2012 Medicare Physician Fee Schedule
Final Rule Summary

On November, 1, 2011, the Centers for Medicare and Medicaid Services (CMS) posted the final Medicare Physician Fee Schedule (MPFS) for 2012. It is expected to be published in the Federal Register on November 28. The rule in its entirety can be found here. The addenda to the rule, including Addendum B, which lists the proposed RVUs for each CPT code, can be found here. The provisions of the rule will be effective January 1, 2012 unless stated otherwise. Comments on those issues subject to comment are due by January 3, 2012.

Highlights of the rule include:

- **Conversion Factor:** Without congressional action, the conversion (CF) will be reduced by 27.4 percent in 2012, due to the SGR formula. Assuming that Congress acts to prevent this reduction, as it has in previous years, we estimate a 2012 CF identical to the 2011 CF of $33.9764 in the prepared charts.
- **Specialty Impact:** The total impact on payment to the average neurologist based on the changes made by the rule is estimated to be a 1% increase for 2012 and a 3% increase in 2013 although the impact on an individual physician will vary depending on the mix of services provided.
- **RUC Review of Potentially Misvalued Codes:** CMS has asked the AMA's Relative Value Update Committee (RUC) to review a number of high volume codes which have not been reviewed in the last 6 years. Included in this request is CPT Code 95819 – Electroencephalogram (EEG), including recording awake and asleep. In the proposed rule, CMS had proposed that the RUC review virtually all of the E/M codes. However, based on comments received CMS decided to withdraw this request to the RUC.
- **Physician Quality Reporting System (PQRS):** CMS is adopting three epilepsy quality measures for claims-based reporting in 2012. These measures are:
  - Documentation of Current Seizure Frequency(ies) of each current seizure type
  - Documentation of Epilepsy Etiology or Epilepsy Syndrome
  - Counseling for Women of Childbearing Potential with Epilepsy

Specialty Impact

Table 84 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The impact, positive or negative, is due to a number of factors highlighted in the table, particularly the continued transition to the new practice expense (PE) values (2012 is the third year of the 4-year transition), the change in the weights assigned to physician work, PE and professional liability insurance (PLI) components, and other changes in the proposed rule.

The overall impact of the 2012 proposed rule on epilepsy services is shown below.

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (mil)	Impact of Work & MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			2013	2012	2013	2012
TOTAL	$83,014	0%	0%	0%	0%	0%
NEUROLOGY	$1,533	0%	3%	2%	3%	1%
NEUROSURGERY	$650	-1%	0%	0%	-1%	-1%

*Table 84 does not include the effects of the January 2012 conversion factor.

Attached to this summary are several charts comparing payment for evaluation and management services (E/M) and neurology-related procedural services from 2011 to 2012. Overall, E/M services will either show no change or a change in the range of + or – 1 percent. The technical component and global service for most of the diagnostic testing procedures (EEGs, evoked potential, etc.) will see substantial increases in payment. For example, the TC for the highest volume EEG code, 95819, will see a 20 percent increase. Most professional component services are either flat for 2012 or will see a modest reduction (less than 1 percent). Epilepsy surgery services payments are relatively flat or modestly increasing.

RUC Review of Potentially Misvalued Codes

In the proposed rule, CMS asked that the RUC review the physician work and practice expense values for all of the evaluation and management (E/M) codes along with a number of high volume/high expenditure services which had not been reviewed by the RUC in the last 6 years. CMS has asked that the following neurology code be reviewed: 95819 – Electroencephalogram (EEG), including recording awake and asleep.

In the final rule, CMS stated that a majority of the commenters indicated that a reexamination of the values of E/M services was not likely to be productive since these codes were recently reviewed and urged CMS to drop the request. CMS accepted these comments and will not ask the RUC to review the E/M codes at this time. A number of commenters, however, urged CMS to recognize some of the non-face-to-face services, such as telephone calls and team conferences, provided by primary care and other physicians who provide care to chronically ill patients. In response, CMS indicated it will continue to explore the valuations of E/M services and other refinements to the physician fee schedule.

Consistent with the proposed rule, in the final rule, CMS asked the RUC to review some 70 of the highest volume procedural codes which have not been reviewed in the last 6 years.

