A Bold Vision to Accelerate Adoption of Value-Based Kidney Care

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Interwell Health is the quality leader in value-based kidney care in the U.S. Interwell takes a team approach to patient care, focusing on CKD and ESKD patients whose significant disease burden is complicated by social needs. One crucial pillar of Interwell's strategy is the prevention of avoidable hospitalizations, combined with prompt follow-up doctor visits for every patient who has recently experienced an in-patient hospital stay. Internal data demonstrates that Interwell's holistic program improves patient outcomes while reducing annual costs for Medicare patients.

Within the U.S. healthcare system, in the past decade, there has been an accelerating shift away from traditional fee-for-service (FFS) payment models towards models focused on rewarding quality while lowering the total cost of care. This emphasis on value, not volume, offers opportunities to pay for comprehensive holistic care not available in a traditional FFS approach.

Fresenius Medical Care has been a pioneer and leader in value-based care (VBC) since 2014. The company created Interwell Health (Interwell) in 2019, a joint venture with nephrologists dedicated to working together in the transition from volume to value. This led to an innovative merger in 2022 between Fresenius Health Partners, the company's VBC division; Interwell Health, the leading nephrology provider network; Cricket Health, a pioneering digital technology and patient engagement company; and Acumen, the leading nephrology-specific electronic health record (EHR) built on the Epic platform.

Today, the new Interwell is growing rapidly to serve the needs of more than 122,000 people with chronic kidney disease (CKD), including those with end-stage kidney disease (ESKD), across a national scale and broad payer mix. Interwell is the largest participant and quality-leader in the government models for kidney care, while also contracting with large national and regional private insurers. The keys to Interwell's future success are implementing strategies that delay CKD progression, effectively managing the transition to ESKD for those whose kidney disease progresses, and reducing hospitalization and mortality rates for patients with advanced kidney disease.

Implementing New Care Models at Scale

To be successful, any value-based company must deliver results for patients and payers at scale backed by a sustainable financial model that includes both shared and full-risk contracts.

Interwell focuses on people living with CKD beginning in stage 3 through ESKD, managing people with significant disease burden complicated by social needs. Interwell's care model centers around a team that includes dietitians, social workers, nurses, and care coordinators, working with a person's nephrologist and primary care physician.

Interwell's model allows us to support the right patients at the right time wherever they are—at the doctor's office, in their home, or at a dialysis center. Interwell's model includes many unique aspects such as:

Predictive Analytics: Risk stratification for patients using Interwell's proprietary machine learning models to identify those most at risk of progression or hospitalization. Many of these machine learning capabilities were relaunched in 2023 to provide better accuracy over a longer period. Knowing who Interwell's patients are, what they need, and when they need it to manage their kidney disease drives the effectiveness of Interwell's clinical interventions.

Largest Provider Network: Collaboration with more than 1,800 nephrologists aligned on the incentives for improving outcomes. Interwell's care team approach is to move away from a siloed and fragmented healthcare delivery system to one that has both the patient and providers at the center.

Acumen Epic Connect: Most-adopted EHR built for nephrologists with new population health tools, access to Epic's Care Everywhere, and custom dashboards. Interwell Care Connect and Acumen Epic Connect enhance seamless communication of care between providers.

Dialysis Center Alignment: For those people transitioning to dialysis in one of Fresenius Kidney Care's 2,600 clinics, we offer coordinated remote care management focused on identifying patients at the highest risk for hospitalization within seven days as well as post-hospitalization transition management. This offers more timely interventions such as adjusting the dialysis prescription to better address adjusting clinical targets such as estimated dry weight.

Care Transition Program: Rapid outreach by a dedicated care team for all patients discharged from the hospital to ensure a visit with their nephrologist within 14 days.

