

May 22, 2025

The Honorable Don Dempsey  
Associate Director for Health, Office of Management and Budget (OMB)  
Eisenhower Executive Office Building  
1650 17th St NW  
Washington, DC 20006

Dear Mr. Dempsey,

We are writing to voice the strong support of the National Kidney Foundation (NKF) in seeing the nomination of dental services inextricably linked, substantially related, and integral to the clinical success of covered medical services used for the treatment of certain Medicare beneficiaries with diabetes included in the proposed Calendar Year (CY) 2026 Physician Fee Schedule proposed rule.

The National Kidney Foundation (NKF) proudly supported the nominations of February 10, 2025, to the Centers for Medicare and Medicaid Services (CMS) for coverage of dental services for beneficiaries with diabetic nephropathy (i.e., diabetic kidney disease) and diabetic retinopathy.

Coverage for dental services for beneficiaries with chronic kidney disease (CKD) associated with diabetes is consistent with the White House's vision to reduce the burden of chronic diseases on the American people, specifically the Make America Healthy Again Commission, and the reorganization of the Department of Health and Human Services (HHS) to elevate chronic disease in the Administration for a Healthy America (AHA). In addition, ensuring beneficiaries with kidney disease due to diabetes can access dental services continues the foundation established by the first Trump Administration's Advancing American Kidney Health Executive Order, demonstrating policy continuity and commitment to improving Americans' health.

Approximately 80 million Americans at risk for kidney disease with diabetes causing most cases of this highly prevalent, disabling, burdensome, and expensive condition. Overall, more than 1 in 7 Americans have kidney disease.<sup>1</sup> CKD is closely related to a range of comorbidities, especially to cardiovascular disease, which lead to high morbidity and mortality.<sup>2</sup> People with CKD who survive its comorbidities may eventually lose all kidney function (ESRD). Once someone has reached kidney failure, he or she depends on dialysis or a kidney transplant to survive.

Management of diabetic kidney disease involves simple, low-cost interventions like controlling blood pressure and blood sugar. The nomination for coverage of dental services for diabetic kidney disease

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<sup>1</sup> *Ibid.*

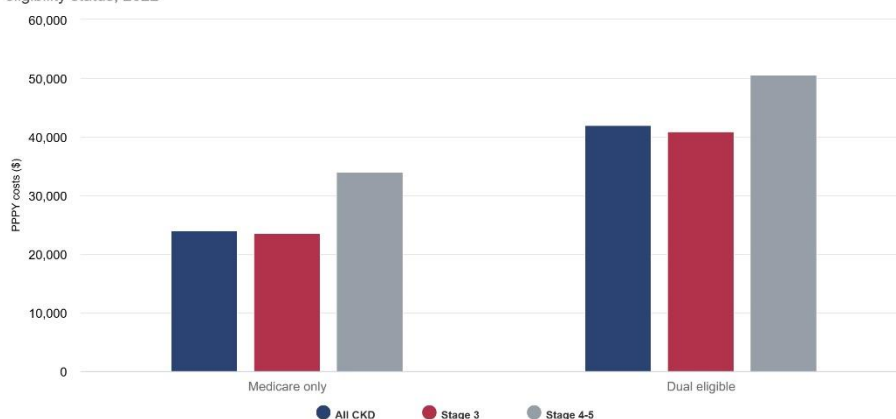
<sup>2</sup> <https://usrds-adr.niddk.nih.gov/2023/chronic-kidney-disease/3-morbidity-and-mortality-in-patients-with-ckd>

notes that conservative periodontal treatment is associated with a clinically significant reduction in HbA1c. The availability of conservative periodontal treatment and/or ancillary treatment to control periodontal infection is therefore expected to also reduce CKD progression and the expenses to the Medicare Trust Fund associated with increasing CKD stage (Figure 1). Healthcare utilization and costs are also substantially reduced when medically necessary oral and dental treatment is provided, as evidenced by extensive analyses of the real-world care experience of more than 1.6 million individuals.<sup>i ii,iii, iv,v,vi, vii viii</sup> These savings emerge from improved clinical outcomes, reduced hospitalizations, and reduced utilization of other healthcare resources.

