



Michael D. Maves, MD, MBA, Executive Vice President, CEO

December 2, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; *75 Fed. Reg. 70,165* (November 17, 2010); CMS-1345-NC.

Dear Dr. Berwick:

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the Centers for Medicare and Medicaid Services' (CMS) request for information concerning accountable care organizations (ACOs) and the Medicare Shared Savings Program. We urge CMS to incorporate the detailed responses below as the agency develops its proposal to implement the ACO and Medicare Shared Savings Program.

1. What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

In order to ensure that small physician practices can successfully serve as ACOs, CMS and other federal agencies should:

- **Create explicit safe harbors from antitrust enforcement and waivers of the Civil Monetary Penalty statute, the Anti-Kickback statute and the Ethics in Patient Referrals (Stark) statute so that small, independent physician practices can work with each other and collaborate with hospitals and other providers to deliver coordinated care for both Medicare beneficiaries and commercially-insured patients.** Currently, all of these laws and associated guidelines favor hospital-based systems with employed physicians, yet the best way to preserve opportunities for appropriate competition in health care and choice for patients is to enable physicians to form ACOs in ways that enable them to continue practicing independently of hospitals and large health systems.

- **Permit ACOs to participate with no more than 5,000 beneficiaries, the minimum number required by law.** CMS has an understandable desire to require that ACOs serve a large number of Medicare beneficiaries in order to increase the statistical confidence of cost and quality measures and reduce the likelihood of making shared savings payments based on purely random variation in patient utilization. Physicians also support accurate measurement and have concerns about basing quality and cost measures on inappropriately small patient populations. However, the larger the number of patients required for the creation of ACOs, the more difficult it will be for small physician practices to participate, and the more likely it will be that there can only be one ACO in many communities. This will decrease choice for patients and reduce competition that can help restrain costs for private payers. Consequently, the requirement for the minimum number of beneficiaries should not be increased beyond the 5,000 established in the Affordable Care Act (ACA) until and unless actual implementation of ACOs clearly demonstrates that a higher level is necessary.
- **Limit any requirements for the structure or internal systems of ACOs to items where there is clear evidence that high-quality, affordable care *cannot* be provided without such structures or systems.** For example, purchasing and maintaining electronic health record systems is very expensive, particularly for small physician practices. While having such systems is *desirable*, there is no evidence that they are *essential* for physician practices to successfully coordinate care and manage costs. Indeed, there are many examples where physician practices deliver high quality, affordable, coordinated care without such systems, and there is evidence showing that implementation of such systems can have negative impacts on the quality and cost of care, particularly during implementation phases. Consequently, making acquisition and implementation of such systems a condition for being designated an ACO would be inappropriate.
- **Modify the existing fee-for-service payment structure to enable physicians to be paid for desirable services and avoid financially penalizing them for reducing unnecessary services.** Shared savings payments alone do not represent true payment reform; they are merely another form of a pay-for-performance bonus on top of a fundamentally broken payment system. Moreover, long lags in calculating and paying these bonuses mean that physicians who change the way they deliver care may be forced to lose money in the short run, an untenable situation given the low payment rates that many already receive. CMS needs to make changes to the existing fee-for-service system so that physicians can be paid in a timely fashion for currently unreimbursed and under-reimbursed services that will improve care for patients and save money for the Medicare program. This can be done either by authorizing new or higher payments for specific CPT codes or making flexible per-patient payments, such as through partial capitation or other methods.

- **Implement effective risk-adjustment methodologies and caps on the costs associated with individual patients so that ACOs are managing performance risk, not insurance risk.** ACOs should be rewarded for how well they help Medicare beneficiaries manage health problems, not for luck in having patients who have relatively few health problems. Any payment models that CMS implements should use an effective risk adjustment methodology so that ACOs are rewarded, not penalized, for accepting sick patients and for addressing their needs in the most effective way possible. Selection of risk adjustment systems should be based on input from physicians and other experts and the methodology should be transparent to all stakeholders. However, risk adjustment alone is not enough, since some patients will have unique problems requiring unusually expensive care that will not be adequately captured by any risk adjustment methodology. Even a single such patient could be financially devastating for a small physician practice, while having a relatively small impact on a large health system. Consequently, in addition to good risk adjustment methodologies, CMS needs to establish limits on an ACO's accountability for the total costs of services to any individual patient.
 - **Limit the extent to which ACOs are accountable for the costs of certain services if they are delivered by only one provider in the community.** In addition to risk adjustment and caps on an ACO's accountability for any individual patient, ACOs should be permitted to have exceptions to the types of services they will be accountable for where there is only one choice of provider in the community and that provider is not part of the ACO. This will avoid penalizing ACOs for the actions of an uncooperative monopoly provider or forcing the ACO into an imbalanced partnership with such a provider.
 - **Provide timely, detailed data to physician practices to enable them to identify opportunities to make improvements in cost and quality and to successfully implement them.** These data need to (a) include information on all services received by patients who have been treated by a physician in the practice during the previous year; (b) be provided in a format that allows detailed analysis and simulation of the potential impact of changes in care delivery on costs; and (c) be delivered to practices at least six months in advance of when applications to serve as an ACO are to be submitted to CMS, and on a monthly basis after they begin functioning as an ACO.
2. **Many small practices may have limited access to capital or other resources to fund efforts from which "shared savings" could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Medicare Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?**

