

Jim Kiamos, CEO, CountyCare Health Plan

Margie Schaps, Executive Director, Health & Medicine Policy Research Group

FEBRUARY 27, 2020

HC3 Emerging Leaders Event sponsored by Oak Street Health

★ **HC3 Emerging Leaders Series** | In-Person at MHub

Harry Kraemer, Author, Professor, and Executive Partner

Haven Allen, CEO, mHUB

Bradley Minkow, Regional Director, Oak Street Health

JUNE 23, 2020

Chicago's Hospital Response to COVID-19

★ **HC3 Thought Leadership** | Online

Paul Casey, MD, MBA, FACEP, Chief Medical Officer and Medical Director of Process Improvement & Patient Experience, Rush University Medical Center, and Associate Professor Rush University

Suzet McKinney, CEO and Executive Director, Illinois Medical District

Heather Nelson, Senior Vice President and CIO, UChicago Medicine

AUGUST 13, 2020

Opportunities for Data to Drive Solutions for COVID-19 and Beyond

★ **HC3 Thought Leadership** | Online

Steven Brown, MSW LCSW, Preventive Emergency Medicine, UI Health

Angie Grover, Co-Founder, Metopio

Sage Kim, PhD, Associate Professor in the Department of Health Policy & Administration, University of Chicago School of Public Health

AUGUST 19, 2020

HC3 Emerging Leaders Event sponsored by Oak Street Health

★ **HC3 Emerging Leaders Series** | Online

Jahmal Cole, Founder and CEO, My Block, My Hood, My City

Mo'Sha Myles, Social Work Program Manager and Diversity, Equity, & Inclusion Officer, Oak Street Health

AUGUST 31, 2020

Addressing Complexities of Care during COVID-19

★ **HC3 Thought Leadership** | Online

Cathy Dimou, MD, Midwest Market Medical Executive, Cigna

Karen Janousek, Chief Population Health & Growth Officer, Sinai Health System

Doug Nemecek, MD, Chief Medical Officer of Behavioral Health, Cigna

Helen Margellos-Anast, MPH, President, Sinai Urban Health Institute

SEPTEMBER 14, 2020

COVID-19 Transmission: What Does the Data Tell us?

★ **Community Event in collaboration with 1871, MATTER and mHUB and P33 Chicago** | Online

Steven Collens, CEO, MATTER

Michelle Hoffman, Senior Vice President of Healthcare & Life Sciences, P33 Chicago

SEPTEMBER 16, 2020

All In Chicago: Where are All the Women in Health Care Leadership?

★ **Community Event in collaboration with CommunityHealth** | Online
Tiosha Bailey, DrPH, MPH, Executive Director, Susan G. Komen Foundation, Chicago
Illliana A. Mora, COO, Ambulatory Services, Cook County Health
Meghan Phillipp, Executive Director, Health Care Council of Chicago
Anne Marie Murphy, PhD, Executive Director, Metropolitan Chicago Breast Cancer Task Force
Urban Health Institute

OCTOBER 1, 2020

Returning to Campus During COVID-19

★ **Community Event in collaboration with 1871, MATTER, mHUB and P33 Chicago** | Online
Michelle Hoffman, Senior Vice President of Healthcare & Life Sciences, P33 Chicago
Bill Sullivan, PhD, Professor of Landscape Architecture, University of Illinois Urbana-Champaign

OCTOBER 6, 2020

HC3 Emerging Leaders Series Event sponsored by Oak Street Health

★ **HC3 Emerging Leaders Series** | Online
Beth Bierbower, Strategic Advisor, Host of B-Time Podcast, Author, Public Speaker
Bradley Minkow, Regional Director, Oak Street Health
Bill Sullivan, PhD, Professor of Landscape Architecture, University of Illinois Urbana-Champaign

NOVEMBER 11, 2020

State of Legislation: Policy Part 1 (Illinois State)

★ **HC3 Transformation Series** | Online
Samantha Olds Frey, CEO, Illinois Association of Medicaid Health Plans (IAMHP)
Nadeen Israel, Vice President of Policy & Advocacy, AIDs Foundation Chicago (AFC)
Heather Steans, Illinois State Senator, 7th Senate District
Cyrus Winnett, Senior Vice President of Public Policy & Government Affairs, Illinois Primary Health Care Association (IPHCA)

NOVEMBER 17, 2020

State of Legislation: Policy Part 2 (Federal)

★ HC3 Transformation Series | Online

Stephanie Altman, Director of Healthcare Justice and Senior Director of Policy, Shriver Center on Poverty Law

David Johnson, Founder and CEO, 4Sight Health

David Smith, Founder and CEO, Third Horizon Strategies and Co-Founder, Health Care Council of Chicago

Vikki Wachino, Former CMS Deputy Administrator and Director of the Center for Medicaid and CHIP Services

DECEMBER 8, 2020

State of the State: Cost Drivers

★ HC3 Transformation Series | Online

Ashish Jha, MD, MPH, Dean of the School of Public Health and Professor of Health Services, Policy, & Practice, Brown University School of Public Health

Lynn Hanessian, Chief Strategist of Health, Edelman

DECEMBER 14, 2020

State of the State: Building a Healthier Chicago

★ HC3 Transformation Series | Online

Allison Arwady, MD, MPH, Commissioner, Chicago Department of Public Health

Meghan Phillipp, Executive Director, Health Care Council of Chicago