Without proactive action the consequences of underdiagnosed and undermanaged CKD will continue to take an extraordinary toll on the American taxpayer and the productivity and quality of life of Americans. The 15 percent of aged Medicare beneficiaries with CKD account for more than a quarter of total fee-for-service Medicare spending (\$86.4 billion).<sup>3</sup>

**Figure 1.** *Per-person per-year spending among older Medicare FFS beneficiaries, by CKD stage and Medicaid eligibility status, 2022.*

Figure 6.6b Per person per year spending among older Medicare FFS beneficiaries, by CKD stage and Medicaid eligibility status, 2022



Data Source: 2024 United States Renal Data System Annual Data Report

Beneficiaries with ESRD account for more than another \$50 billion annually.<sup>4</sup> As more Medicare beneficiaries with kidney disease migrate to Medicare Advantage (MA), MA spending on kidney disease is rapidly increasing. In 2021, Medicare Advantage spend on ESRD increased by 46.4% in one year.<sup>5</sup> For the Medicare program alone, the implications of kidney disease are extreme given that by 2060, the number of people age 85 years and older is projected to triple from its current estimate of 6.7 million to 19.0 million.<sup>6</sup>

Investing in upstream management of chronic kidney disease, including dental services, has well evidenced potential to reduce the burden of chronic kidney failure on the federal government, states, and the commercial market. We hope to have the opportunity to comment in favor of

<sup>3</sup> <https://usrds-adr.niddk.nih.gov/2023/chronic-kidney-disease/6-healthcare-expenditures-for-persons-with-ckd>

<sup>4</sup> <https://usrds-adr.niddk.nih.gov/2023/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>

<sup>5</sup> *Ibid.*

<sup>6</sup> *Kidney disease in the elderly a case-based guide.* (2024). SPRINGER INTERNATIONAL PU.

finalization of the proposal in the forthcoming CY2026 Physician Fee Schedule (PFS) proposed rule. Please contact Miriam Godwin, Vice President of Health Policy at [Miriam.godwin@kidney.org](mailto:Miriam.godwin@kidney.org) should you wish to discuss.

Sincerely,



Kevin Longino, MBA  
NKF CEO & Kidney Patient



Dr. Kirk Campbell  
NKF President

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<sup>i</sup> Jeffcoat MK, et al. Am J Prev Med 2014, Aug;47(2): 166-74. Examined records of 338,891 enrollees in an insurance plan that provided both medical and dental benefits. Enrollees with type 2 diabetes (DM), cardiovascular disease (CAD), cerebrovascular disease (CVD), rheumatoid arthritis (RA) and women who were pregnant were considered. Reporting both total medical costs and hospitalizations, they found that health outcomes were significantly better for enrollees with DM, CVD, CAD, and pregnancy (40.2%, 40.9%, 10.7% and 73.7%, respectively), but not RA with preventive dental treatment. Although this study has been criticized due to methodological issues, it is the first in a series of papers which identified key relationships between dental treatment and diabetes outcomes.

<sup>ii</sup> Nasseh K, et al. Health Econ 2017 Apr; 26(4):519-527. Examined records of 15,002 persons in the Truven Health MarketScan database. Examining individuals with newly diagnosed DM who were in the database for one year and four years after the diagnosis, periodontal treatment was associated with reduced total health care costs (-\$1799) and lower total healthcare costs related to diabetes (-\$408) suggesting better health outcomes.

