

SUPPLEMENTARY MATERIAL

Fixing the Fracture

**Policy Recommendations for Interprofessional Education,
Oral Health Integration, and Collaborative Care**

Recommendations by Anticipated Ease of Implementation

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How to Use This Guide

The white paper recommends advancing distinct policy recommendations spanning accreditation, payment, workforce, and data infrastructure. For readers who want to know where to start, this guide organizes recommendations into three (3) implementation tiers based on the complexity of the action required, the authorities already available, and the degree to which each recommendation depends on other reforms being in place first.

Tier 1 actions can move now using existing authority.

Tier 2 actions require coordinated rulemaking or standards development that take approximately four years to execute.

Tier 3 actions require legislation, multiyear institutional change, or structural redesign that is only reachable once earlier reforms have built the evidence base and political will to support them.

NOTE: The tiers are not a sequence of equal size; Tier 1 is intentionally short and actionable. No single actor can advance all of these, but every stakeholder group has at least one Tier 1 action available to them today. For a stakeholder overview, please see the table that begins on page 22.

Tier 1 • Near-Term Actions: Start Here

These recommendations rely on existing legal authority, existing regulatory cycles, and institutions that can act without waiting for new legislation or multiyear standards processes. They produce early, visible results that build the political will and infrastructure for harder reforms.

1A. Health System Transition Framework (Table I.A)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
1	Require dental coverage as a mandatory benefit in MA; align Medicaid managed care contracts to include adult dental benefits; extend ACA EHB requirements to include adult dental for Marketplace plans.	Congressional action on MA mandatory dental (H.R 2045 or successor legislation); CMS guidance on Medicaid dental carve-in; ACA EHB rulemaking cycle	Congress, CMS, state Medicaid agencies, commercial insurers	1–2 years
2	Require oral health metrics in MSSP ACO quality reporting; pilot CMMI bundled payments for oral-systemic conditions (periodontal-diabetes, prenatal-dental); eliminate same-day billing restrictions in Medicaid.	CMS annual PFS rulemaking; CMMI Innovation Award solicitations; state Medicaid managed care contract amendments	CMS, CMMI, state Medicaid agencies, commercial payers	1–2 years
3	Embed oral health screening, prevention, and comanagement requirements into value-based contracts; require oral health integration as a condition of FQHC Health Center Program participation; include periodontal comanagement as a scored MIPS quality measure.	CMS MIPS quality measure development (annual PFS cycle); HRSA Health Center Program requirements; NCQA HEDIS measure development	CMS, HRSA, NCQA, federal agencies, payers, accrediting bodies	1–2 years
4	Condition HRSA Title VII grants on scope-of-practice modernization compliance; authorize dental hygienist direct access in all federal facilities; fund NHSC dental placements explicitly in FQHCs with integrated medical-dental workflows.	HRSA Title VII reauthorization; NHSC placement priorities; state dental practice act reform	HRSA, state legislatures, licensing boards, dental professional associations	2–4 years
5	Require 1115 waiver demonstrations to report dental utilization stratified by race, ethnicity, income, and geography; pair accountable payment models with equity safeguards and risk-adjusted capitation; integrate oral health into SDOH screening and referral workflows.	CMS 1115 waiver application requirements; CMMI equity reporting framework; state APCD data requirements	Policymakers, CMS, health systems, community-based organizations	1–2 years
6	Condition HRSA Title VII awards on IPE compliance; require HPAC/IPEC harmonization of accreditation standards by 2027; mandate IPP content in initial licensure exams through NBME–JCNDE joint working group by 2028.	HRSA Title VII compliance conditions; HPAC convening process (2027 target); NBME–JCNDE joint working group formation (2028 target)	HRSA, accreditors, HPAC, IPEC, NBME, JCNDE, licensing boards	2–4 years

Acronyms: **ACA** = Affordable Care Act; **ACO** = accountable care organization; **APCD** = All-Payer Claims Database; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **EHB** = Essential Health Benefit; **FQHC** = federally qualified health center; **HEDIS** = Healthcare Effectiveness Data and Information Set; **HPAC** = Health Professions Accreditors Collaborative; **HRSA** = Health Resources and Services Administration; **IPE** = interprofessional education; **IPEC** = Interprofessional Education Collaborative; **IPP** = interprofessional practice; **JCNDE** = Joint Commission on National Dental Examinations; **MA** = Medicare Advantage; **MIPS** = Merit-Based Incentive Payment System; **MSSP** = Medicare Shared Savings Program; **NBME** = National Board of Medical Examiners; **NCQA** = National Committee for Quality Assurance; **NHSC** = National Health Service Corps; **PFS** = Physician Fee Schedule; **SDOH** = social drivers of health

1B. Cost of Continued Fragmentation (Table II.A)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
7	Fund ED diversion strategies and urgent dental access pathways in FQHCs and safety-net hospitals; require Medicaid reimbursement for same-day dental referral and follow-up from ED encounters; establish ED-to-dental warm handoff protocols as a quality reporting requirement.	CMS Medicaid managed care contract amendments; HRSA Health Center Program requirements; state Medicaid quality reporting cycles	CMS, state Medicaid agencies, hospital systems, HRSA	1–2 years
8	Align Medicaid quality measures and payment incentives to discourage palliative-only ED dental care; require antibiotic stewardship and opioid prescribing metrics in dental Medicaid quality reporting; condition reimbursement for dental ED encounters on evidence-based prescribing compliance.	CDC dental antibiotic stewardship guidance; CMS Medicaid quality measure development; state Medicaid managed care quality contracts	CMS, CDC, state Medicaid agencies, commercial payers, state regulators	1–2 years
9	Expand Medicaid and Medicare reimbursement for primary care–based oral health prevention and risk assessment; develop and adopt a periodontal-diabetes comanagement billing code; require oral health screening as a documented element of chronic disease management in value-based contracts.	CMMI Innovation Awards for integrated chronic disease management pilots; CMS annual PFS rulemaking; USPSTF oral health screening recommendation update	USPSTF, CMS, CMMI, Medicaid agencies, commercial payers	1–2 years
10	Incorporate oral health comanagement metrics into all value-based and risk-based payment models; pilot CMMI bundled payments for periodontal-systemic condition management; require medical-dental comanagement documentation as a scored ACO quality measure.	CMS MSSP and CMMI APM framework rulemaking; NCQA HEDIS measure development; state Medicaid plan amendment processes	CMS, CMMI, commercial payers, NCQA	2–4 years
11	Issue clear national coverage, documentation, enrollment, and claims guidance; monitor utilization, denials, access, and equity; and add qualifying clinical circumstances through annual rulemaking when clinical evidence demonstrates that dental care is integral to the success of covered medical services.	CMS annual PFS rulemaking; Medicare Benefit Policy and Claims Processing Manual updates; KX modifier and ICD-10 claim requirements; MAC education and oversight	CMS, MACs, medical and dental professional organizations, health systems	Near term; 1–2 years and ongoing
12	Require dental coverage as a mandatory Medicare Advantage benefit; extend ACA Essential Health Benefit requirements to include adult dental in Marketplace plans; protect and strengthen Medicaid adult dental benefits through federal minimum floor standards.	Congressional action on MA mandatory dental benefit; ACA EHB rulemaking; Medicaid statutory floor for adult dental (federal legislative action)	Congress, CMS, state Medicaid agencies, commercial payers	1–2 years

