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Oral Medical Care Coordination in the United States: Pillar #4 – Payment

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Background

Oral medical care coordination seeks to improve public health outcomes by integrating oral health and primary care (see research brief 34 in this series for more information). While the evidence base on the benefits of oral medical care coordination is robust, less is known about current levels of adoption of coordinated systems in the United States. The University of Iowa conducted the seminal comprehensive literature review on this topic in 2018,[1] and, in 2021, KDHRC undertook a systematic effort to extend and update that research. We examined peer-reviewed articles, state oral health and chronic disease plans, and grey literature on oral medical care integration (see research brief 35 in this series).

From the systematic review we further drilled down on key program characteristics that undergird success, replicability, or sustainability. These components are named as pillars in a framework of change required before oral medical care coordination can be meaningfully implemented on a broad scale. The pillars are **Awareness, Workforce Development and Operations, Information Exchange,** and **Payment.** This brief more deeply describes **Pillar #4: Payment**. Additional briefs describe the other three pillars (see research briefs 36-38 in this series).

Payment (pillar #4) defined

The **Payment** pillar is the component of coordinated care that focuses on establishing sustainable financial models and reimbursement structures that incentivize and support the delivery of coordinated oral health care* and medical services. This pillar emphasizes the creation of payment systems that reward value and patient outcomes rather than the volume of services, while ensuring that providers are financially supported in offering comprehensive, coordinated care.

* In this brief, the term "oral health care" describes care of the teeth, gums, and soft tissue in the mouth, and "dental care" refers to care of teeth and gums.

Key findings: Barriers

Key Themes

- Updated reimbursement models
- Adequate insurance coverage
- Financial incentives
- Billing code standardization

The transformation into a cohesive system of oral medical care coordination presents unique challenges, particularly concerning payment models and financial barriers. Existing payment structures predominantly operate within a fee-for-service model, which generally separates oral health and medical care.[2] This separation creates significant obstacles in reimbursing services that overlap both fields, such as preventive oral health services performed in medical settings or medical screenings conducted in oral health care offices.

Public insurance plans such as Medicare or Medicaid may offer some reimbursement for coordinated care services, such as fluoride varnish application and oral health risk assessments. However, these reimbursements vary widely by state, with differing policies on eligibility, service coverage, and reimbursement rates.[3] Many reimbursement models require providers to go through training to provide oral health services,[4] and some states allow dental hygienists working in non-oral care settings to provide oral health care services.[5] Such variability can deter providers from offering coordinated services due to uncertainties about reimbursement and the administrative burden of navigating complex billing systems.

Private medical insurance plans do not usually cover oral health services, further exacerbating financial barriers to integrated care coordination.[6] Such coverage may be limited, not cover comprehensive coordinated care, nor reimburse for time spent educating patients. Lack of medical insurance coverage for oral preventive services may result in missed opportunities for early detection and management of oral-systemic health conditions.

The literature demonstrates that reimbursement for medically provided oral health services (e.g., dental screenings, oral health counseling, and fluoride varnish and silver diamine fluoride applications) increased provider willingness to deliver services, actual delivery of services, and patient acceptance of services.[3] Conversely, the inability to bill for services is a reason why medical and dental providers do not provide oral health care, even if they are trained and able.[7] Uncertainty about coverage extends to patients as well - patients may decline oral health services due to lack of knowledge about their insurance coverage or unwillingness to risk paying out of pocket.[6]

Key findings: Facilitators

Successful coordinated care delivery relies on oral health insurance coverage, available reimbursement and billing procedures, and payment policies and payment structures. Facilitators for payment included availability and sustainability of grant funding for coordinated care and oral health promotion;[8] high reimbursement rates;[7] Medicaid participation and coverage for integrated services;[4] and ability for organizations to bill and code for coordinated care (e.g., HPV education, A1C tests, and fluoride varnish application).[3] Barriers for payment included the segregation of reimbursement systems and codes,[2] staff, procedures, and medical records;[9] inadequate reimbursement;[2] and lack of availability of providers who accept Medicaid patients.[10] Specifically, a significant limitation is the lack of uniform billing codes and procedures that are used across medical and oral health fields. Current Procedural Terminology codes[11] and oral health billing codes are not always compatible, complicating the billing process for

coordinated services, which may further discourage providers from adopting coordinated care practices because it adds to their administrative workload without clear financial benefits.

Recommendations

The **Payment** pillar presents multifaceted challenges to oral medical care coordination with differing payment models and complex reimbursement structures. Fee-for-service models limit providers and present them with difficult-to-navigate reimbursement policies for medical and oral health services, which often deter providers from adopting coordinated care approaches. The literature suggests that value-based care models, which align financial incentives with patient outcomes, may offer a viable solution to these financial barriers, promoting more widespread adoption of coordinated care practices by shifting the focus from volume to value.[12] Value-based care models may incentivize providers to deliver high-quality, coordinated care that addresses both medical and oral health issues, leading to better patient outcomes and potential cost savings. This model further emphasizes coordinated care and shared savings by rewarding providers for meeting health outcome goals and efficiency metrics. Health care systems can promote comprehensive care that encompasses both oral and systemic health through these frameworks.

While the initial investment into training, technology, and restructuring may appear significant, the long-term benefits are vast – reduced health care costs through preventive care, better management of chronic conditions, more sustainable health care financing, improved patient satisfaction, and overall system efficiency.

To advance a payment system that supports coordinated care, we recommend:

- **Policy changes** to expand insurance coverage to include more preventive oral health care services and increased reimbursement rates to make coordinated care financially viable for providers.
- **Use of standardized billing codes and procedures** across medical and oral health services to simplify the reimbursement process and reduce administrative burdens.
- **Promotion of value-based care models** through policy initiatives that align financial incentives with patient outcomes, encouraging providers to adopt coordinated care practices such as Accountable Care Organizations (ACOs) and patient-centered medical homes (PCMHs).

Conclusion

The coordination of medical and oral health care services has the potential to significantly reshape the landscape of health care delivery. Creating financial incentives for coordinated care making billing for services easier may be systematically challenging but is likely to be one of the biggest motivators for more comprehensive, patient-centered care.

Payment systems and financial structures are foundational to the feasibility of all other pillars. Without sustainable financing, even the most well-designed educational programs and technological systems cannot be effectively maintained. Our recommendations, such as value-based care, can support oral medical care coordination by aligning financial incentives with patient outcomes.

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