BlueCross BlueShield

BlueDistinction® Specialty Care

Selection Criteria:

2026 Bariatric Surgery

Released March 2026

BlueCross BlueShield Association

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Document Overview

The Program Selection Criteria outlines the Quality, Business, and Cost of Care Selection Criteria and evaluation processes used to determine eligibility for the Blue Distinction® Centers (BDC) for Bariatric Surgery program.

Sections of this document include:

1. Blue Distinction Centers for Bariatric Surgery
    - **Table 1:** Data Sources
2. Quality Evaluation
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Blue Distinction Centers for Bariatric Surgery

Blue Distinction Specialty Care is a national designation program, awarded by local Blue Cross and Blue Shield (BCBS) companies, recognizing healthcare providers that demonstrate expertise in delivering quality and affordable health care to meet consumers' specialty care needs – safely, effectively, and cost-efficiently. The goal of the program is to help members find both quality and value for their specialty care needs, while providing a credible foundation on which employers may customize their employee benefits.

The 2026 Blue Distinction Centers (BDC) for Bariatric Surgery program will evaluate hospitals and ambulatory surgery centers with a bariatric surgery program that provides treatment to adults and/or adolescent patients. The Program requires each site of service to be accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Designation as a BDC for Bariatric Surgery differentiates facilities locally, as well as nationally, and includes two levels of designation:

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- **Blue Distinction Centers (BDC):** Facilities recognized for their expertise in delivering specialty care.
- **Blue Distinction Centers+ (BDC+)**: Facilities recognized for their expertise and cost-efficiency in delivering specialty care.

Quality is Key: Only facilities that first meet nationally established quality measures for BDC will be considered for designation as a BDC+.

Evaluation Process

For the 2026 designation evaluation process, MBSAQIP accredited facilities across the country were considered for the Blue Distinction Centers for Bariatric Surgery designation, and were evaluated on Quality, Business, and Cost of Care components. Table 1 below outlines the data sources used for evaluation under this Program.

Table 1: Data Sources

Selection Criteria Components	Data Source	Blue Distinction Centers (BDC)	Blue Distinction Centers+ (BDC+)
Quality	• MBSAQIP Accreditation • Local Blue Plan Quality Criteria *(if applicable)*	✓	✓
Business	• Data supplied by Blue Provider Data (BPD) • Review of Blue Brands Criteria • Local Blue Plan Business Criteria *(if applicable)*	✓	✓
Cost of Care	• Blue Health Plan Claims Data • Local Blue Plan Cost Criteria *(if applicable)*		✓

Note: Designations are awarded to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) was evaluated separately for each location. Health systems and other groups of multiple facilities/clinics are not designated collectively.

Quality Evaluation

Blue Distinction Specialty Care (BDSC) programs establish a nationally consistent approach to evaluating quality with meaningful impact. The Selection Criteria continues to evolve through each evaluation cycle, consistent with medical advances and measurements in each specialty area. The measurement framework for this and other Blue Distinction programs were developed using the following guiding principles:

- Align with credible, evidence-based, transparent, nationally established measures with an emphasis on improved outcomes.
- Implement a nationally consistent evaluation approach.

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- Include measures designed to close clinical care gaps recognized as affecting longevity and quality of life and/or contributing to higher spend.
- Evolve the selection criteria, consistent with medical advances and objective measures demonstrating improved health outcomes.
- Apply a fair and consistent evaluation approach that identifies facilities that meaningfully differentiate the delivery of care.

Quality Measure Selection

Blue Cross and Blue Shield Association (BCBSA) has adopted a new and streamlined approach to identifying and evaluating all MBSAQIP-accredited facilities. This initiative is part of the ongoing evolution of the BDC for Bariatric Surgery program, aimed to reduce administrative workload, enhance program efficiency, and mitigate data delays – in a manner that is objective, transparent, and nationally consistent.

BCBSA collaborated with our analytic partner, Blue Health Intelligence (BHI), to conduct a comprehensive review of national Blue Plan claims data to evaluate bariatric surgery outcomes at both MBSAQIP accredited and non-accredited facilities. This review analyzed post-operative surgical outcomes for two primary bariatric procedures: laparoscopic sleeve gastrectomy (LSG) and primary laparoscopic Roux-en-Y gastric bypass (LRYGB) bariatric procedures (Table 2). Findings from this analysis demonstrated that MBSAQIP accredited programs consistently meet comprehensive quality standards that align with measurable patient outcomes, making additional claims-based quality requirements unnecessary. Based on this analysis, BCBSA confirmed that MBSAQIP accreditation is both an appropriate and sufficient indicator of bariatric surgical quality care. Therefore, MBSAQIP accreditation is now the sole Quality Selection Criterion for the BDC for Bariatric Surgery program.