1B. Cost of Continued Fragmentation (Table II.A) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
13	Pilot Medicaid models that integrate dental benefits into managed care and accountable payment structures; require dental carve-in as a condition of 1115 waiver approval for medical-dental integration demonstrations; establish a federal minimum dental benefit floor as a Medicaid condition.	CMS 1115 waiver application requirements; Medicaid managed care final rule amendments; federal legislative action on Medicaid dental minimum benefit	State Medicaid agencies, CMS, CMMI	2–4 years
14	Incentivize employer-sponsored plans to adopt preventive, integrated oral health benefits through Business Group on Health and Pacific Business Group on Health purchaser coalitions; require dental benefit reporting in employer ERISA filings; model employer oral health integration campaigns on mental health parity advocacy.	ERISA benefit reporting requirements; employer purchaser coalition policy advocacy; IRS guidance on dental benefit tax treatment	Employers, purchaser coalitions, commercial insurers, Congress	2–4 years
15	CMS should condition FQHC prospective payment on documented closed-loop referral completion within 30 days of a dental-related ED encounter; require bidirectional oral health screening documentation in FQHC medical and dental encounters; ONC should require patient-facing dental data access as a federal HIT certification condition.	CMS FQHC prospective payment system requirements; ONC Health IT Certification Program rulemaking; HRSA Health Center Program UDS reporting requirements	CMS, ONC, HRSA, health systems	1–2 years
16	HRSA should prioritize NHSC dental placements in FQHCs with integrated medical-dental workflows; states should authorize dental hygienist direct access in designated rural shortage areas; fund teledentistry infrastructure grants through HRSA Rural Health programs; authorize dental therapists in underserved states.	HRSA NHSC placement priorities; HRSA Rural Health grants; state dental practice act reform; HRSA Title VII compliance conditions	State legislatures, HRSA, CMS	2–4 years
17	Embed oral health integration into all equity-focused payment, workforce, and delivery reforms; require disparity reporting in all APM and ACO contracts that include dental services; condition HRSA Health Center Program grants on documented oral health equity metrics.	CMS APM equity reporting requirements; HRSA Health Center Program equity requirements; state Medicaid equity reporting mandates	Policymakers, CMS, HRSA, payers, health systems	1–2 years

Acronyms: **ACA** = Affordable Care Act; **ACO** = accountable care organization; **APM** = alternative payment model; **CDC** = Centers for Disease Control and Prevention; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **ED** = emergency department; **EHB** = Essential Health Benefit; **ERISA** = Employee Retirement Income Security Act; **FQHC** = federally qualified health center; **HEDIS** = Healthcare Effectiveness Data and Information Set; **HIT** = Health Information Technology; **HRSA** = Health Resources and Services Administration; **IRS** = Internal Revenue Service; **MA** = Medicare Advantage; **MAC** = Medicare administrative contractor; **MSSP** = Medicare Shared Savings Program; **NCQA** = National Committee for Quality Assurance; **NHSC** = National Health Service Corps; **ONC** = Office of the National Coordinator for Health Information Technology; **PFS** = Physician Fee Schedule; **UDS** = Uniform Data System; **USPSTF** = US Preventive Services Task Force

Tier 2 • Midterm Actions

These recommendations require coordinated rulemaking across agencies, cross-accreditor harmonization, or new standards development that can take approximately four years to implement. They build directly on Tier 1 actions and are intended to be near-term actions.

2A. Payment and Delivery System Barriers (Table III.A)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
18	Accelerate transition to APMs that explicitly reimburse care coordination, prevention, and team-based services; standardize coverage and reimbursement for D9992 when its descriptor applies; develop complementary medical and dental coding and payment pathways for bidirectional coordination; require dental inclusion in all new CMS APM frameworks as a condition of model approval.	CMS annual PFS rulemaking; CMMI APM Innovation Award solicitations; ADA/AMA joint coding committee for care coordination CPT/CDT development	CMS, CMMI, state Medicaid agencies, commercial payers, ADA, AMA	1–2 years
19	Explicitly include dental services and outcomes in all MSSP ACO and CMMI APM contracts; require oral health quality metrics as a scored ACO participation condition; include dental providers as eligible ACO participants under the MSSP.	CMS MSSP final rule amendments; CMMI APM framework rulemaking; CMS PFS annual quality measure cycle	CMS, CMMI, state Medicaid agencies	1–2 years
20	Advance beyond add-on incentives toward shared accountability models with joint medical-dental outcome targets; pilot CMMI shared savings models that include dental providers as full ACO participants accountable for whole-person outcomes, not just dental utilization.	CMMI Innovation Awards for shared medical-dental accountability pilots; CMS MSSP track development; state Medicaid managed care contract design	CMS, CMMI, payers, state Medicaid agencies	2–4 years
21	Integrate dental benefits into Medicaid managed care contracts; require dental carved-in as a condition of 1115 waiver approval; issue CMS guidance clarifying that Medicaid MCOs should include dental providers in care coordination workflows regardless of benefit carve-in status.	CMS 1115 waiver application requirements; Medicaid managed care final rule amendments; CMS informational bulletin on dental coordination in managed care	State Medicaid agencies, CMS	2–4 years
22	Expand Medicaid and Medicare reimbursement for nonprocedural, preventive, and team-based dental services; increase dental Medicaid rates as a condition of managed care contract approval; establish consistent coverage and reimbursement for existing care-coordination codes, including D9992, and develop complementary codes or payment pathways for cross-professional activities that existing descriptors do not adequately capture.	State Medicaid rate-setting processes; CMS Medicaid managed care minimum MLR requirements; ADA/AMA joint coding committee development	CMS, state Medicaid agencies, employer purchasers	1–2 years

2A. Payment and Delivery System Barriers (Table III.A) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
23	Streamline dual enrollment pathways for dental providers in medical APMs; develop a simplified Medicare dental provider enrollment pathway for dental providers participating in integrated care models; provide HRSA technical assistance for dental practices entering IPP arrangements.	CMS Medicare provider enrollment rulemaking; state Medicaid provider enrollment simplification; HRSA technical assistance funding for dental IPP participation	CMS, state Medicaid agencies, HRSA	1–2 years
24	Remove same-day billing restrictions in all state Medicaid programs; CMS should issue explicit guidance permitting same-day medical and dental billing in federally qualified settings. Make elimination of same-day billing restrictions a condition of 1115 waiver approval for medical-dental integration demonstrations.	State Medicaid managed care contract amendments; CMS informational bulletin on same-day billing; 1115 waiver standard terms and conditions	State Medicaid agencies, CMS	1–2 years
25	CMMI should establish a formal conversion pathway for successful medical-dental Integration Innovation Awards, with CMS rulemaking authority to standardize reimbursement within three years of demonstrated pilot effectiveness; HRSA should transition successful health center–based IPP models into permanent UDS reporting requirements.	CMMI Innovation Center dissemination and scaling pathway; CMS rulemaking authority under Social Security Act Section 1115A; HRSA UDS reporting requirement updates	CMS, CMMI, HRSA, policymakers	2–4 years
26	Document, disseminate, and scale proven private-sector and state-level models through CMMI; require commercial payers participating in CMMI value-based initiatives to report on dental integration metrics; use Business Group on Health and Pacific Business Group on Health as dissemination channels.	CMMI Innovation Center dissemination authority; employer purchaser coalition policy platforms; CMS reporting requirements for commercial payer CMMI participants	Commercial insurers, CMMI, employers, purchaser coalitions	2–4 years
27	Elevate oral health from MIPS improvement activity to scored quality measure in the next PFS; standardize successful state-level Medicaid integration models through CMS technical assistance and waiver support; require dental outcome metrics as a condition of participation in next-generation ACO program design.	CMS annual PFS rulemaking (next cycle); CMMI dissemination framework; MSSP final rule dental metric requirements	CMS, Congress, state Medicaid agencies	2–4 years

Acronyms: **ACO** = accountable care organization; **ADA** = American Dental Association; **AMA** = American Medical Association; **APM** = alternative payment model; **ASTP** = Assistant Secretary for Technology Policy; **CDT** = Current Dental Terminology; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **EHR** = electronic health record; **FHIR** = Fast Healthcare Interoperability Resources; **HIT** = Health Information Technology; **HL7** = Health Level Seven International; **HRSA** = Health Resources and Services Administration; **IPP** = interprofessional practice; **MCO** = managed care organization; **MIPS** = Merit-Based Incentive Payment System; **MLR** = Medical Loss Ratio; **MSSP** = Medicare Shared Savings Program; **ONC** = Office of the National Coordinator for Health Information Technology; **PFS** = Physician Fee Schedule; **R4** = Release 4 (FHIR Release 4); **UDS** = Uniform Data System