Create payment models that enable ACOs to self-finance improvements

The problems small practices (as well as many larger providers) will face under the shared savings model are broader than just “limited access to capital.” Even practices which have access to capital (either from their own financial reserves or from lines of credit extended by banks) may not be able to construct a feasible business case for the investment of that capital if CMS does not address the issues outlined in the previous section in ways that enable those practices to recoup their investments. In particular:

- CMS should create payment systems that enable ACOs to be paid immediately for key services that are not currently paid under Medicare, *e.g.*, phone calls and email communications with patients and other physicians, use of nurse care managers to provide education and self-management support for patients with chronic disease. The payment options described in Section 7 below can achieve this without increasing the net costs of the Medicare program.
- **Payment systems created by CMS should enable ACOs to accurately project the savings they will be able to retain or the additional payments they will be able to receive if they are successful in restructuring care delivery.** This requires knowing in advance which patients the ACO will be accountable for, knowing the current levels of utilization for those patients and the cost targets the ACO will be expected to achieve and receiving timely data on the ACO’s performance so that mid-course corrections can be made.
- **The FTC should remove barriers preventing ACOs from successfully contracting with private payers to support shared services.** Joint contracting makes it more practical for physicians to make and sustain the investments in infrastructure necessary to support quality improvement. Physicians cannot and should not organize their patient care delivery systems differently for Medicare patients than for commercially insured patients. The per-patient costs of investments to sustain efforts to improve care can be reduced if multiple physicians are sharing in the services those investments support and multiple payers are paying for those services.

Avoid imposing unnecessary requirements that require significant upfront capital

In addition to the above, CMS can reduce the need for upfront capital by avoiding imposing unnecessary requirements on ACOs that require significant capital investments. **CMS should only establish requirements for ACOs that require large capital investments if it provides a financing mechanism to enable physician practices to make those investments.**

Create loan, loan guarantee and technical assistance programs to help small physician practices make the investments needed to become ACOs

Taking the actions above will significantly reduce the need for upfront investment, as well as reduce risks and delays in recouping those investments. However, many small physician practices and newly formed IPAs will still need some kind of financing mechanism in order to make the upfront investments needed. Commercial lenders are unlikely to respond quickly or favorably to requests by ACOs for loans or lines of credit given the complexity of healthcare payment and the radical change that ACO payment systems represent. Physician practices should not be forced to enter into partnerships with hospitals simply to obtain access to capital. CMS could take several actions to increase the ability of small physician practices to obtain financing they need to become ACOs or to participate successfully in partnerships with other providers to form ACOs:

- **Educate banks and other commercial lenders** about the ways that physician practices participating in ACOs will have access to new revenue streams that can be used to repay loans.
 - **Create a loan guarantee program**, similar to the Small Business Administration's successful 7(a) program for small businesses, which would enable small physician practices and IPAs to more easily obtain financing from commercial lenders.
 - **Make grants to non-profit community organizations, such as Regional Health Improvement Collaboratives, to provide grants, loans and technical assistance to help small physician practices and IPAs form ACOs**, particularly in communities where market conditions warrant special assistance. This program could be operated in collaboration with the Health Information Technology Extension Center (HITECH) program established under the HITECH Act.
3. **The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACO's focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are assigned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?**

The core of any successful effort to reduce costs and improve quality in health care is a strong patient-physician relationship. This, in turn, is founded in a voluntary choice by both the patient and physician to begin and maintain that relationship. CMS should seek to encourage and reinforce such voluntary relationships between Medicare beneficiaries and physicians, not weaken them or create substitutes for them.

