June 10-11, 2024 – PTAC Public Meeting

Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models

Presenter and Panelist Biographies

Panel Discussion
(Monday, June 10, 10:30 a.m. – 12:00 p.m. EDT)

Subject Matter Experts

- **Erik Johnson, MBA** – Senior Vice President, Value-Based Care, Optum Advisory
- **Richard A. Feifer, MD, MPH** – Chief Medical Officer, InnovAge
- **Kristofer L. Smith, MD, MPP** – Chief Medical Officer, Landmark Health
- **Marshall H. Chin, MD, MPH** – Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics, Department of Medicine, University of Chicago, and Co-Director, RWJF Advancing Health Equity Program Office

Roundtable Panel Discussion
(Monday, June 10, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

- **Matthew Wayne, MD, CMD** – Chief Medical Officer, Communicare
- **David Gellis, MD, MBA** – Vice President and National Medical Director, Medicare Population Health Programs, One Medical Senior Health
- **Cheryl Phillips, MD, AGSF** – Sr. Program Consultant, The John A. Hartford Foundation
- **Olivia Rogers, RN, MBA** – Vice President and Chief Nursing Officer, Visiting Nurse Association of Texas

Listening Session 1
(Monday, June 10, 2:40 p.m. – 4:10 p.m. EDT)

Subject Matter Experts

- **Brynn Bowman, MPA** – Chief Executive Officer, Center to Advance Palliative Care
- **Paul Mulhausen, MD, MHS** – Chief Medical Director, Iowa Total Care, a Centene health plan
- **Caroline Blaum, MD, MS** – Assistant Vice President, National Committee for Quality Assurance
- **David Kendrick, MD, MPH** – Chief Executive Officer, MyHealth Access Network

Listening Session 2
(Tuesday, June 11, 9:10 a.m. – 10:40 a.m. EDT)

Subject Matter Experts

- **Kurt Merkelz, MD, FAAHPM** – Senior Vice President and Chief Medical Officer, Compassus
- **Betty Ferrell, RN, PhD** – Director and Professor, Division of Nursing Research and Education, Department of Population Sciences, City of Hope
- **Natalie C. Ernecoff, PhD, MPH** – Full Policy Researcher, RAND
- **Ira Byock, MD, FAAHPM** – Emeritus Professor of Medicine and Community & Family Medicine, Dartmouth Geisel School of Medicine

Listening Session 3
(Tuesday, June 11, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

- **Jason H. Feuerman** – President and Chief Executive Officer, LTC ACO
- **Diane E. Meier, MD, FACP** – Founder, Center to Advance Palliative Care
- **Bruce Leff, MD** – Professor of Medicine and Director, Center for Transformative Geriatric Research, Division of Geriatric Medicine, The Johns Hopkins University School of Medicine
- **Marie P. Bresnahan, MPH** – Director of Training , Policy, and Administration in the Viral Hepatitis Program (VH), New York City Department of Health and Mental Hygiene - (Previous Submitter - *Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics* proposal)

Panel Discussion: Biographies
(Monday, June 10, 10:30 a.m. – 12:00 p.m. EDT)

Subject Matter Experts

Erik Johnson, MBA – Optum Advisory

Mr. Erik Johnson brings 25+ years of expertise empowering the health care industry to develop new growth models, value-based care strategies, and payer-provider collaborations. Mr. Johnson has experience leading clients through designing and developing population health strategies for value-based care and operating models that rely on risk sharing between payers and health systems. Other strategies include ACO strategies, policy analysis, data analysis, strategic planning, and organizational design and reinvention. Previously, Mr. Johnson served as the Senior Vice President at Avalere Health where he led the Healthcare Networks consulting practice and oversaw new product development. These efforts empowered health systems to determine adoption strategies for accountable care and payment bundles in addition to the overall guiding strategy. Mr. Johnson earned an MBA from the Stanford Graduate School of Business and a Bachelor of Arts with honor and distinction in Political Science from Stanford University.