2B. Data and Technology Barriers (Table III.B)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
28	ASTP/ONC should extend federal HIT certification to dental EHR vendors with HL7 FHIR R4 compliance as the certification condition; CMS should establish a Meaningful Use–equivalent incentive program for dental providers in Medicaid managed care, conditioning enhanced reimbursement on adoption of certified interoperable systems.	ASTP/ONC Health IT Certification Program rulemaking; CMS Medicaid managed care final rule; CMMI Innovation Award for dental HIT adoption pilots	CMS, ASTP/ONC, health systems	1–2 years
29	ADA and CMS should jointly develop a CDT-to-ICD diagnostic crosswalk standard; expand adoption of SNOMED CT and ICD codes in dental EHR systems; condition federal data infrastructure grants on diagnostic coding compliance.	ADA/CMS joint coding standards development; ASTP/ONC Health IT Certification Program; federal APCD grant conditions	ADA, CMS, ASTP/ONC, dental EHR vendors	2–4 years
30	ASTP/ONC should amend the Health IT Certification Program to include dental-specific HL7 FHIR R4 requirements with a phased compliance deadline established through rulemaking; CMS should create targeted subsidies and technical assistance for interoperable dental IT infrastructure, prioritizing rural and FQHC settings.	ASTP/ONC Health IT Certification Program rulemaking; HRSA Rural Health grants; CMS FQHC technical assistance programs	ASTP/ONC, CMS, HRSA, state agencies	1–2 years
31	CMS should condition FQHC prospective payment on documented closed-loop referral completion within 30 days; fund automated referral pathway development through CMMI Innovation Awards; require bidirectional oral health screening documentation in HRSA Health Center Program UDS reporting.	CMS FQHC prospective payment system requirements; CMMI Innovation Awards; HRSA UDS reporting requirement updates	CMS, CMMI, HRSA, health systems, payers	1–2 years
32	States should provide financial subsidies and technical assistance for dental provider and payer HIE participation; replicate Contexture (Arizona/Colorado) and TECCA models nationally; condition state HIE infrastructure funding on demonstrated dental provider participation rates.	State HIE participation incentive programs; TECCA national framework; ASTP/ONC HIE participation guidance; state legislative mandates for dental HIE participation (modeled on North Carolina)	States, HIE organizations, ASTP/ONC, CMS	2–4 years
33	CMS and NCQA should jointly develop a core set of cross-disciplinary IPP outcome measures explicitly including oral health indicators; align HEDIS and UDS measures with oral-systemic integration goals; require oral health outcome metrics in all CMMI Innovation Award reporting.	CMS/NCQA HEDIS measure development cycle; HRSA UDS reporting updates; CMMI Innovation Award reporting requirements	CMS, NCQA, HRSA, payers	2–4 years

2B. Data and Technology Barriers (Table III.B) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
34	CMS should lead a national measure harmonization process to streamline and consolidate core IPP measures across payers and settings; reduce duplicative reporting requirements; develop a unified oral-systemic measure set that all payers can adopt consistently.	CMS Core Quality Measures Collaborative; National Quality Forum measure harmonization process; CMS Medicaid managed care quality reporting consolidation	CMS, payers, NCQA, providers	2–4 years
35	ASTP/ONC should require patient-facing dental data access as a condition of federal HIT certification; CMS should incentivize dental patient portal adoption in Medicaid managed care contracts; dental EHR vendors should support patient access APIs under the 21st Century Cures Act framework.	ASTP/ONC Health IT Certification Program rulemaking; 21st Century Cures Act patient access API requirements; CMS Medicaid managed care contract standards	ASTP/ONC, CMS, dental EHR vendors	2–4 years
36	Expand All-Payer Claims Databases in all states to fully include dental services and outcomes; require dental claims inclusion as a condition of federal APCD infrastructure grants; AHRQ, CMMI, and HRSA should jointly fund a national IPP evaluation dataset.	Federal APCD grant conditions; state APCD legislation (modeled on Colorado); AHRQ/CMMI/HRSA joint research funding	States, CMS, AHRQ, CMMI, HRSA	2–4 years
37	AHRQ, CMMI, and HRSA should jointly fund a national IPP evaluation dataset with mandatory dental data inclusion; require states receiving federal APCD grants to include dental claims; fund longitudinal studies of medical-dental integration outcomes through NIH/NIDCR.	AHRQ/CMMI/HRSA joint funding solicitations; federal APCD grant conditions; NIH/NIDCR research funding priorities	AHRQ, CMMI, HRSA, NIH/NIDCR, states	2–4 years

Acronyms: AHRQ = Agency for Healthcare Research and Quality; APCD = All-Payer Claims Database; API = application programming interface; ASTP = Assistant Secretary for Technology Policy; CDT = Current Dental Terminology; CMS = Centers for Medicare & Medicaid Services; CMMI = Center for Medicare and Medicaid Innovation; EHR = electronic health record; FHIR = Fast Healthcare Interoperability Resources; FQHC = federally qualified health center; HEDIS = Healthcare Effectiveness Data and Information Set; HIE = Health Information Exchange; HIT = Health Information Technology; HL7 = Health Level Seven International; HRSA = Health Resources and Services Administration; ICD = International Classification of Diseases; IPP = interprofessional practice; NCQA = National Committee for Quality Assurance; NIDCR = National Institute of Dental and Craniofacial Research; NIH = National Institutes of Health; ONC = Office of the National Coordinator for Health Information Technology; R4 = Release 4 (FHIR Release 4); SNOMED CT = Systematized Nomenclature of Medicine–Clinical Terms; TEFCA = Trusted Exchange Framework and Common Agreement; UDS = Uniform Data System

2C. Accreditation, Licensure, and Education Policy (Table IV.A)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
38	HPAC and IPEC should convene a formal harmonization process by 2027; submit revised mandatory IPE language to CODA, LCME, ACGME, CCNE, ACPE, and ARC-PA for adoption in their next standard update cycles; condition HRSA Title VII funding on institutional compliance within three years of standard adoption.	HPAC convening process (target: 2027 submission to accreditors); HRSA Title VII compliance conditions; accreditor standard update cycles	HPAC, IPEC, CODA, LCME, ACGME, CCNE, ACPE, ARC-PA, HRSA	1–2 years
39	CODA, LCME, ACGME, CCNE, and ACPE should each revise standards to name at least one dental profession as a required IPE partner discipline; oral-systemic integration should be listed as an explicit IPE competency domain; condition HRSA Title VII awards on documented inclusion of dental professionals in IPE experiences.	Accreditor standard revision cycles (2027 target); HRSA Title VII compliance conditions; HPAC harmonization process with explicit oral health mandate	CODA, LCME, ACGME, CCNE, ACPE, HPAC, IPEC, HRSA	1–2 years
40	Adopt unified IPE competency language and crosswalks aligned to updated IPEC core competencies across all health professions accreditation standards; require institutions to document how their IPE experiences map to IPEC domains; replace attendance-based compliance with competency-based demonstration requirements.	IPEC core competency update cycle (ongoing); accreditor standard revision cycles; HPAC harmonization process; HRSA Title VII program reporting requirements	IPEC, accreditors, HPAC, HRSA	1–2 years
41	NBME and JCNDE should establish a joint working group to develop minimum IPP content thresholds in initial licensure exams; integrate interprofessional assessment into at least two major licensing exams; pilot performance-based IPP assessment in at least five states for license renewal.	NBME–JCNDE joint working group formation (2027); licensure exam content revision cycles (2028 target); state licensing board pilot programs	NBME, JCNDE, NCLEX consortium, state licensing boards, testing consortia	1–2 years
42	Incorporate IPP and oral-systemic health into initial certification, longitudinal assessment, continuing-certification activities, and practice-improvement requirements; align related CME/CE and faculty-development offerings through professional and educational associations.	Certification exam blueprints; longitudinal assessment; maintenance/continuing-certification requirements; performance-improvement activities; society CME/CE, clinical guidance, and faculty development	ABFM, ABP, ABOG, ABIM, ANCC, AANPCB, AMCB, NCCPA, and relevant specialty certifying bodies; AAFP, STFM, AAP, ACOG, ACP, SGIM, PAEA, AANP, ACNM, and NAPNAP	Next scheduled blueprint, standards, and continuing-certification update cycles
43	State licensing boards should mandate 10% to 20% of required CE hours as IPCE; designate Smiles for Life, NIIOH-endorsed curricula, and other validated interprofessional oral health programs as qualifying IPCE; align IPCE requirements across medical, nursing, dental, and pharmacy licensing boards within each state.	State licensing board rule amendments; NIIOH and 100MMC as IPCE content providers; state-level interprofessional licensing board coordination	State licensing boards, NIIOH, Smiles for Life, 100MMC	1–2 years

