

WHITE PAPER

Fixing the Fracture

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

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Authors

Zachary Brian, DMD, MHA, FICD, FACD, FNAP

Assistant Dean for Community Partnerships and External Affairs
Associate Professor
Director, Dentistry in Service to Community Program
Director, Program for Oral Health Policy
Adams School of Dentistry, University of North Carolina

Judith Haber, PhD, APRN, FAAN

Professor Emerita
Executive Director, Oral Health Nursing Education and Practice (OHNEP)
New York University Rory Meyers College of Nursing

Caroline McLeod, MS, RDH

Value-Based Care Solutions Manager
CareQuest Institute for Oral Health

Hugh Silk, MD, MPH, FAAFP

Professor, Department of Family Medicine & Community Health
Vice Chair of Community Health
University of Massachusetts Chan Medical School

Lisa Simon, MD, DMD

Assistant Professor
Division of General Internal Medicine and Primary Care
Brigham and Women's Hospital
Director, Initiative to Integrate Oral Health and Medicine
Harvard School of Dental Medicine

Tamanna Tiwari, BDS, MDS, MPH

Chair, Department of Primary Dental Care
University of Minnesota School of Dentistry

Hannah J. Cheung, MPH, MS, RDH

Senior Health Sciences Specialist, Analytics and Data Insights
CareQuest Institute for Oral Health

Lisa J. Heaton, PhD

Manager of Scientific Publications, Analytics and Data Insights
CareQuest Institute for Oral Health

Kelly L. Schroeder, MS, RDH

Evaluation Solutions and Insights Manager
Analytics and Data Insights
CareQuest Institute for Oral Health

Rebecca Preston, MPH, CHES

Director, Analytics and Data Insights
CareQuest Institute for Oral Health

Eric P. Tranby, PhD

Senior Director, Analytics and Data Insights
CareQuest Institute for Oral Health

Acknowledgments

Anita Glick, MSW

Professor and Associate Dean Emerita
University of Colorado Anschutz Medical Center

Rebekah Mathews, MPA

Vice President, Health Transformation
CareQuest Institute for Oral Health

Mike Monopoli, DMD, MPH, MS

Frank Scannapieco, DMD, PhD
SUNY Distinguished Professor of Oral Biology
University at Buffalo School of Dental Medicine

Gracie Wallace, MS, RDH

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Preamble

— Zachary A. Brian, DMD, MHA

We have studied this problem long enough.

You may, in fact, have had this thought upon reading this preamble's title. The persistent divide between oral health and whole-person health care is deeply rooted; this is hardly the first effort to tackle it. Nevertheless, in 2026, this paper will argue, a confluence of factors presents a rare, once-in-a-generation policy window to effect real, transformative change. It is time to act.

This is the third paper in a series CareQuest Institute for Oral Health began in April 2025 with a core question: Why has oral health remained so stubbornly isolated from the rest of health care, and what would it take to change that? The first paper, [*Transforming Oral Health Care Through Interprofessional Education*](#), documented the current state of interprofessional education (IPE) — its promise, its pedagogy, its patchwork of progress, and the persistent absence of oral health from its dominant frameworks and programs. The second, [*From Silos to Synergy: Integrating Oral Health into Whole-Person Care Through Interprofessional Practice*](#), took us from the classroom to the clinic, examining what interprofessional practice (IPP)

really looks like when health systems have the will and the resources to build it — and what it costs everyone when they don't.

Both papers came to the same uncomfortable conclusion. The problem is not lack of evidence or a lack of people committed to the cause. The models are there. The clinical rationale is strong. This is how people want to work. And yet, at scale, interprofessional, whole-person care that includes oral health as a full and equal partner remains the exception. Heroic. Dependent on grants. Fragile. Relying on one champion who leaves, one funding cycle that closes, one regulatory interpretation that changes. That is not a training failure but a policy one. And this paper will treat it as such.

The problem is not lack of evidence or a lack of people committed to the cause.

The fracture in the title is not rhetorical. There is one particular fault line along which the US health system is actually broken, and that is the separation of oral health from the rest of health. And that fracture is no accident or oversight. It is the product of a series of conscious historical decisions: separate schools, separate payment systems, separate regulatory structures, separate ideas of what it means to care for a whole person.

The consequences are serious and quantifiable. As we'll see in this paper, emergency departments are spending \$3.9 billion a year on preventable dental visits. Sixty-nine million adults have no dental coverage, almost three times the percentage without health insurance. Fifty-seven million people live in a dental health professional shortage area. There is a chronic disease comanagement gap that requires patients with diabetes, cardiovascular disease, dementia, and preterm pregnancy risk to navigate systems that were never built to interact with each other.

This is not about unfortunate gaps in statistics. These gaps are indictments of a policy architecture that has repeatedly chosen to treat the mouth as separate from the body and to let the most vulnerable populations pay the price for that choice.

I'm writing this preamble at a moment of profound paradox. The case for integration has never been stronger, either clinically or economically. The move to value-based care (VBC), accountable care organizations (ACOs), and population health models is creating structural openings for the very type of interprofessional collaboration this series of white papers has been building toward. At the same time, Medicaid — the primary payer for the populations most harmed by fragmented care — is facing cuts that will force states to reduce the optional benefits most at risk, with adult dental coverage near the top of the list.

In other words, we are closest to a breakthrough just when the safety net is most threatened.

But that tension is no excuse to stop. On the contrary, now is the time to be specific, strategic, and, I might respectfully suggest, noisy.

This paper does not present another survey of what is possible. It's a reckoning of what's broken and a simple argument for how to fix it. We have structured our recommendations around policy domains, actors, mechanisms, and timelines because this work requires more than inspiration; it requires people with authority to make specific decisions in specific venues, and it requires advocates who can hold them accountable to do so.

This is not about unfortunate gaps in statistics. These gaps are indictments of a policy architecture that has repeatedly chosen to treat the mouth as separate from the body and to let the most vulnerable populations pay the price for that choice.

This is for all of you: for federal and state lawmakers who set the payment systems and regulatory structures that make integrated care either financially feasible or structurally impossible; for accreditors and licensing bodies whose standards influence what the next generation of clinicians learns and how they are assessed; for health systems and payers that hold the purchasing power to demand team-based accountability and the data infrastructure to support it; and for the educators, clinicians, and advocates who have been making this case for years and who deserve a policy environment that matches their ambition.

The opening paper in this series asked whether we can train clinicians for collaborative practice. The evidence says yes. The second paper explored whether teams in the real world can deliver on that promise. Yes, again, if the conditions are there.

This paper is asking an even more difficult question: Who is responsible for creating those conditions, what precisely do they need to do, and what should we demand if they don't?

The fact is, we know what to do, and proven models are in hand. We have the urgency. What we have lacked, quite frankly, is the policy coherence to make any of it stick. *Fixing the Fracture* is an argument that we can no longer afford this divide, and it offers a road map for closing it.



Executive Summary

The US health system continues to treat oral health as separate from medical and behavioral health, despite overwhelming evidence that oral health is integral to whole-person health.

This fragmentation undermines care quality, worsens health inequities, strains the workforce, and drives up avoidable costs — particularly for rural communities, communities of color, older adults, and people with chronic disease. Interprofessional education^a (IPE) and interprofessional practice^b (IPP) offer a proven pathway to more equitable, efficient, and person-centered care, yet they remain unevenly implemented and difficult to sustain at scale.

The central challenge is not a lack of innovation or commitment but systems-level policy misalignment. Education systems increasingly promote interprofessional competencies, yet payment, regulation, workforce policy, care pathways, and data infrastructure remain organized around single-profession care. As a result, clinicians are trained for collaboration but constrained by rules, incentives, and systems that make collaborative practice the exception rather than the norm.

Education systems increasingly promote interprofessional competencies, yet payment, regulation, workforce policy, care pathways, and data infrastructure remain organized around single-profession care.

^a Interprofessional education is defined as structured learning in which students from two or more health professions learn with, from, and about one another to develop competencies for team-based care.

^b Interprofessional practice is defined as the real-world delivery of collaborative care: clinicians from multiple disciplines providing comprehensive services to deliver the highest quality of care across settings.

Without intentional alignment, and often without a local champion across these policy domains, interprofessional efforts remain fragile, grant-dependent, and geographically uneven.

This white paper identifies four interlocking barriers that prevent IPE and IPP from becoming routine practice, with a particular focus on the challenges of integrating oral health:

1. **Professional regulatory frameworks** that reinforce siloed scopes of practice and supervision
2. **Education and training infrastructure** that underprepares learners for real-world team-based care
3. **Payment and delivery systems** that undervalue prevention, coordination, and shared accountability
4. **Data and technology systems** that inhibit interoperability, shared measurement, and evaluation of team-based outcomes

Each of the four barriers identified in this paper has a corresponding policy response: accreditation, licensure, and education reform must prepare clinicians for collaborative care; payment and delivery reform must make that care financially sustainable; workforce and practice reform must allow professionals to use their training fully; and health IT and data reform must make coordination, measurement, and accountability possible.

Although oral health is the central focus of this white paper, the barriers it examines — and the responsibility for overcoming them — extend far beyond oral health alone. This paper is intended as a shared agenda in which every stakeholder can see themselves and identify a meaningful role: educators and accreditors; health professionals and health systems; policymakers and regulators; payers; public health and community-based organizations; technology and data partners; and patients and caregivers. No single profession, institution, or sector can create lasting change independently. Progress depends on these stakeholders working collectively to align education and licensure, payment and delivery, workforce and practice policy, and health IT and data infrastructure — turning interprofessional education into interprofessional practice and advancing access, quality, equity, patient experience, and cost.

This paper advances a set of coordinated policy recommendations that align accreditation, licensure, payment, workforce, and data systems around a shared goal: making interprofessional, whole-person care — including oral health — the default rather than the exception. The recommendations identify actionable levers across federal and state policy, education and accreditation, payment reform, workforce modernization, and health IT infrastructure. Its purpose is not to catalogue every solution but to provide a clear framework for moving from isolated successes to sustainable, system-level change.

Frequently Used Acronyms

Core Framework and Care Models

- IPE — Interprofessional education
- IPP — Interprofessional practice
- IPCE — Interprofessional continuing education
- ACO — Accountable care organization
- APM — Alternative payment model
- FFS — Fee-for-service
- VBC/VBP — Value-based care/value-based payment

Federal Programs, Policies, and Payment Systems

- CMS — Centers for Medicare & Medicaid Services
- CMMI — Center for Medicare & Medicaid Innovation
- HRSA — Health Resources & Services Administration
- ACA — Affordable Care Act
- MA — Medicare Advantage
- MIPS — Merit-Based Incentive Payment System

Access, Workforce, and Equity

- FQHC — Federally Qualified Health Center
- HPSA/DHPSA — (Dental) Health Professional Shortage Area

Accreditation, Education, and Licensure

- IPEC — Interprofessional Education Collaborative
- HPAC — Health Professions Accreditors Collaborative
- CODA — Commission on Dental Accreditation
- ACGME — Accreditation Council for Graduate Medical Education
- NBME — National Board of Medical Examiners
- JCNDE — Joint Commission on National Dental Examinations

Health IT, Data, and Measurement

- EHR — Electronic health record
- HIT — Health information technology
- HIE — Health information exchange
- APCD — All-Payer Claims Database
- ASTP/ONC — Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology
- HL7 — Health Level Seven
- FHIR — Fast Healthcare Interoperability Resources
- CPT — Current Procedural Terminology
- CDT — Current Dental Terminology



PART I

Why This Matters — and Why Now

Medical-Dental Integration

For most of the 20th century, dentistry and medicine developed as parallel but separate professions — separate schools, separate payment systems, separate clinical cultures, and separate conceptions of what it means to care for a whole person. That separation was not inevitable. It was a product of historical, financial, and regulatory decisions that treated the mouth as a distinct anatomical territory rather than as an integrated part of human health. The consequences have been profound and inequitable: Patients with unmanaged periodontal disease and poorly controlled diabetes navigate two separate systems that rarely communicate; pregnant women receive prenatal care with no mention of oral health despite strong evidence associating periodontal disease with preterm birth;¹ children with early childhood caries visit emergency departments because primary care and dental care have no shared accountability for prevention or access to care.

Medical-dental integration is not simply one application of interprofessional practice among many. It is the most structurally challenging, the most inequitably distributed, and the most consequential for the populations this paper is most

concerned with: low-income adults, rural communities, people with chronic disease, and communities of color, all of whom bear a disproportionate burden of both oral disease and the systemic conditions it exacerbates. When this paper calls for interprofessional education and practice reform, oral health integration is not the context for that argument — **it is the argument**. IPE and IPP are the mechanisms. Medical-dental integration is the goal.

The Case for Change

The US health system is undergoing rapid and fundamental change, creating structural openings for the kind of interprofessional, whole-person care this paper is calling for. Several converging shifts define this moment.

The rise of **accountable care organizations (ACOs)** and **value-based care (VBC)** models is driving a shift from siloed, fee-for-service approaches to team-based care focused on population health and equity outcomes. ACOs are groups of clinicians, hospitals, and other health care providers who are organized to provide coordinated high-quality care to a designated group of patients, with incentives tied to improved

outcomes from that care.² Coordinated care seeks to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors. VBC is a health care delivery model in which providers, including hospitals and clinicians, are paid based on patient health outcomes.³ Under VBC agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-informed way. VBC differs from a fee-for-service or capitated approach, in which providers are paid based on the quantity of health care services they deliver. The “value” in VBC is derived from measuring health outcomes against the cost of delivering the outcomes.

Meanwhile, **workforce shortages**, especially in rural and other underserved communities, are making clear that maximizing skills, scope, and collaboration across disciplines is critical to expanding access and continuity.⁴ Interprofessional practice also presents a workforce sustainability opportunity. When care coordination, prevention, and shared accountability are adequately supported, clinicians experience improved role clarity, reduced administrative burden, and greater professional satisfaction — factors that are increasingly critical in the context of burnout and workforce attrition. In 2020, the Health Resources and Service Administration (HRSA) reported that 68.7% (4,504 of 6,559) of dental health professional shortage areas (DHPsAs) were in rural or partially rural locations.⁴ More than 31 million people are affected by the shortage of oral health professionals in these rural areas. About 5,500 dental practitioners would be needed in these areas to remove the DHPsA designations, a level of workforce expansion that is not achievable under current dental education and training capacity. Meanwhile, in urban areas, Hispanic and Black individuals were more likely to live in areas with a shortage of dental care and with barriers to transportation that hinder their ability to seek care outside their neighborhoods.⁵ The workforce shortage will not be solved easily, which is another reason for an approach that trains other nondental clinicians to address oral health in a team-based manner.

While the US health system is undergoing structural changes, oral health is gaining recognition as **integral to whole-person care**, with new clinical and policy momentum toward oral-systemic integration.^{6–8} Health system leaders and policymakers, including the World Health Organization (WHO), increasingly recognize that interprofessional teams are essential to meeting the complex needs of an aging and ever more diverse population.^{9–11} Furthermore, WHPA states that effective interprofessional collaborative practice (ICP) can lead to lower incidence and prevalence of disability, increased job

Absent intentional design, interprofessional integration efforts risk defaulting to medical-centric models that incorporate oral health superficially — if at all — rather than as an equal partner in whole-person care.

satisfaction, improved working environments, more equitable care for marginalized populations, and more efficient and sustainable use of resources.¹²

Despite this momentum, oral health remains unevenly integrated into interprofessional education and practice. Absent intentional design, interprofessional integration efforts risk defaulting to medical-centric models that incorporate oral health superficially — if at all — rather than as an equal partner in whole-person care. Many IPE initiatives and team-based care models proceed without required participation from dental professionals, reinforcing oral health’s historical marginalization within broader delivery system reform.¹³

Current interprofessional education and practice approaches, as presently designed and implemented, risk reinforcing rather than reducing health inequities unless they are intentionally reoriented toward equity goals. Fragmented care delivery, particularly the continued separation of oral health from medical systems, disproportionately burdens rural communities, communities of color, low-income populations, older adults, and individuals with chronic disease, who are more likely to experience coverage gaps, workforce shortages, and reliance on emergency departments for preventable conditions.¹⁴

While IPE is increasingly required by educational programs, its uneven implementation, lack of longitudinal clinical collaboration, and frequent exclusion of dental professionals limit its ability to prepare teams to address the social, geographic, and structural drivers of inequity.¹³ Payment and delivery systems further exacerbate disparities by undervaluing prevention, care coordination, and team-based services,¹⁵ while value-based and accountable care models often exclude oral health, maintaining disparities experienced by marginalized populations.¹⁶

Workforce maldistribution, particularly in rural and underserved areas, further underscores the equity consequences of maintaining single-profession models that fail to maximize collaborative scope and shared accountability.¹⁷ Without aligned policies across education, payment, workforce, and data infrastructure, interprofessional efforts remain fragile, grant-dependent, and unevenly distributed. These limitations constrain the health system's ability to deliver equitable, whole-person care at scale despite growing evidence that integrated, team-based models can reduce disparities and improve outcomes for populations historically left behind.

As the health system shifts toward VBC, accountable models, and whole-person population health, only **policy and regulation** can set consistent expectations across education, payment, workforce, and data systems, ensuring that interprofessional, whole-person care (including oral health) is no longer optional, exceptional, or dependent on local champions but instead becomes the default standard of care capable of advancing equity, sustainability, and system-wide impact. Given the pace of system change and converging pressures — fiscal realities, health disparities, and regulatory reforms, among others — health leaders have an unprecedented opportunity to advance policy that empowers IPE and IPP. By responding swiftly and strategically, stakeholders can create a system where oral health is no longer siloed but instead fully integrated into whole-person, team-based care. This period of flux is a call to action. The right policy decisions now can transform how oral health professionals collaborate across disciplines, setting the stage for a sustainable, equitable, and integrated health system into the future.

Given the pace of system change and converging pressures — fiscal realities, health disparities, and regulatory reforms, among others — health leaders have an unprecedented opportunity to advance policy that empowers IPE and IPP.

Definitions and Scope

Before proceeding further, it is useful to define some key concepts that form the foundational scope of this paper. Four terms anchor this paper, and the distinctions between them matter for policy.

- **Interprofessional education (IPE)** is structured learning in which students from two or more health professions learn with, from, and about one another to develop competencies for team-based care. Critically, this means active joint problem-solving, not parallel instruction within separate curricula.^{11, 18}
- **Interprofessional practice (IPP)** is the real-world delivery of that collaborative care: clinicians from multiple disciplines working with shared accountability for outcomes, supported by aligned payment, regulatory, and data systems. IPP requires more than colocation or referral; it requires genuine role integration, shared information, and reimbursement structures that reward coordination and prevention.^{6–9}
- **Integrated care** is the system-level state in which interprofessional collaboration is embedded within delivery, payment, and accountability structures that make whole-person care the default rather than the exception. It's what episodic IPP looks like when it achieves policy durability.
- Finally, **medical-dental integration** is the specific form of interprofessional practice this paper is designed to advance — the systematic inclusion of oral health in primary care and medical settings through shared clinical workflows, bidirectional coordination, interoperable records, and aligned payment.

These four concepts are not interchangeable. IPE is the training mechanism, IPP is the practice goal, integrated care is the system state, and medical-dental integration is the outcome. Table I.A translates these converging shifts into an initial set of policy domains, actionable opportunities, responsible actors, and proposed implementation windows. The opportunities are developed in Parts I–IV and reorganized by anticipated ease of implementation in the companion guide.

TABLE I.A — The Health System in Transition: Why Now

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Insurance Design and Coverage	Fragmented and uneven coverage — particularly for adult dental care — reinforces silos, delays prevention, and shifts avoidable costs to emergency departments (EDs) and public systems. 69 million US adults lack dental insurance, nearly triple the share without health insurance. ¹⁹	Require dental coverage as a mandatory benefit in Medicare Advantage; align Medicaid managed care contracts to include adult dental benefits; extend ACA Essential Health Benefit (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	Near term: 1–2 years
Care Delivery and Payment Reform	The shift toward accountable care and value-based payment exposes the inefficiency of siloed medical and dental systems — yet most APMs and ACOs still exclude oral health from their contracts, quality measures, and financial incentives.	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	Near term: 1–2 years
Oral-Systemic Integration	Oral health is increasingly recognized as foundational to whole-person health — with strong evidence linking periodontal disease to diabetes, cardiovascular disease, preterm birth, respiratory diseases, and dementia ¹ — but policy frameworks and payment systems have not kept pace with the clinical evidence.	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	Near term: 1–2 years

Timelines are author-recommended implementation windows, not existing statutory or regulatory compliance deadlines unless otherwise noted.

