Vermont Association of Hospitals and Health Systems

Hospital Budget Guidance FY2025 Metrics and Benchmarking Summary and Recommendations

VAHHS workgroup recommendations for Metrics refinement

Concentration of Metrics: The VAHHS workgroup has attempted to focus the list of GMCB provided metrics. The aim has been to create a balanced snapshot of measurements that can add value to the analysis of hospital budgets and mitigate extensive administrative burdens, without paralyzing the analytical effort. In its current form, the list of metrics (96) is untenable to the process for purposes of budget compilation and delivery, analysis, deliberation, and decision making, creating unnecessary administrative burden for all parties. The workgroup recognizes that the recommended metrics (listed below) are necessary for a robust and objective analysis of hospital budgets and have, or have the capacity to have, appropriate benchmarks for objective analytical comparison. The recommended/selected metrics cover the GMCB identified groupings of: Target, Affordability, Financial Stability, Revenues Trends, Key Metrics, Access, Clinical Productivity, Operating Efficiency, Labor, Pharmaceutical Expenses, Medical Supplies and Materials, Profitability, Liquidity, Debt, and Asset Management Ratios, and Community Benefits. In sum, there are 45, in all.

No.	Metric	No.	Metric
1	Net patient revenue growth	24	Case mix index
2	Commercial price growth	30	Operating expense per adjusted discharge
4	Operating margin	31	Operating expense growth
5	Charge growth	32	Adjusted discharge growth
5	Medicaid NPR growth	36	Salary & Benefits per FTE- non-MD
6	Medicare Advantage NPR growth	37	FTE growth for direct patient care
7	Medicare - Traditional NPR growth	38	Hospital labor expense
8	Commerical NPR growth	39	Contracted labor expense
9	Net patient revenue per adjusted discharge	40	Pharmaceutical price growth
10	Visit lag	41	Pharmaceutical utilization growth- drug expense per adjusted discharge
11	Referral lag	42	Medical supplies and materials growth
12	Wait Times for Specialty Care	43	Operating margin
13	Average (median) time patients spent in the emergency department before leaving from the visit	44	Total margin
14	Transfer Impedance	45	Operating EBIDA margin
15	Interhospital transfers	48	Current ratio
16	Proportion of medical claim dollars staying home HSA	49	Days cash on hand
17	Prevention Quality Indicator (PQI) 90 rate for HSA	51	Long term debt to capitalization
18	Occupancy rate per staffed bed	57	Days in patient account receivables
19	Average length of stay	58	Average age of plant
20	Average Daily Census	59	Charity care payer mix
21	Adjusted Admissions Per FTE	60	Bad debt payer mix
22	FTE per 1,000 adjusted discharge	ADD	Debt Service Coverage Ratio
23	Work RVUs / Clinical FTEs		

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Quality Metrics: The VAHHS workgroup is recommending that the quality metrics be removed from the process and to refer to the Vermont Hospital Report Cards on VDH's website for measures and data related to quality. The Report Cards represent the most complete and accessible framework on hospital quality to date. Many of the measures also align with the proposed measures in the hospital budget guidance document.

We also recommend a group similar VPQHC's hospital quality framework initiative be convened by the GMCB, consisting of Quality experts and practitioners from hospitals, VPQHC, GMCB, HCA, and other state partner agency representatives that have a stake in quality outcomes to address matters of Quality outside of the budget process. This group can examine the work needed to further implement the VPQHC hospital quality framework measures, as well as provide recommendations and insight on the accuracy, validity, and story behind the numbers for the metrics contained in the hospital report card.

We also recommend that VPQHC periodically present to the board on the ecosystem of hospital quality initiatives as well as its work related to hospital quality.

Improve and Balance Metric Language: In the selected metrics, outlined above, numbered, 19, 44, 48, 49, 51, and 57, the 'why it matters' language often defaults to negative connotations for the metric, or is misleading altogether. The reader should be able to identify the metric and understand the objective nature of why the metric matters to this process and the language should not be set to influence the reader based on negative outcomes alone. Where this has occurred, the workgroup has recommendations for balancing the descriptive language.

TOPIC: **Metric No.**	**Average Length of Stay** **19**
GMCB Proposed Language:	A high average length of stay may indicate that patients are staying in the hospital for an unnecessary amount of days. Such an indicator could suggest delays in discharge due to unnecessary waiting, poor organization of care, delays in decision-making, or difficulties related to discharge planning.
Issue:	Description of metric should be balanced and objective. The current language from an NIH article leans into the negative side of ALOS measurement immediately, without describing what it is or other factors outside of a hospital's control. We should be careful not to create a negative connotation for the metrics in what is to be a fair and balanced assessment process.
Recommendation:	Revise language. *Average Length of Stay (ALOS) is the number of days per inpatient hospitalization and measures the time elapsed between a patient's hospital admission and discharge. Generally, lower length of stay are considered better. Higher length of stay can suggest a variety of issues in getting the patient discharged. Those issues include but are not limited to lack of organization of care and care planning, discharge to appropriate care setting, accessibility of appropriate care setting, patient condition, etc. The balance of ALOS is in making the appropriate decision for continued stay or discharge given the patient's condition vs. early discharge which may drive a readmission or shift costs to an outpatient setting.*