Multiple Procedure Payment Reductions

Currently a 50% multiple procedure payment reduction (MPPR) is applied to the technical component of (TC) of advanced imaging codes provided in the same session**.** This policy is based on the assumption that there are efficiencies in labor, supplies and equipment when more than one imaging procedure is performed. The policy was extended to the Practice Expense (PE) of therapy services (PT, speech therapy and occupational therapy). A 20 percent reduction is applied to the PE of the second and additional therapy codes billed the same day.

In the proposed rule, CMS proposed to apply a 50 percent reduction to the Professional Component of multiple advanced imaging services (MRI, PET, CT) performed in the same session based on the rationale that there are efficiencies when multiple images are interpreted. In the final rule, CMS decided to proceed with this change but has reduced the MPPR adjustment to a 25 percent reduction.

CMS indicated it is still considering additional options which were discussed in the proposed rule to extend the application of the MPPR in the future including:

- Applying the MPPR to the TC of all imaging codes, not just advanced imaging.
- Applying the MPPR to the PC of all imaging codes
- Applying the MPPR to the TC of all diagnostic codes including radiology, audiology, cardiology, neurology, etc.

Geographic Practice Expense Index (GPCI)

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements. CMS is finalizing several changes to the GPCI and how it is applied to payment for physician services:

- A technical change in how the GPCI applies to office rents, purchased services and employee compensation.
- Implementation of a provision of the Affordable Care Act establishing a PE index of 1.0 in several so-called frontier states. These are Montana, Wyoming, North Dakota, South Dakota and Nevada. A PE index of 1.0 would be equivalent to the national average. The actual GPCI in these states would be less than 1.0 so this change raises payments in these states.
- Elimination of the statutory floor on the GPCI the authority for which expired to protect lower cost and rural areas.

While the overall impact of the GPCI changes will be modest (in the range of +/- 1 or 2 percent), removing the floor in some areas will lead to substantial reductions in payment. For instance, payments in Puerto Rico will be reduced by 15 percent and in West Virginia, Oklahoma, Mississippi, Iowa, Kentucky and Arkansas will be reduced by -5 to -6 percent. There are a few geographic areas that will see some increases in the 2-3% range as a result of the change including Seattle Washington and some Maryland localities. Table 86 in the rule, which is attached as Attachment 2, has a complete listing of the estimated changes in the weighted geographic adjustment factor by locality.

Telehealth Services

CMS is adding smoking cessation counseling to the list of approved telehealth services. CMS is also changing the criteria it uses to approve additional telehealth services. CMS also modified the definition of the G codes for inpatient telehealth consultations to include telehealth consultations in an emergency department setting.

Bundling of Payments in Wholly-Owned Physician Practices

For physician practices and other entities that are wholly owned or wholly operated by a hospital, CMS is finalizing its proposal that payment for all diagnostic services and any non-diagnostic services clinically related to a hospital admission and provided within three days of the admission be bundled into the DRG payment. Essentially what this means is that for services with both a professional (PC)) and technical component (TC), only the PC will be paid under Medicare Part B by the carrier and the TC will be considered bundled into the hospital's payment. For codes without a PC/TC breakdown, the physician would only get paid at the facility rate for the practice expenses. In the proposed rule, CMS indicated this policy applied to physician practices that were wholly owned or operated and in the final rule it is extended to other "entities," such as ambulatory surgery centers.

Beginning on January 1, 2012, CMS is establishing a payment modifier, PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days, or 1 day). Wholly owned or wholly operated entities should begin to append the modifier to claims subject to the 3-day payment window at that time. While the modifier is available beginning January 1, 2012, hospitals and their wholly owned or wholly operated entities are not required to utilize it until July 1, 2012, to give them additional time to fully coordinate their billing and to properly bill for diagnostic and related nondiagnostic services subject to the 3-day payment window policy.

2012 Physician Quality Reporting System (PQRS)

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress. Under the current program, those who successfully report quality measures in CY 2012 – 2014 will receive a bonus payment of 0.5 percent of total allowed charges for services provided during the reporting period. An additional 0.5 percent will be available for those who participate in a maintenance of certification (MOC) program required for board certification by a recognized physician specialty organization.

Beginning in 2015, penalties will be assessed for those who do not satisfactorily submit quality date. The initial penalty will be 1.5 percent and rise to 2.0 percent in CY 2016. The reporting period for the 2015 payment adjustment will be January 1, 2013 through December 31, 2013.

For 2012, CMS approved 28 new measures for a total of 211 measures for reporting by claims or registry and 8 new measure groups for a total of 22 measure groups, which are mostly reported by registry.