The post-operative surgical outcome measures from Blue Plan claims, as detailed in Table 2, are not incorporated into the Quality evaluation scoring process. Instead, these measures informed the quality evaluation and MBSAQIP accreditation criterion. The outcome measures will be leveraged as part of the BDC for Bariatric Surgery program's value proposition.

Table 2: Blue Plan Claims Post-Operative Surgical Outcome Measures

Blue Plan Claims Post-Operative Surgical Outcome Measures for Primary LSG and LRYGB (Measures are not used as part of the Quality evaluation scoring process)	
30-Day Complication Rate	30-Day Surgical Site Infection Rate
30-Day Related Reoperation Rate	30-Day Inpatient Hospital Readmission/Admission (ASCs) Rate
7-Day ER Visit Rate	30-Day Anastomotic or Staple Line Leak Rate

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Quality Selection Criteria

The Quality Selection Criteria (Table 3) consist of the following components:

Table 3: Quality Selection Criteria

Quality Selection Criteria	
MBSAQIP Accreditation **Hospitals and Ambulatory Surgery Centers**	Facility must be fully accredited (with no qualifications) by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), in **all** of the following categories applicable as a hospital or ASC: **Accredited Inpatient Center:** • Comprehensive Center • Comprehensive Center with Adolescent Qualifications • Comprehensive Center with Obesity Medicine Qualifications • Comprehensive Center with Adolescent and Obesity Medicine Qualifications • Adolescent Center • Adolescent Center with Obesity Medicine Qualifications • Low Acuity Center • Low Acuity Center with Obesity Medicine Qualifications **Accredited Outpatient Center:** • Ambulatory Surgery Center • Ambulatory Surgery Center with Obesity Medicine Qualifications
Local Blue Plan Quality Criteria (if applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local quality requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for facilities located within its Service Area.

The facility must meet **all** components listed in Table 3 to meet the Quality Selection Criteria for the BDC for Bariatric Surgery designation.

Business Selection Criteria

The Business Selection Criteria (Table 4) consist of the following components:

- Bariatric Surgery procedures
- Facility Participation
- Blue Brands Criteria; and
- Local Blue Plan Business Criteria (if applicable)

The facility must meet **all** components listed in Table 4 to meet the Business Selection Criteria for the BDC for Bariatric Surgery designation.

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Table 4: Business Selection Criteria

Business Selection Criteria	
Bariatric Surgery Procedures	Facility must provide Bariatric Surgery procedures.
Facility Participation	Facility must participate in the local Blue Plan's BlueCard Preferred Provider Organization (PPO) Network.
Blue Brands Criteria	Facility and its corporate family meet BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local Blue Plan Business Criteria (if applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local business requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for facilities located within its Service Area.

Cost of Care Selection Criteria

To qualify for the BDC+ designation, an applicant facility must not only satisfy all nationally established, objective Quality and Business Selection Criteria for BDC, but also must meet **all** of the following Cost of Care Selection Criteria (Table 5). Only applicants meeting **all** Quality, Business, and Cost of Care Selection Criteria will be considered eligible for the BDC+ designation.

Table 5: Cost of Care Selection Criteria

Cost of Care Selection Criteria	
Measure Name	**Selection Criteria Description**
LRYGB Episode Volume	**Greater than or equal to five (≥ 5)** Laparoscopic Roux-en-Y Gastric Bypass Procedures (LRYGB)
LSG Episode Volume	**Greater than or equal to five (≥ 5)** Laparoscopic Sleeve Gastrectomy Procedures (LSG)
Overall Sample	Meets Either LRYGB **and/or** LSG Episode Volume
Composite Cost Index	Facility's Composite Cost Index must be **less than** the applicable State Cost Index. The State Cost Index offers local differentiation and varies objectively and consistently by State, to reflect relative cost efficiencies within each Blue Plan's Service Area.
Local Blue Plan Cost Criteria (if applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply additional local cost requirements as Local Plan Cost Selection Criteria for eligibility in a Blue Distinction Centers program, for facilities located within its Service Area.

