U.S. House Committee on Ways and Means
Subcommittee on Health

Hearing on "Improving Kidney Health Through Better Prevention and Innovative Treatment"

Written Testimony of Dr. Robert Taylor
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Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to speak with you today and discuss ways to improve kidney health through better prevention and innovative care.

My name is Robert Taylor, and I am a practicing nephrologist in Nashville, TN, where I serve as Chief Medical Officer at Dialysis Clinic, Inc. (DCI). I am also a co-founder of REACH Kidney Care (REACH), along with Dr. Doug Johnson, our CEO and Vice Chair of the Board, and Lauren Hollingsworth, REACH's Chief Operating Officer. REACH Kidney Care is a not-for-profit service line of DCI with the primary focus of keeping as many people off dialysis as possible.

Today, I want to tell you about how DCI is making a difference in the lives of patients and their families and offer my thoughts as a practitioner on innovation and prevention in patient-centered kidney care and policies to support these objectives. DCI's experience as a kidney health provider and my experience as a practicing nephrologist inform several policy recommendations I would like to put forward for consideration by this Committee.

1. About DCI

DCI is the only independent national not-for-profit kidney health provider in the United States. This year, we celebrate 55 years of caring for people with kidney disease.

We were founded by Dr. H. Keith Johnson in 1971 to save the lives of eight people in Nashville with kidney failure until they could receive a transplant. During the time before Medicare funding for dialysis, 80% of the patients we served did not have coverage for dialysis care, and the team was relentless in finding funds for patients who could not afford treatment. Using Kentucky Fried Chicken buckets, DCI doctors and staff collected donations at some of Nashville's busiest intersections. These donations helped sustain clinic operations until Medicare began paying for outpatient dialysis in July 1973.

Today, DCI cares for more than 13,500 people on dialysis across more than 240 outpatient facilities in 30 states and the U.S. Virgin Islands. We also provide in-hospital dialysis care in more than 90 hospitals. Our stated mission is "The Care of the Patient is Our Reason for Existence." One of the most important decisions that Dr. Keith Johnson made in the early days of DCI was that it would be a not-for-profit organization. This fundamental decision has allowed us to approach caring for patients with kidney disease in a very different manner because we can make long-term strategic decisions for improved patient care without worrying about an immediate return on investment. This allows us to try innovative approaches to kidney care without the pressure of investor stakeholders expecting immediate returns. DCI has consistently delivered dialysis care with lower mortality, fewer hospitalizations, and lower Medicare costs than other national providers.

DCI has also been at the forefront of kidney transplantation, the optimal therapy for many people with end-stage renal disease (ESRD), or kidney failure. In 2025 alone, we supported 995 life-changing transplants. We like to say that transplant is in our DNA.

Nonprofit Kidney Care Alliance

DCI is also a founding member of the Nonprofit Kidney Care Alliance (NKCA) and has been an active participant in the NKCA since it was founded 15 years ago. Our members comprise small, independent not-for-profit companies that collectively serve approximately 22,500 dialysis patients at more than 326 facilities in 32 states. NKCA members share best practices and address current fragmentation in care for our patients to improve the quality of care and address health disparities in this patient population. In addition, NKCA works with policymakers to tackle important issues that affect people living with kidney disease and actively advocates for public policies that improve access to care across the continuum of kidney disease. Our members also include Centers for Dialysis Care; Central Florida Kidney Centers, Inc.; Dialysis Center of Lincoln, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; Puget Sound Kidney Centers; and The Rogosin Institute.

NKCA members work collaboratively to support one another through clinical discussions, policy advocacy, and collective problem solving. We do so because each member recognizes the value of a robust group of mission-driven, not-for-profit dialysis providers. Each NKCA member operates independently to serve the needs of their patients, provide access as a critical safety net in locations other providers may not go, and bring choice and competition to markets that can support multiple facilities.

REACH Kidney Care

Thirteen years ago, we created REACH Kidney Care to provide upstream, innovative care that empowers people with kidney disease, transplant recipients, and those approaching kidney failure to live their best life possible. This model of care is inspired by our late friend Bill Peckham, who invited us to travel along as he took his hemodialysis machine down the

Rogue River for three days in 2010 and down the Colorado River through the Grand Canyon for eight days in 2013. Bill lived life at the sharp end of the needle and did everything he could to push us to become a better organization and to not treat people with advanced kidney disease as only patients who would end up on dialysis. Bill used to say, "I am living the width of life, not just the length of life." His pioneering spirit reminds us that care planning should focus on the life a patient wants to live—not simply the treatment they receive.

Today, REACH operates in 9 states and is responsible for more than 10,000 individuals across the continuum of kidney disease. REACH provides kidney care for patients with stage 4 and 5 kidney disease, kidney transplant recipients, individuals receiving dialysis, and those at the end of life.