<sup>ii</sup> Smits KP, et al. BMJ Open Diabetes Res Care 2020 Oct;8(1): e001666. Examined records of 41,598 persons with DM in the Netherlands whose records were in a Dutch insurance database. Records were collected from 2012 to 2018. Analyzing health care costs related to DM revealed a median amount of E38.45 (95% confidence interval E11.52 – 263.14) per quarter. When periodontal care was provided, the median health care costs were reduced by E12.03 per quarter (95% confidence interval -E15.77 to -E8.29). This is a 31% reduction in DM related healthcare costs suggesting improved health outcomes.

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<sup>iv</sup> Lamster IB, et al. J Dent Res 2021 Aug;100(9):928-934 and Lamster IB, et al. Front Dent Med 2022 3:952182. Examined records from the New York State Department of Health Medicaid database. All 551,689 enrollees between the ages of 42 and 64 who were continuously enrolled between 2012 to 2015 were analyzed (1st study). Enrollees who did and did not access dental care were compared. For the entire cohort, in a fully adjusted model, preventive dental services were associated with a 3% reduction in visits to the emergency department, and a 13% reduction in in-patient admissions. In terms of healthcare costs, there were no differences in terms of cost per enrollee for emergency department usage but there was a reduction for in-patient cost (-\$380 per year). When analyzing the enrollees in this cohort with a diagnosis of DM (2nd study), a more pronounced reduction in health care utilization and costs were seen for enrollees who accessed preventive dental services. Preventive dental services were associated with a 7% reduction in visits to the emergency department and a 20% reduction in in-patient admissions. Similarly, the cost of in-patient admissions was dramatically lower (-\$823 per year) for enrollees with diabetes who received preventive dental care versus those with diabetes who did not access dental services. These studies are the first to report health outcomes associated with preventive dental care in a publicly insured population. A disproportionate beneficial effect is realized by enrollees with diabetes.

<sup>v</sup> Borah et al. *Compend Contin Educ Dent*. 2022 Mar; 43 (3): 130-139. Examined records from an insurance plan in Arkansas that had an affiliated dental plan. Data for 11,374 enrollees who were in the plan were included in the evaluation. All were enrolled in the plan for one to five years. Comparison was between enrollees with diabetes, coronary artery disease, or both diabetes and coronary artery disease who received conservative periodontal care as compared to those that did not receive such care. The outcome was the total yearly health care costs. With provision of periodontal treatment, they observed a reduction in total health care costs for enrollees with DM (\$515-\$574), CVD (\$548-\$675) and both DM and CVD (\$866-\$1718). This report provides further evidence of the association between preventive dental care and diabetes outcomes, with even greater improvement for enrollees with both diabetes and coronary artery disease.

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<sup>vii</sup> Thakkar-Samtani M, et al. *J Am Dent Assoc*. 2023 Apr;154(4):283-292. Using the IBM MarketScan commercial insurance database and Medicaid databases, examined a total of 671,483 enrollees. For enrollees with DM, the relationship of periodontal treatment in years 1 and 2 to the cost of medical services in year 3. Compared to no periodontal treatment, use of periodontal treatment was associated with a 12% reduction in total health care costs (\$13,915 vs. \$15,739) for those with commercial insurance, and a 14% reduction for those with Medicaid (\$14,796 vs. \$17,181). This study had findings similar to what was reported in "5" above.

<sup>viii</sup> Michalowicz BS, et al. *PLoS One*. 2023 18(8): e0290028. Examined data from 9,503 enrollees in the HealthPartners database. A total of 9,503 enrollees having both periodontitis and DM, CAD or CVD were analyzed for the relationship of treatment for periodontitis to clinical outcomes and the cost of medical care. (There were 4,879 individuals in the DM cohort.) For all groups, enrollees receiving periodontal treatment had a significantly reduced chance of being hospitalized [CAD odds ratio (OR) = 0.71, CVD = 0.73, DM = 0.80]. In this relatively small study, there was no difference in total treatment costs among enrollees who received periodontal care, but lower inpatient costs and higher drug costs were seen.