The difference-in-differences approach tested for changes in rates of growth between the intervention group and the control group, thereby adjusting for any minor differences in baseline costs. In addition, the analysis of covariance was adjusted for differences in beneficiary characteristics — including age, sex, race, Hierarchical Condition Category severity score, presence of heart failure or diabetes, and baseline costs — at the start of each pilot program. In the analysis of covariance, the statistically nonsignificant difference-in-differences effect on the growth in costs for Aetna was more than halved, not increased, implying that Aetna benefited from a healthier intervention population.

Average Medicare monthly care-management fees ranged from 5 to 11% of average payments per beneficiary per month. Hence, the concern over statistical power was unfounded, since we would have found savings rates of only 3 to 4% that were significant at the 95% confidence level, far less than paid fees. We observed improved performance with the refresh population for several companies; however, savings remained statistically nonsignificant and were less than required savings. Our results were consistent across all eight companies and for both the original and refresh populations.

Savings and health outcomes for beneficiaries with very short lengths of eligibility were substantially down-weighted by their fraction of eligible time during the intervention, thereby avoiding any bias from short spells. Substantial regression to the mean (250%) over short periods increases the estimated variance, thereby reducing statistical power. Even so, we still found a cost savings of 3 to 4%. We directly adjusted for regression to the mean by including baseline costs in our models.

Terry and Moisuk affirm what we believe to be major challenges with improving health outcomes in the commercial fee-for-service population in contrast to a managed-care environment in which payers play a role in patients’ access to care. Our evaluation of care management for high-cost beneficiaries at Massachusetts General Hospital showed a statistically significant return on investment of 3:1, given a similar intention-to-treat study design and a substantially smaller sample size. Case managers became integral members of each beneficiary’s primary care team with access to real-time clinical information and face-to-face interactions with primary care physicians and beneficiaries. It may be that both elements are necessary in the fee-for-service population.

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Since publication of their article, the authors report no further potential conflict of interest.


The Human Plasma Lipidome

TO THE EDITOR: In their review, Quehenberger and Dennis (Nov. 10 issue) describe plasma lipids implicated in Gaucher’s disease. Although they could not possibly mention every lipid, we believe it is worth commenting on the cationic amphiphilic glycolipid globotriaosylsphingosine (lyso-Gb3) and its contribution to a better understanding of the pathogenesis and monitoring of Fabry’s disease. High plasma concentrations of lyso-Gb3 were observed in patients with this disease, and these levels correlated with several of its manifestations and decreased in response to enzyme-replacement therapy. Furthermore, lyso-Gb3 promoted vascular smooth-muscle cell proliferation as well as transforming growth factor-β1–mediated synthesis of extracellular matrix components in cultured podocytes at concentrations found in the plasma. In Fabry’s disease, vascular smooth-muscle cells and podocytes are cell targets, whereas fibrosis is a key feature of organ injury. The novelty, from a pathogenetic point of view, resides in the fact that a soluble mediator promotes cell injury in a disease long thought to be the result of intracellular...
The New England Journal of Medicine

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TO THE EDITOR: We question the indication for endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy in the teenager described in Case 32-2011 (Oct. 20 issue). First, acceptable explanations for his recurrent episodes of pancreatitis were discovered (i.e., genetic predisposition triggered by alcohol consumption). Second, there is no objective documentation of sphincter of Oddi dysfunction. Most experts usually perform sphincter of Oddi manometry (SOM) to support the diagnosis. Third, there was no biliary tract abnormality or sphincter stenosis present. Biliary sphincterotomy is beneficial in patients with SOM-proven sphincter of Oddi dysfunction, pancreaticobiliary maljunction, or both. Fourth, it is completely unclear what type of sphincterotomy was performed: biliary or pancreatic? In addition, where was the stent placed? Was it inserted into the common bile duct or the pancreatic duct? Was it used to treat stenosis of the biliary sphincter or to guarantee the flow of pancreatic fluid? In summary, performing a risky procedure (ERCP) in patients with a questionable diagnosis of sphincter of Oddi dysfunction may not result in any benefit and can result in catastrophic pancreatitis. Thus, we want to caution other endoscopists against this practice in similar cases.

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No potential conflict of interest relevant to this letter was reported.


THE AUTHORS REPLY: Although we made every effort to be as broad as possible in our article on the plasma lipidome in health and disease, space restrictions limited the number of lipid biomarkers that we could adequately discuss in the context of their potential use as diagnostic tools. As the most prevalent metabolic storage disorder, Gaucher’s disease was cited as a representative example of the numerous lipid-storage diseases, including Fabry’s disease.

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Since publication of their article, the authors report no further potential conflict of interest.

Case 32-2011: A Man with Recurrent Pancreatitis

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