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Portal messages are now primary care. Who pays for the inbox replies?

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Key Takeaways

- Portal message volume is accelerating while traditional Medicare primary care visit rates decline, shifting workload into asynchronous channels that consume ~2.5 hours per clinic day for many PCPs.
- Per-message patient billing may deter appropriate outreach and worsen disparities; experience from virtual-first practice suggests message overuse is uncommon without imposing financial friction.

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Patient portal messages have become a main way to reach primary care. Doctors need to be paid for it, experts say.



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The time has come for primary care physicians to be paid for responding to patient portal messages, now a main way that people reach their doctors, according to a panel of primary care advocates.

That does not mean charging patients per message, said panelists who run virtual-first, integrated and community health center practices. Rather, the work should be paid as part of a monthly fee for caring for each patient, they said.

As of 2026, patient portal inquiries "can't be the side of your desk," said Jeff Greenberg, M.D., MBA, co-founder of Firefly Health, a virtual-first primary care practice.



Jeff Greenberg, M.D., MBA

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"It can't be the end of the day, you know, after a full day of visits, that you've got all these messages to go through," he said. "It has to be what is expected of you, and part of the model" of payment.

"Access to primary care: real-world experiences and solutions with asynchronous and team-based care" was an online panel discussion during the Nov. 12 open meeting of the Standing Committee on Primary Care of the National Academies of Sciences, Engineering and Medicine (NASEM). That meeting followed the release of "Ensuring Access to High-Quality Primary Care in the United States," the five-year follow up to the committee's [illegible] analysis in "Implementing High-Quality Primary Care."

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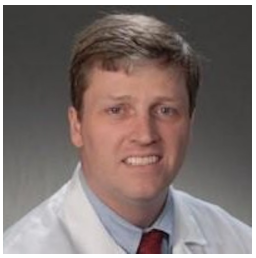
Greenberg spoke during the session moderated by Ishani Ganguli, M.D., M.P.H., associate professor of medicine at Harvard Medical School and a primary care physician at Brigham and Women's Hospital. Other panelists were Libby Hoy, founder and CEO of Patient and Family Centered Care Partners (PFCCpartners); Alan Evans, M.D., a family physician and regional assistant medical director for the Virtual Medical Center at Southern California Permanente Medical Group; and Lawrence D. Ramunno, M.D., M.P.H., MBA, chief medical officer of HealthLinc, a federally qualified health center (FQHC) in northwest Indiana.



Ishani Ganguli, M.D., M.P.H.



Libby Hoy



Alan Evans, M.D.



Lawrence D. Ramunno, M.D., M.P.H., MBA



Andrea A. Anderson, M.D., M.Ed., FAAFP

How big is the inbox?

The share of traditional Medicare beneficiaries with at least one primary care visit in a year fell below 60% as of 2023, Ganguli said, citing her research. At the same time, more care happens between visits when patients reach out electronically. Patient-authored portal messages rose about 150% from 2020 to 2025, according to a study of Epic Cosmos data.

Primary care physicians in a New England practice network averaged about 49 inbox messages a day, well above other specialties. Ganguli said one health system estimates its primary care physicians spend about 2½ hours in the inbox per clinic day, often on nights and weekends.

Report co-author Andrea A. Anderson, M.D., M.Ed., FAAFP, a practicing family physician, described "the amount of pajama time I have almost on a nightly basis to try to keep up with them." Her 6-year-old daughter, she said, wrote in a school essay that a family doctor works on her computer.

Greenberg said practices should flip the usual question. "I almost consider asynchronous care as the default, and the question is, when do [illegible]ally need to call this person, or when do they actually need to visit?" he said.

Should patients pay per message?

Medicare added billing codes for portal messages to the physician fee schedule in 2020, and health systems that bill for some messages aim partly "to sort of make patients think twice," Ganguli said.

Hoy said patients and family caregivers "want their clinicians to be paid and to be paid well," but not through new patient charges.

"I would just say we are in an affordability crisis in this country," Hoy said. Relying on patient payments even in part would create gaps and disparities in who can access care, she said.

Firefly has never charged patients for chat messages, and in eight to 10 years only one patient overused them, Greenberg said.

"Patients are exquisitely price sensitive, and if you start charging them to chat, they won't do it, and we want them to do it," he said.

What payment model works?

Firefly began with fee-for-service contracts that "did not support our model at all," Greenberg said. It moved to capitation and later built its own health plan for employers. "I think that's the only way this works," he said.

FQHCs cannot use the message billing codes, Ramunno said. In an encounter-based payment model, "we're incentivized to have the patient come in or at least call them on the phone so we can bill for it, or else we can't pay our providers."

More base funding through FQHCs' Section 330 grants would let health centers build the technology for asynchronous care, which often does not exist because it isn't paid for, and support clinicians' time on it, Ramunno said.

At Kaiser Permanente, care is funded through per-member, per-month payments, and Evans said he is paid on quality measures, not productivity. Ganguli noted that Medicare's [nced Primary Care Management codes] in theory fold asynchronous care into a monthly payment.

What should policymakers change?

Medicare risk adjustment counts diagnoses only from face-to-face or video visits, so care delivered by message goes unrecognized, Evans said.

“It would be great if we could change that spectrum and say, if you’re taking care of the patient, let’s reimburse that risk based on how you’re taking care of the patient, rather than, it was just reported in a single visit,” Evans said.

Hoy asked that payment cover “the entire loop,” including team members who triage and answer messages. Ganguli said better risk adjustment could steer resources to the clinicians doing the most inbox work.

“Trying to pay per unit per patient is just a fool’s errand. It needs to be capitated,” Ramunno said.

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