TABLE I.A — The Health System in Transition: Why Now *continued*

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Workforce Policy	Workforce shortages and geographic maldistribution — particularly in rural and underserved communities — make single-profession care models increasingly untenable. 75 million people live in Dental Health Professional Shortage Areas. 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	Midterm: 2–4 years
Equity and Social Drivers of Health	Social drivers of health (SDOH) amplify the consequences of fragmented care. Fragmentation disproportionately burdens rural communities, communities of color, older adults, and low-income populations who already face the greatest access barriers.	Require 1115 waiver pilot 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	Near term: 1–2 years
Education-Practice Alignment	Health system transformation is outpacing how the workforce is educated and prepared for team-based care. Most health profession graduates enter practice without having learned to work across disciplines in shared clinical settings. ¹³	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	Midterm: 2–4 years

Acronyms: **ACA** = Affordable Care Act; **ACO** = accountable care organization; **APCD** = All-Payer Claims Database; **APM** = alternative payment model; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare & Medicaid Innovation; **EHB** = Essential Health Benefits; **FQHC** = federally qualified health center; **HPAC** = Health Professions Accreditors Collaborative; **HRSA** = Health Resources and Services Administration; **IPEC** = Interprofessional Education Collaborative; **IPE** = interprofessional education; **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



PART II

The Cost of Inaction

The Cost of Continued Fragmentation

The US finances and delivers oral health through siloed systems — separate benefits, separate providers, and separate data. The result is a cascade of avoidable costs: emergency department overuse for preventable dental problems; missed prevention that worsens chronic disease; duplicative, low-value services; and widening inequities that ultimately increase public and private spending.

Each year, billions of dollars are spent on avoidable ED visits for preventable oral health conditions, with little definitive treatment and high rates of opioid and antibiotic prescribing for tooth pain and infection.

This section quantifies these costs and sets the stage for our proposed policy agenda: aligning financing, regulation, and training so that IPP can deliver whole-person health more efficiently.

ED Utilization and Medication Harms

The consequences of continued fragmentation are substantial and measurable. Each year, billions of dollars are spent on avoidable emergency department (ED) visits for preventable oral health conditions, with little definitive treatment and high rates of opioid and antibiotic prescribing for tooth pain and infection. Missed opportunities for prevention and chronic disease comanagement, particularly for conditions such as diabetes and cardiovascular disease, drive avoidable medical spending and worsen overall health outcomes. Dental coverage gaps affect more than 70 million adults, shifting costs to patients, employers, and public systems through lost productivity, delayed care, and advanced disease.²⁰ These inefficiencies fall most heavily on rural communities,²¹ communities of color, older adults, and low-income populations,⁶ reinforcing inequities that integrated, team-based care is uniquely positioned to address.¹

Dental conditions account for roughly 1% of all US emergency department visits — in most cases for non-traumatic, preventable problems such as caries and abscesses — and EDs rarely have the trained staff to provide definitive dental care. According to national analyses, approximately \$3.9 billion annually is spent on ED visits for dental conditions, with about one fifth of these visits leading to hospital admission.^{22, 23}

Even more troubling, evidence from claims studies shows the ED response is typically palliative, consisting of analgesics or antibiotics plus a referral rather than definitive treatment, which drives repeat visits and downstream costs. Within seven days of a dental-related ED encounter, roughly 55% of patients fill an antibiotic prescription and 40% fill an opioid prescription. Such patterns can be linked to medication harms, antimicrobial resistance, and persistent opioid use.²⁴

IPP helps overcome these challenges. In an integrated, team-based model, dentists, physicians, nurses, behavioral-health clinicians, and care coordinators prevent these events upstream through urgent-access pathway (same-day care for acute dental needs within an integrated care team), risk-based prevention (care calibrated to individual disease risk rather than population-average protocols), and closed-loop referrals, reducing avoidable utilization normalized by current silos.

Missed Prevention Opportunities and Chronic Disease

For high-risk chronic conditions, fragmentation thwarts opportunities to improve health outcomes and lower medical costs. For example, studies of medical and dental claims data show an association between periodontal treatment and lower subsequent medical costs in adults with diabetes mellitus.^{25, 26} Without aligned payment and shared metrics, however, primary care teams rarely screen for periodontal disease, and dental teams are seldom reimbursed for coordinated diabetes-related care.

Diabetes is but one example. Research also links oral health to other chronic systemic conditions such as cardiovascular disease, respiratory disease, preterm birth and low birth weight, and even Alzheimer's disease and other forms of dementia.²⁷

Coverage Gaps in Medicaid, Medicare, and Commercial Insurance

Persistent insurance gaps and uneven coverage, especially for adult dental care, also reinforce medical-dental silos and perpetuate inequities. There are dramatic differences between Medicaid dental coverage for adults in states such as Nevada, which cover only emergency and very basic dental care, and states such as Massachusetts, which offer extensive dental coverage.^{28, 29} The national insurance heterogeneity and coverage shortages are made worse by health inequities

and social drivers of health disparities. People who live in communities with social deprivation have poorer outcomes, including higher hospital readmission rates, increased cardiac disease risk, and more.^{30–32} Interprofessional practice approaches have been able to address these social drivers of health disparities in a more effective manner than the dominant, siloed system.^{33, 34}

Approximately 69 million US adults, or roughly 26% of the adult population, lack dental insurance — nearly triple the share without health insurance — leading many to delay or forgo care until problems are acute.

Approximately 69 million US adults, or roughly 26% of the adult population, lack dental insurance — nearly triple the share without health insurance — leading many to delay or forgo care until problems are acute.¹⁹ Even among those with dental insurance, high coinsurance after a deductible is met means that many patients may be unable to afford more costly procedures such as root canals or dentures. For older adults, traditional Medicare still excludes routine dental services, and while nearly all Medicare Advantage (MA) plans advertise dental benefits, coverage scope and annual maximums vary widely, leading to unpredictable out-of-pocket spending and underuse.³⁵ CMS now permits Medicare Part A and Part B payment for dental services that are inextricably linked to, and substantially related and integral to, the clinical success of specified Medicare-covered services. Examples include medically necessary dental evaluation and treatment associated with certain organ transplants, cardiac valve procedures, cancer treatment, and dialysis. This pathway is an important advance because it requires documented coordination between medical and dental clinicians, but it is not a general dental benefit and does not cover routine preventive or restorative care unrelated to the covered medical service. Policy should therefore pursue two complementary goals: fully implement and evaluate the current medically necessary pathway, including clear claims and provider-enrollment guidance, and expand the qualifying clinical comprehensive dental coverage in Traditional Medicare and consistent minimum standards in Medicare Advantage.³⁶

Medicaid Heterogeneity

Within the Medicaid system specifically, adult dental coverage varies widely by state.³⁷ Many states have expanded benefits in recent years, but access is constrained by low reimbursement rates to providers and workforce shortages,³⁸ pushing urgent care back into EDs and medical settings.²⁴ Inconsistent benefits across payers make coordinated IPP workflows harder to finance and sustain, especially for populations moving between Medicaid, ACA Marketplace, Medicare Advantage, and employer plans.

The fiscal pressure created by the “One Big Beautiful Bill Act” (P.L. 119–21), signed into law on July 4, 2025, further compounds these challenges. By reducing federal Medicaid matching funds, imposing work requirements, and lowering states’ provider tax safe harbor limits (lowering the amount of taxes collected from dental providers that are available to fund Medicaid), the law creates conditions that will force states to make difficult budget decisions — with adult dental benefits, as an optional Medicaid service, among the most vulnerable to reduction or elimination. For states that have made recent progress expanding dental coverage, this law represents a direct threat to gains that took years to build.

Geography and Workforce

Location is also critical. Rural residents are less likely to have a past-year dental visit and more likely to live in DHPSAs, areas defined by HRSA as geographic regions that lack sufficient dental providers to meet the oral health needs of the community. In 2024, about 75 million people lived in DHPSAs, mostly in rural communities.⁴ Multiple analyses show that rural dentist supply is roughly half that of urban areas,³⁹ a persistent gap that leads to travel burdens, delayed care, more dental disease, and higher costs.

Employer and Productivity Costs

These disparities also drive significant impacts on employment and productivity. About one in five US adults (ages 20–64 years) has at least one untreated cavity, with substantially higher rates among people with low incomes, without insurance, or who smoke.⁴⁰ Untreated oral disease leads to pain and can result in higher medical costs in hospital emergency room and pharmacy claims.⁴¹ National surveys show that adults report more than 243 million hours of lost school and work time annually due to oral pain or unplanned dental visits, or about \$45 billion in lost productivity — an avoidable drag on employers and the economy rarely captured in medical-cost trend analyses.⁴²

Duplication, Low-Value Care, and Unmet Consumer Preferences

Siloed benefits and records pose other problems, too, creating duplicative services such as imaging, repeated intake/triage, and fragmented pain management across medical and dental

settings.^{43,44} Patients bounce between urgent care clinics, EDs, and dental clinics, accumulating fees without receiving definitive treatment. Dental-related ED visits are far more likely than nondental ED visits to result in opioid prescribing,²⁴ even though nonsteroidal anti-inflammatory drugs (NSAIDs) combined with acetaminophen are more effective for typical dental pain⁴⁵ — an emblematic inefficiency with real human costs.

The problem extends to interactions between patients and providers as well, as patients’ preferences for whole-body approaches to health in medicine and dentistry are often ignored. According to a 2022 report from CareQuest Institute, most surveyed consumers noted that their medical provider does not ask about their oral health. Meanwhile, a third of consumers reported that their dental providers do not ask them about their overall health.^{46, 47} The same report notes that most adults would be comfortable receiving health screenings and services in the dental setting. For example, 75% of adults were comfortable with blood pressure screening and 65% with diabetes screening.⁴⁷ Health services are not keeping up with consumer demands, and the public is disappointed with the current system.

Race, Income, and Insurance Coverage

Disparities by race, income, and insurance coverage persist as well. Untreated decay is about twice as common among uninsured working-age adults as among those with private coverage, and markedly higher among Black and Hispanic adults, due to structural barriers.⁴⁰ Fragmentation therefore multiplies costs for communities already facing the steepest access barriers, exacerbating disparities that integrated teams could help close.

Why This Matters for Policy

The costs detailed above are not inevitable; they are by-products of policy architecture that for too long has treated oral health as an optional add-on rather than a core part of whole-person care. Coverage silos, fee-for-service (FFS) incentives, accreditation and licensure misalignment, and noninteroperable records make it hard for clinicians to work as one team — and lead the system to pay for and lead to avoidable ED visits, duplicative services, and advanced disease. Despite this convergence of opportunity and evidence, interprofessional practice has not been scaled, largely due to persistent system-level barriers.

The next section addresses these system-level barriers and suggests policy levers to fix them, consistent with this white paper’s framework to scale IPE and IPP.

TABLE II.A — The Cost of Continued Fragmentation

Cost Domain	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Emergency Department Utilization	Preventable dental conditions generate approximately \$3.9 billion in annual ED spending. ²² EDs rarely provide definitive dental care — the typical response is palliative (analgesics or antibiotics) plus referral, driving repeat visits and downstream costs.	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	Near term: 1–2 years
Medication Harms and Safety	Within seven days of a dental-related ED encounter, roughly 55% of patients fill an antibiotic prescription and 40% fill an opioid prescription ²⁴ — patterns linked to antimicrobial resistance, persistent opioid use, and preventable harm. NSAID-acetaminophen combinations are more effective for typical dental pain and yet are underused. ⁴⁵	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	Near term: 1–2 years
Missed Prevention and Chronic Disease	Without aligned payment and shared metrics, primary care teams rarely screen for periodontal disease, and dental teams are rarely reimbursed for diabetes-coordinated care, despite strong evidence linking periodontal treatment to lower subsequent medical costs in adults with diabetes. ^{25, 26} Research also links oral disease to cardiovascular disease, preterm birth, low birth weight, and dementia. ¹	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	Near term: 1–2 years

TABLE II.A — The Cost of Continued Fragmentation *continued*

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Chronic Disease Comanagement	Care coordination remains unreimbursed and unmeasured across virtually all payer types. No current APM or ACO quality measure set requires documented medical-dental comanagement for shared patients.	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	Midterm: 2–4 years
Medicare Medically Necessary Dental Services	Medicare may pay for dental services inextricably linked to specified covered medical services, but the pathway is narrow, operationally complex, and dependent on documented medical-dental coordination and Medicare-enrolled providers.	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 a 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
Insurance Design and Coverage	69 million US adults — nearly triple the share without health insurance — lack dental insurance. ¹⁹ Traditional Medicare excludes routine dental. Medicare Advantage dental benefits vary widely in scope and annual maximums, producing unpredictable out-of-pocket costs. The OBBA (P.L. 119–21) further threatens Medicaid dental coverage gains by forcing states to make difficult budget trade-offs, with adult dental benefits particularly vulnerable as an optional service.	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	Near term: 1–2 years

TABLE II.A — The Cost of Continued Fragmentation *continued*

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Medicaid Fragmentation	State-by-state variability in adult dental coverage, ranging from emergency-only in some states to comprehensive coverage in others, makes it impossible to build consistent interprofessional workflows at scale. Medicaid dental carve-outs further disrupt care coordination and financing.	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	Midterm: 2–4 years
Employer and Economic Productivity	Adults report more than 243 million hours of lost school and work time annually due to oral pain or unplanned dental visits, translating to approximately \$45 billion in lost productivity ⁴² — a cost rarely captured in employer health plan cost-trend analyses.	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	Midterm: 2–4 years

TABLE II.A — The Cost of Continued Fragmentation *continued*

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Consumer Experience and Low-Value Care	Siloed benefits and records create duplicative services — repeated intake, imaging, and fragmented pain management. Most patients report that their medical provider does not ask about their oral health, and one third of adults say that dental providers do not ask about overall health. 75% of patients report comfort with blood pressure screening in a dental setting and 65% with diabetes screening ^{46, 47} — demand that current delivery systems do not meet.	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	Near term: 1–2 years
Geographic Inequities	75 million people live in DHPSAs, ⁴ mostly in rural communities. Rural dentist supply is roughly half that of urban areas — a persistent gap that drives travel burdens, delayed care, and costlier advanced disease.	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	Midterm: 2–4 years

TABLE II.A — The Cost of Continued Fragmentation *continued*

Policy Domain	Key Insight	Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Racial and Socioeconomic Disparities	Untreated decay is approximately twice as common among uninsured working-age adults as among those with private coverage, and markedly higher among Black and Hispanic adults, due to structural barriers. ⁴⁸ Fragmentation multiplies costs for communities already facing the steepest access barriers.	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	Near term: 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 & Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **ED** = emergency department; **EHB** = Essential Health Benefits; **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; **OBBA** = One Big Beautiful Bill Act; **ONC** = Office of the National Coordinator for Health Information Technology; **PFS** = Physician Fee Schedule; **UDS** = Uniform Data System; **USPSTF** = US Preventive Services Task Force



PART III

Why the System Fails

The Four Systems-Level Barriers

This paper and others have made the case that IPE and IPP are essential to achieving high-quality, equitable, and cost-effective care; however, the systems governing US oral health professions are poorly aligned with these goals. The following barriers reflect systems structured around professional authority and single-discipline accountability rather than patient-centered outcomes:

- Professional regulatory frameworks
- Education and training infrastructure
- Payment and delivery systems
- Data and technology systems

These barriers are particularly apparent in the context of attempts to integrate oral health with medical and behavioral health services, where outdated state statutes, inconsistent accreditation requirements, and limited investment in educational infrastructure are evident. This section examines how regulatory misalignment, education and training infrastructure deficits, payment and delivery limitations, and challenges in data and technology undermine the scalability of IPE, limit readiness for IPP, and impede collaborative care as part of routine care delivery.

Barrier 1: Professional Regulatory Frameworks

Accreditation, Competencies, Assessments, Licensing, and State Practice Acts

Siloed **accreditation systems** across medicine, nursing, dentistry, pharmacy, and other health professions continue to prepare students primarily within their own disciplines, limiting the delivery of whole-person care that includes oral health. While some barriers to IPE, such as misaligned schedules or geographic separation, are practical, a larger challenge is accretor inconsistency. Across professions, IPE is defined and evaluated using different terminology, levels of specificity, and evidence standards, requiring institutions to reconcile divergent requirements rather than implement a unified curriculum.

The Health Professions Accreditors Collaborative (HPAC) issued shared guidance on quality IPE planning, assessment, and institutional support, but adoption and enforcement vary.⁴⁹ Dental, medical, nursing, and pharmacy accreditors each reference collaboration or team-based care, yet differ in structure, expectations, and verification — from broad outcome statements to explicit skills and standards. These differences in scope, language, and evidentiary focus create ongoing friction for institutions operating multischool IPE programs.

Many programs cluster IPE in early didactics or discrete simulations that improve attitudes and role clarity but provide limited exposure to the longitudinal, high-stakes coordination of actual care.

Meeting accreditation checklists, however, do not guarantee graduates can function on real teams. Many programs cluster IPE in early didactics or discrete simulations that improve attitudes and role clarity but provide limited exposure to the longitudinal, high-stakes coordination of actual care (shared decision-making, cross-disciplinary handoffs, conflict resolution, data-sharing workflows). HPAC's guidance explicitly urges deliberate design, performance-based assessment, and linkage to clinical learning environments — guidance that typical IPE implementations underdeliver on practice-ready competence.⁴⁹ National consensus work in nursing similarly emphasizes embedding competencies through experiential placements across community, primary care, and telehealth settings, moving from “learning about” to “learning in/with” teams.⁵⁰ Without longitudinal, practice-anchored assessment and a required level of competence, learners can complete IPE yet remain underprepared for IPP.

Lack of Shared IPE Competencies and Assessments

In addition to inconsistencies across professions in accreditation, licensure, and continuing education, there is a lack of consensus about a **standardized set of oral health competencies**. Built on the foundation of the Integration of Oral Health and Primary Care Practice (IOHPCP) competencies, Haber and colleagues developed the HEENOT (head, ears, eyes, nose, oral cavity, and throat) approach for integrating oral health into the assessment, diagnosis, and management of patients in primary, acute, and long-term care as well as community settings.⁵¹ Based on the findings of their scoping review, Goodell and colleagues developed a comparison of oral health competencies in published and grey literature that were transitioned to a set of seven Entrustable Professional Activities (EPAs) and mapped to ACGME residency requirements and Association of American Medical Colleges (AAMC) EPAs for graduating medical students.⁵² Haber and Cipollina⁵³ reported on a comparable set of OHNEP (Oral Health Nursing Education and Practice) and HEENOT competency EPAs adapted from Goodell and colleagues⁵² that were targeted toward registered nurses, nurse practitioners, and nurse-midwifery providers and mapped onto the HRSA

IOHPCP competencies. Systems-level change that reflects consensus across the professions about oral health as a mandated clinical competency has progressed but remains a challenge.

Key to evaluating the educational value of IPE activities are consistent assessments across professions. Previously, medicine had a clinical skills portion in Part 2 of the United States Medical Licensing Examination (USMLE), and the Osteopathic Clinical Skills Exams (COMLEX-USA) Level 2-PE also had a standardized patient experience. However, these tests are no longer required. Moreover, these elements did not truly assess team-based care. In fact, it would be extremely challenging to evaluate these skills properly on a national level via licensing exams. It may make more sense to assess the skill at a school or program level, requiring deans and program directors to affirm that all students are graduating with proper practical skills. In addition to a statement from schools and programs attesting to acquired skills, the written exams could continue with IPE/IPP questions and try to align them across health fields to ensure that all clinicians can demonstrate understanding of basic elements about high-quality, safe, patient-centered team care.