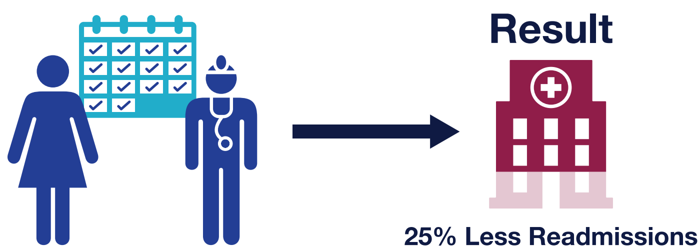
While there are many aspects to Interwell's VBC program, this discussion focuses on how the program addresses two of the largest drivers of costs.

Reducing Hospitalizations

Hospitalizations are not only expensive but create substantial burdens for patients and their caregivers. In addition, discharge from a hospital stay is a transition of care that can fragment patient care absent detailed attention to care coordination. The work to keep people healthier and out of the hospital has a major impact on the health and well-being of the population and success in a VBC program. Approximately one-third of the annual medical costs for Medicare beneficiaries for people living with CKD and ESKD are a result of inpatient hospitalization. Interwell's program focuses on managing patients holistically to prevent avoidable hospitalizations.[1]

Interwell's Care Transition program empowers a team to reach out to patients post-discharge to ensure they see a nephrologist within two weeks. Interwell's analysis of more than 11,000 members showed that those who visited a nephrologist within 14 days of discharge were almost 25 percent less likely to be readmitted within 30 days than those who did not see their doctor (Figure1). The results of all these efforts are healthier patients, fewer hospitalizations, and lower costs for payers.[2]

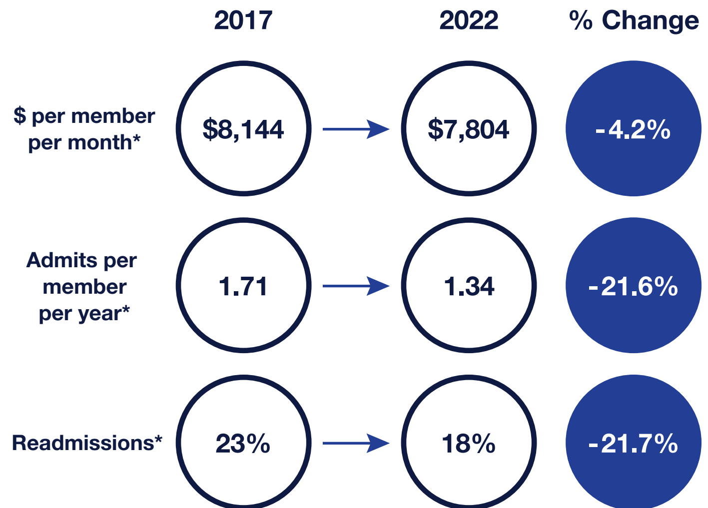
FIGURE 1 | SEEING A NEPHROLOGIST WITHIN 14 DAYS OF DISCHARGE EQUATES TO 25 PERCENT LOWER LIKELIHOOD FOR READMISSION



For one national Medicare Advantage payer, Interwell managed 7,500 members with ESKD to reduce costs per member per month (PMPM) by 4.22 percent, at a time when the Medicare fee-for-service benchmark rose by approximately 10 percent. Over a five-year period (2017–2022), admits per member per year dropped from 1.71 to 1.34, while readmissions dropped from 23 to 18 percent (Figure 2).

For a smaller regional payer, Interwell successfully reduced all-cause hospitalizations among people with late-stage CKD by 25 percent, lowering rates from a baseline of 1.06 admits per member per year (PMPY) to 0.79 PMPY over two years (2021–2022). For all people with ESKD, all-cause hospitalizations were lowered by 30 percent, from a baseline of 1.65 admits PMPY to 1.16 PMPY. These efforts resulted in a 13 percent lower cost of care and total savings of $3.6 million for this regional plan (Figure 3).

