FIRST OPINION

A billing code was supposed to incentivize relationship-based primary care for Medicare patients. It may not be working as hoped

Research shows that the code may not live up to its hype

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By Ishani Ganguli Aug. 28, 2026

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Beatrice (not her real name) is here to see me after her fall, but our visit doesn't end there. I watch the security footage of the fall on her phone, check her head to toe, and plan a pain regimen that won't worsen her gastritis. And then I tackle her renewed anxiety, adjust her thyroid medication, offer an overdue vaccine, and plan for our nurse to check in later that week.

This is what it's always meant to be a primary care doctor. And as of two years ago, Medicare enrollees can find it as a line item on their doctor's bill.

The G2211 code lets doctors bill an additional $16 per visit for providing comprehensive or ongoing, relationship-based care. As a health services researcher and physician who has both studied and billed G2211, I'm intrigued by this code because it renders transactional a concept that is sort of the opposite. Medicare introduced the code in 2024 as a well-meaning effort to invest in primary care as the foundation of our health care system, and just announced that it is sticking with it. But our research points to early signs that it may not work as hoped.

Medicare, which covers most older adults, sets payment rates through a Physician Fee Schedule that is used by Medicare and by most other insurers. Under the advice of a specialty-predominant committee, Medicare has set higher rates for procedures (like cataract surgeries and mole biopsies) than for the visit-based cognitive work (like making new diagnoses and managing chronic conditions) of specialties including primary care.

These per-item, or "fee-for-service," payments cover only a subset of what's needed to deliver the team-based, high-quality primary care that studies consistently link to better health outcomes and longevity. What's not covered is the often between-visit, behind-the-scenes work that is so valuable — like navigating ambiguous symptoms via email, coaching on lifestyle modifications for acid reflux and high blood pressure, or narrowing a medication list cobbled together over years of fragmented care to what a patient really needs.

Such payment distortions can force primary care clinicians to chase higher visit counts at the expense of these other activities and dissuade future doctors and advanced care

practitioners from entering the field. The result is a U.S. primary care system that is underfinanced and understaffed, leaving a growing share of Americans without timely access to high-quality (or any) primary care and ultimately, contributes to our worse health outcomes at higher cost than comparable countries.

Recognizing these challenges, Medicare has tweaked both how and how much they pay for primary care, but progress has been slow. The G2211 code represents one of the latest attempts, and the most recent one for which we have data.

In its first year, the code was billed 26 million times by 1 in 4 of all doctors billing Medicare — pretty good uptake when compared to prior similar codes. But we also find signals that it may not be used as intended. While by law, Medicare cannot restrict billing codes to a certain specialty, G2211 was designed to support "longitudinal and especially primary care" — that is, clinicians practicing primary care and other specialties with a similar holistic, relational approach, like infectious disease doctors who often provide primary care to patients with HIV. Several specialty societies lobbied against the code out of concern they would lose out in the zero-sum game that is the Physician Fee Schedule, but my colleagues and I found that the largest share (43%) of codes were billed by specialist physicians, followed by primary care physicians at 40%. (The rest were by other clinicians such as nurse practitioners and physician assistants.) G2211-billed visits by specialists were often for conditions like acid reflux and mild glaucoma that Medicare may not consider to be serious or complex. In most cases, at least, the doctors billing G2211 for patients saw those patients more than once.

While the PCPs I spoke with dutifully bill the code with each relevant visit, some bemoaned the modest reimbursement and the moral injury of an extra click to codify what we already see as our job.

What do patients think about G2211? After all, while this code represents what most patients want, it is a strange way to be billed for it. I haven't heard from any of my own patients about the $3 or so they may have to pay out-of-pocket. But the cost-sharing was irritating enough for one Medicare enrollee's son (a Wall Street Journal contributor) to write about the expense, and the experience of his mother being quoted the Medicare billing code specifications by way of explanation — that is, for being "nickel-and-dimed"

for this "blithering piffle."

While G2211 is unlikely to transform primary care payment on its own, Medicare's efforts have not ended there. In January 2025, Medicare introduced Advanced Primary Care Management (APCM) codes. Unlike G2211 codes, which are tied to visits (and therefore contribute to the specialty distributions and visit count chasing I mentioned earlier), APCM codes translate into larger, monthly per-patient payments intended to cover the range of work and team members needed for high-quality primary care. And Medicare just announced plans to explore a more ambitious version of these per-patient payments in 2027. We will see.

In the meantime, the G2211 code was meant to support what Americans are looking for — a trusted medical adviser, their personal doctor — and yet have been conditioned through decades of underinvestment in primary care not to expect. But early signs hint that the code is not focused enough on primary care (to the extent G2211 was intended for it) and may be too tied to visits when primary care is so much more.

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Letter to the editor

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