Any method for “attributing” patients to physicians puts CMS in the position of deciding which patients and physicians have a relationship, rather than having that decision made by the physicians and patients themselves. Moreover, all attribution methodologies use inherently arbitrary statistical rules that can easily create misclassifications.

Retrospective attribution is particularly problematic, since neither the patient nor the physician knows that CMS is assigning accountability to the physician for the costs of all of the patient’s care until after the care has already been delivered. Use of retrospective attribution could create an undesirable incentive for ACOs to avoid providing primary care services to new Medicare patients, since a single visit could result in all of the beneficiary’s healthcare costs being attributed to the ACO.

Without active patient support and participation, the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations and reduce the use of unnecessary and duplicative services is inherently limited. If a Medicare beneficiary is unwilling or unable to participate in efforts to better coordinate and manage their care, then an ACO should not be held accountable for the overall costs of services associated with a beneficiary simply because a physician in that ACO provided the beneficiary with a needed primary care service (and as a result had the beneficiary “attributed” to the ACO). Conversely, if a beneficiary and a physician mutually agree to work together to provide high-quality care for the beneficiary’s most critical needs, the ACO that the physician is associated with should not have any savings resulting from that care attributed to other providers based on an arbitrary statistical rule.

Consequently, CMS should seek to maximize the extent to which an ACO is held accountable only for those patients who voluntarily choose its physicians to provide or manage their care, and it should seek to minimize or eliminate the use of statistical attribution methodologies, particularly retrospective attribution after care has already been delivered. At a minimum, CMS should create one payment option as part of the regulations under the Medicare Shared Savings Program that allows beneficiaries to elect participation in an ACO and makes ACO-related payments based only on the beneficiaries who make that election. Ideally, several different payment models should be offered (as described in Section 7 below), each of which is based on patient selection rather than statistical attribution.

In addition, CMS should undertake a proactive effort to educate and encourage beneficiaries to take actions that will help make ACOs successful, e.g., to choose and consistently use a primary care physician as a medical home, select specialty physicians,

hospitals and other providers that coordinate effectively with their primary care medical home and each other, engage in shared decision-making processes with their physicians about appropriate treatments for their conditions and participate in other types of programs developed by their physicians that can maintain and improve their health at an affordable cost. **This education effort should be developed in cooperation with physicians and launched well in advance of the initiation of the ACO program.**

4. How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

Considerable effort and resources have been devoted to developing, testing, and implementing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and CMS should build on this work by using CAHPS to help measure experience of care in ACOs. It is important to recognize, however, that patient and caregiver experience measures such as CAHPS cannot be collected through existing data systems such as claims data and electronic health records. They require special surveys of consumers, and the lack of resources available to conduct these surveys has been a principal barrier slowing their implementation. Consequently, CMS will need to provide financial support for the collection and reporting of consumer experience data. To ensure both objectivity and adequate participation, this needs to be done through independent, community-based organizations, such as Quality Improvement Organizations (QIOs) or Regional Health Improvement Collaboratives (RHICs). Several RHICs, including Massachusetts Health Quality Partners (www.mhqp.org) and Minnesota Community Measurement (www.mnhealthscores.org), already collect and report measures of patient experience along with quality of care measures based on clinical and claims data. RHICs can provide an ideal platform for administering patient experience data with appropriate involvement of physicians and other providers.

Since CAHPS was developed to measure the care delivered by individual types of providers in a fee-for-service environment, additional survey questions will likely need to be developed to measure patient experience issues that will be particularly affected by ACOs. CMS should work with AHRQ and NQF to ensure there is adequate funding for the development, testing and implementation of new measures. Particularly in the near term, different measures may be needed in different communities because the areas where ACOs will focus their cost reduction efforts will likely vary significantly from region to region. An efficient way to address this would be for CMS to provide support to multi-stakeholder RHICs to develop and test new patient experience measures working in collaboration with the physicians and ACOs in their communities (more information on RHICs is available from the Network for Regional Healthcare Improvement (www.NRHI.org)).

Further, until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians and health care organizations to identify opportunities for responding to patient needs. Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of physician performance, health insurer demands or restrictions, or other factors outside a

physician's control, the use of patient satisfaction data is not appropriate for public reporting or financial incentive programs. Moreover, until collection methods associated with patient experience information are uniform and validated, such information should not be used to assess ACO performance.

The ACA does not require public reporting of ACO performance information, and we urge that CMS approach both the collection and any reporting of such information, including patient experience data, thoughtfully to avoid having unintentional adverse consequences for patients.