In areas where we have active REACH programs, we are definitively moving the needle on transplantation. For patients enrolled in REACH, our preemptive kidney transplant rate is greater than 10 percent—more than triple estimated preemptive transplant rates in the United States.

We are also increasing access to home dialysis. In our long-term partnership with Blue Cross Blue Shield of Alabama, 38 percent of people start dialysis at home, more than three times the national average. In this partnership, only 51 percent of people start renal replacement therapy at an in-center dialysis clinic, compared to the national average of 82 percent. In Alabama, and elsewhere, we are turning kidney care on its head.

Rural Health – Tillamook, Oregon and West Plains, Missouri Examples

In partnership with Adventist Health Tillamook, and with support from the DCI Foundation, DCI recently reopened the dialysis center in Tillamook, OR, after it was closed by previous ownership in early 2024. The clinic closure created a significant burden for local patients. Without their neighborhood dialysis clinic, most patients had to drive 120 miles roundtrip to the nearest clinic for life-sustaining dialysis. For many of these patients, the trip was taken on narrow mountain roads in the wee hours of the morning or at night.

While the benefit to patients and the community is clear, the Tillamook clinic will likely operate at a loss. Current reimbursement rates do not cover the full cost of operations. As a mission-driven industry leader, we are committed to having 25 percent of DCI clinics operate in a county where we are the only clinic and ensuring that these clinics are operated in a sustainable manner with ongoing support from the community. For patients receiving dialysis thrice weekly, having an accessible clinic relieves them of hours of transportation in some areas of the country.

We are not always this lucky in rural communities. For instance, DCI operated a clinic in West Plains, MO, for more than 34 years, until our medical director decided to leave. We were able to keep the doors open for an additional 18 months after the doctor left by having

another physician drive three and a half hours each way to cover the clinic. Despite our best efforts to find a new medical director, we were unsuccessful and made the difficult decision to close the clinic simply due to workforce challenges.

Camp Okawehna

For most children with kidney disease in the early 1970s, attending a summer camp simply was not an option. The emotional, physical, and financial burden of dialysis treatments extinguished their hopes for a traditional camp experience. Camp Okawehna, affectionately called "Camp O," changed that. For 50 years, DCI has helped hundreds of children experience the fun and adventure of a week-long overnight summer camp in a safe and welcoming environment. To best serve the campers who need in-center dialysis, we operate a dialysis clinic at Camp O for one week a year.

2. Innovation and Prevention in Patient-Centered Kidney Care

For 30 years, it has been my privilege to care for patients with kidney disease and walk with them and their families across the continuum of care. This often begins with a chronic kidney disease (CKD) diagnosis. With good care, patients with CKD may never need either a kidney transplant or dialysis. The opportunity to work with a robust interdisciplinary team that includes nephrologists, dietitians, care managers, social workers, and pharmacists is essential to the type of care that can prevent the need for renal replacement therapy.

Previously, I struggled with the disconnect between my practice and the dialysis-only focus of dialysis providers. When I joined DCI in 2013, I was inspired by DCI's innovative approach to kidney care, including providing free care in communities for people with CKD to keep them off dialysis.

A few years after I started at DCI, we became pioneer members of the first Centers for Medicare and Medicaid Innovation (CMMI) kidney model, the Comprehensive ESRD Care (CEC) model. We invested heavily in the model, with DCI representing 23% of the ESRD seamless care organizations (ESCOs) that started in October 2015. On weekly calls, we educated leaders of CMMI about the importance of providing better care for people with CKD and the opportunities to increase kidney transplantation. As CMMI worked on the next model, we shared data from our CKD programs to support CMMI efforts to extend their model to include CKD and to increase transplantation.

DCI continues to be an active participant in this next phase, the Kidney Care Choices (KCC) model, started by CMMI in 2022. We continue to share our thoughts with CMMI as we look to the next opportunity to improve health and well-being for Medicare beneficiaries with kidney disease.

Unfortunately, I know from experience that, despite best practices, some patients will progress to kidney failure and require more advanced interventions such as dialysis or

transplant. For a patient with kidney failure, there is nothing as transformative as a kidney transplant. We know that a transplant is the best option for many patients and that making sure they are educated and referred for transplant evaluation is one of the most important steps in keeping them from needing dialysis.

I previously served as medical director of a transplant program at a local hospital in Nashville. We were a smaller program, and I remember the concerns we had about being too aggressive in accepting marginal kidneys, as they were more likely to fail and could flag us for an audit. It led to cautionary care, where kidneys that could have provided higher quality of life, decreased risk of hospitalization, and lower mortality rates were not utilized due to regulatory concerns.

There are instances when dialysis may not be the best choice for a patient needing renal replacement therapy. In a patient-centered, shared decision-making relationship, some patients will choose not to pursue dialysis. Recently, a patient asked me if it was okay to think about not pursuing dialysis. I explained that it was okay and that she could change her mind at any time. I also told her that she could try dialysis and stop if she felt that was best. I explained that my role is not to make decisions for her but to carry out her wishes after helping her understand the implications of any decision.