2C. Accreditation, Licensure, and Education Policy (Table IV.A) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
44	Pilot portfolio-based or performance-based IPP assessment for license renewal in at least five states by 2027; use validated tools, including the ICAR, for assessment design; cosigned care plans, closed-loop referral documentation, and interprofessional case audits should qualify as license renewal evidence.	State licensing board pilot programs; ICAR and similar validated assessment frameworks; CMS Innovation Center funding for IPP renewal assessment evaluation	State regulators, credentialing bodies, CMS Innovation Center	1–2 years
45	HRSA Title VII should fund regional and national learning consortia through IPEC, NIIOH, and 100MMC platforms; federal education dollars should condition engagement on participation in shared IPE infrastructure; the National Center for Interprofessional Practice and Education should serve as the national hub for curriculum sharing, evaluation tools, and faculty development resources.	HRSA Title VII training grants; IPEC national forum infrastructure; National Center for Interprofessional Practice and Education platform; 100MMC state champion network	HRSA, IPEC, NIIOH, National Center for Interprofessional Practice and Education platform, 100MMC, foundations	1–2 years
46	Pair all accreditation and licensure reforms with HRSA Title VII funding for faculty development, IPE coordination roles, and clinical preceptor support; condition Title VII awards on institutional compliance with IPE equity requirements, including placements in rural, tribal, and FQHC settings; provide technical assistance through IPEC and the National Center for Interprofessional Practice and Education.	HRSA Title VII reauthorization; HRSA Title VII compliance conditions and monitoring; IPEC and National Center for IPE technical assistance programs	HRSA, IPEC, National Center for IPE, federal agencies, foundations	Ongoing

Acronyms: **AANP** = American Association of Nurse Practitioners; **AANPCB** = American Academy of Nurse Practitioners Certification Board; **AAP** = American Academy of Pediatrics; **AAFP** = American Academy of Family Physicians; **ABFM** = American Board of Family Medicine; **ABIM** = American Board of Internal Medicine; **ABOG** = American Board of Obstetrics and Gynecology; **ABP** = American Board of Pediatrics; **ACGME** = Accreditation Council for Graduate Medical Education; **ACNM** = American College of Nurse-Midwives; **ACP** = American College of Physicians; **ACOG** = American College of Obstetricians and Gynecologists; **ACPE** = Accreditation Council for Pharmacy Education; **AMCB** = American Midwifery Certification Board; **ANCC** = American Nurses Credentialing Center; **ARC-PA** = Accreditation Review Commission on Education for the Physician Assistant; **CCNE** = Commission on Collegiate Nursing Education; **CE** = continuing education; **CME** = continuing medical education; **CMS** = Centers for Medicare & Medicaid Services; **CODA** = Commission on Dental Accreditation; **FQHC** = federally qualified health center; **HPAC** = Health Professions Accreditors Collaborative; **HRSA** = Health Resources and Services Administration; **ICAR** = Interprofessional Collaborator Assessment Rubric; **INBDE** = Integrated National Board Dental Examination; **IPCE** = interprofessional continuing education; **IPE** = interprofessional education; **IPEC** = Interprofessional Education Collaborative; **IPP** = interprofessional practice; **JCNDE** = Joint Commission on National Dental Examinations; **LCME** = Liaison Committee on Medical Education; **NAPLEX** = North American Pharmacist Licensure Examination; **NAPNAP** = National Association of Pediatric Nurse Practitioners; **NBME** = National Board of Medical Examiners; **NCCPA** = National Commission on Certification of Physician Assistants; **NCLEX** = National Council Licensure Examination; **NIIOH** = National Interprofessional Initiative on Oral Health; **NLN CNEA** = National League for Nursing Commission for Nursing Education Accreditation; **OHNEP** = Oral Health Nursing Education and Practice; **PAEA** = Physician Assistant Education Association; **SGIM** = Society of General Internal Medicine; **STFM** = Society of Teachers of Family Medicine; **USMLE** = United States Medical Licensing Examination

2D. Payment Innovation (Table IV.B)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
47	Explicitly include dental services and outcomes in all APM and ACO contracts; require oral health quality metrics as a scored ACO participation condition; include dental providers as eligible ACO participants under the MSSP; condition CMMI Innovation Award approval on demonstrated dental inclusion plan.	CMS MSSP final rule amendments; CMMI APM framework rulemaking; CMS PFS annual quality measure cycle; CMMI Innovation Award solicitation requirements	CMS, CMMI, state Medicaid agencies, commercial payers	1–2 years
48	Pilot bundled payments for preventive and chronic oral health conditions requiring interprofessional coordination; replicate the New Hampshire Medicaid WIC-dental bundle in at least 10 states; develop a framework informed by CareQuest Institute for Oral Health for bundled periodontal-systemic condition management that coordinates dental and medical care for shared chronic disease patients.	CMS 1115 waiver demonstrations; state Medicaid managed care contract design; CMMI Innovation Awards for bundled oral health pilots; CareQuest Institute bundled payment framework	Medicaid agencies, CMMI, commercial insurers, CMS	1–2 years
49	Launch 1115 waiver demonstrations in at least eight states focused on medical-dental integration; require explicit equity metrics as a waiver design condition — including dental utilization and outcomes stratified by race, ethnicity, income, and geography; condition waiver approval on elimination of same-day billing restrictions and integration of dental providers in managed care coordination workflows.	CMS 1115 waiver application requirements and standard terms and conditions; CMS informational bulletin on dental integration in 1115 waiver design; state Medicaid waiver technical assistance	CMS, state Medicaid agencies	1–2 years
50	Expand risk-adjusted capitated models that include oral health as a covered service and reward team-based care; apply equity safeguards ensuring plans are not financially penalized for serving high-need populations; replicate Oregon CCO oral health withhold-and-incentivize models in other states.	State Medicaid managed care capitation rate-setting; CMS actuarial guidance on risk adjustment for oral health; Oregon CCO model dissemination through CMMI	CMS, Medicaid MCOs, ACOs, state Medicaid agencies	1–2 years
51	Require stratified reporting by race, ethnicity, income, and geography in all medical-dental integration demonstrations; mandate risk adjustment in all capitated oral health models; condition 1115 waiver approval on equity monitoring plan with corrective action requirements if disparities widen.	CMS 1115 waiver standard terms and conditions; CMS equity reporting framework for Medicaid managed care; CMMI Innovation Award equity reporting requirements	CMS, states, Medicaid MCOs	1–2 years
52	CMS should standardize coverage, documentation, enrollment, and claims guidance across MACs; monitor utilization, denials, access, and equity; provide technical assistance to dental providers; and evaluate additional clinical circumstances for inclusion through annual rulemaking.	Annual PFS rulemaking; Medicare manual and claims-processing updates; MAC instructions; provider enrollment and education; KX modifier and ICD-10 reporting; CMMI evaluation where appropriate	Congress, CMS	1–2 years and ongoing

2D. Payment Innovation (Table IV.B) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
53	Congress should require meaningful dental coverage as a mandatory MA benefit; integrate dental providers into MA risk-based models and MSSP ACO quality reporting; establish CMS minimum coverage standards for MA dental benefits to prevent nominal compliance.	Congressional action on MA mandatory dental benefit (H.R. 2045 or successor legislation); CMS MA final rule minimum dental benefit standards; CMS MSSP dental metric requirements	Congress, CMS	1–2 years
54	CMS should elevate oral health integration from MIPS improvement activity to a scored quality measure in the next PFS; develop a crosswalk measure set that rewards documented medical-dental coordination; require dental outcome metrics as a condition of participation in next-generation ACO program design under MSSP.	CMS annual PFS rulemaking (next cycle); CMS MSSP final rule dental metric requirements; CMMI ACO program design requirements	CMS	2–3 years
55	Increase Medicaid and Medicare reimbursement for nonprocedural, team-based oral health services; ensure consistent coverage and reimbursement for existing care-coordination codes, including D9992, and develop complementary medical-dental coding or payment pathways for consultation, referrals, planning, and closed-loop follow-ups; condition Medicaid managed care contract approval on dental reimbursement rate floors.	ADA/AMA joint coding committee for care coordination CDT/CPT development; state Medicaid rate-setting processes; CMS Medicaid managed care minimum MLR requirements	CMS, state Medicaid agencies, ADA, AMA	1–2 years
56	CMMI should establish a formal conversion pathway for successful medical-dental Integration Innovation Awards, with CMS rulemaking authority to standardize reimbursement within three years of demonstrated pilot effectiveness; HRSA should transition successful health center–based IPP models into permanent UDS reporting and FQHC prospective payment requirements.	CMMI Innovation Center dissemination and scaling pathway; CMS rulemaking authority under Social Security Act Section 1115A; HRSA UDS reporting and FQHC prospective payment system updates	CMS, CMMI, HRSA, policymakers	2–4 years
57	CMS and ASTP/ONC should jointly condition enhanced payment rates on adoption of HL7 FHIR R4–certified dental EHR systems; incentivize dental payer participation in state HIEs as a condition of Medicaid managed care contract approval; fund dental HIT interoperability pilots through CMMI Innovation Awards.	ASTP/ONC Health IT Certification Program rulemaking; CMS Medicaid managed care final rule HIT requirements; CMMI Innovation Awards for dental HIT adoption	CMS, ASTP/ONC, payers, Medicaid MCOs	1–2 years

