positivity between participants with SCI and those who were cognitively normal.

Second, they indicate that the absence of correction for education in the analysis presented in Figure 2 could have biased our findings because of differences in educational level between participants with normal cognition and SCI. We have repeated the analysis for the data shown in Figure 2 with correction for education and found no statistically significant difference in amyloid positivity between participants with normal cognition and patients with SCI (mean difference, 84% [95% CI, –13% to 5%]; P = .35).

Third, it is suggested that our definition of SCI was limited and that the normal cognition group may have included participants with SCI. The studies included in our meta-analysis adopted different inclusion criteria for SCI. We defined SCI as referral to a memory clinic in the absence of objective impairment because this could be implemented reliably across studies. This definition also seems compatible with a definition of SCI that is supposed to be more specific for AD.

However, we cannot exclude the possibility that the normal cognition group included participants with SCI according to other definitions. Yet in additional analyses, we selected 6 studies from our meta-analysis that explicitly excluded participants with cognitive complaints from the normal cognition group and still found no statistically significant difference in amyloid positivity between the participants with normal cognition (n = 214) and patients with SCI (n = 413; mean difference, 1% [95% CI, –5% to 7%]; P = .77).

We agree with Wagner and Jessen that more research is needed on the standardization of the SCI construct. Future studies combining biomarkers and long-term neuropsychological and clinical follow-up need to establish whether there is a specific definition of SCI that is associated with amyloid positivity and that is predictive for AD.

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Inclusion of Physicians in Bundled Hospital Payments

To the Editor In a Viewpoint, Drs Mehrotra and Hussey1 described several previous proposals and pilot studies of financial integration of physician and hospital services, and they clearly articulated the historical barriers to its wide-scale adoption by the Medicare program and private third-party payers (health plans and health insurance companies).

There are 2 examples of longstanding bundling of physicians and hospital payments that not only provide precedent beyond the basic proof-of-concept stage but offer momentum to the proposals.

The major federal health care systems for hospital care of Armed Forces members and their dependents (Department of Defense) and military veterans (Department of Veterans Affairs [VA]) have been successfully operating as an integrated single-payer bundled payment plan for decades. Although military2 and VA3 physicians technically receive paychecks (salaried, not fee-for-service) that are separate from the hospital payments, they provide all inpatient and outpatient services for those hospitals.

Most private third-party payers have been making global capitated payments to major academic medical centers (within their centers of excellence networks) for hospital care of patients with organ or bone marrow transplants. The medical center makes the determinations how to distribute the funds to all the various clinicians (including physicians who are not employees) and the individual hospital departments involved with providing these high-cost services.4

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In Reply As Dr Bowman notes, in our Viewpoint we focused on including physicians in bundled hospital payments within the Medicare program.

Medicare is of particular importance in health care given Medicare payment policy changes typically reverberate throughout the system. Nonetheless, we agree with Bowman that it is useful to highlight other pockets of health care for which physicians providing inpatient care do not have to submit a bill for each daily visit.
In the case of the VA, for instance, anecdotal evidence suggests that physicians who switch from providing inpatient care in the private setting to the VA enjoy the freedom of not worrying about billing or whether their notes meet Medicare’s complicated billing requirements.

The experience of these physicians highlights 2 of the key benefits of bundled physicians within inpatient care. More importantly, the examples Bowman cites also emphasize the feasibility of including physicians in hospital payments.

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CORRECTION

Misspelled Name: In the Medical News & Perspectives article entitled “Genomic Technologies Speed Pathogen Detection” published in the July 21, 2015, issue of JAMA,1 a name was misspelled in the text. It should have appeared as Tara Palmore, MD. The article was corrected online.


Author’s Middle Initials Missing in Byline: In the Original Investigation entitled “Association of Cardiometabolic Multimorbidity With Mortality” published in the July 7, 2015, issue of JAMA,2 an author’s middle initials were missing. His name should have read “Maarten J. G. Leening, MD, MSc.” This article was corrected online.


Authors’ Names Reversed: In the Viewpoint entitled “Racial Bias in Health Care and Health: Challenges and Opportunities” published in the August 11, 2015, issue of JAMA,3 the wrong author was listed first. This article was corrected online.


Incorrect Spending Figure in an Editorial: In the Editorial entitled “Medicare and Medicaid, the Affordable Care Act, and US Health Policy” published in the July 28, 2015, issue of JAMA,4 the amount of Medicare and Medicaid costs should have been reported in the billions. This article was corrected online.


Guidelines for Letters

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