Epilepsy Measures. CMS is adopting three epilepsy quality measures for claims-based reporting in 2012. These measures are:

- Documentation of Current Seizure Frequency(ies) of each current seizure type
- Documentation of Epilepsy Etiology or Epilepsy Syndrome
- Counseling for Women of Childbearing Potential with Epilepsy

CMS had proposed two additional measures - Querying and Counseling about Anti-Epileptic Drug (AED) Side Effects and Counseling about Epilepsy Specific Safety Issues – in the proposed rule, but withdrew these measures in the final rule because they were not endorsed by the National Quality Forum.

To successfully report the epilepsy measures for reporting period Jan 1, 2012 – Dec 31, 2012 the eligible professional must:

- Report at least three Physician Quality Reporting System measures; OR
- If less than three measures apply to the eligible professional, report 1-2 measures; AND
- Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
- Measures with a 0% performance rate will not be counted.

An eligible professional (EP) who reports on fewer than three measures through the claims-based reporting mechanism may be subject to the Measure Applicability Validation (MAV) process, which will allow CMS to determine whether an eligible professional should have reported quality data codes for additional measures. Under the MAV process, when an eligible professional reports on fewer than 3 measures, CMS will perform a review to determine whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of eligible professional). If an eligible professional who reports on fewer than 3 measures in 2012 reports on a measure that is part of an identified cluster of closely related measures and does not report on any other measure that is part of that identified cluster of closely related measures, then the eligible professional will not qualify as a satisfactory reporter in the 2012 Physician Quality Reporting System or earn an incentive payment.

Maintenance of Certification Program. The ACA provided for an additional mechanism for reporting quality measures through a Maintenance of Certification Program operated by a specialty board of the ABMS. An additional bonus payment of 0.5 percent for years 2011 through 2014 is provided if the eligible professional participates in the Maintenance of Certification Program for at least one year and completes a Maintenance of Certification Program practice assessment. Maintenance of Certification Programs must qualify as a Physician Quality Reporting System registry in order to submit quality measures on behalf of EPs.

For CY 2012 through 2014, CMS is requiring an eligible professional to participate more frequently than is required in at least one of the four parts of the MOC program. CMS has decided to defer to the entity sponsoring the MOC program to determine if the "more frequently" requirement is met. However, CMS

is requiring that the eligible professional participate in and successfully complete a MOC program practice assessment for the year. An eligible professional may participate in more than one MOC program sponsored by a specialty board or other entity, but only one incentive payment will be provided.

Group Practice Reporting Option (GPRO). CMS finalized its proposal to limit participation in the GPRO to group practices of 25 or more eligible professionals. Those wishing to participate under GPRO would be required to self-nominate by January 31, 2012. Practices wishing to participate in the PQRS and the e-Prescribing (eRx) GPRO programs must indicate that in the self-nomination statement. CMS approved 29 quality measures for reporting under the GPRO, none of which are epilepsy measures.

More information on PQRS can be found here.

The Electronic Prescribing Incentive Program (eRx program)

Electronic prescribing is the transmission using electronic media of prescription or prescription-related information between the prescriber, dispenser, pharmacy benefit manager or health plan, using an electronic prescribing network. The program provides for a combination of incentives and payment adjustments through 2014.

The eRx incentive payment for 2012 is 1.0 percent and 0.5 percent for 2013. Eligible professionals and group practices who are successful e-prescribers may earn an incentive payment based on the estimated total allowed charges for services under Medicare Part B provided during the reporting period. To qualify for the program, eligible practitioners will need to submit e-prescribing measures for at least 25 unique electronic prescribing events in 2012. For group practices of 25-99 and of 100 or more, they must report 625 and 2,500 unique measures respectively. Eligible professionals can report via claims, qualified registry or qualified EHR; however, the requirement must be met by reporting through a single mechanism.

Starting in 2012, eligible professionals who are not successful or do not participate will encounter reductions to their Medicare payments equal to: – 1% in 2012; – 1.5% in 2013; and -2.0% in 2014.
To avoid the 2013 payment adjustment, electronic prescribing measures must be reported at least 25 times between January 1, 2011 – December 31, 2011 or 10 times between January 1, 2012 – June 30, 2012 by individual eligible providers. Group practices of 25-99 must report 625 times and group practices of 100 or more must report 2500 or more times between January 1, 2012 and June 30, 2012.

