Physician-Focused Payment Model Technical Advisory Committee

PTAC
ISSUE BRIEF #4

January 2026

Care Delivery Challenges and Opportunities Related to Integrating Primary and Specialty Care in Population-Based Total Cost of Care (PB-TCOC) Models

HIGHLIGHTS

- Categorizing providers by their primary function within their specialty rather than by their specialty alone, developing care pathways, and clearly defining workflows can help to address challenges related to understanding the roles and responsibilities of primary care providers (PCPs) and specialists at different stages in a patient's disease progression.
- Coordination and communication between PCPs and specialists can be improved by adopting technology that facilitates bidirectional, synchronous, and asynchronous communication, including e-consultations and telehealth.
- Sharing timely data on quality, cost, and utilization can improve care decisions and coordination between PCPs and specialists. Sharing these data can also inform patients' decisions when searching for specialists who deliver high-value care.
- Providing practices with up-front funds to invest in infrastructure and technology not only improves the exchange of timely data between providers and settings, but also encourages participation in value-based care models.

INTRODUCTION

Specialty care providers diagnose, treat, and manage certain health problems within specific areas of medicine, such as cardiology, oncology, and psychiatry. The roles of specialists and primary care providers (PCPs) in delivering care can vary depending on a patient's health needs. Integrating primary and specialty care in population-based total cost of care (PB-TCOC) models can promote collaboration among specialists and PCPs and facilitate the delivery of prospective, longitudinal, whole-person care that focuses on patients and their diseases or conditions rather than on providers and their specialties. PTAC uses the following working definition to characterize specialty integration in the context of value-based care:

> *"Specialty integration is a desired characteristic of population-based models where:*
> - *Primary and specialty care provider roles and responsibilities are clearly delineated throughout the care journey for a given condition or episode of care;*
> - *Specialist care includes a continuum of responsibilities for a patient or condition, including, but not limited to, single consultation, co-management, and primary management;*
> - *Primary and specialty care providers coordinate to provide patient-centered care using bidirectional, synchronous, and asynchronous communication;*

- *Specialists provide consultations and/or ongoing care via multiple modes in a timely manner; and*
- *Primary and specialty care providers have access to use shared real-time data to inform care decisions."*

Integration with primary care can encourage specialists to adopt an approach that is more focused on whole patient care rather than solely performing procedures. However, there are care delivery challenges when integrating primary and specialty care in PB-TCOC models. One challenge is related to clearly defining PCPs' and specialists' roles and responsibilities across a patient's care journey, including understanding when PCPs should engage specialty care (e.g., when to make referrals to specialists) and the extent and duration of co-management between PCPs and specialists. Another challenge is related to sharing timely data between PCPs and specialists to inform care decisions and facilitate care coordination and communication.

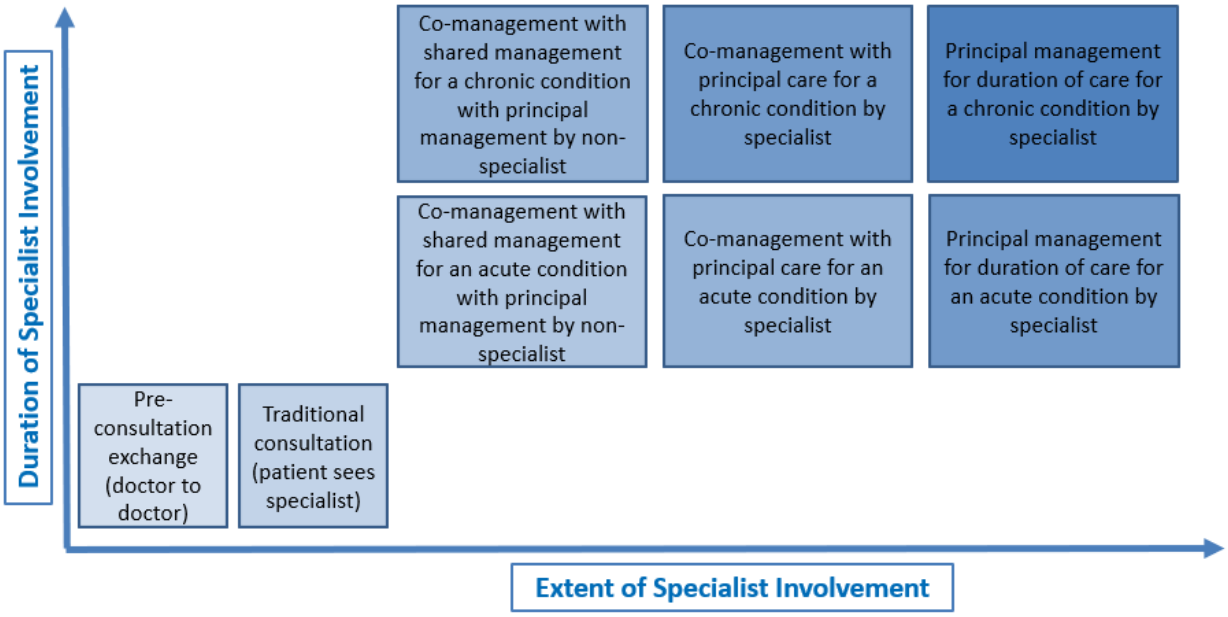
CLEARLY DEFINED ROLES AND RESPONSIBILITIES