Students are rational actors who prioritize learning activities that directly enable success on high-stakes assessments. National and state dental board examinations focus almost exclusively on discipline-specific knowledge and clinical technical skills, with minimal or no assessment of interprofessional or collaborative competencies or skills. When IPE activities are perceived as additional to, rather than integrated with, board-relevant learning, students may view them as distractions from core preparation, particularly during intensive board preparation periods. Until licensing and credentialing examinations incorporate interprofessional competency assessment, requiring candidates to demonstrate communication, collaboration, understanding of role clarity, and team-based problem-solving skills, students will perceive IPE as peripheral to professional qualification.

Misalignment of Licensing, Credentialing, and Continuing Education

After graduation, **licensing and credentialing** remain largely profession-specific, with state licensure boards and facility credentialing processes rarely assessing or rewarding team-based competencies. Licensure exams and renewal requirements focus primarily on discipline-specific knowledge, and privileging decisions seldom incorporate interprofessional performance. While proposals such as national licensure standards and competency-based frameworks — most notably EPAs — offer pathways to better alignment, adoption remains limited. Assessing teamwork through licensure

exams is challenging, and only a few professions include interprofessional content in a meaningful way. Nursing and advanced practice nursing exams incorporate questions on teamwork and collaboration, while medical and physician assistant exams reference team-based care more superficially. Overall, written examinations offer limited insight into practical team-based competence, and clearer expectations and more robust assessment methods are needed to ensure that graduates are prepared for interprofessional practice.

Once individuals are engaged in clinical practice, regulatory reinforcement for team-based competence is also thin.

Continuing education (CE) systems remain siloed (e.g., pharmacy vs. medical vs. nursing vs. dental), with limited cross-crediting for interprofessional learning. In response, federal workforce advisors have repeatedly recommended that HRSA Title VII programs prioritize interprofessional competencies and outcomes, encourage clinical learning environments that model team-based care, and align competency frameworks with practice expectations. These recommendations serve as evidence that current licensure/CE/credentialing regimes are not yet pulling in the same direction.^{54–56}

Even when IPE equips learners with collaborative competencies, many state laws governing scope of practice, supervision, and delegation prevent those skills from being fully realized in real-world care.

State Practice Acts Restricting Collaborative Scopes of Practice

Even when IPE equips learners with collaborative competencies, many **state laws governing scope of practice, supervision, and delegation** prevent those skills from being fully realized in real-world care. Practice acts — statutes that define the legal boundaries of professional activity — are among the most influential yet least adaptable determinants of IPP. These laws often restrict comanagement of patients across professions, settings, or billing structures, reinforcing silos even as care delivery evolves.⁵⁷ Innovation frequently outpaces regulation, with team-based models such as teledentistry, mobile care, and colocation operating in legal grey zones. Compounding these challenges, oral health remains largely absent from credentialing requirements in many medical professions, limiting meaningful integration in both education

and practice.⁵⁸

Many practice acts constrain collaboration through geography-based, supervisory, or procedural requirements. Some statutes mandate the physical presence or proximity of a supervising dentist, physician, or pharmacist even when telehealth could enable safe and effective oversight.⁵⁹ Such limitations can be especially detrimental in rural and underserved areas with persistent workforce shortages. Supervisory mandates further reinforce hierarchical models of care. In many states, dental hygienists, advanced practice registered nurses (APRNs), and physician assistants (PAs) must maintain formal collaborative agreements such as written protocols or standing orders to perform services for which they are already trained and credentialed.^{60, 61}

Procedural rigidity compounds these barriers. State boards often rely on task-specific delegation lists or preapproved standing orders that are slow to change as team roles evolve.⁶² As a result, even modest innovations, such as enabling a dental hygienist to apply silver diamine fluoride in a primary care setting, may require statutory or regulatory change, a process that can take years.

Many practice acts were written for single-profession, single-site models of care and are poorly aligned with modern team-based delivery. They frequently restrict comanagement across locations, prescribe narrow supervisory relationships, or omit competencies central to contemporary IPP, such as telehealth triage or cross-disciplinary care in community settings. National consensus reports have repeatedly called for modernizing scope-of-practice laws to allow clinicians to practice to the full extent of their training within team-based models.^{56, 63} Where these statutes remain rigid, IPP adoption slows — even when educational programs successfully prepare graduates for collaborative practice.

Beyond supervision and geography, the structure of practice acts themselves often excludes interprofessional pathways. Most define professional roles in isolation, emphasizing what a single profession may independently diagnose or perform rather than recognizing shared responsibilities or overlapping competencies.⁶⁴

These dynamics play out differently across professions and states. Dental practice acts in many states continue to require direct or indirect supervision of dental hygienists and restrict delegation to dental settings, limiting integration of preventive services into primary care and community environments.⁶⁵ Nurse practice acts vary widely, with some granting full independent authority and others requiring ongoing physician collaboration.⁵⁶ Pharmacists may participate in disease management only through collaborative practice agreements

(CPAs), which exist in all states but differ substantially in terms of scope and oversight requirements.⁶⁶ Such variation persists despite strong evidence that team-based, cross-disciplinary collaboration improves access and outcomes while maintaining patient safety.⁶⁷

The real-world consequences are substantial. States with restrictive practice statutes experience greater workforce maldistribution and slower adoption of innovative care models.

The real-world consequences are substantial. States with restrictive practice statutes experience greater workforce maldistribution and slower adoption of innovative care models. Nurse practitioners in restricted-practice states face limits on prescribing and treatment management, while those in full-practice states in which APRNs are able to practice without physician supervision or collaboration are better positioned to lead interprofessional teams and expand access in rural areas.^{60, 68} Similarly, dental hygienists in states that permit public health supervision or direct access can deliver preventive services in schools, nursing homes, and FQHCs, whereas those in more restrictive states remain confined to traditional dental offices.⁶⁵ Pharmacists in states with broad CPA authority have demonstrated improvements in chronic disease management, while more restrictive states require physician approval for even minor medication adjustments.⁶⁶ This regulatory patchwork means the feasibility of interprofessional practice depends less on evidence or readiness than on geography.

Restrictive state practice acts represent one of the most entrenched structural barriers to interprofessional practice and, in the context of this white paper, effective integration of oral health with medical and behavioral health care. By design, they regulate safety and quality through delineation of roles — but in doing so, they inadvertently entrench professional silos and constrain collaborative care. Regulatory limitations inhibit the use of telehealth and mobile delivery models essential to reaching underserved populations. Supervisory mandates reinforce hierarchy rather than shared accountability, impeding efficiency and role optimization. Procedural rigidity restricts local innovation, delaying adoption of evidence-based models that rely on overlapping competencies.

Barrier 2: Education and Training Infrastructure

IPE builds the knowledge, skills, relationships, and trust required for collaborative care. But competence alone does not produce IPP. Regulation determines whether professionals are permitted to use what they have learned; payment determines whether collaborative work can be sustained; and data systems determine whether teams can coordinate care, measure results, and be held accountable for shared outcomes. When these conditions are aligned, IPE becomes IPP, and IPP can translate into meaningful improvements in access, quality, equity, patient experience, and cost. When they are not aligned, even excellent education prepares clinicians for a system that prevents them from practicing as they were trained.

Clinical Training Is Rarely Colocated or Team-Based

Even when health profession schools adopt IPE in their classroom curricula, the transition to team-based clinical training rarely follows. Medical, nursing, pharmacy, and dental students are educated in physically separate facilities, assigned to distinct patient populations, and governed by different accreditation timelines and clinical hour requirements. These structural conditions make colocated, comanaged clinical training the exception rather than the rule.

The problem is not simply logistical. Clinical training environments reflect and reinforce professional identity. During rotations, students learn not only technical skills but also to whose authority they defer and with whom they are expected to engage as peers. When dental students complete their clinical hours entirely within dental school clinics and medical students rotate through hospital floors without encountering oral health as a clinical concern, the absence of integration during training becomes the default template for practice after graduation. A scoping review of IPE implementation confirmed that structural and cultural features of training environments, including professional hierarchies and the absence of shared clinical spaces, are among the most consistent barriers to effective interprofessional education.⁶⁹

Oral health is particularly marginalized in this arrangement. Unlike medicine, nursing, and pharmacy, which share overlapping clinical environments in hospitals and primary care settings, dentistry operates through a largely separate delivery infrastructure with distinct patient populations, reimbursement systems, and physical facilities. Dental school clinics are rarely colocated with the academic medical centers and primary care training environments where interprofessional habits are formed, and oral health is frequently absent not just from medical students' clinical rotations but from the interprofessional training frameworks that define what team-based care looks like in practice.^{53, 70}

The data are clear. Where colocated and community-based clinical training has been implemented, meaningful gains in collaborative competency and patient outcomes follow. Models such as interprofessional dedicated education units and FQHC-based training sites have demonstrated that shared clinical environments produce graduates who are better prepared for team-based practice.⁷¹ Studies of dental hygiene students in codesigned IPE clinical experiences have similarly shown improvements in interprofessional readiness and collaborative skills.^{72, 73} The challenge is that these models depend on institutional champions, dedicated grant funding, and scheduling flexibility that most health professions programs cannot sustain at scale without structural policy and accreditation support.

Faculty Development in IPE Is Underfunded and Undervalued

The National Center for Interprofessional Practice and Education **notes that IPE centers in the US are small and underfunded, with limited staff and faculty support.**⁷⁴

The lack of consistent funding for IPE in the US is also found globally.⁷⁵ In one global study, only 52% of all responding institutions had an established IPE program.⁷⁵ Failure to place an appropriate value on faculty development in IPE leads to inadequate funding for the training, which results in a vicious cycle. A scoping review confirmed that lack of funding is a major barrier to IPE.⁶⁹ In a survey, clinicians also expressed concerns about insufficient funding, inadequate physical infrastructure, and professional hierarchies, which could interfere with the effective application of IPE.⁷⁶ Finally, mixed-method study groups have identified insufficient funding as a key barrier.⁷⁷ Together, this evidence should leave little doubt about the importance of funding for the development and maintenance of IPE.

Meanwhile, financial investment in clinical IPE has improved monetary and clinical outcomes. In a German study comparing an interprofessional training team in a hospital setting to usual care, an increase in profit per case of \$1,760 (in US dollars) was associated with the interprofessional team.⁷⁸ This program saw a net profit of \$869,440 after one year of the IP team caring for 494 patients, and also resulted in higher retention of graduates staying on as faculty. A US-based study showed that investing in interprofessional teams in hospital educational settings has an annual cost of \$11,390 per resident in training, demonstrating an increased cost educationally and a net revenue gain clinically.⁷⁹

Another example is the dedicated Educational Unit at Massachusetts General Hospital and Massachusetts General Institute for Health Professions.⁷¹ This team has written about their evolution, their results, evidence of the model's scalability and sustainability, and the factors that contributed to their success in overcoming barriers to clinically based IPE.

A central repository for deans and program directors to learn about these successful programs would be helpful. A program that provided funding and asked educational leaders to choose from a list of models would also provide a clear mechanism for next steps for all schools and programs to adopt some successful approach to clinically based IPE that is backed by leadership.

The consequences of underinvestment are especially acute for oral health integration. When dental and primary care programs share no IPE faculty infrastructure or joint simulation resources, oral health is almost always the first discipline dropped from interprofessional experiences — it is the most logistically complex to include and carries the least political weight within medical and nursing school administrations. Studies of codesigned IPE curricula that explicitly include dental students show measurable improvements in medical and nursing students' oral health knowledge, screening confidence, and referral behavior.⁸⁰ But these programs exist because individual champions secured the infrastructure to sustain them. The policy goal must be to make that fight unnecessary by building shared IPE infrastructure into the accreditation and funding frameworks that both dental and nondental programs depend on.

Clinical and educational systems can indeed work together in IPE and IPP programs to provide high-quality care, produce higher profits, and generate committed graduates while also being financially beneficial to both systems.

Clinical and educational systems can indeed work together in IPE and IPP programs to provide high-quality care, produce higher profits, and generate committed graduates while also being financially beneficial to both systems. It will take a concerted effort to educate educational and clinical leaders and bring them together to share in the up-front costs that will ultimately enable them to reap the rewards of the transformation to a different yet more productive clinical learning system.

Few Incentives Exist for Schools and Clinical Sites to Implement Longitudinal IPE

Longitudinal IPE, which is characterized by sustained, scaffolded interprofessional learning experiences across multiple years of professional health care training, represents a fundamentally different educational approach than episodic IPE activities. Research demonstrates that longitudinal models produce superior outcomes in the training and education of dental students. A three-year quantitative evaluation at an Australian dental school documented increasing correlations between shared learning perceptions and positive clinical experiences, indicating cumulative developmental effects that brief interventions cannot achieve.⁸¹ Similarly, a two-year longitudinal IPE curriculum for dental students produced significant positive changes in interprofessional attitudes across two cohorts, with sustained exposure enabling deeper integration of collaborative competencies.⁸²

Longitudinal IPE requires buy-in from leadership, as well as multiyear curricular integration across professional programs with different academic calendars and developmental sequences.

However, implementation of longitudinal IPE demands substantially greater institutional commitment than episodic activities. A single interprofessional simulation exercise or case discussion can be organized with minimal infrastructure, faculty development, and coordination across programs and health professions schools. In contrast, longitudinal IPE requires buy-in from leadership, as well as multiyear curricular integration across professional programs with different academic calendars and developmental sequences. Faculty engagement is key, as is tracking competency development over time.⁶⁹

Compounding the challenge are accreditation standards, which increasingly mandate interprofessional competencies yet create minimal incentives for longitudinal implementation. The Commission on Dental Accreditation (CODA) Standard 2–20 requires that dental graduates demonstrate competency to “communicate and collaborate with other members of the health care team,” but provides no specification regarding duration, intensity, or developmental progression of IPE experiences.⁷³ This ambiguity allows institutions to

satisfy requirements through episodic activities: a single interprofessional case discussion, brief simulation, or one-time collaborative clinic session, for example, rather than comprehensive longitudinal programs. For resource-constrained dental schools facing competing accreditation demands, this ambiguous requirement creates a rational incentive to pursue the least costly path to compliance.⁸³

The oral health consequence of this incentive structure is direct and documented. When CODA's Standard 2–20 can be satisfied by a single interprofessional case discussion, institutions have no structural reason to involve dental students in experiences with medical, nursing, or pharmacy students over time. The result is a dental graduate who has learned about interprofessional competencies but has never practiced them in a real clinical encounter with a nondental colleague — precisely the deficit that produces the fragmented practice patterns this paper is intended to challenge. Longitudinal IPE that explicitly includes dental students in interprofessional training environments has been shown to improve collaborative competency meaningfully,⁸² but without specific accreditation incentives, these experiences remain the exception.

Educational institutions operate within competitive environments requiring justification of resource allocation through demonstrable returns. Longitudinal IPE programs demand substantial investment: dedicated personnel (IPE coordinators, faculty development specialists), physical infrastructure (interprofessional learning spaces, simulation facilities), technological systems (shared assessment platforms, scheduling coordination tools), and faculty time (curriculum development, facilitation, assessment).¹³ These costs are immediate and quantifiable. In contrast, longitudinal IPE benefits are often more diffuse, long-term, and difficult to attribute to institutional competitive advantage. Dental school administrators report difficulty demonstrating institutional returns that would justify reallocating scarce clinic time or faculty effort to longitudinal IPE when those same resources could support clinical productivity, research infrastructure, or specialty program development, producing more immediately tangible institutional benefits.⁸⁴

Barrier 3: Payment and Delivery Systems

Current Payment Models Are Inadequate for Interprofessional Practice

While the ideal goals of health care are undeniably noble — improving health outcomes, enhancing care delivery, reducing costs, advancing health equity, and supporting the well-being of the health care workforce⁸⁵ — the predominant funding mechanism, fee-for-service (FFS), often interferes with the achievement of these aims. This model reimburses providers based on the volume of services delivered, without consideration

for coordination across providers or accountability for cost, outcomes, or equity.⁸⁶ Typically, payers and patients compensate individual providers or organizations for each discrete service or visit, often delivered in isolation, both physically and technologically. For instance, many primary care practices do not communicate with dental practices due to geographic separation and incompatible electronic health record (EHR) systems, perpetuating fragmentation rather than fostering collaboration.

Additionally, the FFS model incentivizes providers to treat disease after it occurs rather than to prevent it altogether. For example, dental practices often generate more revenue from costly restorative procedures performed in-house than from preventive care or collaborative efforts with other health care providers.⁸⁷ This financial structure discourages proactive, coordinated care and reinforces a reactive approach to health. In essence, the FFS model remains fundamentally misaligned with the ultimate goals of health care.

The limitations of the FFS model have prompted the exploration of alternative approaches to improve health outcomes and manage costs more effectively. For more than a decade, both commercial and public payers, including Medicare & Medicaid, have designed and tested a range of **alternative payment models (APMs)**, guided by the Health Care Payment Learning and Action Network.⁸⁸ These models, across both sectors, aim to incentivize providers to deliver high-quality, coordinated care while fostering innovation and driving improvements in health outcomes and cost efficiency.⁸⁹ In dentistry, APMs have primarily centered on bonus payments, supplementing traditional FFS reimbursements, for achieving specific goals, most notably increasing the delivery of preventive care.⁹⁰ These models, known as performance-based incentives, have gained traction due to the relative ease of layering them onto the existing FFS model. Importantly, they also enable payers and providers to build the necessary capacity to transition toward more advanced payment models, in part, by exploring pilot programs and engaging external partners and stakeholders.⁹¹

A notable limitation of performance-based incentives, however, is their tendency to hinder interprofessional collaboration. These models typically reward providers for completing specific clinical procedures rather than for engaging in activities that enhance care coordination, such as communicating with other providers (an issue exacerbated by lack of interoperability of medical and dental electronic records), strengthening administrative support, or improving patient satisfaction. In response to these challenges, the health care system has begun exploring more advanced payment models that allow health care dollars to support a broader range of clinical and nonclinical services, including interprofessional collaboration. These payment models

are often implemented within ACOs, groups of health care providers who are collectively reimbursed for delivering high-quality, coordinated care to patients.⁹² Notably, a small number of ACOs have incorporated dental care into their models.^{93–95} While these models offer a more supportive framework for interprofessional practice, they still face barriers to fully integrating dentistry into both care delivery and payment structures.

Structural Barriers to Interprofessional Practice Payment

One of the most significant barriers to coordinated care in these ACO models is the **lack of interoperability** between EHR systems used by different providers.⁹⁴ Some ACOs have reported that integrating EHRs between medical and dental providers is prohibitively expensive.⁹⁵ Without a seamless way to share health histories, clinical notes, images, and records of completed procedures, it becomes challenging for providers and payers to jointly monitor and manage patients' health. For example, primary care providers in one ACO who refer patients for oral health services emphasized the need for stronger care coordination support, including access to dental providers via telehealth.⁹⁶ While some ACOs have incorporated dental care into their strategies, most still reimburse dental providers through FFS models or FFS combined with performance-based incentives. These approaches do not require dental providers to participate in advanced, accountability-based payment models, so the financial motivation to engage in collaboration is limited.^{96, 97}

Without a seamless way to share health histories, clinical notes, images, and records of completed procedures, it becomes challenging for providers and payers to jointly monitor and manage patients' health.

Medicaid beneficiaries face some of the steepest barriers to accessing care and thus stand to benefit most from interprofessional practice that facilitates simultaneous medical and dental access. However, in most states, Medicaid programs lack structures to support service integration. Many states contract Medicaid programs separately from other service lines, funding managed care plans that do not interact with care coordination or value-based care efforts that occur elsewhere.⁹⁸ Even states that have developed ACOs within their Medicaid programs through Section 1115 waivers generally

maintain dental care as a separate FFS carve-out, which may not increase dental utilization despite benefits in access to medical services.⁹⁹

The persistent FFS system, which **reimburses dental providers for procedures delivered** rather than for holistic care provided, further limits providers from using valuable clinic time for care coordination, patient counseling (e.g., screening for substance use disorder or chronic conditions), or prevention efforts. In addition, with Medicaid reimbursement rates universally lower than private plan rates, providers may be unwilling to deliver preventive care that, even if reimbursed within the Medicaid fee schedule, does not provide sufficient reimbursement to be cost-effective for a practice. Lastly, in 24 states and many state FQHC billing codes, “same-day billing” restrictions prevent reimbursement of billing codes submitted by two separate providers (e.g., a physician and a dentist, or a social worker and a dentist) in the same day.^{100, 101} These restrictions prevent patients from receiving all needed care within one encounter and significantly reduce the usefulness and cost-effectiveness of colocation in interprofessional practice.