For those who do approach the end of life on dialysis, we have seen that palliative and hospice services are underutilized in the dialysis population. It is important that we ensure that patients at the end of life and their families have the best experience possible.

We are currently running three concurrent programs that allow a patient with a primary diagnosis of ESRD to receive palliative dialysis and hospice services. The palliative dialysis model is focused on patient-centered end-of-life goals where flexibility around decreased time on dialysis, decreased frequency, stopping all unnecessary medications and labs, and liberalizing diet are paramount. More than 100 patients have benefited from the care in these programs. Interestingly, we have seen about 40% of patients end up not having a single dialysis treatment once they have participated in end-of-life decision-making, met the hospice team, and understood they can stop dialysis and continue to receive care from the hospice team. We have also seen that hospice patients who pursue dialysis have four dialysis treatments on average before stopping therapy. Almost all of the patients participating in concurrent care die at home, with their family at their side.

We are very appreciative of the support from many members of this Committee in advocating on behalf of concurrent hospice and dialysis care, including Chairman Smith, Congressman Kelly, and Congresswoman DelBene.

Finally, for many patients, dialyzing at home is an underutilized form of renal replacement therapy, one that is associated with a higher quality of life and decreased risk of hospitalization. Our goal is to increase the number of patients dialyzing at home. Toward that end, I hope you will listen carefully to Ashli's story, which she will share with you.

When I first met Ashli, she had been told that she was not a good candidate for home dialysis. At the time, she was working as a teacher's aide, a role that was important and fulfilling to her. She was willing to learn how to do her own dialysis so that she could continue to work as well as pursue an advanced degree, and through her courage and perseverance she has been dialyzing at home since shortly after I met her. She has faced multiple challenges, including a failed kidney transplant, but has always bounced back with resilience, courage, and curiosity. Her ability to dialyze at home has truly been transformative, and it has been my privilege and honor to care for her.

3. Policy Opportunities

I would like to address some of the policy challenges and opportunities that could allow DCI, other NKCA members, and all patient-centered dialysis providers to further improve care for the patients they serve. My recommendations include:

1. Delay or Prevent ESRD Onset. Incentivize better care for patients with stage 4 and 5 CKD not on dialysis in an effort to prevent or at least delay progression to ESRD. Quality outcome metrics, including increased rates of home dialysis, transplantations, and optimal starts, were improved in the first two years of the CMMI KCC model, indicating that incentive payments can change practice patterns and provide better outcomes for beneficiaries. Ensuring adequate reimbursement and incentives for nephrologists caring for late-stage CKD patients can slow the growth of the ESRD population and improve the lives of patients.

2. Support CMMI Demonstration Models. Encourage CMMI to continue to advance alternative payment models that stimulate innovation and changes in traditional practice patterns and encourage replication in the Medicare Advantage program so that all ESRD beneficiaries may benefit from the outcomes. Frankly, we see increasing challenges in operating these models as the number of Medicare Advantage patients increases and the number of traditional fee-for-service patients who are aligned to the model falls. We believe the CMMI demonstration models work well in driving changes in practice patterns based on fundamental policy changes in reimbursement, particularly when those models are transparent, stable, and developed with community input and support. We support permanence to future models if they demonstrate positive outcomes.

3. Recognize Importance of Adequate Medicare Reimbursement. Ensure Medicare reimbursement rates and annual adjustments are designed and structured to support the viability of smaller providers, not-for-profit providers, and those serving

patients in rural and other underserved communities. We believe that these providers not only deliver high-quality and much-needed care to the patients they serve, but that there is important benefit to all ESRD patients as a result of healthy competition from multiple providers, especially mission-driven not-for-profit dialysis providers.

4. Permit Concurrent Hospice and Dialysis. Allow patients with ESRD as their primary diagnosis to receive concurrent hospice and dialysis. As noted earlier, we appreciate the support from members of this Committee for concurrent dialysis care for hospice patients and are very active in providing this care to our patients. Moreover, we were very pleased that the Comprehensive Kidney Care Contracting (CKCC) model allowed a waiver so that a patient could receive concurrent hospice and dialysis as part of the model. We continue to encourage Congress to advance legislation to allow for concurrent care more broadly.

5. Improve Transplant Rates. Continue to fund innovative approaches to improving transplant rates, including adjustments to quality measures that make it more likely that a more marginal kidney will be transplanted. We support the Increasing Organ Transplant Access (IOTA) models upside risk payment of $15,000 and think that this type of payment policy testing has potential to increase transplant rates and benefit more patients with kidney failure.

4. Conclusion

Thank you for the opportunity to share our story as well as some of the ways we think kidney care can be improved in the United States. I would be glad to serve as a resource for you and other policymakers in thinking about what is best for patients with kidney disease and how to achieve it.