Evolution HEALTH

June 22, 2015

Dear Senate Finance Committee,

On behalf of Evolution Health, LLC and the entire Envision Healthcare Holdings, Inc. (NYSE ticker: EVHC) family, we are pleased to respond to your request for chronic care reform recommendations based upon our real world experience.

Evolution Health's mission is to continuously improve the value of healthcare – across the continuum and for all stakeholders – through innovation, collaboration and excellence. We are an integrated medical practice specializing in team-based care coordination and the management of population health. Our unique medical practices focus on the high-risk, medically-complex, chronically-ill, frail-elderly, mobility-impaired and other vulnerable populations. We have learned that we can improve outcomes for individuals as well as populations while reducing the cost of care by providing meaningful access to care around the clock. In other words, these patients require thoughtful planned as well as unplanned care.

Our parent organization - EVHC
We are a leading national provider of physician-led healthcare services with more than 30,000 affiliated clinicians and 20 million annual patient encounters. We offer a broad range of clinically-based, coordinated care solutions across the patient continuum throughout the United States. We believe our capabilities offer a powerful value proposition to communities, healthcare facilities and payors by helping to improve the quality of care and lower overall healthcare costs. We provide our services on a stand-alone, multi-service and integrated basis under our Evolution Health, EmCare, AMR and Acess2Care components. In healthcare, one size does not fit all. Indeed, one of our most valuable strengths is the ability to develop unique and innovative solutions that match the needs of the local communities and populations we serve.

Evolution Health, with more than 2,000 nurses, therapists, pharmacists, advanced practice providers and physicians in partnership with other EVHC clinicians, coordinates, manages and delivers integrated care for populations using social, clinical and logistical competencies. In-home, mobile, telehealth, remote, post-acute and primary care services are provided 24/7 by integrated medical teams.

EmCare, with nearly 10,000 affiliated physicians and other clinicians, is a leading provider of integrated facility-based physician services, including emergency medicine, hospitalist/inpatient care, anesthesiology, radiology, teleradiology, acute surgery and others.

AMR, with more than 19,000 paramedics and emergency medical technicians, is a leading provider and manager of community-based mobile healthcare, medical transportation services, including emergency ("911"), non-emergency, fixed-wing air ambulance, 911 call centers and disaster response.

Access2Care, is our managed transportation organization, with over 5.5 million non-emergency trips for over 8.5 million Medicare and Medicaid recipients across urban, suburban, rural and highly rural regions to support population outcomes and health services coordination.

We have found success delivering high value care, by synchronizing our unique combination of clinical touch points across care settings using systems of care approaches, inter-professional teams and by

leveraging mobile and telehealth strategies. Learning from our deep and national experience in acute care delivery – in the 911 system, emergency department and hospital – we have achieved improved outcomes by buildings systems of care for the chronically ill just as we have for trauma, heart attack and stroke patients. We call these systems of care mobile integrated healthcare practices (MIHP).

Fundamentally, our ability to improve care coordination among individual providers and across multiple care continua – pre-hospital/hospital/post-hospital, or virtual/mobile/clinic/in-home or well/sick/well – is rooted in the inter-professional team-based care models. We design culturally relevant systems and processes of care to improve the quality of interactions, clinical effectiveness and relationships between elderly patients and care teams.

Our experience has taught us that this organizational "climate of care delivery" is foundational – both for the patient and for the clinical team – to consistently and reproducibly deliver on high quality and cost-effective care. To achieve improved clinical and financial outcomes, our inter-professional team includes the collective and diverse expertise of physicians, nurses, pharmacists, therapists, paramedics, advanced practice nurses, physician assistants and community health workers as well as other critical support functions including logistics and transportation.

By maximizing and integrating the skill sets and competencies of historically siloed professions, we have been able to demonstrate that we can:

- Provide high quality and highly reliable patient care
- Integrate and coordinate care
- Reduce system fragmentation
- Improve transitions in care
- Reduce high cost utilization
- Reduce preventable readmission
- Improve patient primary care connectedness
- Improve access to and utilization of appropriate high-quality care
- Integrate the biopsychosocial approach into person-centered care plans
- Enhance the cultural competence of entire care team
- Maximize healthcare provider satisfaction and sense of worth in a rapidly changing environment

Evolution Health approaches our patients as worthy individuals who often face uncommon and daunting challenges. Patients respond to their circumstances, sometime with limited options, limited knowledge and limited means. Sometimes these choices are flawed, and other times they are the best of what is available. When we can, we bend the patient's care trajectory to favor improved outcomes and improved quality of life using our mobile integrated healthcare practices. Using the principles of choice architecture and behavioral economics, we have offered patients new, safe, effective, convenient and lower cost alternatives for the chronically ill. In fact, our patients prefer to have the delivery system meet them when and where they choose – most often outside of a hospital or clinic and during off-hours. This is a historically underutilized strategy in responding to the demands of an aging population and in delivering integrated care. The right care, in the right place, by the right people, at the right time, for the right cost and with the best experience can be efficiently delivered by mobile and virtual inter-professional team-based care.