Across the country, successful pilot programs and other efforts in individual health systems or clinics have demonstrated the value and the feasibility of integrated care.¹⁰² Yet, without sustainable infrastructure and reimbursement structures, these initiatives rely on substantial stakeholder initiative and are perpetually at risk of being unsustainable. As documented here and elsewhere in the white paper, policy and systemic changes are needed — and are slowly occurring — that support successful IPP and IPE interprofessional practice and education to truly improve care.

Despite the challenges noted above, several noteworthy efforts at clinically and cost-effective medical-dental integration have been made. First, several private payers have invested in large-scale models of medical-dental integration. The Delta Dental SmileWay program provides additional coverage for preventive dental treatment without copayments for patients with chronic medical conditions such as diabetes or chronic kidney disease.¹⁰³ Although this coverage does not require explicit collaboration between medical and dental providers, it acknowledges the value of dental care as a core component of overall health, especially for those at highest risk from chronic illness. Kaiser Permanente Northwest, notably, has integrated nursing staff into their dental clinics to identify “care gaps” (i.e., unmet or uncompleted primary care management, such as influenza vaccination) and found that patients at clinics with this integrated model were more than 1.5 times more likely to have these needs met — an effect that was even larger for patients with unmet social needs, who may stand to benefit the most from integrated care.^{104, 105}

Public payers are also increasingly acknowledging the importance of integrated care, with several notable innovations in reimbursement models. Oregon’s Medicaid ACO model, known as Coordinated Care Organizations (CCO), mandates that dental care be managed by the CCO itself and not through a carve-out contract with a separate dental service provider or FFS system.⁹⁶ Massachusetts requires its Medicaid ACOs to screen all enrolled beneficiaries for unmet oral health needs annually as a quality metric, making the health system directly responsible for ensuring access to oral health care.⁹³ The Medicare program’s novel clarification of policy to provide coverage for dental treatment for patients undergoing select medical treatments also requires dental providers to include both a diagnostic code and documentation of coordination between medical and dental providers for reimbursement;³⁶ updates proposed for 2026 include reimbursement for primary care-based oral health counseling.¹⁰⁶ While promising, the long-term impact of these updates will depend on whether they are paired with durable incentives for cross-disciplinary coordination and mechanisms that meaningfully engage dental providers in interprofessional care delivery.

Additionally, one under-addressed barrier to implementation is provider enrollment. Even when payment pathways exist, many dental providers remain unenrolled in Medicare or Medicaid due to administrative burden, historically limited dental benefits, low reimbursement, and uncertainty about return on investment.¹⁰⁷ As a result, new coverage and integration policies may fail to translate into practice change, particularly in private dental settings that operate outside traditional medical billing systems. Addressing enrollment barriers through streamlined processes, targeted technical assistance, and participation incentives is essential to mobilizing both medical and dental providers as active participants in interprofessional care models.

While the efforts listed above still require clinician and stakeholder awareness and support to succeed, they have the potential to affect thousands of clinicians and millions of patients in a way that can fundamentally change practice. Early implementation experience illustrates both meaningful progress and persistent friction. Although policy clarification has enabled coverage in select clinical scenarios, uptake has been uneven due to documentation complexity, limited provider awareness, enrollment barriers, and uncertainty around medical-dental coordination workflows. These challenges highlight the need for operational guidance and aligned incentives to translate policy intent into routine practice. Ongoing advocacy to expand these efforts across public and private sectors, beyond specific locations and diagnosis categories, presents the opportunity to reach even more Americans in need of high-quality medical and dental care.

TABLE III.A — Payment and Delivery System Fragmentation

Payment and Delivery Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Fee-for-Service Dominance	FFS rewards volume over coordination, prevention, and team-based care. CDT D9992 provides a mechanism to document dental case management and care coordination, but payer coverage and reimbursement are inconsistent. No broadly reimbursed cross-sector mechanism reliably supports bidirectional medical-dental consultation, referral management, shared planning, and closed-loop follow-up as stand-alone services.	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	Near term: 1–2 years
Limited Dental Inclusion in Value-Based Payment Models	Most APMs and ACOs exclude oral health from their contracts, quality measures, and shared savings calculations — making dental providers structurally invisible to accountable care arrangements even when they serve the same patients.	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 Medicare Shared Savings Program.	CMS MSSP final rule amendments; CMMI APM framework rulemaking; CMS Physician Fee Schedule annual quality measure cycle	CMS, CMMI, state Medicaid agencies	Near term: 1–2 years
Performance Incentives ≠ Integration	Bonus-based dental APMs improve prevention within dentistry but rarely require or incentivize collaboration with medical or behavioral health providers. Incentive structures reward individual discipline performance, not joint outcomes across teams.	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	Midterm: 2–4 years

TABLE III.A — Payment and Delivery System Fragmentation *continued*

Payment and Delivery Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Medicaid Dental Carve-Outs	Dental carve-outs in Medicaid managed care create separate financing streams, separate quality reporting, and separate accountability structures — making it structurally impossible to build integrated medical-dental workflows even when colocation or shared staffing exists.	Integrate dental benefits into Medicaid managed care contracts; require dental carve-in as a condition of 1115 waiver approval for medical-dental integration demonstrations; 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	Midterm: 2–4 years
Low and Misaligned Reimbursement	Dental FFS undervalues prevention, counseling, and coordination. Medicaid dental rates are typically 30%–50% below commercial rates, contributing to low provider participation and limited access in the populations most dependent on integrated care.	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	Near term: 1–2 years

TABLE III.A — Payment and Delivery System Fragmentation *continued*

Payment and Delivery Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Provider Enrollment Barriers	Dental providers cannot participate in integrated care models without enrollment pathways designed for their discipline. Most dental providers are not enrolled in Medicare; many face complex dual-enrollment burdens in state Medicaid systems.	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	Near term: 1–2 years
Same-Day Billing Restrictions	Prohibitions on billing for medical and dental services on the same day block colocated, interprofessional encounters — penalizing exactly the care coordination the system should reward.	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	Near term: 1–2 years
Grant-Dependent IPP Models	Many effective IPP initiatives — the Rocky Mountain Collaborative, ¹⁰⁸ Project HAPPEN, ¹⁰⁹ Into the Mouths of Babies ^{110, 111} — depend on short-term grant funding with no pathway to permanent reimbursement. When grants end, models dissolve even when evidence of effectiveness is strong.	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	Midterm: 2–4 years

TABLE III.A — Payment and Delivery System Fragmentation *continued*

Payment and Delivery Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Private Sector Innovation	Kaiser Permanente, Oregon Coordinated Care Organizations, and the New Hampshire Medicaid WIC-dental bundle have demonstrated that medical-dental integration is operationally feasible and financially sustainable at scale. These models are not being systematically replicated.	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 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	Midterm: 2–4 years
Public Payer Momentum	Federal and state Medicaid innovations — e.g., the 2026 PFS recognition of oral health as a MIPS Improvement Activity, Oregon CCO oral health accountability models, and FQHC colocation precedents — demonstrate growing recognition of integration but remain isolated rather than systematically expanded.	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	Midterm: 2–4 years

Acronyms: **ACO** = accountable care organization; **APM** = alternative payment model; **ASTP/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare & Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **CCO** = coordinated care organization; **EHR** = electronic health record; **FFS** = fee for service; **FHIR** = Fast Healthcare Interoperability Resources; **HIT** = health information technology; **HL7** = Health Level Seven; **HRSA** = Health Resources and Services Administration; **IPP** = interprofessional practice; **MCO** = managed care organization; **MIPS** = Merit-Based Incentive Payment System; **MSSP** = Medicare Shared Savings Program; **PFS** = Physician Fee Schedule; **UDS** = Uniform Data System; **WIC** = Women, Infants, and Children program

Barrier 4: Data and Technology Systems

Current Environment and System Barriers to Data and Technology Support for IPP

Technology has become an essential component of modern health care, particularly through the widespread adoption of EHRs for storing health- and care-related information and patient portals enabling individuals to access their own health information. In health care practice, technology plays a vital role in managing health information, enhancing operational efficiency, and facilitating care coordination.^{112, 113} This digital transformation has also led to the generation of vast amounts of digital health data, or information about the health of individuals or populations. Such data are increasingly used to monitor patient health, drive improvements within health care organizations, and inform the development of technology tools.¹¹³ However, the application of health care technology and the use of data vary significantly across health care settings and disciplines. These differences are influenced by factors such as the perceived value and workload of integrating technology and data into clinical practice, and the cost and capabilities of available tools, regulatory requirements, and consumer demand for access to specific health information.^{114, 115}

Coding Siloes and EHR Fragmentation

As noted throughout this paper, historically, health care disciplines such as medicine, dentistry, and behavioral health have operated in silos, which has resulted in development of health information technology systems tailored to the unique needs of each discipline.¹¹⁴ A key difference in technology use lies in coding systems to record, track, and bill for provided services. Medicine primarily uses Current Procedural Terminology (CPT) codes, while dentistry uses Current Dental Terminology (CDT) codes, which rarely employs diagnostic codes that are essential for tracking health diagnoses and outcomes, standardizing information sharing, and supporting accurate billing.^{115, 116} This difference creates “separate languages” across disciplines, necessitating distinct EHR systems that often lack interoperability and the ability to share information. Each discipline also has different operational workflows and documentation needs. Dental records focus on documenting data such as tooth status, periodontal data, and visit and insurance information, while medical records emphasize documenting diagnoses, treatment, and population health.¹¹⁷ These differences in systems needs hinder interoperable record systems and collaboration across care teams.

Technology has become an essential component of modern health care, particularly through the widespread adoption of EHRs for storing health- and care-related information and patient portals enabling individuals to access their own health information.

Standardizing Data Collection and Interoperability

To achieve interoperability between discipline-specific EHR systems, standardized data collection and exchange protocols are essential. In 2021, the first national guidelines for bidirectional data exchange between medical and dental providers were introduced: the Health Level Seven (HL7) and Fast Healthcare Interoperability Resources (FHIR) Implementation Guides.¹¹⁸ These guidelines aim to standardize data models between disciplines and facilitate data sharing and care coordination, but implementation remains challenging. Dentistry’s use of different coding systems than medicine and limited adoption of diagnostic codes complicate data exchanges that ultimately require significant standardization efforts.¹¹⁹ Many dental EHR systems lack the technical capacity to support HL7 and FHIR standards, resulting in manual work for dental providers to coordinate care and complete referrals to other health professionals.¹²⁰ Upgrading to interoperable systems can be cost-prohibitive, especially for small or rural dental practices. Moreover, dental EHR vendors are not required to support HL7 and FHIR standards to achieve federal health IT certification, and most dental-specific systems remain uncertified, leaving little incentive for vendors to prioritize interoperability.¹²⁰ Finally, while there is consumer demand for access to dental record information, patient portal use in dentistry is far more limited than in medicine.⁴⁶

Tracking Quality and Outcomes

The use of different coding systems and electronic records across health disciplines not only hinders communication but also complicates how providers and payers jointly track care quality and patient health outcomes. Organizations like the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) collaborate to develop, test, and evaluate quality measures, yet the number of measures has grown into the thousands over the past decade.^{121, 122} While these measures are well-intentioned, they are often tailored to specific disciplines (e.g., primary care, behavioral health, oral health) or care settings (e.g., hospitals vs. stand-alone medical practices). Additionally, lack of alignment across payer use of measures creates confusion and reporting burdens for providers.^{123, 124} Even with CMS's efforts to establish a core set of measures for widespread, multidisciplinary use, frequent updates and inconsistent implementation continue to pose challenges for both payers and providers, limiting collaboration and evaluation of comprehensive health.^{123, 125}

The use of different coding systems and electronic records across health disciplines not only hinders communication but also complicates how providers and payers jointly track care quality and patient health outcomes.

Data and Technology Policy and Practice Opportunities

Improving exchange of data and common measurement of patient health between health disciplines requires targeted efforts in both practice and policy. Standardizing coding systems and expanding the use of diagnostic codes in dentistry would enable more consistent data sharing and better alignment with broader health care practices. Investments in interoperable dental EHR systems, particularly those that support HL7 and FHIR standards, could reduce manual workflows and enhance care coordination across disciplines. To accelerate adoption, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) should amend the Health IT Certification Program to require HL7 FHIR R4 compliance as a condition of federal certification for dental EHR systems. CMS should establish a Meaningful Use–equivalent incentive program for dental providers participating in Medicaid managed care, using a phased adoption and compliance schedule established through rulemaking. Alongside these federal actions, efforts to align quality measures across disciplines and care settings should reduce reporting burdens and support comprehensive evaluation of patient outcomes. While dentistry has distinct operational needs, it is essential to meet dental providers where they are and foster collaboration across disciplines to develop practical, inclusive solutions that support a harmonized digital health system.

TABLE III.B — Data and Technology Barriers

Data and Technology Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
EHR Fragmentation Across Disciplines	Separate medical, dental, and behavioral health EHRs prevent real-time coordination and shared accountability. Dental EHR vendors are not required to support HL7 FHIR R4 standards, most dental systems remain uncertified, and care coordination between medical and dental providers requires manual workarounds in virtually all settings.	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	Near term: 1–2 years
Coding System Silos	CPT codes in medicine and CDT codes in dentistry, combined with limited adoption of diagnostic coding in dental practice, create incompatible data languages that prevent meaningful data sharing, coordinated billing, and joint quality measurement across disciplines.	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	Midterm: 2–4 years
Lack of Federal HIT Certification for Dental EHRs	Most dental EHRs are not federally certified and are not required to support HL7/FHIR standards, leaving dental EHR vendors with no market incentive to prioritize interoperability. Upgrading to interoperable systems is cost-prohibitive for small, rural, and safety-net dental practices.	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 followed by a phased compliance period; HRSA Rural Health grants; CMS FQHC technical assistance programs	ASTP/ONC, CMS, HRSA, state agencies	Near term: 1–2 years

TABLE III.B — Data and Technology Barriers *continued*

Data and Technology Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Manual and Inefficient Care Coordination	Limited interoperability forces manual referrals, duplicative documentation, and workflow inefficiencies that consume provider time and increase the likelihood of care gaps. Closed-loop referral completion between medical and dental providers is rarely tracked or required.	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	Near term: 1–2 years
Limited Dental Participation in Health Information Exchanges	Dental providers and dental payers participate in state and regional HIE networks at far lower rates than medical providers, leaving critical oral health data outside shared care ecosystems even where HIE infrastructure exists.	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	Midterm: 2–4 years

TABLE III.B — Data and Technology Barriers *continued*

Data and Technology Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
Absence of Shared Outcome Metrics	Quality measures are discipline-specific, with few spanning medical, dental, and behavioral health systems. This makes it impossible to evaluate team-based, whole-person outcomes or to hold integrated care arrangements accountable for the populations they serve.	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	Midterm: 2–4 years
Measurement Overload and Misalignment	Proliferation of unaligned quality measures across payers and settings increases reporting burden for providers without improving care integration. Inconsistent implementation of CMS core measure sets creates confusion and discourages participation in cross-disciplinary accountability arrangements.	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	Midterm: 2–4 years
Limited Patient-Facing Access to Dental Data	Patients have substantially less access to their dental health information than their medical records, limiting engagement, care continuity, and the ability to share information across providers. Patient portal use in dentistry is far more limited than in medicine.	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 be required to 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	Midterm: 2–4 years

TABLE III.B — Data and Technology Barriers *continued*

Data and Technology Barrier	Key Policy Insight	Actionable Policy Opportunity	Named Mechanisms	Primary Policy Actors	Timeline
All-Payer Data Infrastructure Gaps	Fragmented claims data across payers and disciplines prevents system-level analysis of integrated care effectiveness, cost, and equity. Most state All-Payer Claims Databases do not include dental claims, making it impossible to track oral-systemic outcomes at a population level.	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	Midterm: 2–4 years
Data Gaps Limit Evaluation of IPP	Fragmented data systems impede evaluation of IPP effectiveness and return on investment, making it difficult to build the evidence base needed to justify permanent payment reform and scale successful models.	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	Midterm: 2–4 years

Acronyms: **ADA** = American Dental Association; **AHRQ** = Agency for Healthcare Research and Quality; **APCD** = All-Payer Claims Database; **API** = application programming interface; **ASTP/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CDT** = Current Dental Terminology; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare & Medicaid Innovation; **CPT** = Current Procedural Terminology; **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; **HRSA** = Health Resources and Services Administration; **ICD** = International Classification of Diseases; **IPP** = interprofessional practice; **NCQA** = National Committee for Quality Assurance; **NIH/NIDCR** = National Institutes of Health/National Institute of Dental and Craniofacial Research; **SNOMED CT** = Systematized Nomenclature of Medicine — Clinical Terms; **TEFCA** = Trusted Exchange Framework and Common Agreement



PART IV

Unlocking Opportunity — Policy Levers and Systems Solutions

The policy framework that follows is organized around four mutually reinforcing domains: accreditation, licensure, and education; payment and delivery; workforce and practice; and health IT and data infrastructure. State regulatory reform is embedded within Workforce and Practice Reform because practice acts, supervision requirements, delegation authority, credentialing, and scope-of-practice rules determine how the workforce can function at the point of care.

These four domains are designed to be mutually reinforcing: Advancing any one without the others produces incremental gain; advancing all four together produces systemic change.

These domains correspond directly to the four barriers identified in Part III. They should be understood not as separate initiatives but as parts of one system. Education prepares teams to collaborate. Workforce and regulatory policy permit that collaboration. Payment sustains it. Data infrastructure makes it visible, measurable, and accountable. Advancing one domain may produce incremental improvement; aligning all four creates the conditions for durable system change.

Accreditation and licensure reform addresses the regulatory frameworks and education gaps that leave graduates underprepared for real-world team-based care. Payment and delivery reform rewrites the financial incentives that currently reward fragmentation and penalize coordination. Workforce and practice reform modernizes the legal and institutional rules that constrain teams at the point of care. And health information technology and data infrastructure reform creates the shared information environment that interprofessional practice requires to function at scale. These four domains are designed to be mutually reinforcing: Advancing any one without the others produces incremental gain; advancing all four together produces systemic change.

Harmonize Accreditation Standards for IPE

The evidence shows that well-designed IPE can improve learners' knowledge, role clarity, communication, and readiness for collaborative practice, particularly when education is longitudinal, clinically grounded, and assessed through performance. What remains less certain is which model can be implemented consistently across institutions with different resources, clinical environments, and professional programs. The appropriate policy response is therefore to establish clear minimum expectations for interprofessional competence and oral health inclusion while allowing institutions flexibility in how they meet and demonstrate those expectations.

The evidence is clear that interprofessional education, when designed to require students to actively work together across disciplines and not merely learn about each other's professions within separate curricula, produces meaningfully better outcomes for patients, populations, and health systems. That distinction is the core of this paper's argument, and it is the distinction that accreditation reform must make explicit. Changing standards to require IPE is only meaningful if those standards specify that learning must happen through shared, team-based problem-solving rather than parallel instruction. Efforts to solidify IPE across all health professions as a requirement rather than an aspiration must meet and maintain this standard.

Inconsistency: Contrasting Accreditation Language

CODA has clear language in its Accreditation Standards for Dental Education Programs in the section on Practice Management and Health Care Systems.⁷³ Section 2–20 states:

*Graduates **must** be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.*

It goes on to explain the standard's intent:

In attaining competence, students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences, that involve working with other health care professional students and practitioners. Students should have educational experiences in which they coordinate patient care within the health care system relevant to dentistry.

The language here implies a mandate with the word “must.” It is bolded in the document. Furthermore, the intent language explains that this should happen in both the educational and clinical settings. What is not made clear is to which other health professions, or how many, the passage is referring.

Compare the wording of this accreditation standard to that of Family Medicine set by the Accreditation Council for Graduate

Medical Education (ACGME) in the section titled “Curriculum Organization and Resident Experiences,” Section 4.10.d.¹²⁶

Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement.