To avoid the 2014 payment adjustment electronic prescribing measures must be reported 25 times by individuals between January 1, 2012 and December 31, 2012 or 10 times between January 1, 2013 and June 30, 2013. Group practices of 25-99 must report the electronic prescribing measure 625 times between January 1, 2012 and December 31, 2012 or 625 times between January 1, 2013 and June 30, 2013. Group practices of 100 or more must report the electronic prescribing measure 2,500 times between January 1, 2012 and December 31, 2012 or 2,500 times between January 1, 2013 and June 30, 2013.

Significant Hardship Exemptions. The Secretary may exempt eligible professionals from the payment adjustment on a case-by-case basis if complying with the requirement would result in a significant hardship. CMS is proposing the following exemptions:

- The eligible professional or eRx GPRO practices in a rural area with limited high speed internet access.
- The eligible professional or eRx GPRO practices in an area with limited available pharmacies for electronic prescribing.
- Inability to prescribe due to local, state or federal law or regulation.

- Eligible professionals who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period.

Those who believe they qualify under one of the exemptions must provide the following information to CMS by June 30, 2012 for the 2013 payment adjustment and June 30, 2013 for the 2014 payment adjustment:

- The name of the practice and other identifying information.
- The proposed exemption that applies.
- A justification statement describing how compliance would create a significant hardship.
- An attestation of the accuracy of the information provided.

More information on the eRx incentive program can be found here.

Medicare EHR Incentive Program

CMS finalized its proposal to allow eligible professionals participating in the Medicare EHR Incentive Program to report clinical quality measures (CQMs) in 2012 by attesting to the CQMs utilizing CMS certified EHRs or by participating in the voluntary PQRS-Medicare EHR Incentive Pilot. For those individuals participating in the pilot, measures can be submitted either through a PQRS EHR data submission vendor or from a certified PQRS EHR via a web portal. CMS has approved 44 EHR Incentive Program measures.

More information on the EHR incentive program can be found here.

Value-Based Payment Modifier

The ACA directed CMS to apply a separate, budget-neutral payment modifier, known as the value-based payment modifier, to the physician fee schedule payment formula which will be phased in beginning January 1, 2015 through January 1, 2017. The modifier will provide for differential payment under the fee schedule to a physician or group of physicians, and later possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. The final rule sets the initial performance year as CY 2013. Performance during 2013 will be used to calculate the modifier that would apply to items and services furnished under the 2015 MPFS. The quality measures for 2013 are identified in the rule as the PQRS core set (cardiovascular conditions) and Group Practice Reporting Option measures and EHR incentive program measures, which are listed in Tables 80 and 81 of the rule. There are no neurology-related measures included at this time. The rule also describes how cost measures for the conditions (related to the quality measures) will be developed. CMS will propose the complete methodology for the value modifier in the CY 2013 MPFS proposed rule.

More information on the value-based modifier program can be found here.

Attachment 1

TABLE 84: CY 2012 PFS FINAL RULE WITH COMMENT PERIOD TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU AND MPPR CHANGES*