FIGURE 2 | RESULTS FROM A NATIONAL MEDICARE ADVANTAGE PAYER FOR ESKD



Improving Optimal Starts

The latest government payment model, Kidney Care Choices (KCC), rewards physicians for optimal starts. This is defined as transitioning from CKD with a pre-emptive kidney transplant, home peritoneal dialysis (PD), or starting home hemodialysis or in-center hemodialysis with a permanent arteriovenous (AV) access (AV graft or AV fistula) but not with a tunneled catheter. United States Renal Data System (USRDS) data show that up to 85 percent of new hemodialysis starts include some type of catheter.[1] A recent retrospective study found that optimal starts decrease post-dialysis costs by $16,565 per patient per year when compared to unplanned starts.[3]

Interwell utilizes a combination of resources to help practices improve optimal starts:

- Predictive analytics to help identify and target higher-risk patients
- Kidney disease education course and patient materials (Interwell Learning)
- Interwell Renal Care Coordinators (RCCs) embedded in physician practices
- Performance-based programs that align clinical and financial goals

Approximately one-third of the annual medical costs for Medicare beneficiaries for people living with CKD and ESKD are a result of inpatient hospitalization.

FIGURE 3 | STRONG CLINICAL AND FINANCIAL RESULTS FROM A REGIONAL HEALTH PLAN

CKD Stage 4 and 5

	2021 Baseline		2022	
$ per member per month	$2,240	→	$1,947	**-13%**
Admits per member per year	1.06	→	0.79	**-25%**

$1.97 Million Total Savings

ESKD

	2021 Baseline		2022	
$ per member per month	$9,600	→	$8,378	**-13%**
Admits per member per year	1.65	→	1.16	**-30%**

$1.69 Million Total Savings

Since the company's first contract in VBC in 2014, RCCs have been embedded into physician practices to help with care transition and education. This program now totals 80 RCCs embedded in 50 practices across the country. In the remaining situations, Interwell leverages remote nurses who work with patients telephonically in coordination with the practice. Interwell works closely with its nephrology partners to develop the specific processes, education, and training needed to drive success in the KCC program.

Interwell has also developed a specialized learning program for nephrology practices to use with their patients with CKD. In 2023, Interwell's affiliated practices using the Interwell Learning kidney disease education program observed a 68 percent optimal start rate, compared to a 57 percent optimal start rate for practices not using this program.

Real-World Impact

The shift to value requires new ways of working and more holistic approaches to care delivery. While the data already shows cost savings and improved outcomes, it's each story behind that data, from a pre-emptive transplant to delayed progression, that is a reason to celebrate the potential of value-based care.

Dr. George Hart
Chief Medical Officer
Interwell Health

Dr. Hart is a native of eastern North Carolina and attended Wake Forest University for both his undergraduate and medical degrees. After finishing a nephrology fellowship at the Mayo Clinic he joined Metrolina Nephrology Associates (MNA) in 1992. For 15 years he served as medical director for the kidney and pancreas transplant programs at Carolinas Healthcare System. He was president of MNA from 2005–2022. Dr Hart was a medical director for various FKC dialysis units from 1995–2022 and serves on the Corporate Medical Advisory Board for Fresenius Medical Care. In March 2020, Dr Hart joined the leadership team of Interwell Health as Chief Medical Officer.

Dr. Terry Ketchersid
Senior Vice President, Medical Office
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Dr. Ketchersid received a BA in Chemistry from Austin College and his MD degree from The University of Texas Southwestern Medical School in Dallas. After completing an Internal Medicine residency in Dallas, and a Nephrology Fellowship at the University of Missouri, Dr. Ketchersid practiced nephrology for 15 years with the Danville Urologic Clinic, serving as the practice's President and CEO in 2004 and 2005. At Halifax Regional Health System, his roles included Chairman of the Pharmacy and Therapeutics Committee, Chief of Medicine, and Chief Quality Officer.

In 2007, Dr. Ketchersid completed the Executive MBA program at Duke University's Fuqua School of Business, earning the Fuqua Scholar honor. In 2008, he joined the Acumen Electronic Health Record Senior Management team where he served as the company's Chief Medical Officer 2009–2013. From 2014 to 2022 Dr. Ketchersid served as the Chief Medical Officer for Fresenius Medical Care's Integrated Care Group. In 2022 he joined Interwell Health as Senior Vice President within the organization's Medical Office. Dr. Ketchersid served on the board of directors for the Renal Physicians Association 2016–2022.

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