A general requirement to understand or work with other professions does not ensure inclusion of oral health; standards and implementation guidance must name oral health and a dental profession explicitly, or require an equivalent oral-health-integrated experience when a dental program is not locally available.

The standard is further explained in the next section, 4.10.d.1:

This should include integration of multiple non-physician professionals (e.g., behavioral health specialists, certified nurse midwives, clinical nurse specialists, lab technicians, nurse practitioners, pharmacists, physician assistants) to augment education, as well as interprofessional team clinical services.

This is clearer, in that there is a descriptor that denotes “multiple” nonphysician professionals, and it lists examples. However, in the previous standard (4.10.d), the word “should” is used rather than “must.” And in the list of possible professionals to engage with, the dental field is not mentioned. As stated earlier, it is imperative that the same language that is used for residency accreditation also be used for family medicine licensure — in this case, ACGME and the American Board of Family Medicine must align the specificity of the requirement. If there were universal language and intent for all health professions, then this would be less of an issue.

The Need for Unified IPE Competency Language

The issue is that each health profession is still using its own interpretation of the IPE competencies and placing its own emphasis on certain aspects of the competencies. The IPEC competencies were created for a reason: “to develop a common language through a consensus set of competencies capable of unifying health professionals in the shared pursuit of improving healthcare delivery and health outcomes through interprofessional teamwork.”¹¹

The key words here are “consensus,” “unifying,” and “shared pursuit.” In addition to these clear statements, IPEC is committed to tracking “mandates” and alignments. With the caveats that the health professions and their programs are each unique, there is still room for greater specificity in IPE competency language and intent. For example, all the health professions could use the word “must” to mandate IPE and

remove words like “should.” They could clarify that IPE must include three or more health professions. The consensus guidelines might also require that at least one professional be a dentist, given the strong evidence that oral health influences overall health and well-being. A national survey of 2,245 deans and program directors across 13 nondental primary care professions (e.g., pediatrics, family medicine, physician assistants, nurse practitioners) showed that less than half were including the dental profession as one of the health professions they were engaging with for IPE.¹²⁷ Meanwhile, more than 80% felt that oral health training was important for their health learners.

These efforts outlined in the IPEC recommendations would require a convergence of the major health professional accreditation organizations to harmonize the language and competencies. IPEC has already engaged 22 of these national organizations to create the IPE competencies. Harmonizing the language would be the next logical step.

Recommendation for Accreditation Reform

Oral health must be treated throughout these recommendations not merely as one of many health professions to include but as a clinical exemplar for operationalizing interprofessional collaboration. If accreditation standards, licensing exams, and workforce policies do not explicitly name oral health integration as a requirement, institutions will continue to satisfy the letter of the standard with experiences that exclude dentistry entirely. Every recommendation in this section is written with that explicit mandate in mind.

In pursuit of the goals outlined above, we recommend the following:

- Strengthen and harmonize the language for IPE curricula to include classroom-based education *and* clinical or community-based training.
- Change aspirational language to a clear mandate for IPE across all health professions, replacing “should” with “must” in accreditation standards.
- Clarify language to be certain that IPE includes at least three health professions and that these health professions are not in the same field (e.g., dental hygiene cannot count for those in dental training).
- Add language to stipulate that at least one dental profession (dentist, dental hygienist, dental assistant, dental therapist, dental resident) be one of the health professions that schools and programs must engage with for IPE. When on-site or institutional access to a dental profession is not available, other methods to meaningfully include oral health in IPE should be used,

such as utilizing alternative educational modalities or establishing partnerships with external dental programs or community-based dental providers.

- Designate equity as an explicit accreditation design requirement. IPE experiences must include populations and settings that reflect health disparities, including rural, tribal, FQHC, and safety-net settings. HRSA Title VII funding should condition awards on compliance with this equity-centered standard.

These recommendations underscore a critical distinction reinforced throughout this paper: Interprofessional education is the training mechanism, but interprofessional practice is the goal. The value of IPE is not measured by whether students from different professions sit in the same classroom but by whether graduates can actively collaborate — solving clinical problems together as a functioning team — once they enter practice. Oral health must be explicitly named as a core component of that team experience, not treated as an elective add-on when institutional resources allow.

Without stronger, clearer, and consistently aligned language in the IPE competencies, each health profession (and, consequently, its schools and programs within it) will continue to interpret the mission differently. While progress has been made in IPE over the last two decades, some programs continue to do only the minimum to satisfy the letter of the standard. Harmonizing language and intent is one mechanism to improve the educational outcomes of IPE, diversify the learning, and produce a generation of health professionals that can capably provide comprehensive health care in teams.

Harmonizing language and intent is one mechanism to improve the educational outcomes of IPE, diversify the learning, and produce a generation of health professionals that can capably provide comprehensive health care in teams.

IPEC, working with HPAC and its 22 member organizations, should convene a formal harmonization process targeting completion by 2027. Revised language should be submitted to CODA, Liaison Committee on Medical Education (LCME), ACGME, Commission on Collegiate Nursing Education (CCNE), National League for Nursing Commission for Nursing Education Accreditation (NLN, CNEA), Accreditation Council for Pharmacy Education (ACPE), and Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) for adoption in their next update cycles. HRSA Title VII funding should condition awards on institutional compliance within three years of adoption.

The national bodies responsible for entry-to-practice testing and certification should establish a joint process, coordinated with IPEC, to define minimum IPP and oral health content thresholds. Participants should include the USMLE program, cosponsored by FSMB and NBME; JCNDE for dental examinations; NCSBN for NCLEX; ANCC and AANPCB for nurse practitioner certification; AMCB for certified nurse-midwives and certified midwives; NCCPA for physician assistant certification; and equivalent bodies. State licensing boards should align their requirements with these national standards and pilot performance-based IPP assessment for renewal. Specialty boards should separately incorporate IPP and oral-systemic health into initial and continuing board certification for practicing clinicians.

Accreditation and state licensure are necessary but not sufficient to change expectations for practicing clinicians.

Accreditation and state licensure are necessary but not sufficient to change expectations for practicing clinicians. National specialty certification boards shape initial and continuing board certification, while professional societies and faculty organizations influence continuing education, clinical guidance, faculty development, and adoption within practice communities. Implementation should therefore engage the American Board of Family Medicine, American Board of Pediatrics, American Board of Obstetrics and Gynecology, American Board of Internal Medicine, and relevant national nursing, midwifery, and physician assistant certifying bodies, together with professional and educational organizations

including AAFP, STFM, AAP, ACOG, ACP, SGIM, PAEA, AANP, ACNM, and NAPNAP. These organizations should align certification blueprints, continuing-certification activities, CME/CE, faculty development, and clinical guidance with interprofessional oral health competencies.

Encouraging/Mandating Interprofessional Assessments in Licensing Exams and Licensing Recertification

While harmonizing accreditation standards sets the expectations for what programs must teach, licensure, certification, and CE requirements ultimately determine what professionals are accountable for demonstrating in practice. Currently, most professional licensing boards reinforce single-discipline competence rather than the interprofessional skills essential for modern team-based care. To bridge this critical gap between education and clinical reality, policy must shift the accountability structure for individual clinicians.

1. Integrate IPE Content into Initial Licensing Exams

Current high-stakes licensing exams such as the Integrated National Board Dental Examination (INBDE) and the NCLEX are primarily designed to assess minimum safety and competency within a single profession. This siloed structure fails to validate a core IPEC competency: the ability to recognize, refer, and communicate effectively across disciplinary boundaries at the moment of entry to practice.

The Policy Opportunity:

Licensing bodies should collaborate to develop and integrate interprofessional simulation or case-based assessment modules into existing high-stakes exams.

Assessment Mechanism:

This does not require a separate exam but rather the inclusion of scenario-based questions that evaluate the learner's judgment regarding role recognition and collaborative decision-making. For example, questions could assess the ability of a newly licensed provider to screen a patient for behavioral health issues, recognize when a patient's needs require a different discipline's expertise, and initiate an appropriate response, whether that means a formal referral, a collaborative consultation, or comanaged care with a dental, behavioral health, or pharmacy provider. Tools like the Interprofessional Collaborator Assessment Rubric (ICAR) and similar frameworks already provide psychometrically validated methods for translating these competencies into assessable criteria.¹²⁸

Mechanism for Collaboration:

Since licensing is state-based, this change requires national testing consortia to work together to pilot joint assessment components or develop shared rubrics.

Such collaboration will ensure that IPE standards are maintained regardless of the candidate's specific licensing jurisdiction.

Intended Impact:

Mandating this type of assessment sends an unambiguous signal to health professional education programs that IPE is a required competency for practice, driving curricular compliance beyond mere attendance toward measurable skill attainment.

2. Mandate Interprofessional Continuing Education (CE)

The disciplinary silos created by initial licensure are reinforced by continuing education mandates, which typically require CE hours to be specific to the licensed profession, often neglecting collaboration entirely. This separation inhibits lifelong IPP learning.

The Policy Opportunity:

State licensing boards should amend statutes and rules to designate a portion of required CE hours — say, 10% to 20% — as interprofessional continuing education (IPCE).¹²⁹

Evidence of Value:

Studies show that engagement in IPCE is linked to improved knowledge, attitudes, competence, and performance for health care professionals, with some institutions reporting 12% fewer medical incidents in programs with IPCE components in place.¹²⁹

Furthermore, the Federation of State Medical Boards (FSMB) already recognizes IPCE credit as a valid means of satisfying CME requirements for medical license renewal, establishing a crucial precedent for this cross-disciplinary recognition.

IPCE Requirements:

This mandatory IPCE should require all participating professionals (e.g., dentists, nurses, nurse practitioners, physical therapists, social workers) to learn together in courses planned by and for health care teams. The content must address a shared clinical or system goal, such as pain management, chronic disease prevention and management, or optimizing transitions of care. These aims can be accomplished by integrating the Smiles for Life Curriculum,¹³⁰ as noted throughout this paper.

Administrative Model:

Policy should formally recognize the Joint Accreditation for Interprofessional Continuing Education model, which is administered by multiple national accreditation bodies, such as AANP, ACNM, and NAPNAP. This model allows a single CE activity to grant credit to multiple professions simultaneously, overcoming the massive administrative hurdle of siloed state board approvals. This regulatory

step would actively break down silos among practicing clinicians, creating professional accountability for continuous learning in team environments.

3. Require IPE Assessment for License Recertification

For certain advanced or independent practitioners (such as dental hygienists or dental therapists with public health supervision permits, APRNs in full practice states, and pharmacists with broad collaborative authority), a higher standard of continuous collaborative competence should be enforced at the point of recertification. Traditional written exams often fail to capture the application of knowledge in a complex team setting.

The Policy Opportunity:

States should pilot and scale programs requiring portfolio-based or performance-based IPP assessment for license renewal, especially for providers in autonomous roles. This approach is favored for measuring the application of knowledge and skills in real-world professional settings, particularly at senior career levels.

Mechanism and HIT Integration:

Recertification could involve submitting evidence collected directly from the practice setting. Health information technology (HIT) systems, particularly modern electronic health records (EHRs), should be leveraged to track and report on collaborative indicators such as:

- **Cosigned Care Plans:** Documents requiring cosignatories from two or more professions (e.g., a dentist and a physician)
- **Closed-Loop Referrals:** Automated tracking of internal referrals made to nonpeer providers (e.g., primary care to dental hygienist) to ensure the patient was seen
- **Case Audits:** Submission of documentation detailing the successful coordination, communication, and referral of a patient with complex health care needs with at least two other nonpeer providers

Model Implementation:

Advanced certifications, such as those offered by the Board of Pharmacy Specialties (BPS), are already adopting continuing professional development (CPD) frameworks that require documenting academic, professional, and interprofessional study. These frameworks can be easily adapted by state licensing boards to verify ongoing IPP commitment. Existing resources, such as Smiles for Life, a nationally recognized oral health curriculum for primary care providers, demonstrate that accessible, structured CE tools for medical-dental integration already exist and should be incorporated into IPP CE requirements for nondental providers.¹³⁰

Impact:

By linking continued licensure to proven collaborative performance and ongoing IPCE, licensing bodies can move beyond basic knowledge retention to validate the complex, applied team skills necessary to safely and efficiently manage the chronic and behavioral health issues that characterize 21st-century medicine. This shift holds practitioners accountable for behaviors that demonstrably lead to improved patient outcomes and better system efficiency.

Creating Learning Consortia to Develop Shared Curricula and Metrics

No single national examination can likely fully reproduce the complexity of real-world team-based care. That limitation, however, is not a reason to leave interprofessional competence unassessed. Written and clinical licensure examinations should evaluate the knowledge, judgment, communication, and role clarity required for IPP, while schools and training programs should assess performance where it can be observed directly: through simulations, shared care plans, interprofessional case reviews, observed handoffs, and closed-loop referral activities.

Under this combined model, national examinations would establish a common expectation that collaborative practice is part of professional competence, while educational programs would verify that learners can apply those competencies in practice. Deans and program directors could attest that graduates have met defined performance standards, supported by documented local assessment. This approach creates national accountability without attempting to force the full complexity of team-based care into a single national practical examination.

Consequently, it is essential that mandates are accompanied by means to accomplish the demands made on the schools and programs. A mandate without such resources becomes a burden that is resented. When it comes to IPE, there are already a plethora of resources and goodwill to create even more. It is essential to have places for educators and leaders to go to learn from others and share ideas. A survey of dental deans in the US found that while 96% of dental schools were engaging in IPE, 17% had no mechanism for evaluating the learning, and only 41% carried out robust evaluations of skills.¹³¹ This study also showed that less than 40% were using the IPEC document to inform their IPE efforts. As stated earlier in this section, only a minority of nondental primary care programs and schools are engaging with dental education schools and residencies.

Mobilizing National IPE Consortia

There are currently several national organizations that are engaging the health professions in IPE and others that are addressing oral health education in nondental professions. These organizations could collaborate to create learning consortia and share ideas, best practices, and connections for co-learning.

IPEC could assume a more continuous and active role, offering regular forums and training sessions. Regional groups could meet through the national platform as well. The National Center for Interprofessional Practice and Education (National Center) already has robust offerings, including an annual meeting, a webinar series, and an interactive map showing which programs are engaging in IPE. The next step is to secure full commitment from all health professional schools. More incentives to join and engage are needed. One possibility would be to condition federal education dollars on a commitment to having faculty leads join the effort.

Leveraging Existing Curricular and Training Platforms

The Consortium for Oral Health, a collaboration between the Oral Health Resource Center (OHRC) and the Association of State and Territorial Dental Directors (ASTDD), hosts a monthly Oral Health Café forum. This interactive webinar brings together medical, dental, and public health educators and professionals to share best practices. This is a forum that could be used for sharing IPE curricula and evaluation tools. They also maintain a library of oral health articles, best practices, and updates, and send out a newsletter.

It is essential that mandates are accompanied by means to accomplish the demands made on the schools and programs. A mandate without such resources becomes a burden that is resented.

The National Interprofessional Initiative on Oral Health (NIIOH) is a national leader in growing an interdisciplinary workforce to address the nation's health and oral health needs. NIIOH convenings, tools, and resources activate thousands of educators, health professionals, and national organizations to work together, creating a new standard for oral health care. The Oral Health Nursing Education and Practice program (OHNEP), a core partner of NIIOH, is a national workforce-capacity initiative that equips faculty, preceptors, students, and practicing clinicians to integrate oral health and its links to overall health. Through faculty and preceptor development, curriculum integration, interprofessional simulation and live clinical learning, and establishment of oral health best practices in care settings, OHNEP demonstrates how a national platform can move oral health from an elective topic to a routine component of professional education and practice. Lastly, Smiles for Life is part of this triad of organizations. As mentioned previously in this paper, Smiles for Life is the nation's most comprehensive and widely used oral health curriculum for primary care clinicians. It has been officially endorsed by 23 national organizations¹³⁰ and is in wide use in professional schools and postgraduate training programs. For schools and programs that engage in IPE that pertains to oral health, resources from these organizations will make those efforts easier.

Implementing Regional Networks and Shared Metrics

Certain efforts may be more effective at a more regional or local level. The 100 Million Mouths Campaign (100MMC) is a national effort that trains an oral health education champion in each state to engage with primary care schools and programs to increase quality oral health curricula.¹³² 100MMC is already in 36 states and expanding; state champions are already engaging with hundreds of programs across the country and have trained thousands of learners. It would be logical to leverage this initiative to bring together deans and program directors from dental and nondental educational schools and programs for collaborative training using the educational resources outlined above.

The 2023 IPEC document includes ideas for metrics to track and evaluate systems.¹¹ Various consortia could report out on actual implementation outcomes that can be shared. This will require assistance from other sources, and it would be appropriate for the federal government and HRSA to financially support efforts to coordinate next steps. IPE journals (e.g., *Journal of Interprofessional Education and Practice*, *Journal of Research in Interprofessional Practice and Education*, *Journal of Interprofessional Care*) could also help disseminate IPE with more open-access articles.

Through faculty and preceptor development, curriculum integration, interprofessional simulation and live clinical learning, and establishment of oral health best practices in care settings, the Oral Health Nursing Education and Practice program demonstrates how a national platform can move oral health from an elective topic to a routine component of professional education and practice.

TABLE IV.A — Accreditation, Licensure, and Education Policy

Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Accreditation Standards	IPE requirements exist across health professions accreditation but are inconsistently defined, enforced, and interpreted. Most standards use aspirational language that allows institutions to satisfy requirements through minimal, episodic activities rather than meaningful longitudinal experiences.	HPAC and IPEC should convene a formal harmonization process by 2027; revised mandatory IPE language should be submitted to CODA, LCME, ACGME, CCNE, NLN CNEA, ACPE, and ARC-PA for adoption in their next standard update cycles; HRSA Title VII funding should condition awards 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	Near term: 1–2 years
Inclusion of Oral Health	Oral health integration is optional or omitted in many nondental IPE programs despite strong evidence of oral-systemic connections. When accreditation standards do not explicitly name dentistry as a required IPE partner discipline, institutions consistently satisfy requirements with experiences that exclude dental students entirely.	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; HRSA Title VII awards should condition funding 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	Near term: 1–2 years
Shared IPE Competency Frameworks	Professions apply IPEC competencies unevenly, undermining shared understanding and assessment of interprofessional readiness. Less than 40% of dental schools use the IPEC document to inform their IPE efforts. Accreditors reference IPEC competencies without requiring demonstrable alignment.	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	Near term: 1–2 years

TABLE IV.A — Accreditation, Licensure, and Education Policy *continued*

Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Licensure Exam Content	Initial licensing exams — INBDE, NCLEX, USMLE, NAPLEX — reinforce single-discipline competence and rarely assess interprofessional collaboration. This signals to health profession programs that IPP is educationally optional, regardless of what accreditation standards require.	NBME and JCNDE should establish a joint working group to develop minimum IPP content thresholds in initial licensure exams; integrate interprofessional simulation-based or case-based 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	Near term: 1–2 years
Specialty Certification and Continuing Certification	State licensure establishes legal authority to practice, but specialty boards and national certifying bodies shape the ongoing knowledge, performance improvement, and continuing-certification expectations of practicing clinicians.	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
Continuing Education Requirements	CE requirements perpetuate siloed learning throughout professional careers. Most CE mandates require hours within a licensed profession, with no requirement for interprofessional content. This reinforces the discipline-specific identity formed during training and limits ongoing IPP skill development.	State licensing boards should mandate 10%–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	Near term: 1–2 years

TABLE IV.A — Accreditation, Licensure, and Education Policy *continued*

Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
License Renewal and Recertification	Ongoing collaborative competence is rarely assessed after initial licensure. Once licensed, clinicians are not required to demonstrate IPP skills regardless of how much the evidence base or their practice environment has evolved.	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	Near term: 1–2 years
Learning Consortia and Shared Infrastructure	Schools lack shared venues, platforms, and funding to codevelop curricula, metrics, and evaluation tools. 17% of dental schools conduct no evaluation of IPE learning; only 41% have robust skills evaluation. ¹³¹ Most institutions build IPE infrastructure from scratch rather than building on existing national platforms.	HRSA Title VII should fund regional and national learning consortia through IPEC, NIIOH, OHNEP, 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, OHNEP, National Center for Interprofessional Practice and Education, 100MMC, foundations	Near term: 1–2 years
Resource Enablement	Mandates without resources create institutional resistance, inequitable implementation, and nominal rather than substantive compliance — particularly for under-resourced dental and primary care programs in rural and safety-net settings.	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

TABLE IV.A — Accreditation, Licensure, and Education Policy *continued*

Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
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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; **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

Payment and Delivery

Current payment systems routinely reimburse procedures while overlooking the coordination, prevention, referral management, and shared planning on which interprofessional care depends. Although integrated and value-based models show promise, oral health remains inconsistently represented, and the evidence is not yet sufficient to prescribe one payment model for every population and setting. The proportionate response is to remove known payment barriers, develop credible measures, test integrated models with defined evaluation requirements, and create a pathway for successful approaches to move from temporary demonstrations to permanent reimbursement.