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TOPIC: Metric No.	Total Margin 44
GMCB Proposed Language:	When compared to operating margin, can show whether a hospital made up for losses through other means.
Issue:	Description of metric is not accurate given the nature of what determines and drives the Total Margin results.
Recommendation:	Revise language. *Total Margin is the ratio related to profitability indicating the percentage of gain or loss from operations and non-operating revenue to total revenue. A higher positive ratio indicates more favorable results, however, it should be noted that total margins can be driven in large part by Unrealized gains or losses that are the results of investment activity and does not have the Cash impact on profitability in the same manner that operating margin does.*

TOPIC: Metric No.	Current Ratio 48
GMCB Proposed Language:	A current ratio that is in line with the industry average or slightly higher is generally considered acceptable. A current ratio that is lower than the industry average may indicate a higher risk of distress or default. Similarly, if a company has a very high current ratio compared with its peer group, it indicates that management may not be using its assets efficiently.
Issue:	Description of metric should be balanced and objective. The latter part of the description makes concerning assumptions. The current ratio is also a point-in-time metric from the balance sheet and thus such assumptions could be misleading given the timing of the data being reviewed. The current ratio is not an 'efficiency' measurement.
Recommendation:	Revise language. *Current ratio is a working capital ratio and measure of financial liquidity. It is the number of dollars held in current assets per dollar of current liabilities. High values imply a good ability to pay short-term obligations (due within one year) and low values imply a lesser ability. The ratio indicates how a company maximizes the liquidity of its current assets to settle short-term debt and payables.*

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TOPIC: Metric No.	Days Cash on Hand 49
GMCB Proposed Language:	Days cash on hand (DCOH) is an important measure of hospital liquidity. The hospital needs a certain amount to meet the requirements of lenders, rating agencies, and others. But if DCOH is too high, it may indicate that cash is not being deployed to areas of the business generating higher returns.
Issue:	Description of metric should be balanced and objective. The latter part of the description is not a factor in DCOH as a metric. There are a variety of reasons that DCOH could be high, including but not limited to, cash flow risk appetite, aggregated operational surplus, capital planning needs, EMR transition cash impacts, potential borrowing rate offset and restrictions on cash for specific projects.
Recommendation:	Revise language. *Days cash on hand (DCOH) is an important measure of hospital liquidity. The hospital needs a certain amount to meet operating expenses, sustain operations during difficult financial periods, and therefore is often a requirement of lenders, rating agencies, and others. It not only reflects liquidity based on past operating results, but it has great bearing on the potential of investment in future results e.g. capital asset replacement, access expansion, emergency reserves in lieu of borrowing, and donor restrictions on cash for specific initiatives.*

TOPIC: Metric No.	Long Term Debt to Capitalization 51
GMCB Proposed Language:	This ratio can be used to determine a hospital's primary source of financing. Higher ratios indicate that a hospital is using debt as its primary source of financing and thus has a greater risk of insolvency.
Issue:	Description of metric should be balanced and objective. The focus on the negative connotation does not balance with the positive of having a good LTD to Cap ratio. Additionally, with long-term debt being a necessary component of a capital intensive industry, it is important to note that debt funding helps drive some of the change and goals of healthcare in Vermont.
Recommendation:	Revise language. *The LTD to Cap ratio is the measure of the proportion of Long-Term Debt in a capital structure and can be used to determine a hospital's primary source of financing. A lower proportion or percentage is desirable because it allows for obtaining of more favorable terms (i.e., lower interest rates) when borrowing and a higher ratio can indicate that a hospital is using debt as its primary source of financing and can carry a higher risk of insolvency.*

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TOPIC: Metric No.	Days in Patient AR 57
GMCB Proposed Language:	If AR days are high, it may indicate that a hospital has a problem with medical collection or billing processes.
Issue:	Description of metric should be balanced and objective. The focus on the negative connotation does not balance the positive of having a good AR Days number. Lower AR Days are indicative of solid revenue cycle management. Good AR Days turnover can maximize cash flows, maintain or improve DCOH, and be an indicator of efficient financial performance.
Recommendation:	Revise language. *Days in Patient Accounts Receivable is the average number of days in collection that patient accounts receivable remain outstanding. A lower number is favorable, since it indicates good collection practices that result in sufficient cash flow and infrequent short-term financing. A higher number may indicate that an organization is having difficulty with collection of receivables which can impact cash flow and days cash on hand balances.*

Recommended Addition: The metric Debt Service Coverage Ratio (DSCR) is one that has been reported to the GMCB for many years. It is also cited in the 2025 Budget Guidance Section V, subsection C(h) as a metric that should be spoken to by hospitals. It is recommended that this metric be added so that the GMCB can have a metric that aids in understanding a company's ability to pay for the debt associated with capital structure.