Richard A. Feifer, MD, MPH – InnovAge

Dr. Rich Feifer is Chief Medical Officer at InnovAge, a multi-state provider of PACE programs, serving frail dual-eligible seniors by delivering comprehensive patient-centric care that enables them to age independently for as long as possible. He has direct responsibility for all medical, nursing, behavioral health, dental, in-home, and pharmacy services, in addition to population health and clinical quality. Prior to joining InnovAge, Dr. Feifer was Chief Medical Officer at Genesis HealthCare, one of the nation's largest skilled nursing, rehabilitation, and long-term care providers. During the COVID-19 pandemic, Dr. Feifer provided national leadership surrounding the care and safety of nursing home patients. Throughout his tenure at Genesis, he led the medical directors and a team of over 550 providers who cared for Genesis patients. In that capacity, Dr. Feifer also served as Chief Medical Officer of the Genesis HealthCare Accountable Care Organization (LTC ACO), the first national ACO focused on nursing home patients. Before Genesis, Dr. Feifer was Aetna's Chief Medical Officer of National Accounts. He led Clinical Consulting, Strategy, and Analysis, which helped our nation's largest employers improve the health and productivity of their members. He also previously served as Vice President of Clinical Program Innovation and Evaluation at Medco, where he was responsible for the organization's portfolio of care enhancement programs. Dr. Feifer has served on various boards and committees, providing strategic and fiduciary leadership. He currently is a Director at the Accreditation Commission for Health Care, one of the largest healthcare accreditors. A graduate of Brown University and the University of Pennsylvania School of Medicine, Dr. Feifer is a board-certified internist with experience in population health, primary care, geriatrics, and urgent care medicine at the Fallon Clinic. He received his MPH in Health Services Management from Columbia University and is currently an Assistant Clinical Professor at the University of Connecticut.

Panel Discussion: Biographies *(Continued)*
(Monday, June 10, 10:30 a.m. – 12:00 p.m. EDT)

Subject Matter Experts

Kristofer L. Smith, MD, MPP – Landmark Health

As Home and Community's Senior Physician, Dr. Kristofer Smith works to create a seamless patient experience across the organization's pillars. He leads clinical affordability initiatives and clinical model redesign efforts. Dr. Smith works closely with other provider groups to identify opportunities for collaboration. As Chief Medical Officer of Landmark Health, Dr. Smith leads efforts to establish a high quality and clinically effective home-based medical care model for patients with serious illness. He oversees clinical model design, learning and development, quality of care standards, and clinical improvement activities. Prior roles include Chief Clinical Officer at Prospero Health, a home-based palliative care company, President of naviHealth's Home-based Medical Care division, and SVP of Population Health at Northwell Health. Dr. Smith has published papers on advanced care models for the frail elderly and regularly gives national talks on health policy, the frail elderly, and the intersection of payment reform and clinical redesign. He currently serves on the board of the American Academy of Home Care Medicine. Dr. Smith worked as a house calls physician for more than a decade, providing primary and palliative care to the frail homebound elderly.

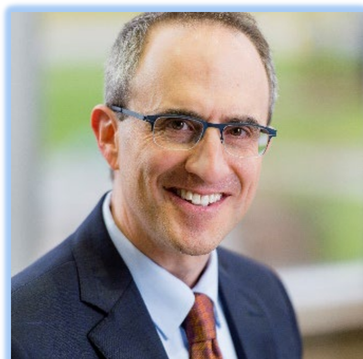
Marshall H. Chin, MD, MPH – University of Chicago

Dr. Marshall Chin, Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics at the University of Chicago, is a practicing general internist and health services researcher who has dedicated his career to advancing health equity through interventions at individual, organizational, community, and policy levels. Through the Robert Wood Johnson Foundation Advancing Health Equity: Leading Care, Payment, and Systems Transformation program, Dr. Chin collaborates with teams of state Medicaid agencies, Medicaid managed care organizations, frontline health care delivery organizations, and community-based organizations to implement payment reforms to support and incentivize care transformations that advance health equity within an anti-racist framework. He also co-chairs the Centers for Medicare & Medicaid Services Health Care Payment Learning and Action Network Health Equity Advisory Team. Dr. Chin evaluates the value of the federally qualified health center program, improves diabetes outcomes in Chicago's South Side through health care and community interventions, and improves shared decision making among clinicians and LGBTQ persons of color. He also applies ethical principles to reforms to advance health equity, discussions about a culture of equity, and what it means for health professionals to care and advocate for their patients. Dr. Chin uses improv and standup comedy, storytelling, and theater to improve training of students in caring for diverse patients and engaging in constructive discussions around systemic racism and social privilege. Dr. Chin is a graduate of Harvard College and the University of California at San Francisco School of Medicine, and he completed residency and fellowship training in general internal medicine at Brigham and Women's Hospital, Harvard Medical School. He has received mentoring awards from the Society of General Internal Medicine and University of Chicago. He is a former President of the Society of General Internal Medicine.