Medicaid and Private Payment Innovation

The fragmentation between medical and dental payment systems presents a clear opportunity to develop more integrated and sustainable approaches to fund interprofessional practice. Interprofessional practice is not synonymous with colocation. Rather, it requires shared accountability, aligned incentives, interoperable data, and intentional workflows that support collaboration across settings. Because payment systems include health care providers, public and commercial payers, and individuals paying out of pocket, it is essential to align policy priorities across these groups. While the limitations of the fee-for-service model have prompted exploration into value-based payment approaches, early iterations, like pay-for-performance, still primarily incentivize discipline-oriented procedures rather than collaboration and improved health outcomes. Therefore, alternative payment models that actively promote interprofessional collaboration in oral health should be explored and evaluated.

Bundled Payments

Bundled payments offer one such model, wherein providers receive a single, comprehensive fee for a range of services related to a specific procedure or condition.¹³³ These models have been piloted by Medicaid, Medicare, and commercial payers for services such as joint replacement and perinatal care. Because these types of care typically involve multiple providers, bundled payments encourage coordination and shared accountability for health outcomes within the constraints of a fixed budget. Evidence has shown that bundled payment models can lead to enhanced collaboration and cost savings across the health care system.¹³³

As bundled payments show a clear pathway for collaboration, including involving specialists, Medicaid agencies and commercial payers should consider them for facilitating interprofessional practice to improve oral health. New

Because payment systems include health care providers, public and commercial payers, and individuals paying out of pocket, it is essential to align policy priorities across these groups.

Hampshire Medicaid offers a compelling model. Under this model, a single fee is paid for dental hygienists to work with medical staff at Women, Infant, and Children (WIC) clinics to deliver a bundle of preventive services, including dental screening, toothbrush dental prophylaxis, fluoride varnish, sealants, interim therapeutic restoration, silver diamine fluoride, and oral health education, to children eligible for Medicaid.⁶⁰

In New York, the Medicaid Total Care for General Population model pays managed care plans and their contracted medical providers to report on pediatric member access to oral health examination.¹³⁴ While the fee rewards medical providers for reporting on dental care access and not for working directly with dental providers, it serves as a starting point for stronger coordination across disciplines, increasing awareness of access, common patients, and collaborative work from which a bundled incentive could be built. Additionally, a framework developed by CareQuest Institute could be used by payers to test bundled payment models to manage periodontal disease within dental settings and coordinate care with medical peers to address coexisting systemic conditions using care coordination, case management, and consultation.¹³⁵

Accountable Payments

Accountability-focused models, such as capitation payments, give payers or providers a single up-front fee (often higher than traditional fee-for-service rates) to manage patients' health and coordinate care across multiple providers over a defined period.¹³⁶ These payments are typically risk-adjusted based on factors such as chronic conditions and social drivers of health. The model promotes accountability by placing financial responsibility on providers: If spending exceeds the fixed fee, providers pay the extra cost, but if spending remains below the fee, they may keep a portion as profit. Capitation models have been piloted by Medicaid, Medicare, and commercial payers, with evidence showing improved care management, reduced unnecessary services, and overall cost savings.

However, research also indicates that these models may lead to providers restricting services for complex or marginalized populations in efforts to control costs.¹³⁶

Capitation models make the health care dollar more flexible because payers go beyond reimbursement for a restricted set of services and support providers who spend dollars addressing social drivers of health and coordinating care. This makes them ideal for IPP to improve oral health. In fact, many ACOs utilize capitation payment models, and a few include dental care. In Oregon, many coordinated care organizations (CCOs) go beyond paying dental providers via a fee-for-service model and are exploring a range of oral health accountable payment strategies. These include withholding portions of existing up-front fee payments from dental providers and delivering them based on performance against measure benchmarks (e.g., dental examinations, sealants), integrating oral health incentives into primary care visits, and total cost of care models that include dental services.⁹⁶ Permanente Dental Associates with the Kaiser Foundation Health Plan operates a capitation model that promotes preventive care, screening, and referrals between medicine and dentistry to address chronic health conditions.⁹⁵ These models demonstrate how payers can drive effective interprofessional practice and lay the groundwork for testing more capitation approaches that pay health care providers flexibly to coordinate care, communicate with one another, provide preventive oral health care, and manage chronic diseases and social drivers of health.

In addition to Medicaid-focused models, there is an opportunity for commercial payers to participate in accountable payment arrangements through Medicare Advantage (MA). While dental coverage is typically offered as an optional add-on benefit in these plans, the separate and often costly premiums result in low uptake and limited coverage, leading to high out-of-pocket expenses for beneficiaries.¹³⁷ Legislators could address this gap by making dental coverage a required benefit within MA plans. Doing so would create a clearer pathway for commercial dental insurers to participate in existing Medicare capitation programs such as the Medicare Shared Savings Program (MSSP) for ACOs and could incentivize dental providers to become integral members of the comprehensive, accountable care team.¹³⁸

Section 1115 waiver demonstrations should be designed with explicit equity metrics requiring participating plans to report dental utilization and outcomes stratified by race, ethnicity, income, and geography. Capitation rates should be risk-adjusted to account for social complexity, ensuring that plans are not financially penalized for serving high-need populations.

Large employers and health care purchasers also represent an underutilized policy lever for advancing medical-dental integration. Through the Pacific Business Group on Health, the Business Group on Health, and state purchasing coalitions, employers can require that health plans integrate dental benefits, include oral health metrics in provider scorecards, and reimburse care coordination between medical and dental providers. Mental health parity advocacy offers a useful model: Organized purchaser demand has meaningfully shaped commercial plan design. A parallel employer coalition focused on oral health integration could accelerate commercial sector change faster than regulatory timelines allow.

Furthermore, the Medicare Merit-Based Incentive Payment System (MIPS), which financially rewards medical providers for quality improvement activities, presents CMS with an opportunity to formally integrate oral health into primary care. By recently recognizing oral health as a quality improvement activity for reimbursement adjustment, MIPS-eligible clinicians are now motivated to take steps such as completing oral health training, routinely conducting oral health risk assessments and intraoral screenings, educating patients on the connection between oral and systemic health, providing counseling on disease prevention, and coordinating care with dental providers.¹³⁹ However, unless oral health activities are elevated from optional quality improvements to meaningful, rewarded components of MIPS scoring, their ability to drive sustained interprofessional practice and provider behavior change may remain limited.

Maximizing Alternative Payments Through Strong Technical Infrastructure

Successful IPP and alternative payment models depend on strong HIT infrastructure, particularly the ability to collect and share relevant patient data across providers and payers. To support this, CMS should consider stronger financial incentives for HIT adoption and data exchange in dentistry.¹¹⁷ These incentives could encourage EHR vendors, payers, and dental providers to pilot solutions that address infrastructure gaps, such as the administrative burden of claim processing, fragmented EHR systems, and lack of dental data available to consumers, by investing in standardized data capture and interoperable platforms that are available to patients. Payers with both medical and dental lines of business are well positioned to lead, as they can leverage integrated medical and dental records to support comprehensive reporting and coordinated care. This enhanced infrastructure would enable payment models that reward interprofessional collaboration by supporting shared data, coordinated care, and accountability-based reimbursement across medical and dental systems.

TABLE IV.B — Payment Innovation

Payment Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Dental Inclusion in APMs and ACOs	Most alternative payment models exclude dental care entirely, limiting accountability for whole-person outcomes and making dental providers structurally invisible to the accountable care arrangements that increasingly govern medical and behavioral health. Without dental inclusion, APMs cannot drive the medical-dental integration this paper recommends.	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 Medicare Shared Savings Program (MSSP); condition CMMI Innovation Award approval on demonstrated dental inclusion plan.	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	Near term: 1–2 years
Bundled Payment Models	Bundled payments incentivize coordination across providers for a defined episode of care but are underused for oral health despite strong evidence from state-level pilots. The New Hampshire Medicaid WIC-dental bundle — which pays a single fee for dental hygienists working with medical staff to deliver preventive services to Medicaid-eligible children — provides a proven replicable model.	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 CareQuest Institute–informed framework 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	Near term: 1–2 years

TABLE IV.B — Payment Innovation *continued*

Payment Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Medicaid Demonstration Authority	Medicaid's 1115 waiver authority provides significant flexibility to test medical-dental integration models, but oral health integration is rarely prioritized in waiver design. Most states have not used this authority to require dental inclusion in managed care accountability structures.	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 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	Near term: 1–2 years
Accountable/Capitated Payments	Capitation payments give payers or providers a single up-front fee to manage patient health across multiple providers — making the health care dollar flexible for prevention, coordination, and addressing social drivers of health. Oregon CCOs, Kaiser Permanente Dental, and select Medicaid MCOs demonstrate that capitated models can include oral health and drive interprofessional accountability.	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, state Medicaid agencies	Near term: 1–2 years

TABLE IV.B — Payment Innovation *continued*

Payment Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Safeguards for Equity	Accountability models may unintentionally discourage care for complex or marginalized populations if capitation rates do not adequately account for social complexity or if reporting requirements do not surface disparities. Without explicit equity guardrails, integrated payment models risk replicating existing inequities at scale.	Require stratified reporting by race, ethnicity, income, and geography in all medical-dental integration demonstrations; mandate risk adjustment in all capitated oral health models to account for social complexity; 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	Near term: 1–2 years
Medicare Dental Services Inextricably Linked to Covered Medicare Care	CMS can pay for medically necessary dental services when they are integral to the clinical success of specified Medicare-covered services. Coverage depends on documented coordination and remains limited to defined clinical circumstances, leaving implementation and access gaps.	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	Near term: 1–2 years and ongoing
Medicare Advantage Dental Coverage	Optional dental benefits in Medicare Advantage (MA) lead to inconsistent access, high out-of-pocket costs, and unpredictable annual maximums. Nearly all MA plans advertise dental benefits, but coverage scope varies widely — producing significant underuse among the Medicare population most in need of oral-systemic integration.	Congress should require meaningful dental coverage as a mandatory MA benefit; integrate dental providers into MA risk-based models and MSSP ACO quality reporting; CMS should establish minimum coverage standards for MA dental benefits to prevent merely nominal compliance.	Congressional action on proposing dental coverage under Traditional Medicare (H.R. 2045 or successor legislation); CMS MA final rule on minimum dental benefit standards; CMS MSSP dental metric requirements	Congress, CMS	Near term: 1–2 years

TABLE IV.B — Payment Innovation *continued*

Payment Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Medicare Quality Programs (MIPS/MSSP)	The 2026 Medicare Physician Fee Schedule recognized oral health as a MIPS Improvement Activity — a meaningful first step. However, improvement activities are optional and unscored. Until oral health integration is elevated to a scored quality measure, its ability to drive sustained provider behavior change and interprofessional practice at scale remains limited.	CMS should elevate oral health integration from MIPS Improvement Activity to a scored quality measure in the 2027 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 the MSSP.	CMS annual PFS rulemaking (2027 cycle); CMS MSSP final rule dental metric requirements; CMMI ACO program design requirements	CMS	Near term: 1–2 years
Enhanced Reimbursement for Team-Based Care	FFS reimbursement significantly undervalues the coordination, counseling, and prevention activities that interprofessional practice requires. Dental Medicaid rates are typically 30% to 50% below commercial rates, contributing to low provider participation and access failures in exactly the populations most dependent on integrated care.	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	Near term: 1–2 years

TABLE IV.B — Payment Innovation *continued*

Payment Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Beyond Grant-Funded IPP	Many of the most effective IPP initiatives — e.g., the Rocky Mountain Collaborative, Project HAPPEN, ¹⁰⁹ Into the Mouths of Babies, OHNEP — depend on short-term grant funding with no pathway to permanent reimbursement. When grants end, models dissolve even when evidence of effectiveness is strong and communities depend on continued access.	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	Midterm: 2–4 years
HIT as Payment Infrastructure	Payment reform depends on shared, reliable data to support accountability, measure outcomes, and calculate risk-adjusted capitation rates. Without interoperable dental EHR systems, even well-designed integrated payment models cannot function — providers cannot document coordination, payers cannot measure outcomes, and accountable care arrangements cannot include dental in shared savings calculations.	CMS and ASTP/ONC should jointly condition enhanced payment rates on adoption of HL7 FHIR-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 on HIT requirements; CMMI Innovation Awards for dental HIT adoption	CMS, ASTP/ONC, payers, Medicaid MCOs	Near term: 1–2 years

Acronyms: **ACO** = accountable care organization; **ADA** = American Dental Association; **AMA** = American Medical Association; **APM** = alternative payment model; **ASTP/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CDT** = Current Dental Terminology; **CMMI** = Center for Medicare & Medicaid Innovation; **CMMI APM** = Centers for Medicare & Medicaid Innovation Alternative Payment Model; **CMS** = Centers for Medicare & Medicaid Services; **CCO** = coordinated care organization; **CPT** = Current Procedural Terminology; **EHR** = electronic health record; **FFS** = fee for service; **FHIR** = Fast Healthcare Interoperability Resources; **FQHC** = federally qualified health center; **HIE** = health information exchange; **HIT** = health information technology; **HL7** = Health Level Seven; **HRSA** = Health Resources and Services Administration; **IPP** = interprofessional practice; **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; **OHNEP** = Oral Health Nursing Education and Practice; **Project HAPPEN** = Hospital Acquired Pneumonia Prevention by Engaging Nurses; **PFS** = Physician Fee Schedule; **UDS** = Uniform Data System; **WIC** = Women, Infants, and Children program

Workforce and Practice Reform

Evidence from direct-access hygiene, dental therapy, teledentistry, community-based care, and other flexible workforce models demonstrates that professionals can safely contribute more fully to team-based care when policy permits them to practice to the extent of their education and competence. The effects of any individual reform will vary with local workforce supply, payment, referral capacity, and implementation support. State practice acts, supervision standards, delegation rules, and credentialing requirements should therefore be modernized alongside clear competency expectations, patient protections, implementation assistance, and ongoing evaluation.

Advancing interprofessional practice also requires the dental profession to examine its own structural barriers to collaboration. Dental education has historically emphasized technical skill within a single-discipline model, often producing graduates who are competent clinicians but underprepared for team-based workflows. Dental professional associations, dental schools, and the CODA can all play roles in normalizing collaborative practice, investing in IPE faculty, and advocating for scope changes that enable allied dental professionals — dental hygienists, dental therapists, and dental assistants — to function as active members of interprofessional care teams rather than as subordinates to a single supervising dentist. Policy change is more durable when the profession being integrated actively champions its own reform.

Workforce capacity is not only a question of statutory scope. It also depends on whether faculty, preceptors, and practicing clinicians have the competencies, teaching resources, implementation support, and clinical models needed to make oral health part of team-based care. National initiatives such as OHNEP, NIOH, Smiles for Life, and the 100 Million Mouths Campaign provide tested infrastructure that policy can support and scale rather than requiring every institution to build from scratch.

Workforce policy is one of the most powerful — and often overlooked — levers for advancing interprofessional practice. Even when education, payment, and data systems begin to align, outdated workforce rules can still prevent clinicians from working together in meaningful ways. Scope-of-practice laws, supervision requirements, credentialing processes, and practice acts continue to reflect a health system designed for single-profession care rather than the team-based reality of modern practice.

These barriers are not abstract. They shape what kinds of care can actually happen in clinics, community settings, and safety-net systems every day. In rural and underserved

Workforce policy is one of the most powerful — and often overlooked — levers for advancing interprofessional practice.

communities especially, rigid workforce rules limit flexibility, constrain access, and make it harder for teams to respond to real patient needs. If IPP is to move beyond pilots and pockets of innovation, workforce and practice policy must be updated to reflect how care is delivered now — and how it must be delivered in the future.

Modernizing Scope of Practice for Team-Based Care

Many state scope-of-practice statutes were written decades ago, long before teledentistry, community-based prevention, or integrated primary care models were commonplace. As a result, clinicians are often restricted from practicing to the full extent of their training, even when there is strong evidence supporting safe and effective collaboration.

Oral health professionals — dentists, dental hygienists, dental therapists, and dental assistants — bring specific, often-underutilized competencies to interprofessional teams: identification of oral-systemic disease connections, early detection of conditions such as diabetes and hypertension through oral assessment, and prevention counseling that complements medical care. Workforce and scope-of-practice policy must be designed to recognize and activate these contributions.

Modernization efforts should therefore focus on expanding permissible scopes of practice to support preventive services, care coordination, and community-based delivery — particularly when these services are provided as part of an interprofessional team. Supervision requirements also warrant reconsideration. Geographic or colocation mandates, while historically rooted in safety concerns, frequently create unnecessary barriers in settings where virtual consultation and team-based oversight are both feasible and effective. Updating these requirements to allow competency-based, team-oriented supervision would significantly expand access while preserving accountability.

The variation in dental hygienist scope of practice across states deserves particular attention. In some states, dental hygienists can provide preventive and educational services under general supervision or with direct access authority; in others, they are limited to working under the direct supervision

of a dentist. This inconsistency directly limits the extent to which dental hygienists, who are ideally positioned as frontline oral health collaborators in primary care, schools, and community settings, can function as full interprofessional team members. Modernizing scope-of-practice rules should specifically address dental hygiene authority as a workforce equity and access issue, not just a regulatory formality.

This patchwork of state authority is not merely an inconvenience for individual practitioners. It is one of the primary structural reasons why interprofessional care models that succeed in states with permissive dental hygiene practice acts cannot be replicated at scale nationally. This is why federal policy levers, including HRSA Title VII compliance conditions, are essential to driving convergence rather than waiting for state-by-state reform to happen organically.

Dental therapy represents one of the most significant oral health workforce innovations of the past decade. Dental therapists are CODA-accredited, mid-level oral health providers who work under dentist supervision to provide routine restorative and preventive services in settings and communities where dentists are scarce. As of 2024, 14 states have authorized dental therapists to practice, with evidence from Alaska, Minnesota, and other early-adopting states demonstrating improved access, comparable quality of care, and particular effectiveness in reaching rural, tribal, and low-income populations.¹⁴⁰ A 2022 report from HRSA's Advisory Committee on Training in Primary Care Medicine and Dentistry explicitly recommended expanding dental therapy through Title VII training programs as a strategy for equitable workforce development, a recommendation that aligns directly with this paper's call for HRSA Title VII compliance conditions in health professions education.¹⁴¹ States modernizing scope-of-practice frameworks should explicitly include dental therapy authorization as part of that effort. Similarly, minimally invasive care strategies, including silver diamine fluoride (SDF) application, atraumatic restorative treatment, and caries risk-based protocols, expand the services that allied oral health professionals can provide and should be embedded in IPE competency frameworks as standard tools for community-based team care.

Teledentistry offers another example of team-based care. When explicitly authorized and appropriately regulated, it can support consultation, triage, referral, and comanagement across settings.¹⁴² Yet in many states, its use remains constrained by outdated statutory language. Clarifying and codifying teledentistry as a standard tool for interprofessional care would unlock collaboration that is already technologically possible but legally uncertain.

Reducing Friction in Credentialing and Privileging

Even when scope-of-practice laws allow collaboration, credentialing and privileging processes can quietly undermine it. Integrated care environments such as FQHCs, ACOs, hospital-based clinics, and community health systems often require clinicians to navigate duplicative, profession-specific credentialing pathways that were never designed for shared care models.