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Quality is Key: Only facilities that first meet nationally established Quality and Business Selection Criteria for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+.

Cost of Care Selection Criteria were set based on the following market goals:

- National Cost Savings: Designated facilities must demonstrate a cost savings differential greater than 20% compared to all other facilities (based on both those evaluated and those not eligible for BDC+) across the entire national program.
- Local Service Area Differentiation: Cost savings are also evaluated within an individual Plan's Service Area, allowing for localized differentiation. These savings may vary at the State level. For further details, contact the local Blue Plan.
- Geographic Coverage and Accessibility: Broad geographic distribution and member accessibility, targeting accessibility in the majority of states and top 50 Metropolitan Statistical Areas (MSAs).

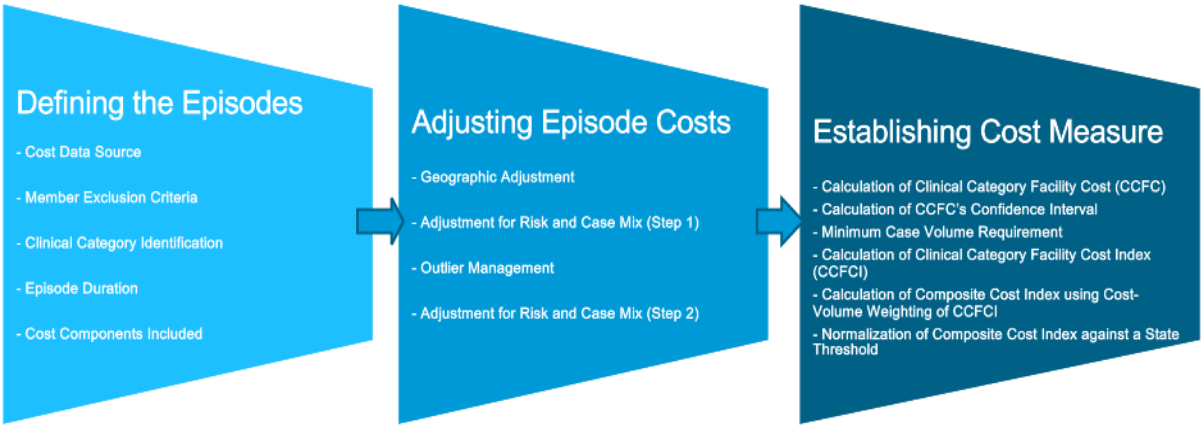
Cost of Care Evaluation

Cost of Care measures were designed in response to market and consumer demands for cost savings and more affordable health care. The Cost of Care Selection Criteria was used to provide a consistent and objective approach to identify BDC+ facilities. The following section outlines the specific inputs and methodology used in evaluating Cost of Care.

Cost of Care Methodology Framework

The Cost of Care evaluation uses a consistent framework to define and adjust episodes, and to establish and compare the resulting cost measures.

Figure 1: Cost of Care Methodology Framework Illustration



Defining Cost Episodes of Care

The Cost of Care evaluation was based on a nationally consistent analysis of Blue Plan Claims data. To provide validity for comparisons, cost analytics for the BDC for Bariatric Surgery program

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focuses on two primary procedures: laparoscopic sleeve gastrectomy (LSG) and laparoscopic Roux-en-Y gastric bypass (LRYGB).

Cost Data Source

Each facility's cost of care is calculated using adjusted allowed amounts for bariatric surgery specific episodes of care for actively enrolled Blue Members, derived from available Blue Plans' PPO claims data with an episode trigger date from **January 1, 2022, through December 31, 2024, and paid through March 31, 2025**.

Clinical Category Identification Criteria

Within the BDC for Bariatric Surgery program, episodes of care are identified using Blue Claims data and defined based CPT procedure codes billed by hospitals and physicians. The CPT codes used to trigger episodes for bariatric surgeries are detailed in Table 6 below.

Table 6: Clinical Category and CPT Procedure Codes

Clinical Category	CPT Procedure Codes
Clinical Category 1: Roux-en-Y Gastric Bypass (RYGB)	CPT 43644: Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
	CPT 43645: Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
Clinical Category 2: Sleeve	CPT 43775: Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)

For fair and accurate cost comparisons across clinical categories, adjustments are made to account for the impact of significant co-morbidities using established risk adjustment methodologies. Additionally, cases with unusually high costs are proactively managed, as outlined below.

