September 11, 2025

Submitted electronically via:
Regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1832-P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2026 Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The Santa Fe Group appreciates the opportunity to offer comments to the Centers for Medicare and Medicaid Services (CMS) on the CY 2026 Physician Fee Schedule Proposed Rule (PFS).

The Santa Fe Group (https://santafegroup.org/) is a 501(c)(3), action-oriented think tank with a passion to improve lives through oral health. Since its inception 27 years ago, the Santa Fe Group has served as a neutral convener, communicator, connector, and catalyst on critical national issues such as oral cancer, dental education, children's oral health, improved primary care access, the importance of linking medical and dental health systems, and most recently, expanding oral health care for our nation's seniors.

We are proud to be joined in this submission by the Santa Fe Group's Coalition for Oral Health Policy (COHP), a key thought leader in the oral health community, and the Consortium for Medically Necessary Oral Health Coverage, a diverse partnership of 250 organizations united in support of Medicare coverage of medically necessary oral and dental treatment.

As a result, we wish to express our gratitude to CMS for its work to advance **Medical-Dental Integration (MDI)** and expand access to oral and dental services. For decades, the Medicare program has explicitly excluded coverage "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." Instead, payment was only allowed under Medicare Part A in the expressly limited circumstances of "inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services." (Social Security Act Section 1862(a)(12))

Recognizing the integral relationship between oral health care and improved clinical outcomes, CMS has recently taken historic steps to clarify that Medicare payment is available for oral health treatment services when they are inextricably linked and substantially related and integral to the clinical success of certain Medicare-covered medical services. As confirmed in this PFS proposed rule, "In the CY 2023 PFS final rule (87 FR 69663 through 69688), we clarified and codified at § 411.15(i)(3) that Medicare payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting when the dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered services." (page 336)

Long sought by clinicians, beneficiaries, academicians, and advocates, this progress was put in meaningful motion in 2020 when the medically necessary coverage framework was established during the President's first term. Since then, CMS has carefully reviewed clinical evidence to assess whether the identification and resolution of dental disease significantly optimizes the outcome of certain covered medical services. CMS also made it possible for stakeholders to request additional payment clarification, and the resulting annual nominations process is fostering meaningful policy discussions and development in the health care community.

To date, medical services for which clarification of Medicare payment for oral and dental services has been approved include the following:

- organ and stem cell transplant surgery,
- cardiac valve replacement,
- valvuloplasty procedures,
- head and neck cancer treatment,
- chemotherapy,
- chimeric antigen receptor (CAR) T-cell therapy,
- high-dose bone-modifying agents used in the treatment of cancer, and
- dialysis treatment for End Stage Renal Disease (ESRD).

Supplementing this effort, CMS is proposing to further actualize medical-dental integration by integrating oral health screening into primary care using the Merit-based Incentive Payment System (discussed below). Through these efforts, the Administration is charting an important course to better outcomes and lower cost. After all, by enabling more older adults and patients with disabilities to realize improved oral health, vital progress can be made towards high-quality, cost-effective care for all who rely on Medicare.

Medical-Dental Integration: Clinical Value

A primary example of the integral nature of oral systemic health can be found in oral infections such as periodontitis. Striking two-thirds of older Americans, periodontitis has a damaging impact not solely in the mouth but throughout the body. Indeed, extensive research conducted here in the U.S. and around the world has revealed the close linkage between oral infections such as periodontitis and costly chronic conditions, including diabetes, heart disease, dementia, and stroke. Untreated oral infections have also

been documented as precluding, delaying, and even jeopardizing numerous Medicare-covered medical services. By contrast the delivery of oral health care has been proven effective in controlling systemic inflammation, preventing costly utilization, and reducing the costs borne by Medicare and taxpayers.

For these reasons, timely and targeted treatment of oral infections is crucial to sparing Medicare beneficiaries clinical harm and relieving taxpayers of substantial cost. In fact, major insurance carriers already provide medically necessary oral coverage to chronically ill enrollees due to its proven utility in dramatically reducing hospitalization and emergency department admission rates as well as overall coverage costs. As a result, the steps CMS has taken since 2020 are to be applauded for their contribution to making improved outcomes and lower cost possible throughout the Medicare program.

Medical-Dental Integration: Fiscal Value

As documented by the analyses listed below, dental services reduce the risk of medical complications, improve clinical outcomes, and lower healthcare utilization. Encompassing more than 1.6 million patients, these studies provide important evidence of the power of timely oral health to reduce total healthcare costs:

Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions (Am J Prev Med)

- 338,891 health insurance enrollees
- Improved outcomes for cardiovascular disease (40.9%), type 2 diabetes (40.2%), and cerebrovascular disease (10.7%)

The Relationship between Periodontal Interventions and Healthcare Costs and Utilization (Health Econ.)