These processes tend to focus narrowly on individual credentials rather than on how clinicians function as part of a team. Recognizing interprofessional competencies, shared workflows, and collaborative responsibilities within credentialing frameworks can significantly reduce administrative burden and accelerate the deployment of team-based care in integrated settings. Privileging standards — set by professional associations, certification organizations, health system credentialing committees, and state licensing boards — should also explicitly authorize activities such as comanagement, shared care planning, and cross-disciplinary referral rather than treating them as informal or exceptional practices.

Updating Practice Acts to Reflect How Care Is Delivered

Practice acts remain one of the most consequential — and least flexible — policy determinants of IPP. When statutes define professional roles in isolation, they reinforce silos even as education and payment systems push toward integration. Collaboration becomes something that requires workarounds, waivers, or pilot status rather than an expected mode of practice.

Updating practice acts to better reflect team-based care does not mean abandoning professional standards or patient safety. Rather, it means incorporating permissive language that enables delegation, collaboration, and shared accountability where appropriate. This is especially important in safety-net and rural settings, where rigid role definitions can make it impossible to assemble teams capable of meeting community needs.

Viewed together, workforce and practice reforms provide the legal and operational foundation for IPP to function as intended. Without these changes, investments in education, payment reform, and data infrastructure will continue to run up against structural limits at the point of care. With them, interprofessional practice can move from exception to expectation, supporting access, quality, and sustainability across the health system.

TABLE IV.C — Workforce and Practice Reform

Workforce Policy Lever	Core Issue Addressed	Actionable Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Scope-of-Practice Laws	Outdated scope definitions — written decades before teledentistry, community-based prevention, and integrated primary care models existed — limit dental hygienists, dental therapists, and allied dental professionals from collaborating and delivering preventive, community-based care to the full extent of their training.	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	Near term: 1–2 years
Dental Hygienist State-to-State Variation	The variation in dental hygienist scope of practice across states, ranging from direct access authority in some states to mandatory on-site dentist supervision in others, directly limits the extent to which dental hygienists can function as full interprofessional team members. This patchwork is one of the primary structural reasons why IPP models that succeed in permissive states cannot be replicated nationally. Federal policy levers are essential to driving convergence rather than waiting for state-by-state reform to happen organically.	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	Midterm: 2–4 years

TABLE IV.C — Workforce and Practice Reform *continued*

Workforce Policy Lever	Core Issue Addressed	Actionable Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Supervision Requirements	Rigid geographic and colocation supervision mandates requiring a dentist to be physically present or on-site constrain care delivery in rural and safety-net settings where assembling a traditional supervision arrangement is operationally impossible. These requirements were designed for a single-profession model and have not been updated to reflect team-based, virtual, or community-based care realities.	States should shift from location-based to competency-based supervision models; update dental practice acts to allow general supervision and telehealth-based oversight in Dental Health Professional Shortage Areas; 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	Near term: 1–2 years
Teledentistry Authorization	Legal ambiguity in most states limits use of virtual tools for consultation, triage, comanagement, and referral — even though the technology is available and has demonstrated effectiveness in Alaska, Oregon, and Minnesota. Teledentistry remains constrained by outdated originating-site restrictions and unclear reimbursement pathways in most Medicaid programs.	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	Near term: 1–2 years

TABLE IV.C — Workforce and Practice Reform *continued*

Workforce Policy Lever	Core Issue Addressed	Actionable Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Community-Based Oral Health Models	Preventive oral health services remain overwhelmingly tied to traditional dental office settings — a structural mismatch with the community, school, primary care, and long-term care environments where the patients most in need of integrated oral health care actually are.	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 legislatures, HRSA, FQHC programs, school-based health center networks, state health departments	Near term: 1–2 years
Credentialing in Integrated Settings	Duplicative, profession-specific credentialing pathways in FQHCs, ACOs, hospital-based clinics, and community health systems were never designed for shared care models. They slow team deployment, create administrative burden, and effectively exclude dental providers from integrated care arrangements that require medical staff credentialing.	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	Near term: 1–2 years

TABLE IV.C — Workforce and Practice Reform *continued*

Workforce Policy Lever	Core Issue Addressed	Actionable Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Privileging Standards	Collaborative activities — comanagement, shared care planning, cross-disciplinary referral, and interprofessional consultation — are frequently excluded from formal privileging criteria, meaning that even when scope-of-practice laws permit these activities, health system credentialing committees treat them as informal or exceptional rather than standard practice.	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	Near term: 1–2 years
Practice Act Modernization	Practice acts represent the most consequential and least flexible policy determinant of IPP. When statutes define professional roles in isolation — without permissive language for delegation, collaboration, or shared accountability — they reinforce silos even as education and payment systems push toward integration. Rigid role definitions make collaboration a workaround rather than an expected mode of practice.	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	Near term: 1–2 years

TABLE IV.C — Workforce and Practice Reform *continued*

Workforce Policy Lever	Core Issue Addressed	Actionable Policy Opportunity	Named Mechanisms	Primary Actors	Timeline
Safety-Net and Rural Focus	Workforce rigidity disproportionately affects rural and safety-net communities, where team-based flexibility is most needed and single-profession care models are least sustainable. Rural dentist supply is roughly half that of urban areas, and 75 million people live in Dental Health Professional Shortage Areas. ⁴ Scope restrictions that are merely inconvenient in well-resourced urban settings become absolute access barriers in rural and frontier communities.	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 OBBBA Rural Health Transformation Program	Policymakers, HRSA, state health departments, rural health organizations	Ongoing
Alignment with Payment and Data Reform	Workforce reform in isolation fails to translate into sustainable IPP. Scope-of-practice changes mean little without reimbursement authority for newly authorized services. Credentialing reforms are undermined if EHR systems do not support shared documentation. Practice act modernization is insufficient if payment models do not reimburse the team-based activities that updated scopes permit.	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/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CMS** = Centers for Medicare & Medicaid Services; **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; **MSSP** = Medicare Shared Savings Program; **NHSC** = National Health Service Corps; **OBBBA** = One Big Beautiful Bill Act; **SBHC** = school-based health center

Health IT and Interprofessional Data Infrastructure

Interprofessional practice cannot function reliably when medical and dental teams cannot exchange information, complete referrals, or measure shared outcomes. The need for interoperability is clear, but dental adoption remains uneven, implementation costs are significant, and the return on investment is not distributed equally across providers and payers. Federal certification policy, targeted adoption incentives, common data standards, and shared outcome measures represent a proportionate response, provided that implementation support prioritizes small, rural, community-based, and safety-net practices that might otherwise be left behind.

As technology becomes increasingly vital across all disciplines of health care practice, it is essential for care teams to leverage digital tools and health data collaboratively to support patients in achieving optimal health outcomes. Several opportunities exist to advance this goal, including establishing aligned data standards across disciplines, particularly for oral health, and investing in interoperable EHR systems through regulatory, technical, and economic initiatives. With progress on these infrastructure improvements, the development, testing, and reimbursement of shared metrics for interprofessional practice and overall patient health represent a significant opportunity for progress of sustainable interprofessional practice.

Data Standardization

Effective communication across health disciplines depends on the ability to share health information seamlessly, which requires alignment in the “languages” used by each field. However, establishing consensus among dental professionals on the clinical care elements and health information that should be consistently documented in electronic records remains a work in progress.¹⁴³ Recent guidance from organizations such as the ADA and a national task force is helping advance this effort by encouraging the adoption of diagnostic standards like SNOMED CT and ICD codes across dentistry and other health disciplines.¹²⁰ These coding systems enable consistent terminology across electronic records, allowing providers to share standardized health indicators while using their respective record platforms and meeting their distinct discipline needs.

One organization leading the way in implementing diagnostic standards is Apple Tree Dental, which serves children, adults, and older adults who face barriers to care, including individuals with disabilities. By integrating ICD codes with treatment and demographic data, Apple Tree Dental can better understand and communicate patient information across providers and care settings while also evaluating how their services affect patient health outcomes.¹⁴⁴ As guidance to standardize health

information evolves, it will be equally important for these and other organizations who implement them to share best practices for effective and scalable implementation.

Investing in Interoperable EHR Systems

Developing and implementing interoperable EHRs requires not only the commitment of health care teams but also significant investment from, and collaboration with, government regulators and electronic record vendors. The ADA has contributed to this effort by defining dental-specific data elements within national guidelines for bidirectional data exchange using Health Level Seven (HL7) and Fast Healthcare Interoperability Resources (FHIR).¹⁴⁵ It has also provided guidance on standards for storing and exchanging digital radiography images through Digital Imaging and Communication in Medicine (DICOM), which is intended to support interoperability across the health care industry.¹⁴⁵ However, for these standards to be effectively implemented, they must be actively promoted by regulatory bodies such as the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) as a part of HIT certification programs and adopted by vendors who develop electronic record systems. Without such broader support, even well-defined standards risk remaining theoretical rather than practical tools for improving care coordination and data exchange.

Health Information Exchange Organizations

Health information exchange (HIE) organizations likewise play a critical role in facilitating the secure sharing of health data among providers, payers, and patients. These organizations enable stakeholders to connect their electronic systems to a common platform, allowing access to shared information and helping build a more comprehensive view of an individual's health and the services they've received.¹⁴⁶ HIE networks have contributed to improved data accessibility, enhanced public health monitoring, and greater care efficiency at regional and state levels — and, more recently, nationally, through initiatives like the Trusted Exchange Framework and Common Agreement (TEFCA) led by the US Department of Health and Human Services.^{147, 148} Despite these advancements, participation by dental electronic record vendors and dental providers in HIE networks remains limited. Technical barriers and the financial investment required to join these exchanges have hindered involvement, even in states where legislation mandates dental provider participation.¹¹⁷ Without the inclusion of dental providers and dental payers, critical health information remains inaccessible, limiting the full potential of integrated health data systems.

State and regional HIE organizations can incentivize participation from dental providers and payers through financial subsidies or technical assistance for participation.

One example is Contexture, a regional HIE organization that invites health providers and payers to connect and share data, which has successfully engaged multiple dental providers and payers across Arizona and Colorado.¹⁴⁹ Similarly, states could establish an All-Payer Claims Database, as Colorado did through regulatory action. This approach has enabled the state to aggregate Medicaid, Medicare, and commercial claims data across multiple health disciplines, including dentistry.¹⁵⁰ With this robust data infrastructure, Colorado stakeholders have been able to better understand health care utilization, total costs, care quality, and health outcomes across health disciplines and patient populations. A state mandate for dental provider participation in state and regional health information exchange networks is a strategy worth exploring. For example, North Carolina legally requires that all dentists receiving state funds for care provide basic patient clinical and demographic information to the state-designated HIE.¹¹¹ However, state and federal regulators must also provide financial incentives for adoption.

Federal Incentive Programs

While noble in intent, federal incentive programs to promote health information exchange have a mixed track record and can certainly be improved. Historically, federal incentive programs aimed at promoting adoption of certified HIT by health care providers have excluded key care settings and disciplines, such as skilled nursing facilities, psychiatric facilities, and even dental practices.¹⁴⁷ Future incentive structures from CMS should take a more inclusive approach, ensuring that all members of the care team are supported in adopting interoperable health IT solutions, as evidence shows that the majority of dental providers surveyed were unfamiliar with national health information exchange efforts or incentives for EHR adoption.¹⁵¹ Additionally, ONC/ASTM should consider integrating dental-specific criteria into their voluntary certification programs for HIT vendors. Doing so would encourage vendors to incorporate standardized dental components into their software, making them eligible for federal certification and better positioned to support integrated care.

Finally, while the use of artificial intelligence (AI) in dentistry is rapidly expanding, it should be viewed as a strategic tool to strengthen a health care system that integrates oral and systemic health.¹⁵² AI can support technical integration by enabling dental providers and payers to leverage application programming interfaces (APIs) to participate more effectively and automatically in HIE networks, facilitating streamlined data sharing with reduced administrative burden. Future work may elaborate on ways in which AI can facilitate and even replace health records as they currently exist.

Shared Metrics and Monitoring for IPP

Advancements in data and technology infrastructure will increasingly enable interprofessional care teams to leverage shared measures and reimbursement models that support whole-person care and improved health outcomes. Research shows that physicians value a standardized measure of oral health;¹⁵³ however, most existing measures are discipline-specific, with few spanning medical, dental, and public health systems.¹⁴⁷ By streamlining the most essential oral and general health services and indicators, it becomes easier for diverse health disciplines to collaboratively assess and improve care and outcomes.

One noteworthy example that others can learn from is the Marshfield Clinic, one of the largest integrated health systems in the US. Operating in Wisconsin and Michigan, their system features an interoperable health record infrastructure that connects medical and dental disciplines, enabling providers to collaboratively prevent and manage conditions like oral health and diabetes.⁵⁸ Their shared EHR system facilitates electronic data exchange and cross-disciplinary health risk assessment in support of a unified approach to measuring whole-person health. By gaining a comprehensive understanding of their patient population, the Marshfield Clinic has been able to deliver better-tailored preventive care and successfully participate in value-based payment models.⁵⁸ While it is not feasible for every medical or dental practice to implement an integrated EHR, this example highlights the value of collaboratively measuring patient health and care delivery; it can serve as a guiding vision for electronic record vendors, providers, and regulators to work toward.

The FDI World Dental Federation recommends that measurement align with a core set of indicators, including data on dental health (such as periodontal disease, oral cancer, caries, and endodontic health), medical health and diagnoses (including behavioral health), medical devices and implants, prescriptions, and diagnostic imaging.¹¹⁹ Electronic health record vendors should consider how to integrate these indicators into their platforms. At the same time, regulators such as CMS and Congress can support adoption by offering financial incentives (e.g., grants, tax breaks) and aligning national measure sets (such as HEDIS and UDS) with core indicators. A streamlined set of measures would empower payers to design reimbursement models that incentivize a consistent set of services and health outcomes, fostering interprofessional collaboration and whole-person care. It would also enhance the ability to monitor overall health system performance. Finally, it would provide patients with a clearer understanding of their health status and how their providers work together to support their well-being.

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Interoperable EHR Investment	Interprofessional care cannot scale without interoperable medical, dental, and behavioral health records. Dental EHR vendors are not required to support HL7 FHIR R4 standards, most dental systems remain uncertified, and care coordination between medical and dental providers requires manual workarounds in virtually all settings, creating administrative burden that makes IPP operationally unsustainable at scale.	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	Near term: 1–2 years
Dental Inclusion in HIT Certification	Dental EHR vendors are largely excluded from federal HIT certification and incentive programs — the primary market drivers that have produced interoperable EHR adoption across medicine and nursing. Without certification requirements and financial incentives, dental EHR vendors have no market incentive to prioritize interoperability, and dental providers have no financial support for upgrading to interoperable systems.	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 of 2029; pair certification requirements with financial incentives for small, rural, and safety-net dental practices that face cost barriers to adoption.	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	Near term: 1–2 years

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever *continued*

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Data Standards and Coding Alignment	CPT codes in medicine and CDT codes in dentistry, combined with limited adoption of diagnostic coding in dental practice, create incompatible data languages that prevent meaningful data sharing, coordinated billing, and joint quality measurement. Most dental EHR systems do not use ICD diagnostic codes, making it impossible to link oral health data to systemic disease management in shared records or population health platforms.	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	Midterm: 2–4 years
Health Information Exchange Participation	Dental providers and dental payers participate in state and regional HIE networks at far lower rates than medical providers, leaving critical oral health data outside shared care ecosystems even where HIE infrastructure exists. Technical barriers and the financial investment required to join HIEs have prevented dental participation even in states where legislation mandates it.	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	Midterm: 2–4 years

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever *continued*

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
All-Payer Claims Database Expansion	Fragmented claims data across payers and disciplines prevents system-level analysis of integrated care effectiveness, cost, and equity. Most state All-Payer Claims Databases do not include dental claims, making it impossible to track oral-systemic outcomes, evaluate medical-dental integration pilots, and identify disparities at a population level. Colorado's APCD, established through regulatory action and including dental claims, provides the replicable model.	Expand All-Payer Claims Databases 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; 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	Midterm: 2–4 years
Shared IPP Outcome Metrics	Discipline-specific quality measures make it impossible to evaluate team-based, whole-person outcomes or to hold integrated care arrangements accountable for the populations they serve. Most existing measures are designed for single-discipline reporting — few span medical, dental, and behavioral health systems. The Marshfield Clinic model, which features an interoperable record connecting medical and dental disciplines and enabling shared chronic disease management, demonstrates what shared metrics can enable at the health system level. ⁵⁸	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	Midterm: 2–4 years

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever *continued*

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Measurement Harmonization and Burden Reduction	Proliferation of unaligned quality measures across payers and settings increases reporting burden for providers without improving care integration. Inconsistent implementation of CMS core measure sets creates confusion, discourages participation in cross-disciplinary accountability arrangements, and makes it difficult to compare outcomes across integrated care models.	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	Midterm: 2–4 years
Patient-Facing Access to Dental Data	Patients have substantially less access to their dental health information than their medical records, limiting engagement, care continuity, and the ability to share information across providers. Patient portal use in dentistry is far more limited than in medicine, and most dental EHR systems do not support the patient access APIs required under the 21st Century Cures Act.	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; CMS should 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	Midterm: 2–4 years

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever *continued*

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Performance Monitoring and Dashboards	Interprofessional care teams lack actionable, real-time feedback on their collective performance across disciplines and settings. Without shared dashboards that track medical-dental coordination, referral completion, chronic disease comanagement, and equity metrics, teams cannot identify gaps, payers cannot enforce accountability, and policymakers cannot evaluate whether integration is working.	CMMI should fund development of cross-sector IPP performance dashboards; health systems and state Medicaid agencies should 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	Midterm: 2–4 years
Federal Incentive Programs	Prior federal HIT incentive programs — Meaningful Use, the Medicare & Medicaid EHR Incentive Programs — excluded dentistry, safety-net settings, and key allied health disciplines. This created a two-tier system in which medicine and nursing built interoperable digital infrastructure while dentistry was left behind. Future programs must be designed inclusively from the start.	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 that future federal HIT incentive programs explicitly include dental providers, dental payers, FQHCs, school-based health centers, and safety-net dental 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	Midterm: 2–4 years

TABLE IV.D — Health IT and Interprofessional Data Infrastructure Policy Lever *continued*

Health IT and Data Policy Lever	Key Policy Insight	Recommended Policy Action	Named Mechanisms	Primary Actors	Timeline
Emerging Technologies — AI and APIs	Artificial intelligence and application programming interfaces (APIs) offer significant potential to reduce administrative burden, automate data exchange, and support care coordination across medical and dental systems. AI is already expanding in dentistry for diagnostic imaging, caries detection, and periodontal assessment — but its integration into interprofessional data workflows remains largely unrealized.	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	Midterm: 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/ONC = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; CDT = Current Dental Terminology; CMMI = Center for Medicare & Medicaid Innovation; CMMI APM = Centers for Medicare & Medicaid Innovation Alternative Payment Model; CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; EHR = electronic health record; FHIR = Fast Healthcare Interoperability Resources; HEDIS = Healthcare Effectiveness Data and Information Set; HIE = health information exchange; HIT = health information technology; HL7 = Health Level Seven; HRSA = Health Resources and Services Administration; ICD = International Classification of Diseases; IPP = interprofessional practice; NCQA = National Committee for Quality Assurance; 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



PART V

Strategic Framework — From Vision to Action

Cross-Sector Policy Action Framework

The recommendations in this white paper are only as durable as the policy alignment behind them. No single stakeholder — not CMS, not CODA, not state legislatures, not health systems — can achieve whole-person health integration alone. The barriers documented throughout this paper are structural and interlocking: Fragmented regulatory frameworks, underdeveloped education infrastructure, inadequate payment systems, and siloed data and technology reinforce one another. Dismantling them requires coordinated, simultaneous action across sectors.

The table that follows translates this paper's analysis into a coordinated set of policy recommendations organized by stakeholder. For each group, it identifies the highest-priority actions, the named federal and state mechanisms through which those actions can be taken, target timelines grounded in existing regulatory and legislative cycles, and measurable indicators of success. These are not aspirational directions — they are specific asks, tied to specific levers, that can be acted on now.