Achieving durable improvements in coordinating care and improving outcomes for the chronically ill requires meaningful options for both planned and unplanned care. We provide these options for populations by:

- **Identifying the high risk and decoding individual needs.**
  This includes identification of individuals with disproportionate and/or preventable utilization, physically finding them in the community, and assessing the range of medical and psychosocial drivers.

- **Establishing authentic connections with patients.**
  Success in care navigation relies upon bonds of trust that arise through respectful interpersonal connection at a cultural level.
- **Nudging patients towards superior alternatives.**
  Breaking the cycle of ineffective and high-cost utilization requires the provision of practical and acceptable alternatives seen by the patient as superior to past options.

Inter-professional team based care, system approaches and mobile delivery create synergies between each component – the collective effect is greater than the sum of the parts. Our transitional care programs have demonstrated significant reductions in readmissions for Medicare beneficiaries, with typical all-cause 30-day readmission rates of 5-9%. (Evolution Health Office of Clinical Effectiveness). Our unplanned care model has also been impactful in preventing high-cost utilization, peer reviewed literature estimates $560 million in potential annual savings to Medicare if the low-acuity (34%) 911 EMS ambulance transports were managed using clinically-appropriate and lower cost alternatives. (*Health Affairs* 2013 32:12, 2142-2148)

Challenges based on our collective experience

We applaud the spirit of the chronic care management, transitional care management and bundled payment for care improvement initiatives. To meaningfully impact the chronic disease for the Medicare population, however, provider teams and delivery systems must be aligned through broader policy and payment structures that optimize clinical integration. Our success to date with Medicare beneficiaries has been limited by the fee-for-service reimbursement models that align activity by only certain members of the care team with volume as opposed to the quality, outcomes and experience of care delivered by the collective system and team. As has been seen with Medicare Advantage and the successful accountable care organizations, integrated delivery and systems of care approaches position patients, providers and care teams with a shared orientation towards value.

Existing managed care delivery systems remain deeply rooted in high-cost, variable quality and traditionally defined models that center on acute care hospitals, clinic based care and singular professional service reimbursement models. Re-engineering policy and establishing alternative structures to drive effective care coordination, streamlined payment, improved clinical and experiential outcomes at lower costs, will require risk-arrangements for populations that empower team-based delivery and leverage non-traditional touch points across care settings. Prospective payment, downside risk, outcomes-based reimbursement, capitation and other models can help all stakeholders share a common interest in managing care more effectively, often within the community or at home.

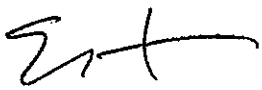
Recommendations based on our collective experience

- Alternative policy and payment structures that align physicians, nurses, pharmacists, therapists, paramedics, nurse practitioners, physician assistances and community health workers.
- Risk arrangements specifically designed for team-based models and systems of care for that impact clinical and financial outcomes for the chronically ill.
- Integrated delivery systems of care that include novel combinations of non-facility/non-clinic based touch points such as mobile physician practices, home care agencies, EMS systems, hospice agencies, telemedicine, telehealth, remote monitoring and virtual care team models.
- Incorporate, integrate and align transportation services, through policy and payment, to improve population health outcomes, enhance the experience of care and reduce costs

- Appreciate that emergency and acute care providers can be powerful advocates for prevention and chronic care redesign because they see what happens, and often catch patients, when others have failed
- Redesign existing reimbursement for acute, post-acute, and emergency services to support actual patient needs, inter-professional care teams and alternative sites of service, as opposed to singular definitions of these services or 'one-size fits all'
- Redesign 911 ambulance reimbursement to support appropriate patient navigation, not just transportation to an Emergency Department
- Reimburse providers and systems for choice architecture and alternative menu offerings that safely reduce utilization and facilitate lower cost/clinically effective options for patients
- Incentivize information sharing to support coordination, reduce wasteful spending and improve outcomes between disparate touch points across care settings

We would be willing and delighted to meet with members of the working group in person to share additional perspective, experience and outcomes from our practices. This dialogue offers an opportunity to catalyze and encourage common purpose for all stakeholders in improving the health and value of care for chronically ill Medicare beneficiaries.

Sincerely,



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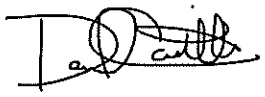

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