Letters

RESEARCH LETTER

HEALTH CARE POLICY AND LAW

Use of and Revenue From the G2211 Longitudinal Care Code Among Primary Care Clinicians and Practices

Primary care has well-demonstrated population health benefits, but full realization of these benefits has been constrained by underinvestment.[1] In January 2024, the Centers for Medicare & Medicaid Services introduced billing code G2211 to better support longitudinal, relationship-based care,[2] a core primary care function historically undervalued in Medicare's physician fee schedule.[1] This visit add-on code (reimbursement of approximately $16) can be included on evaluation and management visits where the clinician serves as the patient's ongoing focal point of care or primarily manages a serious or complex condition. While early uptake of G2211 across specialties has been documented,[3] prior studies have not examined how primary care practitioners (PCPs; including nurse practitioners and physician assistants) and practices are using G2211, whether use reflects established beneficiary-PCP relationships, and how use may contribute to primary care revenue.

Supplemental content

Methods | Using 2023-2024 100% traditional Medicare claims, we conducted a cross-sectional descriptive study of G2211 billing for eligible primary care visits among adults continuously enrolled from 2023 to 2024, attributed to a PCP in 2023 (based on Medicare Shared Savings Program methodology[4]), and with 1 or more primary care visits in 2024 (eMethods in Supplement 1). G2211-eligible primary care visits were evaluation and management visits (*Current Procedural Terminology* codes 99202-99205 and 99211-99215, excluding modifier 25) with a PCP (defined using specialty codes and prescribing-based algorithms[5]). To assess whether G2211 uptake aligned with established beneficiary-PCP relationships, we used prior-year PCP attribution as a proxy. We classified each visit as occurring with the attributed PCP, with another PCP in the same practice (practice defined by tax identification number), or with a PCP in a different practice.

We described G2211 billing overall and by the beneficiary's relationship to the visit PCP. We estimated associations of patient, PCP, and practice characteristics (eMethods in Supplement 1) with G2211 billing using a visit-level mixed-effects modified Poisson regression with random intercepts for PCPs nested within practices. We estimated the share of explained variance attributed to sequentially ordered patient-, clinician-, and practice-level covariates. Finally, we estimated observed and potential G2211 primary care practice revenue weighted by number of attributed patients under alternative uptake scenarios in which all eligible visits within each beneficiary-PCP relationship category were billed with G2211. See eMethods in Supplement 1 for additional details.

This study followed STROBE reporting guidelines. The study was deemed exempt from review by Mass General Brigham's institutional review board owing to use of deidentified data.

Results | Among 16 165 992 PCP-attributable beneficiaries with an eligible primary care visit in 2024, 11 105 805 (18.0%) eligible primary care visits included G2211 billing (**Table**). More than one-third of these beneficiaries' PCPs (93 410 of 243 377 [38.4%]) and 11 015 of 48 343 (22.8%) beneficiaries' practices billed G2211 at least once. Among those billing G2211, median (IQR) G2211 use was 27.2% (7.9%-48.9%) for PCPs and 19.8% (5.0%-43.4%) for practices.

Of G2211-billed primary care visits, 7 591 792 (68.4%) occurred with the attributed PCP, 1 826 115 (16.4%) with another PCP in the same practice, and 1 687 898 (15.2%) with a PCP in a different practice (**Figure**). Among G2211-eligible visits, the proportion of G2211 billing was 20.2% for visits with the attributed PCP, 17.0% for visits with other PCPs in the same practice, and 12.4% for visits with PCPs in a different practice. In adjusted models, more variation in visit-level G2211 billing was attributed to practice-level (31.7%) and clinician-level characteristics (22.2%) than to patient-level characteristics (4.3%). G2211 billing was more likely for visits involving patients of White race or with more chronic conditions, physicians (vs nurse practitioners or physician assistants) or PCPs with fewer years since training, or larger practices or practices with a greater share of primary care clinicians (Table). G2211 billing was rare in urgent care and retail clinic settings.