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (in millions)	Impact of Work and MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			Full	Tran	Full	Tran
TOTAL	$83,313	0%	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$196	0%	-1%	-1%	-1%	-1%
ANESTHESIOLOGY	$1,756	0%	2%	1%	2%	1%
CARDIAC SURGERY	$386	0%	-2%	-2%	-3%	-2%
CARDIOLOGY	$6,808	0%	-3%	-1%	-3%	-2%
COLON AND RECTAL SURGERY	$147	0%	3%	2%	3%	1%
CRITICAL CARE	$255	0%	0%	0%	0%	-1%
DERMATOLOGY	$2,950	0%	1%	1%	1%	1%
EMERGENCY MEDICINE	$2,677	0%	-1%	-1%	0%	-1%
ENDOCRINOLOGY	$416	0%	2%	1%	2%	1%
FAMILY PRACTICE	$5,689	0%	2%	1%	2%	1%
GASTROENTEROLOGY	$1,852	0%	1%	0%	1%	0%
GENERAL PRACTICE	$655	0%	2%	1%	2%	1%
GENERAL SURGERY	$2,285	0%	1%	0%	1%	0%
GERIATRICS	$203	0%	2%	1%	3%	1%
HAND SURGERY	$123	0%	2%	1%	2%	1%
HEMATOLOGY/ONCOLOGY	$1,922	0%	-1%	0%	-1%	0%
INFECTIOUS DISEASE	$601	0%	2%	1%	2%	1%
INTERNAL MEDICINE	$10,826	0%	2%	1%	2%	1%
INTERVENTIONAL PAIN MGMT	$450	-2%	0%	0%	-1%	-2%
INTERVENTIONAL RADIOLOGY	$208	-1%	-3%	-1%	-4%	-2%
MULTISPECIALTY CLINIC/OTHER	$91	1%	0%	0%	1%	1%
NEPHROLOGY	$2,022	0%	0%	0%	0%	0%
NEUROLOGY	$1,533	0%	3%	2%	3%	1%
NEUROSURGERY	$650	-1%	0%	0%	-1%	-1%
NUCLEAR MEDICINE	$54	0%	-3%	-1%	-3%	-1%
OBSTETRICS/GYNECOLOGY	$679	0%	1%	1%	1%	1%
OPHTHALMOLOGY	$5,328	0%	3%	2%	3%	1%
ORTHOPEDIC SURGERY	$3,584	-1%	0%	0%	0%	-1%
OTOLARNGOLOGY	$1,003	0%	2%	1%	2%	1%
PATHOLOGY	$1,129	0%	-2%	-1%	-2%	-1%
PEDIATRICS	$68	0%	1%	0%	1%	0%
PHYSICAL MEDICINE	$933	0%	2%	1%	2%	1%
PLASTIC SURGERY	$343	0%	2%	1%	1%	0%
PSYCHIATRY	$1,154	0%	0%	0%	0%	0%
PULMONARY DISEASE	$1,769	-1%	-1%	-1%	-1%	-2%
RADIATION ONCOLOGY	$1,981	0%	-10%	-6%	-10%	-6%
RADIOLOGY	$4,716	-1%	-4%	-2%	-5%	-3%
RHEUMATOLOGY	$528	0%	-1%	0%	-1%	-1%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges (in millions)	Impact of Work and MP RVU Changes	Impact of PE RVU Changes		Combined Impact	
			Full	Tran	Full	Tran
THORACIC SURGERY	$369	-1%	-2%	-1%	-3%	-2%
UROLOGY	$1,925	0%	-3%	-2%	-3%	-2%
VASCULAR SURGERY	$745	0%	-2%	-1%	-2%	-1%
AUDIOLOGIST	$57	1%	-8%	-5%	-7%	-4%
CHIROPRACTOR	$752	0%	2%	2%	2%	2%
CLINICAL PSYCHOLOGIST	$567	0%	-5%	-3%	-5%	-3%
CLINICAL SOCIAL WORKER	$394	0%	-6%	-3%	-6%	-3%
DIAGNOSTIC TESTING FACILITY	$839	0%	-8%	-3%	-8%	-3%
INDEPENDENT LABORATORY	$1,057	0%	-3%	-1%	-3%	-1%
NURSE ANES / ANES ASST	$738	0%	3%	2%	3%	2%
NURSE PRACTITIONER	$1,385	0%	2%	1%	2%	1%
OPTOMETRY	$990	0%	4%	2%	4%	2%
ORAL/MAXILLOFACIAL SURGERY	$44	0%	3%	2%	3%	2%
PHYSICAL/OCCUPATIONAL THERA	$2,349	0%	6%	4%	6%	4%
PHYSICIAN ASSISTANT	$1,021	0%	1%	0%	1%	0%
PODIATRY	$1,921	0%	4%	2%	4%	2%
PORTABLE X-RAY SUPPLIER	$99	0%	5%	4%	5%	4%
RADIATION THERAPY CENTERS	$74	0%	-11%	-6%	-11%	-6%
OTHER	$18	0%	3%	3%	3%	3%

* Table 84 shows only the payment impact on PFS services. We note that these impacts do not include the effects of the January 2012 conversion factor change under current law.