- 15,002 newly diagnosed diabetes patients
- Lower total health care costs (-$1799) and lower healthcare costs related to diabetes (-$408)

Effect of Periodontal Treatment on Diabetes-related Healthcare Costs: a Retrospective Study (BMJ Open Diabetes Res Care)

- 41,598 diabetes patients
- 31% reduction in diabetes-related healthcare costs

The Impact of Periodontal Treatment on Healthcare Costs in Newly Diagnosed Diabetes Patients (Diabetes Res Clin Pract.)

- 23,771 health insurance enrollees
- 4% reduction in total healthcare costs, 13% reduction in hospital costs, 7% reduction in diabetes drug cost

Dental Services and Health Outcomes in the New York State Medicaid Program (J Dent Res)

- 551,689 Medicaid enrollees
- 7% reduction in emergency department visits, 20% reduction in inpatient admissions, and $823 reduction inpatient costs

Association Between Preventive Dental Care and Healthcare Cost for Enrollees With Diabetes or Coronary Artery Disease: 5-Year Experience (Compend Contin Educ Dent)

- 11,374 health insurance enrollees
- Lower total costs for enrollees with diabetes ($515-$574), cardiovascular disease ($548-$675) and both diabetes and cardiovascular disease ($866-$1718)

Periodontal Treatment Associated with Decreased Diabetes Mellitus-related Treatment Costs (J Am Dent Assoc)

- 671,483 health insurance and Medicaid enrollees
- 12% reduction in health insurance costs and 14% reduction in Medicaid costs

Periodontal Treatment and Subsequent Clinical Outcomes and Medical Care Costs (PLoS One)

- 9,503 patients with periodontitis and diabetes, coronary heart disease, or cardiovascular disease
- Lower risk of hospitalization, lower inpatient costs, and higher drug costs

Continued emphasis on oral and dental treatment services as an integral element of whole-person health offers the promise of improved outcomes and efficiency for Medicare beneficiaries and taxpayers alike. With the Administration working to realize the goals of its Make America Healthy Again initiative, we therefore urge the White House, Department of Health and Human Services (HHS), and CMS to take every step available to establish and implement the most clinically- and cost-effective policy advancing oral systemic health.

Medical-Dental Integration: Medically Necessary Coverage

As noted above, CMS responded in 2022 to longstanding oral health community appeals by proposing to allow Medicare payment for dental services in outpatient as well as inpatient settings when those services are deemed to be inextricably linked to and substantially related and integral to the clinical success of Medicare-covered services. This policy is of crucial importance, as Section 1862(a)(12) of the Medicare statute had long been interpreted as precluding payment for any dental services except in certain very limited circumstances involving inpatient hospitalization. As also noted, CMS established an annual process that enables stakeholders to nominate medically necessary dental services for Medicare payment.

With this context in mind, we are appreciative of, but also disappointed in, the proposed Physician Fee Schedule for 2026. For the first time since 2021, the PFS does not propose to clarify Medicare payment for additional medically necessary dental services. Leading members of the oral health community submitted a nomination for diabetes-associated retinopathy and nephropathy, providing extensive evidence in support of coverage. Summarized in the next section, this nomination emphasizes that clarification related to these conditions would be of tremendous benefit to patients and taxpayers. We are mindful, however, that the last year in which the PFS was silent on medically necessary coverage was 2021, the first year of the prior Administration during which the process of staffing key roles in HHS and CMS was underway. This year being the first year of the second Trump Administration, we recognize a similar dynamic as many positions are still in the process of being filled.

That said, we appreciate the PFS' expression of openness to further nominations, as excerpted here:

Since CY 2023, we have discussed our commitment to review submissions we receive through the public submissions process. We have also expressed our intention to continue to engage in discussions with the public on a wide spectrum of issues relating to Medicare payment for dental services that may be inextricably linked to other covered services. For CY 2026, we are not making any proposals in response to the submissions that we received and will take the information and recommendations submitted into consideration for the future. (page 338)

We are deeply grateful for the annual nomination process and the careful consideration Agency staff have provided to the nominations received to date. As a result, we look forward to our continued participation in this process and will submit one or more nominations by the next deadline of February 10, 2026.