Roundtable: Biographies
(Monday, June 10, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

Matthew Wayne, MD, CMD – Communicare



Dr. Matthew Wayne is the Chief Medical Officer for CommuniCare Family of Companies. CommuniCare operates 130 skilled nursing facilities in seven states. In addition, the organization has an Institutional Special Needs Plan that serves residents in three of those states. Dr. Wayne is also Chief Medical Officer for Personalized Health Partners, CommuniCare's integrated medical practice of 125 plus clinicians. The medical practice is the primary clinical support for Partnership in Health, a High Needs REACH ACO participant. Dr. Wayne has practiced in the post-acute and long-term care setting for 25 years and is boarded in both Internal Medicine and Geriatric Medicine. He is also a past president of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

David Gellis, MD, MBA – One Medical Senior Health

Dr. David Gellis is National Medical Director for Medicare Population Health Programs at One Medical where he is responsible for clinical outcomes, risk adjustment, and total cost of care strategies for the Senior Health at-risk business line. He joined Iora Health -- a pioneer in redesigned value-based primary care -- as a Primary Care Physician (PCP) in 2013 and supported teams in a variety of market and central executive roles through Iora's acquisition by One Medical in 2021. Dr. Gellis received his MD and MBA from Harvard University and completed internal medicine training at Brigham and Women's Hospital.

Cheryl Phillips, MD, AGSF – The John A. Hartford Foundation

Dr. Cheryl Phillips is the immediate past President and CEO of the Special Needs Plan Alliance, a national leadership association for special needs and Medicare-Medicaid plans serving vulnerable adults. Currently, she is a Senior Program Consultant for the John A. Hartford Foundation's Age-Friendly Health Systems initiative. Dr. Phillips has extensive experience in health policy, Medicare Advantage, special needs plans, and the Program of All-inclusive Care for the Elderly (PACE). As a fellowship-trained geriatrician her clinical practice focused on the long-term care continuum. Dr. Phillips is a past President of the American Geriatrics Society and is also a past President of the American Medical Directors Association – The Society for Post-Acute and Long-Term Care Medicine. She continues to serve on multiple technical advisory groups for chronic care, LTC quality, home and community-based services, and person-centered measures, and has provided multiple testimonies to the U.S. Congress. Dr. Phillips served as a Primary Care Health Policy Fellow under Secretary Tommy Thompson.

Roundtable: Biographies *(Continued)*
(Monday, June 10, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

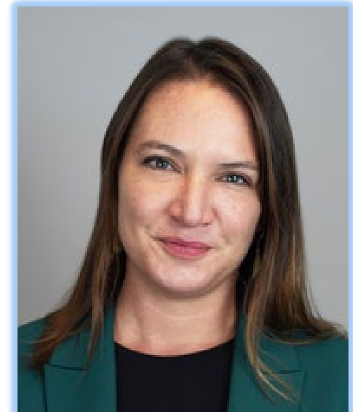
Olivia Rogers, RN, MBA – Visiting Nurse Association of Texas

After graduating from UT-Houston Health Science Center with a bachelor's degree in nursing, Ms. Olivia Rogers spent the majority of her nursing career in critical care, specifically ICU/CCU with an emphasis in cardiac care. She left the hospital world in 2010 to join the Visiting Nurse Association Hospice and has been with the Visiting Nurse Association since that time as a field nurse, case manager, branch manager in Collin County, and now as the Vice President and Chief Nursing Officer for Visiting Nurse Association. Hospice care truly encompasses everything Ms. Rogers loves about nursing from critical thinking to direct patient care, family support, and collaboration with many different disciplines and physicians. The Visiting Nurse Association embodies what it means to care for people well and provide meaning, expertise, and support at the end of life, and this is Ms. Rogers' passion.