Attachment 2

TABLE 86: CY 2012 GEOGRAPHIC ADJUSTMENT FACTORS (GAFS) CHANGES UNDER CURRENT LAW AND THE FINAL RULE WITH COMMENT PERIOD

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	**CY 2011 GAF**	**CY 2012 GAF (Current law/reg)**	**CY 2012 GAF (Final Rule)**	**% Change CY 2011 to CY 2012 (current)** Col (C)/ Col (B)-1	**% Change CY 2012 (Curr) to CY 2012 (Final)** Col (D)/ Col (C)-1	**% Change Combined Impact CY 2011 to CY 2012** Col (D)/ Col (B)-1
PUERTO RICO	0.903	0.786	0.771	-13%	-2%	-15%
WEST VIRGINIA	0.972	0.910	0.910	-6%	0%	-6%
OKLAHOMA	0.955	0.904	0.898	-5%	-1%	-6%
MISSISSIPPI	0.961	0.910	0.908	-5%	0%	-6%
REST OF MISSOURI	0.962	0.903	0.909	-6%	1%	-5%
ARKANSAS	0.945	0.893	0.896	-6%	0%	-5%
REST OF LOUISIANA	0.965	0.914	0.915	-5%	0%	-5%
IOWA	0.950	0.898	0.903	-5%	1%	-5%
KENTUCKY	0.959	0.917	0.914	-4%	0%	-5%
BEAUMONT, TX	0.978	0.925	0.933	-5%	1%	-5%
ALABAMA	0.949	0.905	0.908	-5%	0%	-4%
TENNESSEE	0.959	0.918	0.918	-4%	0%	-4%
NEBRASKA	0.947	0.905	0.909	-4%	0%	-4%
REST OF MAINE	0.961	0.922	0.923	-4%	0%	-4%
IDAHO	0.959	0.926	0.923	-3%	0%	-4%
SOUTH CAROLINA	0.959	0.925	0.925	-4%	0%	-4%
KANSAS	0.964	0.923	0.930	-4%	1%	-4%
INDIANA	0.966	0.928	0.932	-4%	0%	-4%
METROPOLITAN BOSTON	1.106	1.079	1.068	-2%	-1%	-3%
REST OF GEORGIA	0.970	0.936	0.937	-4%	0%	-3%
REST OF TEXAS	0.973	0.934	0.940	-4%	1%	-3%
NORTH CAROLINA	0.970	0.934	0.938	-4%	0%	-3%
UTAH	0.982	0.946	0.951	-4%	1%	-3%
MANHATTAN, NY	1.153	1.142	1.118	-1%	-2%	-3%
REST OF PENNSYLVANIA	0.986	0.957	0.958	-3%	0%	-3%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	**CY 2011 GAF**	**CY 2012 GAF (Current law/reg)**	**CY 2012 GAF (Final Rule)**	**% Change CY 2011 to CY 2012 (current)** Col (C)/ Col (B)-1	**% Change CY 2012 (Curr) to CY 2012 (Final)** Col (D)/ Col (C)-1	**% Change Combined Impact CY 2011 to CY 2012** Col (D)/ Col (B)-1
LOS ANGELES, CA	1.106	1.099	1.075	-1%	-2%	-3%
NEW ORLEANS, LA	1.005	0.980	0.977	-2%	0%	-3%
SOUTH DAKOTA**	0.978	0.952	0.951	-3%	0%	-3%
NEW MEXICO	0.979	0.949	0.954	-3%	1%	-3%
REST OF ILLINOIS	0.985	0.950	0.960	-4%	1%	-3%
REST OF MICHIGAN	0.985	0.962	0.962	-2%	0%	-2%
ALASKA*	1.289	1.289	1.259	0%	-2%	-2%
VENTURA, CA	1.113	1.105	1.091	-1%	-1%	-2%
REST OF NEW YORK	0.965	0.948	0.946	-2%	0%	-2%
CONNECTICUT	1.094	1.086	1.074	-1%	-1%	-2%
MONTANA**	0.996	0.976	0.978	-2%	0%	-2%
OHIO	0.992	0.970	0.975	-2%	1%	-2%
METROPOLITAN KANSAS CITY, MO	0.996	0.975	0.979	-2%	0%	-2%
NORTH DAKOTA**	0.979	0.964	0.963	-2%	0%	-2%
ANAHEIM/SANTA ANA, CA	1.129	1.129	1.111	0%	-2%	-2%
NYC SUBURBS/LONG I., NY	1.161	1.159	1.143	0%	-1%	-2%
SAN MATEO, CA	1.199	1.194	1.182	0%	-1%	-1%
REST OF FLORIDA	1.014	0.996	1.000	-2%	0%	-1%
HAWAII	1.074	1.091	1.060	2%	-3%	-1%
EAST ST. LOUIS, IL	1.016	0.997	1.003	-2%	1%	-1%
REST OF MASSACHUSETTS	1.040	1.039	1.027	0%	-1%	-1%
REST OF OREGON	0.968	0.950	0.956	-2%	1%	-1%
SAN FRANCISCO, CA	1.198	1.194	1.185	0%	-1%	-1%
WISCONSIN	0.965	0.949	0.955	-2%	1%	-1%
ARIZONA	0.989	0.977	0.979	-1%	0%	-1%
FORT WORTH, TX	0.991	0.981	0.982	-1%	0%	-1%
VERMONT	0.982	0.980	0.974	0%	-1%	-1%
METROPOLITAN ST. LOUIS, MO	0.988	0.971	0.980	-2%	1%	-1%
NORTHERN NJ	1.120	1.105	1.111	-1%	1%	-1%
SOUTHERN MAINE	0.997	0.993	0.990	0%	0%	-1%
MIAMI, FL	1.108	1.100	1.101	-1%	0%	-1%
AUSTIN, TX	0.992	0.979	0.986	-1%	1%	-1%
WYOMING**	1.002	0.994	0.996	-1%	0%	-1%
HOUSTON, TX	1.008	0.992	1.002	-2%	1%	-1%
METROPOLITAN PHILADELPHIA, PA	1.068	1.062	1.062	-1%	0%	-1%
OAKLAND/BERKELEY, CA	1.133	1.136	1.128	0%	-1%	0%
VIRGINIA	0.978	0.971	0.974	-1%	0%	0%
DETROIT, MI	1.060	1.047	1.056	-1%	1%	0%
REST OF NEW JERSEY	1.074	1.066	1.072	-1%	1%	0%
BRAZORIA, TX	0.996	0.977	0.995	-2%	2%	0%
RHODE ISLAND	1.042	1.039	1.041	0%	0%	0%
DC + MD/VA SUBURBS	1.124	1.125	1.123	0%	0%	0%
MARIN/NAPA/SOLANO, CA	1.119	1.127	1.119	1%	-1%	0%
DELAWARE	1.012	1.010	1.013	0%	0%	0%