Acronyms: **ACO** = accountable care organization; **ADA** = American Dental Association; **AMA** = American Medical Association; **APM** = alternative payment model; **ASTP** = Assistant Secretary for Technology Policy; **CCO** = coordinated care organization; **CDT** = Current Dental Terminology; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **CPT** = Current Procedural Terminology; **EHR** = electronic health record; **FHIR** = Fast Healthcare Interoperability Resources; **FQHC** = federally qualified health center; **HIE** = Health Information Exchange; **HIT** = Health Information Technology; **HL7** = Health Level Seven International; **HRSA** = Health Resources and Services Administration; **MA** = Medicare Advantage; **MAC** = Medicare administrative contractor; **MCO** = managed care organization; **MIPS** = Merit-Based Incentive Payment System; **MLR** = Medical Loss Ratio; **MSSP** = Medicare Shared Savings Program; **PFS** = Physician Fee Schedule; **R4** = Release 4 (FHIR Release 4); **UDS** = Uniform Data System; **WIC** = Women, Infants, and Children (Special Supplemental Nutrition Program for Women, Infants, and Children)

2E. Workforce and Practice Reform (Table IV.C)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
58	States should enact dental hygienist direct access legislation; explicitly authorize dental therapy in states not yet doing so; condition HRSA Health Workforce grants on documented scope-of-practice modernization compliance; prioritize scope reform in states with the highest density of DHPSAs.	CMS MSSP final rule amendments; CMMI APM framework rulemaking; CMS Physician Fee Schedule annual quality measure cycle; CMMI Innovation Award solicitation requirements	CMS, CMMI, state Medicaid agencies, commercial payers	1–2 years
59	HRSA Title VII compliance conditions should require states to report on dental hygienist scope status as a funding eligibility condition; federal workforce data collection should track direct access authorization rates by state; HRSA should use technical assistance funding to support states pursuing dental hygiene scope modernization and position direct access as the national standard toward which federal incentives drive convergence.	HRSA Title VII compliance conditions and monitoring; HRSA Bureau of Health Workforce data collection; HRSA technical assistance funding for state scope reform; Oral Health Workforce Research Center state-by-state tracking	HRSA, state legislatures, licensing boards, ADHA	2–4 years
60	States should shift from location-based to competency-based supervision models; update dental practice acts to allow general supervision and telehealth-based oversight in DHPSAs; condition HRSA NHSC dental placements on assignment to settings with competency-based supervision authority.	State dental practice act reform; HRSA NHSC placement conditions; state telehealth parity laws applied to dental supervision	State regulators, licensing boards, HRSA	1–2 years
61	CMS should issue explicit Medicaid reimbursement guidance for teledentistry services including asynchronous store-and-forward consultation; states should codify teledentistry in dental practice acts with explicit cross-disciplinary consultation provisions; remove originating site restrictions that require patients to travel to a dental office to initiate a teledentistry encounter.	CMS Medicaid teledentistry reimbursement guidance; state dental practice act reform; state telehealth parity legislation applied to dentistry; HRSA telehealth grant programs	States, CMS, professional licensing boards, HRSA	1–2 years
62	Expand authority for dental hygienists and allied dental professionals to practice in community, school, FQHC, and medical settings as full IPP team members; fund mobile and school-based dental integration through HRSA NHSC and Health Center Program grants; explicitly authorize dental therapists to practice in community settings with general supervision.	State dental practice act reform; HRSA NHSC and Health Center Program grant requirements; school-based health center federal funding (Title V, HRSA SBHC program); dental therapy authorization legislation	State legislators, HRSA, FQHC programs, school-based health center networks, state health departments	1–2 years
63	Streamline credentialing in integrated care environments by recognizing shared interprofessional competencies and team roles; adopt standardized credentialing frameworks for dental providers in medical settings developed jointly by HRSA, CMS, and relevant professional associations; condition HRSA Health Center Program participation on having a documented dental provider credentialing pathway.	HRSA Health Center Program requirements; CMS FQHC conditions of participation; Joint Commission credentialing standards; professional association credentialing framework development	Health systems, HRSA, CMS, Joint Commission, professional associations	1–2 years

2E. Workforce and Practice Reform (Table IV.C) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
64	Professional associations, certification organizations, health system credentialing committees, and state licensing boards should update privileging criteria to explicitly authorize comanagement, shared care planning, and cross-disciplinary referral as standard practice; health systems should adopt joint medical-dental privileging pathways for integrated care team members.	Joint Commission privileging standards; health system medical staff bylaws reform; professional association credentialing guidance updates; CMS conditions of participation for FQHCs and hospital-based clinics	Health systems, professional associations, certification organizations, state licensing boards, Joint Commission	1–2 years
65	State legislatures should revise dental and medical practice acts to include permissive language supporting delegation, collaboration, and shared accountability across disciplines; model reform on states with successful dental hygiene direct access and dental therapy legislation; HRSA should provide technical assistance and model legislation to states pursuing practice act modernization.	State legislative sessions; HRSA technical assistance funding; National Partnership for Dental Therapy and ADHA model legislation; state dental and medical board joint rulemaking authority	State legislatures, HRSA, dental and medical licensing boards, professional associations	1–2 years
66	Prioritize workforce reforms that explicitly enable flexible team-based care in safety-net and rural systems; HRSA NHSC placements should support integrated care team roles for dental providers, not just solo dental practice placements; condition rural health grants on documented scope-of-practice modernization; fund dental therapy training programs through HRSA Title VII in states with high DHPSA burden.	HRSA NHSC placement priorities and conditions; HRSA Rural Health grants; HRSA Title VII training grants; state rural health transformation programs funded under OBBA Rural Health Transformation Program	Policymakers, HRSA, state health departments, rural health organizations	Ongoing
67	CMS, ASTP/ONC, and state Medicaid agencies should formally coordinate workforce and HIT rulemaking timelines to ensure scope-of-practice changes are accompanied by simultaneous reimbursement authority and EHR support; create an interagency IPP policy coordination mechanism between HRSA, CMS, and ASTP/ONC to align reform timelines across workforce, payment, and data domains.	Interagency coordination between HRSA, CMS, and ASTP/ONC; state Medicaid agency coordination with state licensing boards; CMMI Innovation Award design requirements for workforce-payment alignment	CMS, ASTP/ONC, HRSA, state Medicaid agencies, state licensing boards	Ongoing

Acronyms: **ADHA** = American Dental Hygienists' Association; **ASTP** = Assistant Secretary for Technology Policy; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **DHPSA** = Dental Health Professional Shortage Area; **EHR** = electronic health record; **FQHC** = federally qualified health center; **HIT** = Health Information Technology; **HRSA** = Health Resources and Services Administration; **IPP** = interprofessional practice; **NHSC** = National Health Service Corps; **OBBA** = One Big Beautiful Bill Act; **ONC** = Office of the National Coordinator for Health Information Technology; **SBHC** = school-based health center

2F. Health IT and Data Infrastructure Policy Lever (Table IV.D)