A specialist typically manages a patient for the condition aligned with the provider's specialty and not for the patient's entire spectrum of health care. However, depending on a patient's condition and the severity of the condition, the duration of specialty care provided to the patient may be short, or it may extend into comprehensive, continued management over time. Specialist care includes a continuum of responsibilities to coordinate patient care with PCPs. Specialists can assume one or more of the following roles when caring for a patient:

- A pre-consultation exchange between physicians, where the specialist provides guidance, support, and consultation to the PCP who maintains responsibility for the patient's care;
- A traditional consultation, where the patient is evaluated by the specialist;
- Co-management between the PCP and specialist, where the specialist assumes co-responsibility with the PCP and manages a set of problems related to the patient's condition; and/or
- Principal management by the specialist, where the specialist assumes full responsibility for principal care of a specific condition while the PCP coordinates preventive care and manages other conditions the patient might have.

Figure 1 illustrates the extent and duration to which specialists may be involved in delivering care in coordination with PCPs.

Figure 1. Specialists' Roles in Delivering Care in Coordination with PCPs Varies Based on the Extent and Duration of Involvement Needed



Abbreviation: PCP, primary care provider
Source: Adapted from the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Improving Care Delivery and Integrating Specialty Care in Population-Based Models. March 2, 2023. https://aspe.hhs.gov/sites/default/files/documents/2ffb75f3de3c194f8a43743e18e5a9c9/PTAC-Mar-2-PCDT-Findings.pdf. Figure originally adapted from American College of Physicians. The Patient-Centered Medical Home Neighbor. The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. (2010).

There can be challenges to understanding the roles and responsibilities of primary and specialty care providers—both individually and collectively—throughout a patient's care journey for a given condition or episode of care. Potential overlap between multiple specialists can further blur providers' roles and responsibilities. Given specialists' spectrum of responsibilities for managing certain conditions, it may be more appropriate to categorize providers by their primary function within their specialty—such as screening, acute care, and chronic longitudinal care—rather than by their specialty alone. Using this approach, providers can then be held accountable for the patient's care in this context, regardless of their specialty.

PCPs face challenges with knowing when to engage specialty care, including when to make referrals to specialists, and understanding the duration of co-management with specialists. One solution is to develop care pathways and clearly defined workflows to indicate when it is appropriate for a PCP to make a specialty referral, what information the referring provider needs, and who will be responsible for managing the patient's care. Further, clearly communicating the purpose of a specialist referral (e.g., single consultation, co-management of the patient) will help to clarify providers' roles and responsibilities in managing the patient's care. Starting with the referral process, there should be clear communication between providers regarding why the patient is being referred, the goals for the referral, the role of the specialty care provider, and the process for transitioning care management back to the PCP once the patient is stable. Conversations between the primary care and specialty care management teams should begin early through a pre-consultation exchange to determine if a specialty consultation is appropriate and identify any tests to order before the patient is evaluated by the specialist. When specialty care is appropriate, incorporating specialty care earlier in a patient's care journey may lead to better patient outcomes.

The use of technology to facilitate bidirectional, synchronous, and asynchronous communication can help to define provider roles and responsibilities and improve collaboration between PCPs and specialists. E-consultations and telehealth are important in supporting coordination and integration between primary and specialty providers, particularly for behavioral health care and medication safety. In addition, e-consultations can reduce unnecessary referrals. For example, e-consultations can allow a PCP to obtain consultation from a specialist in real time while actively meeting with a patient. Similarly, telehealth can improve primary and specialty care coordination, particularly in areas where there is limited access to specialists. Allowing primary and specialty care providers to use flexible modes of communication can promote high-value care by facilitating the process of determining when care coordination should occur and identifying which provider(s) should be accountable for the patient's care. In addition, leveraging tools that facilitate communication between providers can encourage specialist engagement in value-based care models. There is a need for additional work to understand how to effectively measure and assign value to communication and collaboration between primary and specialty care providers.