Episode Duration and Continuous Eligibility Requirement

Each episode type has time windows before and after the episode trigger event within which services may be included. The trigger start date is the First Service Date from the facility header claim identified as the trigger claim. The episode window for both clinical categories of Bariatric surgery begin 30 days prior to date of the index admission and end 90 days following discharge from the index admission. Episodes were included in the analysis only if the member was continuously eligible for relevant (primarily PPO) BCBS benefits throughout the episode duration.

Cost Components Included in Episode

After an episode is "triggered," services are linked to the episode in a comprehensive and consistent manner to improve completeness and comparability of costs. Claims were included in all treatment episodes for which the claim was determined to be relevant. Pharmacy claims are not included in treatment episodes for facility cost evaluation.

Member Inclusion/Exclusion criteria:

The final subset of episodes included in Blue Distinction Centers+ (BDC+) measurement is identified by applying inclusion or exclusion criteria based on both general episode characteristics

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and procedure-specific clinical logic (i.e., BCBS PPO product, age, gender, matching, and availability of a geographic adjustment factor [GAF]). The specific inclusion/exclusion criteria for the BDC for Bariatric Surgery program is included in Table 7, below.

Table 7: Summary of Episode Inclusion/Exclusion Criteria

Criteria	Inclusion/Exclusion Specifications
Blue Plan Claims Timeframe and Primary Index Inclusion	• **Blue Plan Claims Timeframe:** January 1, 2022, through December 31, 2024, and paid through March 31, 2025. • **Primary index procedure** (laparoscopic sleeve gastrectomy, laparoscopic Roux-en-Y gastric bypass) occurred between January 1,2022 through December 31, 2024 • Blue Plan Claim was matched to the corresponding applicant facility
Episode Duration Inclusion	• **Look-Back Period** = 30 days prior to the date of the index admission. • **Index Admission** = Primary laparoscopic sleeve gastrectomy or primary laparoscopic Roux-en-Y gastric bypass • **Look-Forward Period** = 90 days post discharge from index admission
Episode Cost Components Inclusion	• Episode includes both **facility and professional** charges (except for an ASC billing through professional claims only) • Includes only procedures with appropriate trigger code (Table 6, above) • Includes only procedures with appropriate diagnosis code of Obesity (Appendix A, below) • **Look-Back Period** = services provided for pre-operative evaluation or preparation • **Index Admission** = services corresponding to the triggering procedure, a supporting component for the surgery, a sequela; a service pertaining to the patient's underlying condition for which the surgery was provided; or an unrelated co-morbidity • **Look-Forward Period** = services provided as a supporting component of the surgery itself or if provided as care for a complication of the surgery or underlying condition
Member Eligibility Status Inclusions	• Member was continuously enrolled in a Blue Plan PPO product for the duration of the episode. • Member age less than or equal to 64 years old at time of surgery • Member gender female or male (unknown gender was excluded from episode)
Site of Service Inclusions	• Hospital inpatient (includes hospital outpatient) • Ambulatory Surgery Center
Member Discharge Status Exclusions	• Exclude members with discharge status either death in medical facility or Left Against Medical Advice for procedure admission

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Criteria	Inclusion/Exclusion Specifications
Episode Exclusions	• Excludes episodes with evidence of diagnosis codes indicating high-cost comorbidity (e.g., cancer, CRF) • Excludes episodes with evidence of unrelated procedures (i.e., overlapping episodes)

In subsequent analytic steps outlined over the next sections, clinical category costs were adjusted by factors known to have a predictable impact on costs of care. High-cost outlier episodes were managed to limit the impact on average costs for a facility. No other clinical exclusions were applied.

Adjusting Episode Costs

Adjustments to episode costs are needed for both the validity and fairness of cost comparisons among facilities, and included two types of adjustments:

- Factor adjustment – which adjusts for factors known to have a predictable impact on costs of care; and
- Outlier management – which protects against rare, unpredictable, high-cost and very low frequency events that could have a dramatic impact on average costs for a facility.

Two types of factor adjustments are commonly made in health care cost comparisons:

- Adjustments for predictable cost differences related to geography; and
- Adjustments for predictable cost differences due to risk or, more specifically, due to differences in the clinical characteristics of patients and age that have a measurable and predictable impact on costs.