#	Recommendation	Key Mechanism	Primary Actors	Timeline
68	ASTP/ONC should require dental EHR vendors to support HL7 FHIR R4 as a condition of federal HIT certification; CMS should create a Meaningful Use–equivalent incentive program for dental providers in Medicaid managed care, conditioning enhanced reimbursement rates on adoption of certified interoperable EHR systems; ASTP/ONC should issue formal guidance by 2027 with full compliance deadlines by 2029.	ASTP/ONC Health IT Certification Program rulemaking; CMS Medicaid managed care final rule; CMMI Innovation Award for dental HIT adoption pilots; ASTP/ONC guidance on dental EHR interoperability requirements	CMS, ASTP/ONC, states, dental EHR vendors	1–2 years
69	ASTP/ONC should amend the Health IT Certification Program to include dental-specific HL7 FHIR R4 requirements; issue formal guidance in 2027 identifying dental EHR certification criteria; establish a compliance deadline; pair certification requirements with financial incentives for small, rural, and safety-net dental practices.	ASTP/ONC Health IT Certification Program rulemaking (2027 guidance, 2029 compliance); HRSA Rural Health grants for dental HIT adoption; CMS FQHC technical assistance programs; CMMI dental HIT pilot funding	ASTP/ONC, CMS, HRSA, dental EHR vendors	1–2 years
70	Accelerate adoption of SNOMED CT and ICD diagnostic coding in dental EHR systems; ADA and CMS should jointly develop a CDT-to-ICD diagnostic crosswalk standard; condition federal data infrastructure grants on diagnostic coding compliance; ASTP/ONC should include diagnostic coding adoption as a dental HIT certification criterion.	ADA/CMS joint coding standards development; ASTP/ONC Health IT Certification Program dental criteria; federal APCD grant conditions; FDI World Dental Federation data standards guidance	ADA, CMS, ASTP/ONC, dental EHR vendors, FDI World Dental Federation	2–4 years
71	States should provide financial subsidies and technical assistance for dental provider and payer HIE participation; replicate the Contexture model (Arizona and Colorado) and TECCA national framework nationally; condition state HIE infrastructure funding on demonstrated dental provider participation rates; explore state legislative mandates for dental HIE participation modeled on North Carolina’s requirement for dentists receiving state funds.	State HIE participation incentive programs; TECCA national framework (ASTP/ONC); Contexture model dissemination; state legislative mandates for dental HIE participation; ASTP/ONC HIE participation guidance	States, HIE organizations, ASTP/ONC, CMS, dental providers and payers	2–4 years
72	Expand APCDs in all states to fully include dental services and outcomes; require dental claims inclusion as a condition of receiving federal APCD infrastructure grants; AHRQ, CMMI, and HRSA should jointly fund a national IPP evaluation dataset inclusion; prioritize states with active 1115 waiver medical-dental integration demonstrations for APCD expansion funding.	State APCD legislation (modeled on Colorado); federal APCD grant conditions; AHRQ/CMMI/HRSA joint research funding solicitations; CMS 1115 waiver APCD requirements	States, CMS, AHRQ, CMMI, HRSA	2–4 years

2F. Health IT and Data Infrastructure Policy Lever (Table IV.D) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
73	CMS and NCQA should jointly develop a core set of cross-disciplinary IPP outcome measures explicitly including oral health indicators; align HEDIS and UDS measures with oral-systemic integration goals; require oral health outcome metrics in all CMMI Innovation Award reporting by 2027; draw on FDI World Dental Federation recommended core indicator set for dental data elements.	CMS/NCQA HEDIS measure development cycle; HRSA UDS reporting requirement updates; CMMI Innovation Award reporting requirements; FDI World Dental Federation core indicator guidance	CMS, NCQA, HRSA, payers, CMMI	2–4 years
74	CMS should lead a national measure harmonization process to consolidate core IPP measures across payers and settings; reduce duplicative reporting requirements; develop a unified oral-systemic measure set that all payers can adopt consistently; align national measure sets including HEDIS and UDS, with a shared core set of oral health integration indicators.	CMS Core Quality Measures Collaborative; National Quality Forum measure harmonization process; CMS Medicaid managed care quality reporting consolidation; HRSA UDS and HEDIS alignment workgroup	CMS, NCQA, National Quality Forum, payers, providers, HRSA	2–3 years
75	ASTP/ONC should require patient-facing dental data access as a condition of federal HIT certification; require dental EHR vendors to support patient access APIs under the 21st Century Cures Act framework; incentivize dental patient portal adoption in Medicaid managed care contracts; issue ASTP/ONC guidance clarifying that 21st Century Cures Act information blocking provisions apply to dental records.	ASTP/ONC Health IT Certification Program rulemaking; 21st Century Cures Act patient access API requirements; CMS Medicaid managed care contract standards; ASTP/ONC information blocking guidance for dental records	ASTP/ONC, CMS, dental EHR vendors	2–4 years
76	CMMI should fund development of cross-sector IPP performance dashboards; deploy dashboards tracking medical-dental coordination rates, closed-loop referral completion, shared chronic disease management outcomes, and disparities by race, ethnicity, income, and geography; make dashboard reporting a condition of 1115 waiver participation.	CMMI Innovation Awards for IPP dashboard development; CMS 1115 waiver reporting requirements; HRSA Health Center Program UDS dashboard requirements; state Medicaid managed care quality reporting	CMS, CMMI, HRSA, health systems, state Medicaid agencies, payers	2–4 years
77	CMS and ASTP/ONC should jointly design an inclusive Meaningful Use–equivalent program for dental providers in Medicaid managed care, conditioning enhanced reimbursement rates on adoption of HL7 FHIR R4–certified dental EHR systems by 2028; ensure future federal HIT incentive programs explicitly include dental providers, dental payers, FQHCs, school-based health centers, and safety-net dental practices practices as eligible participants.	CMS Medicaid managed care final rule HIT requirements; ASTP/ONC Health IT Certification Program rulemaking; Congressional appropriations for dental HIT incentive program; HRSA Health Center Program HIT requirements	CMS, ASTP/ONC, Congress, HRSA	2–4 years

2F. Health IT and Data Infrastructure Policy Lever (Table IV.D) *continued*

#	Recommendation	Key Mechanism	Primary Actors	Timeline
78	ASTP/ONC should issue guidance on responsible API-enabled medical-dental data exchange; CMS should incentivize AI-assisted care coordination tools that meet interoperability standards in Medicaid managed care contracts; ADA should develop guidance on ethical AI use in dental practice including data sharing and patient consent standards; ensure AI tools used in integrated care settings comply with HL7 FHIR R4 interoperability requirements.	ASTP/ONC API guidance and rulemaking; CMS Medicaid managed care contract standards for AI-assisted coordination tools; ADA AI ethics guidance; ASTP/ONC information blocking rules applied to AI-generated dental data	ASTP/ONC, CMS, ADA, dental EHR vendors, health systems	2–4 years and ongoing

Acronyms: **ADA** = American Dental Association; **AHRQ** = Agency for Healthcare Research and Quality; **AI** = artificial intelligence; **APCD** = All-Payer Claims Database; **API** = Application Programming Interface; **ASTP** = Assistant Secretary for Technology Policy; **CDT** = Current Dental Terminology; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **EHR** = electronic health record; **FDI** = FDI World Dental Federation (formerly Fédération Dentaire Internationale); **FHIR** = Fast Healthcare Interoperability Resources; **FQHC** = federally qualified health center; **HEDIS** = Healthcare Effectiveness Data and Information Set; **HIE** = Health Information Exchange; **HIT** = Health Information Technology; **HL7** = Health Level Seven International; **HRSA** = Health Resources and Services Administration; **ICD** = International Classification of Diseases; **IPP** = interprofessional practice; **NCQA** = National Committee for Quality Assurance; **ONC** = Office of the National Coordinator for Health Information Technology; **R4** = Release 4 (FHIR Release 4); **SNOMED CT** = Systematized Nomenclature of Medicine–Clinical Terms; **TEFCA** = Trusted Exchange Framework and Common Agreement; **UDS** = Uniform Data System

Tier 3 • The Long Game: Structural Transformation

The recommendations provided in this section require legislation, multiyear institutional reform, significant new federal investment, or significant redesign of existing systems. They represent where the system changes at scale and are sequenced once Tiers 1 and 2 have built the evidence base and political will to sustain them. Note that some Tier 3 actions (particularly Medicare Advantage and the Medicaid benefit floor) are time-sensitive despite their complexity.