TIMELY DATA AND DATA SHARING

Primary and specialty care providers need access to real-time, high-quality data—particularly during consultations and referrals—to inform care decisions and promote care coordination. Patients also need access to data when making choices about specialty care providers. However, providers and patients lack access to timely data on quality, cost, and utilization, as well as the types of procedures provided by specialists. There also is variation in how data are used and shared between primary and specialty care providers and across care settings.

PCPs use quality, cost, and utilization data to inform decisions when making referrals to specialists who deliver high-value care. Accessing data on quality, cost, and utilization can also help providers identify opportunities to lower spending and create value. Making data transparent, accessible, and in a format that is easily usable is important for both providers and patients. For example, digital tools could be developed to provide PCPs with transparent metrics on specialists, such as cost of care, quality of care based on STEEEP (safe, timely, effective, efficient, equitable, and patient-centered) principles, clinical outcomes, and patient-oriented goal outcomes. Digital tools could also be developed to provide PCPs and patients with relevant data when searching for and selecting specialists who provide specific types of procedures. Such tools could allow PCPs and patients to compare specialists based on key metrics, such as average episode cost, patient risk score, or patient rating. Standardizing data collection across specialists could also help to support specialists' participation in value-based care.

Interoperable electronic health record (EHR) systems can assist with streamlining the transfer of information between organizations. Interoperable EHRs allow for the exchange of real-time data between providers and settings. This exchange of data can inform patient care and facilitate coordination between PCPs and specialists, particularly during consultations and referrals. Standardizing technology can also help identify specific information that should be transferred when a provider makes a referral to a specialist.

Developing the infrastructure and technology necessary for sharing data in value-based care models, such as establishing telehealth platforms and interoperable EHRs, requires substantial initial and ongoing financial investments. As such, it is important to provide practices with up-front funds to invest in infrastructure and technology to improve data exchange. Building up-front payments into models can also encourage the transition to value-based care, particularly among small specialist practices. Finally, practice transformation takes time. Rather than focusing solely on immediate and short-term returns on

investment, long-term efforts to improve specialty integration in PB-TCOC models must be considered, including focusing on infrastructure development. Efforts to improve the exchange of timely data across providers and settings also have payment model considerations, such as putting practices in a position to take on financial risk linked to outcomes.[1]

CONCLUSION

Clearly defining providers' roles and responsibilities across a patient's care journey and improving access to timely data between PCPs and specialists are two main care delivery challenges when integrating primary and specialty care in PB-TCOC models. Classifying providers by their primary function rather than by their specialty alone, developing care pathways and clearly defined workflows, and adopting flexible modes of communication, including e-consultations and telehealth, can help to clarify provider roles and responsibilities at different stages in a patient's disease progression. PCPs and specialists should have access to shared, real-time data to inform referrals and care decisions and promote care coordination. Digital tools that deliver metrics on specialists can help support both providers and patients with understanding and comparing the cost and quality of care associated with specialists. Providing practices with up-front funds to invest in infrastructure and technology can improve the exchange of data across providers and settings and support providers in their transition to value-based care.

RESOURCES

The following resources are publicly available on the ASPE PTAC website:

- Report to the Secretary: Improving Care Delivery and Specialty Integration in PB-TCOC Models
- Environmental Scan: Improving Care Delivery and Integrating Specialty Care in Population-Based Models
- Preliminary Comments Development Team (PCDT), Improving Care Delivery and Integrating Specialty Care in Population-Based Models, March 2, 2023

ABOUT PTAC

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to make comments and recommendations to the Secretary of Health and Human Services on proposals for physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities. Within this context, PTAC also reflects on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Accordingly, PTAC has held an ongoing series of theme-based discussions on developing and implementing value-based care. The content in this PTAC Issue Brief is based on publicly available information from PTAC's theme-based discussions, including PTAC presentations and recommendations, presentations by stakeholders and experts, environmental scans, original research, and PTAC reports to the Secretary.

[1] Payment model considerations when integrating primary and specialty care in PB-TCOC models are discussed in more detail in PTAC Issue Brief #5.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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SUGGESTED CITATION
Physician-Focused Payment Model Technical Advisory Committee (PTAC). Care Delivery Challenges and Opportunities Related to Integrating Primary and Specialty Care in Population-Based Total Cost of Care (PB-TCOC) Models. PTAC Issue Brief No. 4. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. January 2026.

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