Listening Session 1: Biographies
(Monday, June 10, 2:40 p.m. – 4:10 p.m. EDT)

Subject Matter Experts

Brynn Bowman, MPA – Center to Advance Palliative Care (CAPC)



As Chief Executive Officer of the CAPC, Ms. Brynn Bowman presides over the organizational and content strategy that serves more than 1,700 CAPC member health care organizations, including over 70,000 clinicians and administrators. Previously CAPC Chief Strategy Officer, she succeeds Dr. Diane Meier. Ms. Bowman is a nationally recognized leader in scaling practice and culture change in health care delivery for people with serious illness. An expert in palliative care education, she specializes in health care leadership, palliative care business and financing, palliative care program design, palliative care education for nonpalliative care specialists, and palliative care delivery during the COVID-19 pandemic. Her work has been instrumental in the development of clinician engagement and education strategies to equip the U.S. health care workforce with the skills needed to care for patients with serious illness, and their families. Ms. Bowman was a 2020/2021 Health and Aging Policy Fellow, where she served with the Senate Finance Committee. She has co-chaired three of the National Academies of Sciences, Engineering, and Medicine (NASEM) Roundtable on Quality Care for People with Serious Illness workshops focused on workforce and the impact of the COVID-19 pandemic. In 2016, she won the Brandon Hall Group Silver Excellence in Learning Award for Best Use of Mobile Learning: CAPC Online Curriculum. Ms. Bowman has served on a number of advisory groups, including the C-TAC Summit Development Committee and Moonshot, the Stakeholder Advisory Committee of the American College of Surgeons Geriatric Surgery Verification Program, Aquifer palliative care curriculum development for medical students, and the Serious Illness Care Program Implementation Collaborative. In 2018–19, Ms. Bowman led a consensus process to grow the field of pediatric palliative care that codified a road map of priority actions and led to the development of a national coordinating pediatric palliative care task force.

Listening Session 1: Biographies
(Monday, June 10, 2:40 p.m. – 4:10 p.m. EDT)

Subject Matter Experts

Paul Mulhausen, MD, MHS – Iowa Total Care, a Centene health plan

Dr. Paul Mulhausen is a geriatrician with a deep interest in the health and wellbeing of vulnerable Americans and older adults in the United States. Dr. Mulhausen is an experienced clinician, medical educator, and advocate for high-quality care. He serves on the Board of Directors for the American Geriatrics Society and is active in Medicare quality improvement and Medicaid managed care. Dr. Mulhausen served on the CMS Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup from 2015–2023 and chaired the workgroup from 2017–2019. He is the Chief Medical Officer at Iowa Total Care, a Centene health plan in Iowa, and serves as part of a care team providing Medication Assisted Treatment to people suffering from opioid addiction. He received his medical degree from the University of Minnesota in 1987 and completed his postgraduate medical education at the Duke University School of Medicine. He is a Fellow in the American College of Physicians and the American Geriatrics Society.

Caroline Blaum, MD, MS – National Committee for Quality Assurance

Dr. Caroline Blaum is an Assistant Vice President at the National Committee for Quality Assurance (NCQA). She joined NCQA in September 2020 and is closely involved in quality content development and implementation for chronic diseases, complex patients, and home and community-based care. She leads projects that draw on her previous clinical, administrative, and research experience at the intersection of quality measurement, delivery system implementation, and policy relevance. From 2012–2020, Dr. Blaum was the Diane and Arthur Belfer Professor of Geriatric Medicine and Director of the Division of Geriatric Medicine and Palliative Care. At NYU, she maintained an active clinical practice and supervised clinical education for medical trainees in geriatrics and palliative care. Dr. Blaum led an extensive reach research program in translational research that was supported by the NIA, AHRQ, PCORI, and The John A. Hartford Foundation concerning models of care for vulnerable populations, multiple chronic conditions, frailty, and diabetes in older adults. She has over 100 peer reviewed papers and chapters. Prior to going to NYU, Dr. Blaum was Professor of Internal Medicine, Geriatric and Palliative Medicine at the University of Michigan, and a Research Scientist at the Ann Arbor VA Geriatrics Research, Education and Clinical Center. She served as the Assistant Dean for Clinical Affairs at the University of Michigan Medical School, and as an Associate Medical Director of the University of Michigan's Faculty Group Practice, directing the University of Michigan Health System's Population Health Program. Dr. Blaum led the University of Michigan's activities related to care delivery innovations such as its Accountable Care Organization (ACO), Patient Centered Medical Home, Advanced Primary Care Medicare Demonstration, and various other initiatives. She has also served as the Medical Director of a nursing home, a home health agency, and a Medicare Advantage Plan. Dr. Blaum has been active in national policy work and was the founding Chair of the American Geriatrics Society's (AGS) Quality Performance and Measurement Committee. She was AGS's representative to the AMA-Physician Consortium for Performance Improvement (AMA-PCPI) and served on the National Quality Forum (NQF) Hospital Outcomes Steering Committee and co-chaired the NQF Steering Committee to Develop a Framework for Quality Measurement for Patients with Multiple Chronic Conditions.