3A. Payment — Sustainable Models

#	Recommendation	Key Mechanism	Primary Actors	Timeline
79	CMMI should establish a formal conversion pathway for successful medical-dental integration Innovation Awards with a permanent reimbursement standard within three years of demonstrated pilot effectiveness; HRSA should transition successful Health Center–based IPP models into permanent UDS reporting and FQHC prospective payment requirements.	CMMI Innovation Center dissemination and scaling pathway; CMS rulemaking under Social Security Act Section 1115A; HRSA UDS and FQHC prospective payment system updates	CMS, CMMI, HRSA, policymakers	2–4 years
80	Integrate dental benefits into Medicaid managed care contracts; require dental carved-in as a condition of all 1115 waiver approvals; issue CMS guidance clarifying that Medicaid MCOs must include dental providers in care coordination workflows regardless of benefit carve-in status.	CMS 1115 waiver requirements; Medicaid managed care final rule amendments; CMS informational bulletin on dental coordination in managed care	State Medicaid agencies, CMS	2–4 years
81	Expand risk-adjusted capitated models that include oral health as a covered service and reward team-based care; apply equity safeguards ensuring plans are not financially penalized for serving high-need populations; replicate Oregon CCO oral health withhold and incentive models in other states.	State Medicaid managed care capitation rate-setting; CMS actuarial guidance on risk adjustment for oral health; Oregon CCO model dissemination through CMMI	CMS, Medicaid MCOs, ACOs, state Medicaid agencies	1–2 years
82	Document, disseminate, and scale proven private-sector and state-level integration models through CMMI; require commercial payers participating in CMMI value-based initiatives to report on dental integration metrics; use Business Group on Health and Pacific Business Group on Health as dissemination channels to employer purchasers.	CMMI Innovation Center dissemination authority; employer purchaser coalition policy platforms; CMS reporting requirements for commercial payer CMMI participants	Commercial insurers, CMMI, employers, purchaser coalitions	2–4 years

Acronyms: **ACO** = accountable care organization; **CMMI** = Center for Medicare and Medicaid Innovation; **CMS** = Centers for Medicare & Medicaid Services; **FQHC** = federally qualified health center; **HRSA** = Health Resources and Services Administration; **IPP** = interprofessional practice; **MCO** = managed care organization; **UDS** = Uniform Data System

3B. Coverage — Legislative Action Required

#	Recommendation	Key Mechanism	Primary Actors	Timeline
83	Require dental coverage as a mandatory MA benefit through congressional action; establish minimum coverage standards to prevent nominal compliance; expand Medicare Part B to include comprehensive dental coverage.	Congressional action on MA mandatory dental benefit (H.R. 2045 or successor legislation); CMS MA final rule minimum dental benefit standards	Congress, CMS	1–2 years (legislative window)
84	Establish a federal minimum dental benefit floor as a Medicaid condition; protect and strengthen Medicaid adult dental benefits against OBBBA-driven reductions through federal minimum floor standards.	Congressional action on Medicaid statutory floor for adult dental (federal legislative action); ACA EHB rulemaking	Congress, CMS, state Medicaid agencies, commercial payers	2–4 years
85	Extend ACA EHB requirements to include adult dental for Marketplace plans.	ACA EHB rulemaking cycle	Congress, CMS	2–4 years

Acronyms: **ACA** = Affordable Care Act; **CMS** = Centers for Medicare & Medicaid Services; **EHB** = Essential Health Benefit; **MA** = Medicare Advantage; **OBBBA** = One Big Beautiful Bill Act.

3C. Workforce — Multiyear Statutory Reform

#	Recommendation	Key Mechanism	Primary Actors	Timeline
86	Authorize dental therapy in states not yet doing so; embed dental therapy authorization in HRSA Title VII training grants; explicitly authorize dental therapists to practice in community settings with general supervision; embed minimally invasive care strategies in IPE competency frameworks.	State legislative sessions; HRSA Title VII reauthorization; National Partnership for Dental Therapy model legislation; dental therapy authorization legislation	State legislatures, HRSA, dental professional associations	1–4 years
87	State legislatures should revise dental and medical practice acts to include permissive language for delegation, collaboration, and shared accountability; model reform on states with successful dental hygiene direct access and dental therapy legislation; HRSA should provide technical assistance and model legislation to states pursuing practice act modernization.	State legislative sessions; HRSA technical assistance funding; National Partnership for Dental Therapy and ADHA model legislation; state dental and medical board joint rulemaking authority	State legislatures, HRSA, dental and medical licensing boards, professional associations	1–4 years

Acronyms: **ADHA** = American Dental Hygienists' Association; **HRSA** = Health Resources and Services Administration; **IPE** = interprofessional education

3D. Data — Infrastructure at Scale

#	Recommendation	Key Mechanism	Primary Actors	Timeline
88	Expand APCDs in all states to fully include dental services and outcomes; require dental claims inclusion as a condition of receiving federal APCD infrastructure grants; AHRQ, CMMI, and HRSA should jointly fund a national IPP evaluation dataset with mandatory dental data inclusion.	State APCD legislation (modeled on Colorado); federal APCD grant conditions; AHRQ/CMMI/HRSA joint research funding solicitations; CMS 1115 waiver APCD requirements	States, CMS, AHRQ, CMMI, HRSA	2–4 years
89	ADA and CMS should jointly develop a CDT-to-ICD diagnostic crosswalk standard; expand adoption of SNOMED CT and ICD diagnostic codes in dental EHR systems; condition federal data infrastructure grants on diagnostic coding compliance; ASTP/ONC should include diagnostic coding adoption as a dental HIT certification criterion.	ADA/CMS joint coding standards development; ASTP/ONC Health IT Certification Program dental criteria; federal APCD grant conditions; FDI World Dental Federation data standards guidance	ADA, CMS, ASTP/ONC, dental EHR vendors, FDI World Dental Federation	2–4 years
90	AHRQ, CMMI, and HRSA should jointly fund a national IPP evaluation dataset with mandatory dental data inclusion; require states receiving federal APCD grants to include dental claims as a funding condition; fund longitudinal studies of medical-dental integration outcomes through NIH/NIDCR.	AHRQ/CMMI/HRSA joint funding solicitations; federal APCD grant conditions; NIH/NIDCR research funding priorities	AHRQ, CMMI, HRSA, NIH/NIDCR, states	2–4 years

Acronyms: ADA = American Dental Association; AHRQ = Agency for Healthcare Research and Quality; APCD = All-Payer Claims Database; ASTP = Assistant Secretary for Technology Policy; CDT = Current Dental Terminology; CMS = Centers for Medicare & Medicaid Services; CMMI = Center for Medicare and Medicaid Innovation; EHR = electronic health record; FDI = FDI World Dental Federation (formerly Fédération Dentaire Internationale); FHIR = Fast Healthcare Interoperability Resources; HIT = Health Information Technology; HL7 = Health Level Seven International; HRSA = Health Resources and Services Administration; ICD = International Classification of Diseases; IPP = interprofessional practice; NCQA = National Committee for Quality Assurance; NIDCR = National Institute of Dental and Craniofacial Research; NIH = National Institutes of Health; ONC = Office of the National Coordinator for Health Information Technology; SNOMED CT = Systematized Nomenclature of Medicine–Clinical Terms

3E. Education — Deep Structural Change

#	Recommendation	Key Mechanism	Primary Actors	Timeline
91	Build shared IPE curricula across medicine, nursing, dentistry, pharmacy, and social work that require active team-based problem-solving, not parallel instruction; invest in IPE faculty development and dedicated IPE coordination roles; create FQHC-based and community-based IPP training sites at scale (target: ≥100 nationally).	HPAC harmonization process (2028 target); HRSA Title VII training grants; IPEC core competency alignment; National Center for IPE learning consortia; NIIOH and 100MMC as curriculum and faculty development resources	Educational institutions, HRSA, FQHC networks, accreditors	2–4 years+

Acronyms: 100MMC = 100 Million Mouths Campaign; FQHC = federally qualified health center; HPAC = Health Professions Accreditors Collaborative; HRSA = Health Resources and Services Administration; IPE = interprofessional education; IPEC = Interprofessional Education Collaborative; IPP = interprofessional practice; NIIOH = National Interprofessional Initiative on Oral Health

Recommendations by Stakeholder Group

The tables below cross-reference recommendations by the stakeholder group with primary responsibility for action, drawn from Table VI.A of the white paper. Recommendation numbers correspond to the numbering in this guide.

