High Rates of Overtreatment for Type 2 Diabetes in Older Adults

Overtreatment of type 2 diabetes is common and potentially harmful in older adults, according to a primary care study in *Diabetes, Obesity and Metabolism*.

The observational study included 1002 patients being treated for type 2 diabetes at five Dutch primary care centers, including 319 patients aged 70 years or older. These older patients were classified into subgroups according to Dutch guidelines, based on glycated hemoglobin targets: 7%, 7.5%, and 8%. Levels of personalized care for type 2 diabetes were assessed, focusing on overtreatment.

The analysis identified 165 patients aged 70 or older with an HbA1c target of greater than 7%. In this group, 54.0% of patients had microvascular complications, compared to 35.2% of those with lower HbA1c targets. Rates of macrovascular complications were 33.3% versus 17.7%, respectively. Patients with higher HbA1c targets were almost more likely to use five or more medications and more likely to be frail.

Of the 165 patients, 64 were overtreated: a rate of 38.8%, or 20% of all patients aged 70 years or older. Most overtreated patients were frail and used five or more medications. About 20% had episodes of hypoglycemia, while nearly 30% had accidents involving falls.

For patients with type 2 diabetes aged 70 or older, the risk of harm associated with HbA1c targets under the conventional 7% seems to outweigh the benefits. There are indications of overtreatment in this group of patients in the United States as well as Europe. In the Netherlands, more than 85% of patients with type 2 diabetes are managed in primary care.

The new study suggests that many older adults with type 2 diabetes are overtreated, with probable harmful consequences. “Personalized treatment in older people with type 2 diabetes is not common practice,” the researchers write. They suggest that guidelines defining a lower HbA1c limit might be helpful to prevent overtreatment [Hart HE, et al. Overtreatment of older patients with type 2 diabetes mel- linus in primary care. *Diabetes Obes Metab* 2017; DOI: 10.1111/dom.13174].

Kidney Disease in Childhood Increases Adult ESRD Risk

Any history of childhood kidney disease is associated with a substantially increased risk of end stage renal disease (ESRD) in adulthood, reports a study from Israel in *The New England Journal of Medicine*.

The historical cohort study included more than 1.5 million Israeli adolescents undergoing medical assessment before military conscription between 1967 and 1997. History of childhood kidney disease was assessed, including congenital anomalies of the kidney and urinary tract, pyelonephritis, and glomerular disease. When evaluated at a mean age of 17.7 years, all individuals had normal kidney function and blood pressure.

Risk of ESRD in adulthood was assessed by linkage to the national ESRD registry. During a mean follow-up of 30 years, 2490 individuals developed ESRD.

Any type of childhood kidney disease was associated with a fourfold increase in the risk of ESRD during adulthood: hazard ratio (HR) 4.19. Adjusted HRs were 5.19 for congenital anomalies, 4.03 for pyelonephritis, and 3.85 for glomerulonephritis.

Childhood kidney disease was also associated with younger age at ESRD onset, with an HR of 10.40 for risk of ESRD among adults younger than 40. The excess risk decreased with longer follow-up, but remained significant up to 40 years follow-up.

Although most childhood kidney disease has a favorable prognosis, the impact on lifelong risk of chronic kidney disease has been unclear. This nationwide study shows an increased risk of ESRD among those with any history of childhood kidney disease, despite apparently normal kidney function in adolescence.


Policy Update

Telehealth and Telemedicine Reimbursement Get Big Boost from Passage of Two-Year Budget Deal

By David White

Telehealth and telemedicine reimbursement received big boosts in the two-year budget deal signed into law by President Donald Trump on February 9, 2018, with one senator saying the law does more for Medicare coverage of telehealth than any past legislation.

The budget deal included parts of the Creating Chronic Care Act advocated for by the American Society of Nephrology (ASN) and fellow members of the Telehealth/Remote Monitoring Coalition. Targeted at Medicare’s telehealth and telemedicine reimbursement rules, the new law:

- adds the patient’s home, without geographic restriction, to the list of originating sites for monthly telehealth assessments with a nephrologist, beginning in 2019, allowing for home dialysis monthly ESRD-related clinical assessments through telehealth in Medicare;
- eliminates geographic restrictions on telestroke consultation services, beginning in 2019;
- expands telehealth coverage under Medicare Advantage Plan B, beginning in 2020;
- gives Accountable Care Organizations more flexibility to use telehealth services; and
- extends for two years the Centers for Medicare & Medicaid Services’ (CMS) Independence at Home demonstration, which establishes home-based primary care teams for Medicare beneficiaries with multiple chronic conditions and increases the cap on the total number of participating beneficiaries from 10,000 to 15,000.

Currently, Medicare pays only for certain telehealth services under Part B, normally in the form of face-to-face video conferencing. Under the new law, Medicare can pay for telehealth benefits, such as telemonitoring and medication therapy management, under private Medicare Advantage plans starting in 2020.

The next step is for Medicare to decide what services should be covered. *Bloomberg News* reported that CMS Administrator Seema Verma said during a February 6 conference that telehealth coverage provisions will be included in this year’s Medicare payment rules, which are expected in the spring.

The three major rules that govern nephrologists’ reimbursement and will need adjustments to implement the new law are the rules on the Quality Payment Program (QPP), End-Stage Renal Disease Prospective Payment System/Quality Incentive Program (ESRD PPS/QIP), and the Physician Fee Schedule. The ASN Quality Committee reviews these three rules annually and makes comments/recommendations for CMS to consider. The 2018 Physician Fee Schedule reflects CMS’ intent to move further in this direction already. This year, it includes reimbursement for remote patient monitoring and CPT codes for telemedicine for the first time.

March Deadlines for Submission of 2017 Data for the Quality Payment Program

To potentially earn a positive payment adjustment under MIPS (Merit-based Incentive Payment System), send in data about the care you provided and how your practice used technology in 2017 to MIPS by the March 31, 2018, deadline. In order to earn the 5% incentive payment by significantly participating in an Advanced APM, just send quality data through your Advanced APM.

CMS Web Interface users (groups with 25 or more clinicians, including APM entities) have a shorter timeframe to submit quality data, as the submission deadline closes March 16, 2018, at 8 p.m. Eastern Time. Go to qpp.cms.gov