Medical-Dental Integration: Oral Health Screening

In the meantime, we wish to express our deep appreciation for the PFS' proposal to Integrate Oral Health Care in Primary Care by in the Merit-based Incentive Payment System (MIPS) for primary care. by incorporating oral health risk assessment and intraoral screening using the HEENOT approach, education, counseling, and documentation as part of a patient's primary care management. This proposal provides greatly appreciated recognition of the importance and impact of oral health on systemic diseases like diabetes, cardiovascular, and respiratory conditions. Specifically, the PFS provides:

MIPS eligible clinicians that practice primary care will include an oral health risk assessment and intraoral screening as part of a patient's primary care management. The MIPS eligible clinician will provide education and counseling to the patient to include the importance of oral health and the impact of oral health on systemic diseases. For patients without a dental home and/or those with oral health needs, a dental referral will be provided. (page 1702)

In this manner, the PFS supports the vital role of oral health in the care of Medicare beneficiaries. Given that nearly half of all beneficiaries have no dental coverage, primary care settings are critical points of access for older adults without a dental home, improving oral health literacy and using dental networks to make referrals for needed dental care. Additionally, requiring Smiles for Life for reimbursement eligibility and Geriatric Oral Health as one of the required modules, the PFS is rightfully positioning oral health as a key educational and practice management tool for all primary care clinicians.

We are equally grateful for the commentary provided in the draft rule, which closely dovetails with the evidence the oral health community has worked to develop, compile, and present for CMS' consideration. Key elements of this commentary, set forth on pages 1702-1703, include the following:

Oral health is closely related to overall health.

The Kaiser Family Foundation (KFF) identified nearly half of all people on Medicare have no dental coverage …. Medicare spends $520 million annually on dental-related emergency department [visits].

[A] significant portion of the Medicare population has or is at risk for chronic health conditions, which can be further complicated by poor oral health.

Dental issues can be early indicators of systematic diseases, such as Alzheimer's, and may also lead to severe health complications such as diabetes and cardiovascular disease, all of which have a significant impact on the Medicare population.

If these issues were caught and managed early, many of those expenditures could be avoided.

[N]early two-thirds of the older adult population in the United States experienc[e] periodontitis….

[I]ntegrating age appropriate oral health concerns into general medicine may lead to improvements in older adults' oral health conditions and improve quality of life.

There is growing evidence that health outcomes improve when dental assessments by medical professionals are integrated into care.

[M]edical-dental integration (MDI) activity can positively address the oral health needs of a high-risk and medically complex population by increasing access, and promoting comprehensive, continuous patient care.

Taken together, we applaud these statements as powerful reinforcement of the Agency's commitment to advance whole person health and its recognition of the improved outcomes and lower costs medical-dental integration makes possible. We therefore look forward to working with the Administration as it operationalizes its focus on treating the whole person for the benefit of patients and taxpayers alike.

<u>Medical-Dental Integration</u>: Medicare Payment Clarification Related to Diabetes

A leading opportunity for continued progress can be found in the issue of diabetes-associated retinopathy and nephropathy. As detailed in nominations submitted to CMS on February 10 of this year, the delivery of appropriate dental services in accordance with clinical guidelines and standards of care is inextricably linked and substantially related and integral to the optimal outcome of covered medical services related to diabetes-associated retinopathy and nephropathy:

- Diabetes-associated retinopathy is the most common diabetic eye complication and a leading cause of blindness. The primary driver of this condition is chronic high blood sugar from poorly managed diabetes. Without glycemic control, costly complications and $3 billion in annual costs result, including $500,000 to $1,000,000 for individuals suffering blindness due to this condition, $20,000 per treatment of vitreous hemorrhage, and $15,000 per surgery for retinal detachment.

- Diabetes-associated nephropathy, meanwhile, is the leading cause of kidney failure in America and is driven by chronic high blood sugar from poorly managed diabetes. Without glycemic control, costly complications drive more than $50 billion in annual spending, including $90,000 per patient per year for dialysis treatment, $25,000 for cardiovascular disease treatment, $30,000 per amputation, and $40,000 for the treatment of neuropathy injuries.

In both cases, fortunately, complications and costs can be avoided by glycemic control, which reduces the progression of health-related conditions associated with diabetes-associated nephropathy and retinopathy by 50% to 76%, respectively. Further, the most effective method for improving glycemic control among