Stakeholder Group	Priority Actions (with recommendation cross-references)
Federal Policymakers (Congress, CMS, HRSA, ASTP/ONC)	Require mandatory dental coverage in MA (Recs 1, 12, 53); expand Medicare Part B to include comprehensive dental coverage; elevate oral health to a scored MIPS quality measure in the 2027 PFS (Recs 2, 27, 54); require dental inclusion in all MSSP ACO and CMMI APM contracts (Recs 2, 19, 47); eliminate same-day billing restrictions in Medicaid through CMS guidance (Recs 2, 24); launch ≥8 state 1115 waiver demonstrations (Recs 5, 49); condition HRSA Title VII grants on documented IPE compliance including dental profession inclusion (Recs 6, 37–39, 45); extend federal HIT certification to dental EHR vendors with HL7 FHIR R4 compliance (Recs 28, 30, 67, 68, 70); establish a Meaningful Use–equivalent incentive program for dental providers in Medicaid managed care (Recs 28, 68, 77).
State Governments (Legislatures, Medicaid Agencies, Boards of Health)	Enact dental hygienist direct access legislation (Recs 4, 58); codify teledentistry as a standard interprofessional care tool (Rec 61); launch 1115 waiver demonstrations for medical-dental integration with explicit equity metrics (Recs 5, 49); expand APCDs to include dental services and outcomes (Recs 36, 72, 88); integrate dental benefits into Medicaid managed care contracts (Recs 13, 21, 80); authorize dental therapy in states not yet doing so (Recs 58, 86); remove same-day billing restrictions in Medicaid programs (Recs 2, 24); revise dental and medical practice acts to include permissive language for delegation and shared accountability (Recs 65, 87).
Educational Institutions (Health Professions Schools, Academic Health Centers)	Build shared IPE curricula requiring active team-based problem-solving (Recs 6, 91); invest in IPE faculty development and dedicated IPE coordination roles (Recs 45, 46, 91); create FQHC-based and community-based IPP training sites — target ≥100 nationally (Rec 91); document and share outcomes from IPE programs (Rec 45); proactively pursue HPAC-aligned accreditation language (Recs 38–40).
Accreditors and Licensing Boards (CODA, LCME, ACGME, CCNE, ACPE, NBME, JCNDE)	Harmonize IPE accreditation language to mandate — not suggest — interprofessional training including at least one dental profession as a named required partner (Recs 38–40); replace “should” with “must” paired with graduated implementation timelines (Rec 39); establish NBME–JCNDE joint working group by 2027 for IPP licensure exam integration by 2029 (Rec 41); mandate 10%–20% of CE hours as IPCE (Rec 43); require equity-centered clinical placements in safety-net, rural, and tribal settings (Recs 39, 46); pilot performance-based IPP assessment for license renewal in ≥5 states by 2028 (Rec 41).
Payers and Health Systems (CMS, Medicaid MCOs, Commercial Insurers, Employers)	Include dental services and outcomes in all APM and ACO contracts (Recs 2, 17, 47); create billing codes for medical-dental care coordination (Recs 18, 55); pilot bundled payments for oral-systemic conditions — periodontal-diabetes, prenatal-dental (Recs 9, 48); transition successful IPP grant pilots into permanent reimbursement through CMMI conversion pathways (Recs 25, 56, 82); update credentialing and privileging standards to authorize comanagement, shared care planning, and cross-disciplinary referral as standard practice (Recs 61, 62); engage Business Group on Health and Pacific Business Group on Health to drive commercial sector integration (Recs 14, 26, 82).

Stakeholder Group	Priority Actions (with recommendation cross-references)
Community Health Organizations (FQHCs, CHCs, Safety-Net Systems)	Serve as demonstration sites for integrated IPP models (Recs 5, 31, 49, 55, 82); build oral health formally into care team structures and staffing models (Recs 3, 10, 15); implement closed-loop referral systems with documented completion tracking (Recs 15, 31); report dental utilization and outcomes stratified by race, ethnicity, income, and geography (Recs 5, 17, 51); develop workforce pipelines for underrepresented communities (Rec 66).
Credentialing Bodies and Professional Associations	Update licensure exams, credentialing standards, and professional codes of ethics to reflect IPP as a core competency (Recs 40, 64); develop joint medical-dental credentialing pathways for integrated care settings (Rec 63); advocate within professional communities for scope-of-practice modernization and dental therapy authorization (Recs 58, 62, 86, 87); support NBME–JCND E joint working group for IPP licensure exam integration (Rec 41).
Health IT Leaders and Data Stewards	Support ASTP/ONC extension of federal HIT certification to dental EHR vendors with HL7 FHIR R4 compliance by 2028 (Recs 28, 30, 67, 68); invest in interoperable EHR systems integrating oral health alongside medical and behavioral health data (Recs 28, 68); deploy cross-sector IPP performance dashboards (Rec 76); expand APCD participation to include dental claims (Recs 36, 72, 88); ensure patient-facing dental data access through interoperable portals consistent with 21st Century Cures Act requirements (Recs 35, 75).
Providers and Clinical Leaders	Practice with a whole-person lens that explicitly includes oral health as integral to overall health; use interprofessional case huddles, warm handoffs, shared care plans, and closed-loop referrals as standard practice — not exceptional workflows; document and report interprofessional encounters to support payment reform and outcomes evaluation; advocate within clinical settings for integrated workflows, shared data systems, and cross-professional trust; precept, mentor, and model interprofessional practice including oral health integration for learners across disciplines.
Philanthropy and Funders	Fund sustainable IPE and IPP infrastructure — faculty training, IPE coordination roles, learning collaboratives, and rigorous evaluation — that outlasts individual grant cycles; invest in state and regional policy efforts advancing scope-of-practice reform, dental therapy authorization, integrated payment models, and workforce modernization; fund CMMI-complementary pilots with documented pathways to permanent reimbursement; champion oral health integration and health equity as cross-cutting investments in health system transformation.

Acronyms: 100MMC = 100 Million Mouths Campaign; ACO = accountable care organization; ACPE = Accreditation Council for Pharmacy Education; ACGME = Accreditation Council for Graduate Medical Education; APCD = All-Payer Claims Database; APM = alternative payment model; ASTP = Assistant Secretary for Technology Policy; CCNE = Commission on Collegiate Nursing Education; CHC = community health center; CMS = Centers for Medicare & Medicaid Services; CMMI = Center for Medicare and Medicaid Innovation; CODA = Commission on Dental Accreditation; EHR = electronic health record; FHIR = Fast Healthcare Interoperability Resources; FQHC = federally qualified health center; HIT = Health Information Technology; HL7 = Health Level Seven International; HPAC = Health Professions Accreditors Collaborative; HRSA = Health Resources and Services Administration; ICD = International Classification of Diseases; IPE = interprofessional education; IPEC = Interprofessional Education Collaborative; IPP = interprofessional practice; JCND E = Joint Commission on National Dental Examinations; LCME = Liaison Committee on Medical Education; MA = Medicare Advantage; MCO = managed care organization; MIPS = Merit-Based Incentive Payment System; MSSP = Medicare Shared Savings Program; NBME = National Board of Medical Examiners; NIIOH = National Interprofessional Initiative on Oral Health; ONC = Office of the National Coordinator for Health Information Technology; PFS = Physician Fee Schedule; R4 = Release 4 (FHIR Release 4); UDS = Uniform Data System

Source Note:

Derived from *Fixing the Fracture: Policy Recommendations for Interprofessional Education, Oral Health Integration, and Collaborative Care* (October 2026). All recommendation numbers correspond to this guide's numbering system. For full policy context, named mechanisms, and success indicators, refer to Tables I.A, II.A, III.A, III.B, IV.A, IV.B, IV.C, IV.D, V.A, and VI.A in the white Paper.

CareQuest Institute for Oral Health

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