Listening Session 1: Biographies *(Continued)*
(Monday, June 10, 2:40 p.m. – 4:10 p.m. EDT)

Subject Matter Experts

David Kendrick, MD, MPH – MyHealth Access Network

Dr. David Kendrick is the Principal Investigator and Chief Executive Officer of MyHealth Access Network, Oklahoma's non-profit health information network, which ensures that every Oklahoman's complete health record is securely available where and when they need it for care and health decision-making. MyHealth serves more than 3 million patients and is focused on improving health in Oklahoma and beyond by implementing a community-wide infrastructure for health care IT. MyHealth was one of the original Beacon Communities selected by the Office of the National Coordinator for Health IT. MyHealth is focused on providing advanced health information exchange, community-wide care coordination tools, and a robust decision support platform to support providers and patients in improving health.

Dr. Kendrick is the immediate past chair of the Board of Directors for the National Committee for Quality Assurance (NCQA), which developed the first comprehensive quality measurement programs with HEDIS, as well as certification programs for Patient Centered Medical Homes and Specialty Care. While Chair, Dr. Kendrick proposed the creation of a Data Aggregator Validation program that recognizes the cost and resources efficiencies brought to the quality measurement process by data aggregators with validated high-quality data. Dr. Kendrick is also a member of the board of the Patient Centered Data Home® program, and previously served on both the boards of the Strategic HIE Collaborative, and the Networks for Regional Health Improvement before their recent merger to become the Civitas Networks for Health. Dr. Kendrick has been elected to the board of the new Civitas organization. Dr. Kendrick served as the Senior Counsel for Interoperability to National Health IT Coordinator, Dr. Karen DeSalvo, and continues to serve as a consultant to various state and federal agencies.

Dr. Kendrick also chairs the Department of Medical Informatics at the University of Oklahoma's School of Community Medicine, and serves the OU Health Sciences Center as the Assistant Provost for Strategic Planning. The Department of Medical Informatics provides clinical information systems support to OU Physicians as well as analytics services for clinical operations and research. In addition, the Department operates a Health Access Network for the Oklahoma Healthcare Authority, providing care management services, quality improvement support, and technology for Oklahoma physicians serving more than 100,000 patients.

Listening Session 2: Biographies
(Tuesday, June 11, 9:10 a.m. – 10:40 a.m. EDT)

Subject Matter Experts

Kurt Merkelz, MD, FAAHPM – Compassus

Dr. Kurt Merkelz is Senior Vice President and Chief Medical Officer at Compassus. Dr. Merkelz leads the company's quality and clinical initiatives, ensuring the delivery of quality patient outcomes and increased access to end-of-life care across the communities Compassus serves. Dr. Merkelz has held this role since 2017. Previously, he served as medical director for the Compassus program serving Houston. Throughout his career, he has focused on caring for older adults. His perseverance in raising industry benchmarks for quality hospice care earned him the Compassus R. Sean Morrison, M.D., Award for Outstanding Achievement in Hospice Physician Leadership in 2012, and his work in standardized care delivery garnered Compassus national recognition by the National Quality Forum in 2020. Dr. Merkelz earned his medical degree from the University of Texas Health Science Center and completed residencies in family medicine and geriatric medicine at the University of Cincinnati. Dr. Merkelz is triple board certified in hospice and palliative care medicine, family practice, and geriatrics. He also serves on several national organization committees, including the American Academy of Hospice and Palliative Medicine (AAHPM), the Society for Post-Acute and Long-Term Care Medicine (AMDA), and the National Quality Forum (NQF).