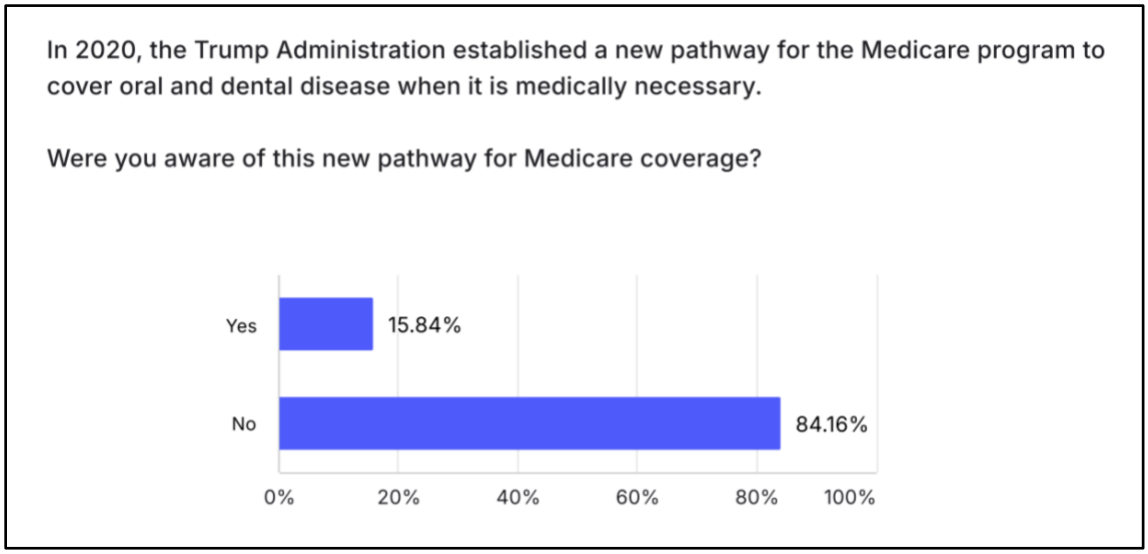
patients with untreated or advanced periodontitis and diabetes-associated retinopathy or nephropathy is the delivery of timely, targeted oral health treatment.

Clinical studies document that treatment of oral infections, such as periodontitis and related inflammation, meaningfully improves the medical management of diabetes-associated retinopathy and nephropathy. Indeed, when medically necessary oral and dental treatment is provided, however, health outcomes improve, healthcare utilization is reduced, and Medicare costs are substantially decreased. By contrast, non-treatment of chronic dental infections exacerbates insulin resistance, worsens glycemic control, and intensifies diabetes-related complications including retinopathy and nephropathy.

Older Americans' Viewpoint

Due to the powerful clinical and fiscal benefits of Medical-Dental Integration, a national survey of registered voters age 65+ conducted by Centiment for the Consortium for Medically Necessary Oral Health Coverage in April 2025 found overwhelming support among older American voters for policy action that advances beneficiary access to oral health care.

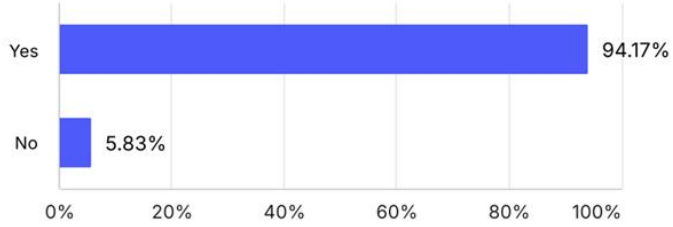
Of interest, most older voters were not aware about the medically necessary framework established in 2020 during President Trump's first term:



When informed of this action and that further consideration was being given this year to clarifying Medicare payment for beneficiaries with diabetes-associated retinopathy and nephropathy, an even greater share of older voters expressed their support:

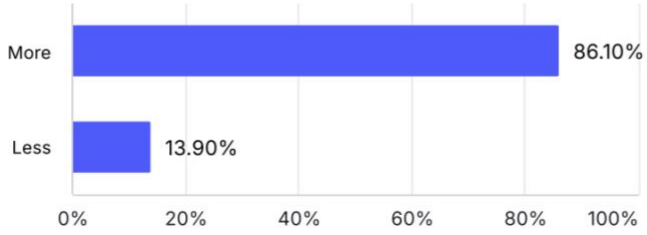
The Trump Administration is now considering whether to update the Medicare program to make coverage of medically necessary dental health care services available to older Americans who have been diagnosed with diabetes and related conditions.

Would you support Medicare being updated to include such medically necessary dental care coverage?



Should the Administration elect to continue advancing whole-person care through Medical-Dental Integration policy, as suggested by the excerpts above, it appears such action would be favorably viewed by older voters as a key part of the President's Make America Healthy Again initiative:

If the Trump Administration updates the Medicare program to provide coverage of medically necessary dental health care services for older Americans with diabetes-related conditions, would you be more or less supportive of the Administration's efforts to Make America Healthy Again?

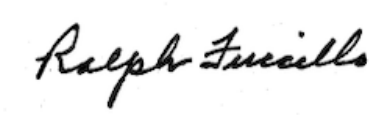


Conclusion

We appreciate this opportunity to provide comments about the Proposed Physician Fee Schedule for 2026. We hope our input will be of value to CMS' important work and stand ready to serve as a resource to the Agency as it continues striving towards a healthier America.

If you have any questions about our comments, please do not hesitate to contact Ralph Fuccillo at rfuccillo@cambridgeconcord.com or 617-877-0620

Sincerely,



Ralph Fuccillo
President, Santa Fe Group