Geographic Adjustment

BDSC programs use a nationally consistent approach to evaluating facilities. Adjustment for difference in geographical cost is needed to support credible comparison of facilities in different markets, with different underlying costs that a facility cannot readily control. For this reason, cost comparisons typically include adjustments for geographic differences in the prices that a facility pays for the goods and services routinely used in the production of health care services, such as labor, utilities, and rent. A set of Geographic Adjustment Factors (GAF) has been developed by the Centers for Medicare and Medicaid Services (CMS) to adjust Medicare provider payments. The BDC for Bariatric Surgery program used CMS' set of CY2024 GAF values to adjust episode cost comparisons; specifically, this cycle used GAFs for 112 Geographic Practice Cost Index (GPCI) locality levels, as defined by CMS.

The ZIP code of the facility providing the episode trigger service was used to identify the applicable GAF. Specifically, the GAF used was selected from the trigger claim, reflecting the attributed facility's ZIP code, and was applied to all claims included in the episode.

The GAF was applied to adjust the actual cost of an episode by "leveling the playing field" between facilities in high-cost areas versus low-cost areas. This was accomplished by dividing the episode's unadjusted allowed amount by the applicable GAF, calculated as **Adjusted Cost** = **Actual**

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Cost / GAF.

Adjustment for Risk and Case-Mix

Adjustment for differences in patient risk was needed to support the credible comparison of episode costs for different facilities. Risk adjustment was used to account for cost differences related to differences in patient comorbidities and conditions for patients undergoing the same treatment or admitted for the same principal condition. For example, episode costs for patients with diabetes would be expected to be higher than episode costs for patients without diabetes.

Blue Health Intelligence (BHI), BCBSA's data analytics partner, selected the Charlson Comorbidity Index (CCI), enhanced with the CDC's four Social Vulnerability Index (SVI) themes, to adjust episode cost for differences in patient illness burden and community-level social risk. The CCI's 19 clinically validated conditions form the clinical core of the model, while the SVI variables capture external factors ("themes") – poverty, household composition & disability, minority status, and housing/transportation – that influence utilization. Unlike alternative models such as CMS-HCC, which are optimized for prospective payment and can mask real variation in physician practice patterns, the CCI + SVI specification balances transparency, parsimony, and statistical power, so that the adjustment focuses on factors outside the provider's control.

As an indicator of patient complexity, the combined CCI + SVI risk score is used to adjust episode costs so that differences reflect provider performance rather than patient mix. Each member's risk profile is derived from administrative claims and residence data:

- **Comorbidities:** Diagnosis codes from the 12-month look-back window (ending one day before episode starts) are mapped to the 19 CCI conditions. Each condition is flagged as a binary indicator (1 = present, 0 = absent).
- **Social risk:** The member's ZIP-code is linked to the latest SVI dataset, yielding percentile ranks (0–100) for the four themes.
- **Demographics:** Age-group and gender indicators are added to capture non-linear age effects and gender-specific cost differences.

A regression model then fits separately for members with and without pharmacy coverage, using total annual cost as the dependent variable and the CCI, SVI, age, and gender indicators as predictors. The resulting coefficients become the risk weights; summing the intercept and applicable weights produces each member's predicted cost. Predicted costs are normalized, so the population mean risk score equals 1.00, yielding an intuitive relative-risk index. Members without sufficient claims history receive the baseline risk score of the intercept.

By capturing both medical and social complexity in a transparent, additive framework, BHI can compare providers on an "apples-to-apples" basis – even for smaller practices – while retaining clear clinical interpretability of every risk factor in the model.

Outlier Management

The purpose of outlier management is to protect against rare, unpredictable high-cost events that could have a dramatic impact on a provider's calculated average cost performance. A variety of techniques are commonly used for outlier management. Costs were geographically adjusted as described above. Geographically adjusted episode costs were then winsorized accordingly for each clinical category and risk level distribution. For the BDC Bariatric Surgery evaluation, per-episode costs were winsorized (capped) at the 98th percentile for high costs and at the 2nd percentile for low costs of episodes for each applicable distribution.

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Minimum Episode Volume Requirement – National

At the national level, a minimum of 20 episodes per risk cohort was required to calculate consistent cost estimates in each sub-category level. All joint risk cohorts met this threshold, and none were excluded from the analysis.

Calculation of Risk Adjustment Factor and Expected Episode Costs

The mean of the geographically adjusted, winsorized episode costs for each clinical category/risk level combination at the national level will be expected cost for that clinical category/risk level combination. The national expected cost for each clinical category/risk level combination will be divided by the national mean cost for the clinical category, to calculate the Risk Ratio for each clinical category/risk level combination.