Betty Ferrell, RN, PhD – City of Hope

Dr. Betty Ferrell, RN, PhD, MA, CHPN, FAAN, FPCN has been in nursing for 46 years and has focused her clinical expertise and research in pain management, quality of life, and palliative care. Dr. Ferrell is the Director of Nursing Research & Education and a Professor at the City of Hope Medical Center in Duarte, California. She is a Fellow of the American Academy of Nursing and she has over 500 publications in peer-reviewed journals and texts. Dr. Ferrell is Principal Investigator of the "End-of-Life Nursing Education Consortium (ELNEC)" project. She directs several other funded projects related to palliative care in cancer centers and QOL issues. Dr. Ferrell was Co-Chairperson of the National Consensus Project for Quality Palliative Care. Dr. Ferrell completed a Master's degree in Theology, Ethics and Culture from Claremont Graduate University in 2007. She has authored 12 books including the *Oxford Textbook of Palliative Nursing* (5th Edition, 2019) published by Oxford University Press. Dr. Ferrell is co-author of the text, *The Nature of Suffering and the Goals of Nursing* published by Oxford University Press (2nd Ed, 2023) and *Making Health Care Whole: Integrating Spirituality into Patient Care* (Templeton Press, 2010). In 2013, Dr. Ferrell was named one of the 30 Visionaries in the field by the American Academy of Hospice and Palliative Medicine. In 2019, she was elected a member of the National Academy of Medicine. In 2021, Dr. Ferrell received the Oncology Nursing Society Lifetime Achievement Award and she was inducted as a "Living Legend" by the American Academy of Nursing.

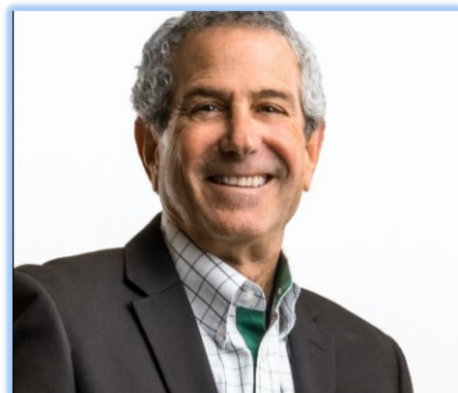
Listening Session 2: Biographies *(Continued)*
(Tuesday, June 11, 9:10 a.m. – 10:40 a.m. EDT)

Subject Matter Experts

Natalie C. Ernecoff, PhD, MPH – RAND

Dr. Natalie Ernecoff is a Full Policy Researcher at RAND in Pittsburgh, PA. Her research focuses on developing, implementing, and evaluating systems-level palliative care, hospice, and home care interventions. Dr. Ernecoff's work includes health care system informatics, electronic health record (EHR)-based interventions, systematic identification of serious illness populations, and collaborative models of palliative care delivery. She has conducted work across serious illness care, including among people living with chronic kidney disease, Alzheimer's disease and Alzheimer's disease-related dementias, cancer, and critical illness. Dr. Ernecoff is experienced in qualitative and mixed methods research, implementation science, population health management, program evaluation, and clinical research. Dr. Ernecoff holds a PhD in Health Policy and Management from the University of North Carolina and an MPH in Behavioral and Community Health Sciences from the University of Pittsburgh.

Ira Byock, MD, FAAHPM – Dartmouth Geisel School of Medicine



Dr. Ira Byock is a leading physician, author, and public advocate for improving care for people living with serious medical conditions. He has been involved in hospice and palliative care since 1978. Dr. Byock's research has contributed to conceptual frameworks for the lived experience of illness, measures for subjective quality of life, and counseling methods for life completion and wellbeing. He is a past President of the Academy of Hospice and Palliative Medicine. From 1996 to 2006, Dr. Byock directed a national grant project of the Robert Wood Johnson Foundation that developed prototypes for concurrent palliative care within mainstream health care. From 2003 to mid-2013, he led the palliative care program at Dartmouth-Hitchcock Medical Center and the Dartmouth health system based in Lebanon, N.H.

During his tenure at Dartmouth, Dr. Byock spearheaded health service delivery models for concurrent life-extending and palliative care in acute inpatient, outpatient specialty clinics, academic and community-based primary care, and long-term and chronic care settings. Dr. Byock is an Emeritus Professor of Medicine and Community & Family Medicine at Dartmouth's Geisel School of Medicine. He has authored numerous articles in academic journals and opinion essays in national newspapers. His books include *Dying Well*, *The Four Things That Matter Most*, and *The Best Care Possible.*

Listening Session 3: Biographies
(Tuesday, June 11, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

Jason H. Feuerman – LTC ACO

Mr. Jason Feuerman is the Founder, President and Chief Executive Officer of LTC ACO, the first Medicare Shared Savings Program ("MSSP") of its type dedicated exclusively to management of the full Medicare spend of nursing facility residents throughout the United States. As the only MSSP ACO serving residents throughout the country, LTC ACO has been able to produce consistent and predictable results generating more than $60M in shared savings since 2016. It currently operates in more than 1,500 skilled nursing facilities with in excess of 2,500 participating providers. As the largest MSSP ACO of its type, it presently assumes risk for nearly 20,000 Medicare Fee-for-Service beneficiaries which consume in excess of $400M annually. Prior to founding LTC ACO, Mr. Feuerman served as President of the Health Plan and Public Sector Divisions of Value Options, Inc. Prior to joining Value Options, Mr. Feuerman served as President of Bravo Health, a subsidiary of Cigna, Inc. and as President of Senior Care Centers of America, a leading provider of adult day health services. He holds a Bachelor of Science in Finance and Economics from the University of Maryland.