The patient-weighted median (IQR) G2211 revenue generated by G2211-billing practices was $67 179 ($14 337-$208 261), representing a median (IQR) 1.4% (0.6%-2.1%) of total primary care revenue per practice (median [IQR], $6 343 757 [$2 016 459-$16 305 706]). If G2211 were billed for all eligible visits with attributed PCPs, practices could generate an additional median (IQR) of $103 375 ($17 550-$313 355) per practice. Alternatively, billing all eligible visits with any PCP in the attributed practice could yield an additional median (IQR) of $154 854 ($21 445-$477 458) per practice.

Discussion | In this national study of primary care visits in traditional Medicare, there was substantial early uptake of G2211 billing (though less than the 90% projected by the Centers for Medicare & Medicaid Services[2]), most commonly in visits with beneficiaries' attributed PCPs. Differences in billing by beneficiary-PCP relationship were small, and substantial variation in G2211 use was associated with practice- and clinician-level factors. While nonattributed clinicians within practices contribute to team-based continuity, the results suggest that the longitudinal relationships G2211 was intended to support may not be the primary driver of billing decisions. Greater uptake in larger practices likely reflects resources needed to capitalize on billing opportunities, consistent with evidence

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Table. Patient, Clinician, and Practice Characteristics Associated With G2211 Billing in Primary Care Visits[a]

Characteristic	Total, No.[b]	G2211 billed, No. (%)[b]	Adjusted relative risk (95% CI)
Total	61 825 604	11 105 805 (18.0)	NA
Patient level			
Age, y			
<65	4 308 690	592 889 (13.8)	0.91 (0.91-0.92)
65-74	24 049 971	4 205 715 (17.5)	1 [Reference]
75-84	24 240 906	4 564 554 (18.8)	1.05 (1.05-1.05)
≥85	9 226 037	1 738 647 (18.8)	1.05 (1.05-1.06)
Sex			
Female	36 255 866	6 212 281 (17.1)	0.99 (0.99-0.99)
Male	25 596 920	4 983 902 (19.5)	1 [Reference]
Race and ethnicity[c]			
Asian	1 872 867	260 012 (13.9)	0.92 (0.91-0.92)
Hispanic	2 848 957	362 814 (12.7)	0.81 (0.81-0.82)
Non-Hispanic Black	3 828 877	653 198 (17.1)	0.96 (0.96-0.96)
Non-Hispanic White	51 124 007	9 469 885 (18.5)	1 [Reference]
Other	2 150 896	359 926 (16.7)	0.94 (0.93-0.94)
Medicaid eligibility			
Dual eligible	7 253 451	913 120 (12.6)	0.84 (0.84-0.84)
Non-dual eligible	54 572 153	10 192 685 (18.7)	1 [Reference]
No. of chronic conditions			
0-1	5 806 761	905 585 (15.6)	1 [Reference]
2-5	27 580 792	4 995 809 (18.1)	1.12 (1.12-1.12)
≥6	28 438 051	5 204 360 (18.3)	1.17 (1.17-1.18)
Clinician level			
Sex			
Female	27 840 940	4 874 828 (17.5)	1.01 (1.01-1.01)
Male	33 956 445	6 230 823 (18.3)	1 [Reference]
Years since training			
1-10	14 041 476	2 480 433 (17.7)	1 [Reference]
11-20	12 372 992	2 392 334 (19.3)	0.97 (0.97-0.97)
21-30	15 279 644	3 045 999 (19.9)	0.96 (0.96-0.96)
≥31	18 261 961	2 969 998 (16.3)	0.81 (0.81-0.81)
Specialty/training			
Internal medicine	22 625 048	4 606 230 (20.4)	1 [Reference]
Family medicine	22 313 837	4 322 043 (19.4)	0.97 (0.97-0.97)
General practice	806 691	62 259 (7.7)	0.58 (0.57-0.58)
Other primary care physician[d]	633 221	150 819 (23.8)	1.14 (1.14-1.15)
Nurse practitioner or physician assistant	15 446 807	1 964 454 (12.7)	0.52 (0.52-0.53)
Practice level			
Total clinicians			
1	8 296 058	774 380 (9.3)	1 [Reference]
2-10	6 151 296	1 091 082 (17.7)	1.71 (1.71-1.72)
11-50	10 895 106	1 615 990 (14.8)	2.39 (2.38-2.40)
≥51	36 483 144	7 624 353 (20.9)	3.06 (3.05-3.08)
Clinicians in primary care, %			
0-49	28 393 279	5 037 738 (17.4)	1 [Reference]
50-99	13 869 552	3 206 922 (23.1)	1.27 (1.27-1.28)
100	18 311 572	2 682 013 (14.6)	1.33 (1.33-1.34)