5. The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

To promote patient-centered care, ACOs will need measures that apply across disciplines and settings, account for multiple chronic conditions and provide information on the outcome of care. The medical community is working through the Physician Consortium for Performance Improvement (PCPI) to develop these measures as well as a framework for blending individual measures into a composite score that creates a more comprehensive picture of where improvement, resources and incentive payments should be focused.

While physicians support the development and use of increasingly sophisticated measures, there are also significant methodological limitations regarding risk adjustment, attribution and aggregation that must be taken into account. At this time, there are no widely accepted models that accurately attribute care provided through multidisciplinary teams, or when a patient's care is provided by multiple physicians or across two or more care settings. CMS' plan for evaluating patient-centered care should clearly address and resolve any attribution issues prior to requiring the collection and use of this information.

Further, an ACO's success in being "patient-centered" is best evaluated by patients' experience with the care provided by the ACO, not by whether the ACO meets specific standards established by CMS. Creating effective mechanisms for assessing patients' and caregivers' experience, as discussed in the previous section, should be the primary way that CMS measures patient-centeredness.

However, CMS can play a critical role in promoting patient-centeredness, because an ACO's ability to be patient-centered will depend heavily on the way CMS structures the payment systems and requirements for ACOs. In particular:

- An ACO needs to know who its patients are and have each patient actively working with the ACO to successfully manage his or her care. **Consequently, allowing patients to select ACOs rather than using statistical attribution methods, and encouraging patients to work proactively with their physicians and other providers, as described**

in more detail in Section 3, will provide the foundation for more patient-centered care.

- **Physicians need the flexibility to customize care for a particular patient in a way that works effectively for that patient, rather than being forced to provide a particular type of care simply because that is what Medicare will pay for.** For example, a physician should be able to be paid for answering a patient's phone call if that will provide more timely and effective assistance than an office visit. CMS should make the kinds of changes to the fee-for-service system described in Section 7 so that physicians can be paid upfront for currently unreimbursed and under-reimbursed services that will improve care for patients and save money for the Medicare program.
 - Physicians should not be penalized for accepting unusually sick patients into their care or customizing a patient's care to meet their unique needs. **Consequently, the kinds of effective risk adjustment and risk limits described in Section 1 must be included as part of any payment models implemented.**
- 6. In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?**

Types of Quality Measures

At least in the initial years of the ACO program, CMS should avoid requiring ACOs to collect and report quality measures beyond those that are already being required under other CMS programs, such as the Physician Quality Reporting System (PQRS), formerly the PQRI. Not only are these existing measures extensive and expensive to collect, they are heavily focused on preventive health care, which is the type of service for which providers are least likely to be rewarded under short-term ACO contracts.

Although additional quality measures may ultimately be warranted, it is impractical to develop a single national set of such measures prior to implementation of the Medicare Shared Savings Program, because the areas where ACOs will focus their cost reductions will likely vary significantly from region to region, and measures that may be appropriate for one ACO model may not be appropriate for another. ACOs should be allowed to report on a hybrid of nationally and locally focused quality measures related to their particular patient population. CMS should consult with measure developers like the PCPI as it seeks to define performance measures, including whether this information supports benchmarking for improvement at the population, organizational or group practice level. At this early stage, when there is so much we do not yet know about ACOs, a one-size-fits-all approach would be a mistake.

Further, CMS should support the ability of multi-stakeholder organizations, such as RHICs and QIOs, to work with ACOs in the community to collect and report additional quality measures tailored to the unique needs of individual communities. All measures should be developed in cooperation with the PCPI and should require reporting on measure sets that include intermediate and long-term outcome measures based on a patient population.

Because some subspecialties currently lack measures, and a data collection and reporting system that addresses their scope of practice, reporting requirements should be phased in to ensure that physicians have the opportunity and resources to participate on a widespread basis.

In setting up the quality measurement standards for ACOs, CMS should consider that the PQRS includes only a small number of “intermediate” outcomes measures related to diabetes, chronic kidney disease, end-stage renal disease and eye care. These focus on short-term outcomes, whereas true “outcome” measures are longitudinal and population-based. Additional resources and time are necessary to gather an evidence base, assess methodologies for risk-adjustment and test the measures for feasibility and reliability prior to broad based implementation across health care settings.