The companion guide, *Fixing the Fracture: Recommendations by Anticipated Ease of Implementation*, reorganizes the policy actions in this white paper into implementation tiers. It is intended for readers who are ready to move from agreement to execution: identifying what can begin under existing authority, what requires coordinated rulemaking or standards development, and what depends on legislation or longer-term structural reform. The guide does not present a separate policy agenda; it provides an implementation pathway for the recommendations advanced here.

**No single stakeholder —
not CMS, not CODA, not state
legislatures, not health systems
— can achieve whole-person
health integration alone.**

TABLE V.A — Policy Recommendations Organized by Stakeholder

Stakeholder	Priority Actions	Key Mechanisms and Timeline	Success Indicators
Federal Policymakers (Congress, CMS, HRSA, ASTP/ONC)	Require dental coverage as a mandatory Medicare Advantage benefit; elevate oral health from MIPS Improvement Activity to scored quality measure in the 2027 PFS; require dental inclusion in all MSSP ACO and CMMI APM contracts; authorize HRSA Title VII grants conditioned on IPE compliance; extend federal HIT certification to dental EHR vendors with HL7 FHIR R4 compliance; eliminate same-day billing restrictions through CMS guidance; establish a Meaningful Use–equivalent incentive program for dental providers in Medicaid managed care. Fully implement and evaluate Medicare payment for dental services inextricably linked to covered medical care, including clear national claims and enrollment guidance, monitoring of access and denials, and evidence-based expansion of qualifying clinical circumstances.	CMS annual PFS rulemaking (2027 quality measure cycle); HRSA Title VII reauthorization; Congressional action on MA mandatory dental benefit; ASTP/ONC Health IT Certification Program rulemaking (2026 guidance, 2028 compliance); CMS Medicaid managed care final rule; CMMI Innovation Award solicitations. Target: 1–2 years.	Medicare Advantage mandatory dental benefit enacted; oral health elevated to scored MIPS quality measure; dental services included in ≥50% of new APM contracts; ASTP/ONC dental EHR certification requirement in effect; same-day billing restrictions eliminated through CMS guidance.
State Governments (Legislatures, Medicaid Agencies, Boards of Health)	Enact dental hygienist direct access legislation; codify teledentistry as a standard interprofessional care tool; launch 1115 waiver demonstrations for medical-dental integration with explicit equity metrics; expand All-Payer Claims Databases to include dental services and outcomes; integrate dental benefits into Medicaid managed care contracts; authorize dental therapy in states that have not done so; remove same-day billing restrictions in Medicaid programs.	State legislative sessions; CMS 1115 waiver applications (2026–2027 launch target); state APCD legislation modeled on Colorado; Medicaid managed care contract amendments; state dental practice act reform. Target: 2026–2028 for waiver launch and scope reform; 2027–2029 for APCD expansion.	≥10 states with updated dental hygienist direct access statutes; ≥8 states with active 1115 waiver demonstrations including medical-dental integration; same-day billing restrictions removed in ≥20 state Medicaid programs; ≥15 states with dental data fully included in APCD.
Educational Institutions (Health Professions Schools, Academic Health Centers)	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; proactively pursue HPAC-aligned accreditation language; document and share outcomes from IPE programs.	HPAC harmonization process (target: 2027 submission to accreditors); HRSA Title VII training grants; IPEC core competency alignment; National Center for IPE learning consortia; OHNEP, NIOH, Smiles for Life, and 100MMC as faculty, preceptor, clinician, curriculum, and implementation resources. Target: 2027–2028.	≥30% of health professions schools with documented longitudinal IPE curricula explicitly including dentistry; ≥100 FQHC and community-based IPP training sites established nationally; HRSA Title VII compliance rates tracked and reported annually.

TABLE V.A — Policy Recommendations Organized by Stakeholder *continued*

Stakeholder	Priority Actions	Key Mechanisms and Timeline	Success Indicators
Accreditors and Entry-to-Practice Licensing/Certification Bodies	Harmonize mandatory IPE standards that explicitly include oral health; align entry examinations and certification blueprints; and coordinate state licensure and CE rules. Actors should include CODA, LCME, ACGME, CCNE, NLN CNEA, ACPE, ARC-PA, ACME, FSMB/NBME, JCNDE, NCSBN, ANCC, AANPCB, AMCB, NCCPA, and state boards.	HPAC convening process (2027 target); NBME–JCNDE joint working group formation (2026) with exam integration target of 2028; accreditor standard update cycles; state licensing board CE rule amendments. Target: 2027 standard revision; 2028 exam integration.	All major health professions accreditors adopt mandatory IPE language including oral health by 2027; NBME and JCNDE joint IPP assessment content integrated into at least two licensure exams by 2028; ≥5 states piloting performance-based IPP license renewal assessment by 2027; IPCE requirements in place in ≥15 states by 2028.
Specialty Boards and Professional/Educational Associations	Incorporate IPP and oral-systemic health into initial and continuing specialty certification, longitudinal assessment, CME/CE, faculty development, clinical guidance, and member-facing implementation tools. Actors should include ABFM, ABP, ABOG, ABIM, AAFP, STFM, AAP, ACOG, ACP, SGIM, PAEA, AANP, ACNM, NAPNAP, and analogous organizations.	HPAC convening process (2027 target); NBME–JCNDE joint working group formation (2026) with exam integration target of 2028; accreditor standard update cycles; state licensing board CE rule amendments. Target: 2027 standard revision; 2028 exam integration.	All major health professions accreditors adopt mandatory IPE language including oral health by 2027; NBME and JCNDE joint IPP assessment content integrated into at least two licensure exams by 2028; ≥5 states piloting performance-based IPP license renewal assessment by 2027; IPCE requirements in place in ≥15 states by 2028.
Payers and Health Systems (CMS, Medicaid MCOs, Commercial Insurers, Employers)	Explicitly include dental services and outcomes in all APM and ACO contracts; pilot bundled payments for preventive and chronic oral health conditions; eliminate same-day billing restrictions; require dental coverage in Medicare Advantage; incentivize interoperable dental HIT adoption; transition successful IPP grant pilots into permanent reimbursement models; engage employer purchaser coalitions — Business Group on Health, Pacific Business Group on Health — to drive commercial sector integration.	CMS APM framework rulemaking; state Medicaid plan amendments; commercial plan design through employer purchaser coalitions; CMMI Innovation Center dissemination and scaling pathway; CMS Medicaid managed care contract standards. Target: 2026–2027 for Medicaid; 2027–2028 for commercial sector.	Same-day billing restrictions eliminated in ≥20 state Medicaid programs; dental outcome metrics included in ≥25% of ACO quality measure sets; ≥3 commercial payer bundled medical-dental preventive care pilots launched; dental coverage included as mandatory MA benefit.

TABLE V.A — Policy Recommendations Organized by Stakeholder *continued*

Stakeholder	Priority Actions	Key Mechanisms and Timeline	Success Indicators
Community Health Organizations (FQHCs, CHCs, Safety-Net Systems)	Serve as demonstration sites for integrated IPP models; build oral health formally into care team structures and staffing models; document and share outcomes data to support payment reform and CMMI scaling pathways; develop workforce pipelines for underrepresented communities; implement closed-loop referral systems with documented completion tracking; report dental utilization and outcomes stratified by race, ethnicity, income, and geography.	HRSA Health Center Program requirements and UDS reporting; CMS FQHC prospective payment system; CMMI Innovation Awards; HRSA NHSC placement priorities for integrated care settings. Target: Ongoing with formal evaluation milestones at 2027 and 2029.	≥500 FQHCs with oral health formally integrated into care team workflows and documented in UDS reporting; closed-loop referral completion rates tracked in ≥200 FQHCs; outcomes data on medical-dental integration submitted to CMMI annual reporting; ≥10 documented community-based IPP workforce pipeline programs serving underrepresented populations.

Acronyms: 100MMC = 100 Million Mouths Campaign; **AAFP** = American Academy of Family Physicians; **AANP** = American Association of Nurse Practitioners; **AANPCB** = American Academy of Nurse Practitioners Certification Board; **ABFM** = American Board of Family Medicine; **ABIM** = American Board of Internal Medicine; **ABOG** = American Board of Obstetrics and Gynecology; **ABP** = American Board of Pediatrics; **ACO** = Accountable Care Organization; **ACGME** = Accreditation Council for Graduate Medical Education; **ACNM** = American College of Nurse-Midwives; **ACP** = American College of Physicians; **ACPE** = Accreditation Council for Pharmacy Education; **AMCB** = American Midwifery Certification Board; **ANCC** = American Nurses Credentialing Center; **APCD** = All-Payer Claims Database; **APM** = Alternative Payment Model; **ARC-PA** = Accreditation Review Commission on Education for the Physician Assistant; **ASTP/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CCNE** = Commission on Collegiate Nursing Education; **CE** = continuing education; **CHC** = community health center; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare and Medicaid Innovation; **CMMI APM** = Center for Medicare and Medicaid Innovation Alternative Payment Model; **CODA** = Commission on Dental Accreditation; **CME** = Continuing Medical Education; **EHR** = electronic health record; **FHIR** = Fast Healthcare Interoperability Resources; **FSMB** = Federation of State Medical Boards; **FQHC** = federally qualified health center; **HIT** = health information technology; **HL7** = Health Level Seven International; **HPAC** = Health Professions Accreditation Collaborative; **HRSA** = Health Resources and Services Administration; **HIT** = Health Information Technology; **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; **MA** = Medicare Advantage; **MCO** = Managed Care Organization; **MIPS** = Merit-Based Incentive Payment System; **MSSP** = Medicare Shared Savings Program; **NAPNAP** = National Association of Pediatric Nurse Practitioners; **NBME** = National Board of Medical Examiners; **NCCPA** = National Commission on Certification of Physician Assistants; **NCSBN** = National Council of State Boards of Nursing; **NHSC** = National Health Service Corps; **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; **PFS** = Physician Fee Schedule; **SGIM** = Society of General Internal Medicine; **STFM** = Society of Teachers of Family Medicine; **UDS** = Uniform Data System



PART VI:

Conclusion

The Case for Aligned Action

This white paper has documented how four interlocking barriers — fragmented regulatory frameworks, underdeveloped education infrastructure, inadequate payment systems, and siloed data and technology — prevent interprofessional education and practice from becoming the norm rather than the exception in US health care. The evidence base is clear. Periodontal disease worsens diabetes outcomes. Unmanaged oral infections fill emergency departments at a cost of \$3.9 billion annually. Sixty-nine million adults lack dental insurance. Seventy-five million people live in Dental Health Professional Shortage Areas. The populations bearing the greatest burden of these failures are the same populations already marginalized by our health system: low-income adults, rural communities, communities of color, older adults, and people with chronic disease.

What has been missing is not evidence. It is policy alignment. The four-domain framework and stakeholder action priorities in this paper are designed to provide that alignment — not through aspirational language but through specific asks tied to named mechanisms, existing authorities, and defined timelines.

Redesigning — Not Patching — the System

Incremental progress within individual domains is no longer sufficient. IPE programs that exclude dental students, accreditation standards that use “should” instead of “must,” payment models that exclude oral health from ACO contracts, and EHR systems that cannot exchange dental data with medical providers — these are not isolated gaps. They form a self-reinforcing system that makes fragmentation the path of least resistance.

That system must be redesigned across these interlocking domains simultaneously.

1. Accreditation, Licensure, and Education Policy:

HPAC and IPEC should convene a formal harmonization process by 2027, producing mandatory IPE language submitted to CODA, LCME, ACGME, CCNE, ACPE, and ARC-PA for adoption. Every standard should name at least one dental profession as a required IPE partner. NBME and JCNDE should establish a joint working group by 2026 to integrate IPP content into initial licensure exams by 2028. State licensing boards should mandate 10%–20% of CE hours as interprofessional continuing

education. HRSA Title VII funding should condition awards on institutional compliance, including equity-centered placements in safety-net, rural, and tribal settings.

2. Payment and Delivery Reform: CMS should elevate oral health from a MIPS Improvement Activity to a scored quality measure in the 2027 Physician Fee Schedule. All MSSP ACO and CMMI APM contracts should require dental services and outcomes as participation conditions. Same-day billing restrictions should be eliminated in all state Medicaid programs. Medicare Advantage should be required by Congress to cover dental as a mandatory benefit. Section 1115 waiver demonstrations in at least eight states should test medical-dental integration with explicit equity metrics. CMMI should establish a formal conversion pathway for successful IPP pilots into permanent reimbursement.

3. Workforce and Credentialing Systems: States should enact dental hygienist direct access legislation and authorize dental therapy as needed. Teledentistry should be codified as a standard interprofessional care tool with explicit Medicaid reimbursement guidance from CMS. Credentialing and privileging standards should be updated to explicitly authorize comanagement, shared care planning, and cross-disciplinary referral as standard practice. HRSA NHSC placements should explicitly support integrated care team roles for dental providers in shortage areas.

State dental and medical practice acts should be revised to include permissive language for delegation, collaboration, and shared accountability. Supervision requirements should shift from location-based to competency-based models. HRSA Title VII compliance conditions should require states to report dental hygienist scope status and drive convergence toward direct access as the national standard rather than waiting for state-by-state reform to happen organically.

4. Data and Measurement Infrastructure: ASTP/ONC should extend federal HIT certification to dental EHR vendors with HL7 FHIR R4 compliance as the certification condition by 2028. CMS and NCQA should develop a core set of cross-disciplinary IPP outcome measures including oral health indicators, aligned with HEDIS and UDS. All-Payer Claims Databases in all states should be expanded to include dental services and outcomes. CMMI should fund cross-sector IPP performance dashboards tracking medical-dental coordination, closed-loop referral completion, and disparities by race, ethnicity, income, and geography.

These four domains are not a menu of independent options; they are a system. Advancing any one of them without the others produces incremental gain. Advancing all five together produces the structural change this paper is designed to achieve.

Stakeholder Action Priorities

The task now is to move from knowing what must change to deciding who will act, through which authority, and on what timeline. The companion guide, *Recommendations by Anticipated Ease of Implementation*, provides that next step by organizing this paper's policy actions according to implementation complexity and identifying opportunities that can begin now. Not every action can be completed immediately. Every sector, however, has an action it can begin, and accountability should start with whether it does.

The table below summarizes the most consequential actions for each stakeholder group. It is designed to be read quickly by representatives from any sector and to leave no ambiguity about what this paper is asking each group to do. Full policy detail, named mechanisms, timelines, and success indicators for each stakeholder are in the Cross-Sector Policy Action Framework in Section V.

TABLE VI.A — Summary of the Most Consequential Actions for Each Stakeholder Group

Stakeholder	Priority Actions
Policymakers (Federal and State)	- Require dental coverage as a mandatory Medicare Advantage benefit. - Elevate oral health to a scored MIPS quality measure in the 2027 PFS. - Require dental inclusion in all MSSP ACO and CMMI APM contracts. - Eliminate same-day billing restrictions in all state Medicaid programs. - Launch in ≥8 states 1115 waiver demonstrations for medical-dental integration with equity reporting requirements. - Enact dental hygienist direct access legislation and authorize dental therapy in states not yet doing so. - Condition HRSA Title VII grants on documented IPE compliance including dental profession inclusion.

TABLE VI.A — Summary of the Most Consequential Actions for Each Stakeholder Group *continued*

Stakeholder	Priority Actions
Educators and Accreditors	• Replace “should” with “must” in IPE accreditation standards, paired with graduated implementation timelines. • Name at least one dental profession as a required IPE partner discipline in all major health professions accreditation standards by 2027. • Establish NBME–JCNDE joint working group by 2026 for IPP licensure exam integration by 2028. • Mandate 10%–20% of CE hours as interprofessional continuing education. • Build FQHC-based and community-based IPP clinical training sites. • Invest in IPE faculty development and dedicated coordination roles.
Payers and Health Systems	• Include dental services and outcomes in all APM and ACO contracts. • Ensure consistent coverage and reimbursement for existing care-coordination codes, including D9992, and develop complementary medical and dental coding payment pathways for bidirectional consultation, referral management, shared planning, and closed-loop follow-up. • Pilot bundled payments for oral-systemic conditions — periodontal-diabetes, prenatal-dental. • Transition successful IPP grant pilots into permanent reimbursement through CMMI conversion pathways. • Update credentialing and privileging standards to authorize comanagement, shared care planning, and cross-disciplinary referral as standard practice. • Engage Business Group on Health and Pacific Business Group on Health to drive commercial sector integration. • Operationalize Medicare coverage for dental services inextricably linked to covered medical care through medical-dental coordination, reliable referral and claims workflows, and support for Medicare enrollment of dental providers.
Credentialing Bodies and Professional Associations	• Update licensure and certification exams, credentialing standards, and professional codes of ethics to reflect interprofessional practice as a core competency. • Update privileging criteria to explicitly authorize comanagement, shared care planning, and cross-disciplinary referral. • Support NBME–JCNDE joint working group for IPP licensure exam integration. • Develop joint medical-dental credentialing pathways for integrated care settings. • Advocate within professional communities for scope-of-practice modernization and dental therapy authorization. • Incorporate interprofessional oral health competencies into specialty certification and continuing-certification blueprints, longitudinal assessment, performance-improvement activities, and profession-specific CME/CE. • Use national professional and faculty organizations to support implementation in practice and training settings.

TABLE VI.A — Summary of the Most Consequential Actions for Each Stakeholder Group *continued*

Stakeholder	Priority Actions
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. • Invest in interoperable EHR systems integrating oral health alongside medical and behavioral health data. • Deploy cross-sector IPP performance dashboards tracking medical-dental coordination, closed-loop referral completion, and health disparities. • Expand APCD participation to include dental claims. • Ensure patient-facing dental data access through interoperable portals consistent with 21st Century Cures Act requirements.
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. • Mentor, model, and assess 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: **ACO** = accountable care organization; **APCD** = All-Payer Claims Database; **APM** = alternative payment model; **ASTP/ONC** = Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology; **CE** = continuing education; **CMS** = Centers for Medicare & Medicaid Services; **CMMI** = Center for Medicare & Medicaid Innovation; **EHR** = electronic health record; **FHIR** = Fast Healthcare Interoperability Resources; **FQHC** = federally qualified health center; **HIT** = health information technology; **HL7** = Health Level Seven; **HRSA** = Health Resources and Services Administration; **IPE** = interprofessional education; **IPP** = interprofessional practice; **JCNDE** = Joint Commission on National Dental Examinations; **MIPS** = Merit-Based Incentive Payment System; **MSSP** = Medicare Shared Savings Program; **NBME** = National Board of Medical Examiners; **PFS** = Physician Fee Schedule



Whole-Person Health Cannot Wait

The consequences of inaction are not hypothetical. Every day, patients navigate systems designed around professions rather than people. A person with uncontrolled diabetes and untreated periodontal disease sees a physician who does not ask about their gums and a dentist who does not ask about their A1C. A pregnant woman in a rural community receives prenatal care with no mention of oral health, despite evidence linking periodontal disease to preterm birth. A child in a low-income neighborhood visits an emergency department for a preventable dental abscess because there is no Medicaid-accepting dental provider within reach and primary care never screened for the cavity that caused it.

These are not system failures at the margins. They are the predictable, documented outcomes of policy architecture that has treated oral health as an optional add-on for decades. The cost is real: \$3.9 billion in annual dental ED spending that delivers little definitive care; \$45 billion in lost productivity; missed diagnoses; preventable hospitalizations; and widening disparities that fall hardest on the communities already bearing the greatest burden of chronic disease.

The opportunity is equally real. Payment mechanisms exist or can be created. The accreditation and licensure levers are identified. The workforce models — dental therapy, direct access hygiene, teledentistry, community-based prevention — are proven. What has been missing is the policy will to align them.

This white paper is a call to align. Not to study the problem further. Not to pilot another isolated program that dissolves when the grant ends. But to use the authorities, mechanisms, and momentum that already exist to build the system that patients have always deserved — one where oral health is not siloed from whole-person care, where interprofessional teams are the norm rather than the exception, and where the zip code, insurance status, race, or income of a patient does not determine whether they receive integrated, dignified care.

*The evidence is clear. The path is mapped.
The window is open.*

Now we build it — together.

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