Diane E. Meier, MD, FACP – Center to Advance Palliative Care

Dr. Diane Meier is immediate past Chief Executive Officer of the Center to Advance Palliative Care (CAPC.org), a national organization devoted to increasing access to quality palliative care for people living with a serious illness and their families in the United States. Under her leadership the number of palliative care programs in U.S. hospitals has more than tripled in the last 15 years. She is Co-Director of the Patty and Jay Baker National Palliative Care Center; Professor of Geriatrics and Palliative Medicine; Professor of Medicine; Catherine Gaisman Professor of Medical Ethics; and was the Founder and Director of the Hertzberg Palliative Care Institute, 1997–2011, all at the Icahn School of Medicine at Mount Sinai in New York City. Dr. Meier was named one of 20 People Who Make Healthcare Better in the U.S. by HealthLeaders Media 2010, and was elected to the National Academy of Medicine of the National Academy of Sciences in 2013. She received the Gustav O. Lienhard Award of the National Academy of Medicine and the AHA-HRET TRUST Award, both in 2017, as well as a MacArthur Foundation Fellowship in 2008. Dr. Meier served as a Health and Aging Policy Fellow in Washington DC in 2009–2010, working both on the Senate's HELP Committee and at the Department of Health and Human Services. Dr. Meier has over 200 peer-reviewed publications in the medical literature. Her most recent book, *Meeting the Needs of Older Adults with Serious Illness: Challenges and Opportunities in the Age of Health Reform*, was published in 2014.

Listening Session 3: Biographies *(Continued)*
(Tuesday, June 11, 1:00 p.m. – 2:30 p.m. EDT)

Subject Matter Experts

Bruce Leff, MD – The Johns Hopkins University School of Medicine

Dr. Bruce Leff is Professor of Medicine at the Johns Hopkins University School of Medicine with joint appointments in the Johns Hopkins Bloomberg School of Public Health and the Johns Hopkins School of Nursing. He cares for patients in the acute, ambulatory, and home settings. Dr. Leff's research focuses on novel models of care delivery for older adults, multi-morbidity, risk prediction, and quality improvement, with an emphasis on home-based models of care, including Hospital at Home, home-based primary care, CAPABLE, and others. He is Co-Lead of the Hospital at Home Users Group and also the National Home-Based Primary Care Learning Network.

Dr. Leff is past Chair of the Geriatric Medicine Board of the American Board of Internal Medicine (ABIM) and ABIM Council and past President of the American Academy of Home Care Physicians. He is past member of the editorial board of the Annals of Internal Medicine and currently serves on the Board of Trustees of the American Board of Internal Medicine Foundation.

Marie P. Bresnahan, MPH – New York City Department of Health and Mental Hygiene

Ms. Marie Bresnahan is working currently as the Director of Training , Policy, and Administration in the Viral Hepatitis Program (VHP) at the New York City Department of Health and Mental Hygiene. She began work in the VHP as the Director of Project INSPIRE (Innovate and Network to Stop hepatitis C and Prevent complications via Integrating care, Responding to needs and Engaging patients and providers) which was funded as a Center for Medicare and Medicaid Innovation Health Care Innovation Awards in Round Two and was designed to demonstrate a model of service delivery and payment that can reduce morbidity and death from chronic illnesses and reduce costs associated with its complications, using chronic HCV infection as a case study.

Prior to working at the NYC Health Department, Ms. Bresnahan worked at the American Liver Foundation and she was a founding member of the National Viral Hepatitis Roundtable. Ms. Bresnahan worked previously at the New York AIDS Coalition, Cicatelli Associates (the Training Center for Health Professionals), and at Covenant House, and she has a Master of Public Health from the City University of New York.

The New York City Department of Health and Mental Hygiene is a previous PTAC proposal submitter with the *Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics* proposal.