The Risk Adjustment Factor (which is the inverse of the Risk Ratio) is multiplied by each facility's geographically adjusted and winsorized facility episode costs for each clinical category/risk level combination to normalize for risk, resulting in a final episode cost that is both geographically adjusted and risk adjusted.

Establishing a Cost Measure

Each episode was attributed to the facility where the primary surgery occurred, based on trigger events that occurred at that facility for each of the two clinical categories: laparoscopic sleeve gastrectomy and laparoscopic Roux-en-Y gastric bypass. Each facility has a separate calculation for the Clinical Category Facility Cost (CCFC) based on the median value of the adjusted episode costs. Confidence intervals (90 percent) were calculated around each Clinical Category Facility Cost (CCFC) measure; the Upper Confidence Limit (UCL) of the measure was divided by the National Median Episode Cost to become the Clinical Category Facility Cost Index (CCFCI). The combined cost index of the median UCL was rounded down to the nearest 0.025 for consistency and to prevent facilities from being excluded from BDC+ eligibility due to insignificant variances. The rounded median UCL was the measure used for cost scoring. For reliability, a minimum of five (5) episodes was required within a clinical category for the data to be included in the calculation of a Composite Facility Cost Index (CompFCI) for a facility.

Using each of the Clinical Category Facility Cost Index values, an overall Composite Facility Cost Index (CompFCI) was calculated for the facility. Each Clinical Category Cost Index was weighted by that facility's own volume and facility costs to calculate a composite measure of cost called the Composite Facility Cost Index (CompFCI).

The CompFCI for each applicant facility, calculated using the UCL of individual clinical category facility cost indices (CCFI), were then compared to the Cost Index Threshold set by BCBSA. A facility was selected as eligible for BDC+ designation if its CompFCI was lower than the Cost Index Threshold set by BCBSA. **For the 2025 BDC for Bariatric Surgery program, the Cost Index Threshold set by BCBSA is the State Cost Index.** The State Cost Index offers local differentiation and varies by State, to reflect relative cost efficiencies within each Blue Plan's Service Area.

In the case where there is more than one CompFCI for a singular facility, the following conditions are considered:

1. If there is enough volume to meet the Cost of Care's volume requirements at one Plan, but not enough at other Plan(s), then the eligibility decision using the CompFCI measured at the Plan with enough volume and the Cost Index Threshold is used for all conditions

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2. If there is enough volume to meet the Cost of Care's volume requirements at each of the applicable Plans, then each of the facility's CompFCI scores must meet the Cost Index Threshold ("higher of" methodology)

Questions

Contact your local Blue Plan with any questions.

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for facilities located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable health care. Each facility's cost of care is evaluated using data from its Local Blue Plan. Facilities in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on www.bcbs.com. Individual outcomes may vary. For details on a facility's in-network status or your own policy coverage, contact your Local Blue Plan and ask about your facility before making an appointment.

Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

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Appendix

Table 8: Obesity Diagnosis Codes

ICD-10 Diagnosis Code	ICD-10 Diagnosis Codes Description
E66.01	Morbid (severe) Obesity due to excess calories
E66.09	Other Obesity due to excess calories
E66.2	Morbid (severe) Obesity with alveolar hypoventilation
E66.811	Obesity, Class 1 (BMI 30.0 – 34.9)
E66.812	Obesity, Class 2 (BMI 35.0 – 39.9)
E66.813	Obesity, Class 3 (BMI 40. and above)

Table 9: Bariatric Surgery Geographic Adjustment Factor (GAF)

State	GAF Region	GAF
AK	ALASKA	1.271
AL	ALABAMA	0.923
AR	ARIZONA	0.983
AR	ARKANSAS	0.916
CA	SAN FRANCISCO-OAKLAND-BERKELEY (SAN FRANCISCO/SAN MATEO/ALAMEDA/CONTRA COSTA CNTY)	1.212
CA	SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1.224
CA	OXNARD-THOUSAND OAKS-VENTURA	1.082
CA	LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES/ORANGE CNTY)	1.097
CA	NAPA	1.151
CA	SAN FRANCISCO-OAKLAND-BERKELEY (MARIN CNTY)	1.213
CA	VALLEJO	1.149
CA	BAKERSFIELD	1.037
CA	CHICO	1.031
CA	FRESNO	1.031
CA	HANFORD-CORCORAN	1.031
CA	MADERA	1.031
CA	MERCED	1.031
CA	MODESTO	1.031
CA	REDDING	1.031
CA	RIVERSIDE-SAN BERNARDINO-ONTARIO	1.045
CA	SACRAMENTO-ROSEVILLE-FOLSOM	1.070
CA	SALINAS	1.075
CA	SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY)	1.230
CA	SANTA CRUZ-WATSONVILLE	1.085