(continued)

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Table. Patient, Clinician, and Practice Characteristics Associated With G2211 Billing in Primary Care Visits[a] (continued)

Characteristic	Total, No.[b]	G2211 billed, No. (%)[b]	Adjusted relative risk (95% CI)
Region			
Northeast	11 119 626	1 953 836 (17.6)	1 [Reference]
South	25 739 135	4 903 332 (19.1)	1.08 (1.08-1.09)
Midwest	11 959 005	2 149 301 (18.0)	0.97 (0.97-0.97)
West	12 104 292	1 936 741 (16.0)	0.95 (0.95-0.95)
Urbanicity			
Metropolitan	57 890 421	10 413 869 (18.0)	0.95 (0.94-0.95)
Nonmetropolitan	3 935 183	691 936 (17.6)	1 [Reference]
Clinic type			
Urgent/retail clinic	280 032	8540 (3.0)	0.11 (0.11-0.12)
Non-urgent/retail clinic	61 545 572	11 097 265 (18.0)	1 [Reference]

Abbreviation: NA, not applicable.

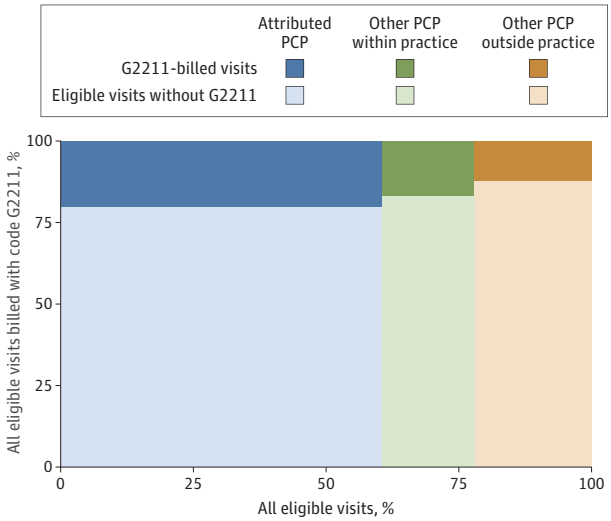
[a] Adjusted results are from a multivariable model that includes all included covariates.

[b] Groups may not sum to the total in cases with missing data.

[c] Race and ethnicity data are based on Research Triangle Institute codes in Centers for Medicare & Medicaid Services claims data (see eMethods in Supplement 1). Other race includes American Indian or Alaska Native and unknown/other (all individuals whose race could not be sorted into one of the other named categories). These categories were grouped together owing to small sample sizes.

[d] Other primary care specialties include pediatrics, geriatrics, and preventive medicine.

Figure. Graph of Primary Care Visits by G2211 Billing Status and Patient–Primary Care Practitioner (PCP) Relationship



Shaded areas represent the number of visits in each group among all eligible visits (N = 61 825 604). Group-specific proportions of G2211-biled visits among eligible visits were 20.2% (7 591 792 of 37 495 086) among attributed PCPs, 17.0% (1 826 115 of 10 751 056) among other PCPs within practice, and 12.4% (1 687 898 of 13 579 462) among other PCPs outside the practice.

on other new Medicare codes.[6,7] Because we defined these practices using tax identification numbers (the heterogeneous levels of organization under which practices bill and receive payments[6,7]), findings should be interpreted in this context.

These findings suggest that as G2211 becomes more established, it could meaningfully contribute to primary care financing alongside other incremental efforts by Medicare.[1] At the same time, given challenges in targeting payments to primary care via visit-based, specialty-agnostic mechanisms,[3] Medicare's goals to strengthen primary care[8] may be better met through direct support of primary care functions (eg, through prospective, population-based payments).

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