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Medicare Locality	**CY 2011 GAF**	**CY 2012 GAF (Current law/reg)**	**CY 2012 GAF (Final Rule)**	**% Change CY 2011 to CY 2012 (current)** Col (C)/ Col (B)-1	**% Change CY 2012 (Curr) to CY 2012 (Final)** Col (D)/ Col (C)-1	**% Change Combined Impact CY 2011 to CY 2012** Col (D)/ Col (B)-1
DALLAS, TX	1.004	0.997	1.005	-1%	1%	0%
FORT LAUDERDALE, FL	1.061	1.062	1.063	0%	0%	0%
VIRGIN ISLANDS	0.998	0.997	1.000	0%	0%	0%
POUGHKPSIE/N NYC SUBURBS, NY	1.037	1.039	1.040	0%	0%	0%
NEW HAMPSHIRE	1.007	1.012	1.010	0%	0%	0%
QUEENS, NY	1.140	1.150	1.144	1%	-1%	0%
CHICAGO, IL	1.081	1.076	1.085	0%	1%	0%
ATLANTA, GA	1.002	0.997	1.006	0%	1%	0%
MINNESOTA	0.969	0.968	0.973	0%	1%	0%
GALVESTON, TX	0.997	0.995	1.002	0%	1%	1%
COLORADO	0.989	0.990	0.994	0%	0%	1%
REST OF CALIFORNIA	1.025	1.038	1.032	1%	-1%	1%
REST OF WASHINGTON	0.987	0.985	0.996	0%	1%	1%
NEVADA**	1.024	1.031	1.036	1%	0%	1%
SUBURBAN CHICAGO, IL	1.061	1.059	1.077	0%	2%	2%
BALTIMORE/SURR. CNTYS, MD	1.052	1.070	1.068	2%	0%	2%
PORTLAND, OR	0.991	0.995	1.007	0%	1%	2%
REST OF MARYLAND	1.004	1.024	1.021	2%	0%	2%
SANTA CLARA, CA	1.156	1.164	1.176	1%	1%	2%
SEATTLE (KING CNTY), WA	1.045	1.056	1.075	1%	2%	3%

*GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.

** GAFs reflect a 1.0 PE GPCI floor for frontier States as required by the Affordable Care Act.