Due to the low reliability of current efficiency measures, more work will also be necessary in this area before these tools can be used in determining physician ratings or scores. Incorrect reporting of physician performance can mislead patients, disrupt patient/physician relationships, unfairly damage physician reputations, inappropriately redistribute physician compensation and potentially generate negative unintended consequences for patient access to care.

Standards of Performance

The standard of performance on any quality measures that CMS chooses should be “no decrease in quality,” at least initially. CMS should not seek to force arbitrary improvements in quality measures on ACOs at the same time they are seeking ways to reduce costs without rationing care for patients. Although it is likely that in many cases, providers will improve quality either as a means of reducing costs or in conjunction with cost reduction efforts, it is impossible to predict in advance where those improvements will occur because, as noted earlier, the areas where cost reductions will be sought and the methods of doing so will differ from ACO to ACO. CMS should seek to assure patients that ACOs will not result in lower quality care, not to promise them that any particular aspect of quality will improve. CMS should also support the flexibility of ACOs to choose the areas where they focus quality improvement and cost reduction efforts, not distract them by imposing unrelated quality improvement goals (particularly without corresponding changes in payment).

- 7. What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority**

under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

Additional Payment Models CMS Should Implement

CMS should implement at least two payment models in addition to the “shared savings” approach in order to support ACOs:

- **Partial Capitation:** Under this payment model, an ACO would agree to accept a pre-defined monthly per-patient payment during a multi-year period that would be used to cover all of the costs of care for a defined group of patients. The payment would be lower than what CMS would project paying for those patients under the current fee-for-service system. This model would enable physician practices with experience in successfully managing capitation contracts under Medicare Advantage and commercial insurance to deliver better care to Medicare fee-for-service beneficiaries as well as guaranteed savings to the Medicare program. For example, the Center for Healthcare Quality and Payment Reform has developed a detailed description of how this model could be implemented and its advantages compared to shared savings, and we would urge that CMS use it as a framework for implementing Section 1899(i)(1) of the ACA.
- **Virtual Partial Capitation:** A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment; individual providers who volunteered to participate would bill for individual services, the total billings would be compared to the budget and the payments to the providers in the ACO would be adjusted up or down to keep the total payments within the budget. In addition, it would be desirable if CMS would implement two additional transitional payment models in order to make it more feasible for primary care practices and specialty practices to transition successfully to more accountable care delivery.
- **An Accountable Medical Home Payment:** This would give a primary care physician practice, multi-specialty group, or IPA the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions and use high-tech diagnostic imaging where it is not necessary or appropriate. This payment model would enable primary care practices to improve care for Medicare beneficiaries and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. The Puget Sound Health Alliance and the Washington State Health Care Authority are working to put this model in place in the state of Washington next year for commercial payers and Medicaid plans, and CMS could use the approach they have developed in the Medicare program.

- **Condition Specific Capitation:** This would be a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by the provider receiving the payment or other providers. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Method of Implementing the Payment Models

Ideally, all of the above payment models would be implemented under Section 1899(i) of the ACA. Each of them can be structured in a way that meets the ACO eligibility requirements of Section 1899(b)(2) and the budget neutrality criterion of Section 1899(i)(2)(B).

However, if CMS cannot implement some of these payment models under the Medicare Shared Savings Program and chooses to do so under the Center for Medicare and Medicaid Innovation (CMMI), it should do so in a way that enables maximum participation by a wide range of providers:

- The criteria for participation should be clearly defined in advance, and any provider which meets the eligibility requirements should be permitted to participate.
- The criteria should avoid structural requirements or major capital investments that preclude small physician practices from participating.
- There should be no arbitrary limits on the number of providers who can participate in a payment model that is structured to assure budget neutrality. CMS should only place limits on the number of providers that can participate in payment models if the payment models are not explicitly structured to ensure budget neutrality.
- Providers should be able to participate without regard to whether other CMS demonstrations are implemented in the same geographic area. Since CMS has indicated that ACOs can be implemented under Section 1899 regardless of whether other demonstrations are underway in the same areas, it is undesirable to prohibit alternative models of ACO payment from being implemented in those areas.

Donald Berwick, MD

December 2, 2010

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The AMA appreciates the opportunity to provide our views concerning CMS' request for information about ACOs and the Medicare Shared Savings Program, and we look forward to working with CMS to implement this program in a manner that addresses the concerns above and allows participation by a wide range of physician practices.

Sincerely,

A handwritten signature in black ink that reads "Mike Maves". The signature is written in a cursive, flowing style.

Michael D. Maves, MD, MBA