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State	GAF Region	GAF
CA	SANTA ROSA-PETALUMA	1.101
CA	STOCKTON	1.031
CA	VISALIA	1.031
CA	YUBA CITY	1.031
CA	EL CENTRO	1.032
CA	SAN DIEGO-CHULA VISTA-CARLSBAD	1.083
CA	SAN LUIS OBISPO-PASO ROBLES	1.049
CA	SANTA MARIA-SANTA BARBARA	1.072
CA	REST OF CALIFORNIA	1.031
CO	COLORADO	1.021
CT	CONNECTICUT	1.062
DC	DC + MD/VA SUBURBS	1.123
DE	DELAWARE	0.999
DT	DETROIT	1.025
FL	FORT LAUDERDALE	1.031
FL	MIAMI	1.075
FL	REST OF FLORIDA	0.992
GA	ATLANTA	1.004
GA	REST OF GEORGIA	0.952
HI	HAWAII, GUAM	1.050
IA	IOWA	0.938
ID	IDAHO	0.936
IL	EAST ST. LOUIS	0.996
IL	SUBURBAN CHICAGO	1.048
IL	CHICAGO	1.056
IL	REST OF ILLINOIS	0.976
IN	INDIANA	0.943
KS	KANSAS	0.938
KS	METROPOLITAN KANSAS CITY	0.976
KY	KENTUCKY	0.940
LA	NEW ORLEANS	0.977
LA	REST OF LOUISIANA	0.945
MA	METROPOLITAN BOSTON	1.106
MA	REST OF MASSACHUSETTS	1.028
MD	BALTIMORE/SURR. CNTYS	1.058
MD	REST OF MARYLAND	1.012
ME	SOUTHERN MAINE	0.991
ME	REST OF MAINE	0.946
MI	REST OF MICHIGAN	0.967

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State	GAF Region	GAF
MN	MINNESOTA	0.982
MO	METROPOLITAN ST. LOUIS	0.978
MO	REST OF MISSOURI	0.935
MS	MISSISSIPPI	0.923
MT	MONTANA	0.999
NC	NORTH CAROLINA	0.952
ND	NORTH DAKOTA	0.980
NE	NEBRASKA	0.933
NH	NEW HAMPSHIRE	1.011
NJ	NORTHERN NJ	1.112
NJ	REST OF NEW JERSEY	1.072
NM	NEW MEXICO	0.965
NV	NEVADA	0.994
NY	MANHATTAN	1.136
NY	NYC SUBURBS/LONG ISLAND	1.162
NY	POUGHKPSIE/N NYC SUBURBS	1.082
NY	QUEENS	1.141
NY	REST OF NEW YORK	0.966
OH	OHIO	0.961
OK	OKLAHOMA	0.942
OR	PORTLAND	1.041
OR	REST OF OREGON	0.979
PA	METROPOLITAN PHILADELPHIA	1.043
PA	REST OF PENNSYLVANIA	0.964
PR	PUERTO RICO	1.002
RI	RHODE ISLAND	1.024
SC	SOUTH CAROLINA	0.953
SD	SOUTH DAKOTA	0.974
TN	TENNESSEE	0.933
TX	BRAZORIA	1.001
TX	DALLAS	1.004
TX	GALVESTON	1.001
TX	HOUSTON	1.026
TX	BEAUMONT	0.954
TX	FORT WORTH	1.000
TX	AUSTIN	1.018
TX	REST OF TEXAS	0.972
UT	UTAH	0.967
VA	VIRGINIA	0.984

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State	GAF Region	GAF
VI	VIRGIN ISLANDS	1.002
VT	VERMONT	0.977
WA	SEATTLE (KING CNTY)	1.116
WA	REST OF WASHINGTON	1.014
WI	WISCONSIN	0.953
WV	WEST VIRGINIA	0.951
WY	WYOMING	0.989

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