TOPIC: Metric No.	Debt Service Coverage Ratio Not Included - Should be Added
GMCB Proposed Language:	N/A
Issue:	This metric is considered very useful to understand a company's ability to pay for debt associated with capital structure and can be coupled with leverage and liquidity measurements.
Recommendation:	*Debt Service Coverage Ratio can help understand how a company can service its debt annual obligations using operating cash flow. A higher DSCR is considered better than a lower one. The appropriateness of the ratio is dependent on the consumer of the information. This is an example of where a credible industry benchmark can be put to good use.*

Commercial Price/Growth: It is recommended that the GMCB clarify in the guidance how Commercial Prices should be established in the process. For example, if a hospital proposes raising Outpatient prices 5%, Inpatient prices 5%, and Professional prices 0%, the average price increase for the budget to achieve the necessary NPR/FPP would be 3.5%. Would the maximum negotiating percentage be 3.5% (aggregate) or 5% to allow for the necessary 3.5% aggregate figure for the budget to be attained?

Additionally, capping commercial price growth or the same rate for all payers, as written in the current guidance, may have unintended consequences that 1) removes a hospital's flexibility to create a level playing field across the payers, would lock in the competitive price advantage one payer has over another, 2) removes a hospital's flexibility to address prior year payment denial strategies some payers employ more than others after a contract has been negotiated, not pay the agreed to rate. The latter, is beginning to have an impact on revenues and the denials are generally coming in the form of 'Modifiers.'

Pharmacy Utilization Growth: We recommend 340B/outpatient pharmacy costs be excluded from this comparison as cost growth is a function of growth in this line of business, which is non-patient revenue. 340B is a vital pharmaceutical component of care for many uninsured, low-income people and should be withheld from this calculation.

Benchmarks

- **Benchmarks:** What are GMCB's Benchmarking expectations? Last year, the GMCB approached benchmarking in the comparative analytics space by looking at a specific metric's peer group median and carving that median into upper and lower quartiles. It is not clear whether that will be the case for the 2025 Budget process. Will benchmarks be clearly marked for what is considered positive performance vs improvement needed?
- **Operating Margin benchmark:** As the 2025 Budget Guidance highlights, Operating Margin is one of the most important factors of hospital finances. It is recommended that GMCB provide an appropriate and credible industry benchmark for Operating Margin that considers not only operations, but capital transformation improvement needs as well. This would indicate to the GMCB that margins greater than 0%, should be greater than 2%, for purposes of this process and financial health and reinvestment. There are several available, credible, industry options for benchmarks ranging from S&P, Fitch, Moody's, etc.
- **Fitch A Median:** Clarity is needed by the GMCB to understand which comparator group within Fitch will be used.
- **Peer Groups: (Please see separate Peer Group analysis attached)** Peer groups are a form of benchmarking and play a vital role in the reader's ability to gauge the appropriateness of a measurement. Within the peer group, it will be essential to understand the GMCB's benchmarking expectations as of March 31, 2024. E.g., peer group median, upper vs lower quartile and identifying language of value of upper vs lower vs on median.
- **Adaptive/HCRIS Data to Benchmark Interface:** As work on the AHEAD model revenue reconciliation has shown, the ability to reconcile Adaptive data to data generated from HCRIS has proven to be exceedingly difficult. There are several metrics in the workbook where the attempt to interface Adaptive data with HCRIS as a benchmark is proposed. HCRIS data should never be considered a reliable comparison tool between hospitals (in and outside of VT) because Cost Reports aren't necessarily comparative across peers due to the differences in how hospitals/systems are set up and report hospital and home office level expenses, some hospitals employ their medical staff others do not as well as other differences. Therefore, it is recommended that this not be attempted without a significant effort at data validation to ensure the benchmark (HCRIS) can appropriately represent the data being extracted from Adaptive. With a condensed interactive schedule this year between the VAHHS workgroup and the GMCB

staff, this work has not been undertaken at the required level of scrutiny to ensure accuracy of outcomes, and the capacity to explore alignment of Adaptive data with the suggested benchmark or find better options for benchmarks has been limited. Within the overall benchmark listing above, benchmarks that interface Adaptive with HCRIS benchmarks are numbered 9,20,22,30,31,32,37,38,39,59,60. These are useful measurements to analyze a budget submission, but we recommend a better benchmark comparison be found to ensure accuracy of measurement. For example, number 9, NPR per Adjusted D/C there are many different grouper versions that are used for various purposes, and they should not compare to nationwide database if the grouper used is not the same. For example, using the Medicare MS_DRG grouper, it is not an all-payer grouper. It does not have a complete dataset for DRGs with low or non-existent Medicare volume such as Obstetrics and Newborn related DRGs to have accurate weights. There are also many versions of the same grouper.

Bad debt and Charity care (numbers 59, 60) are important to track and analyze as part of this process and they are part of what the VAHHS group believes should be measured in this process but here too, the rules are very different between what is required to be reported on the Medicare cost report and what is required to be reported on the financial statements. For example, for Medicare bad debt and charity care you cannot submit write-off amounts greater than deductibles and coinsurance. The Schedule S10 excludes Medicare bad debt but you cannot add the two together because Medicare bad debt excludes excess over deductible and coinsurance and the non-Medicare bad debt on the S10 may or may not exclude this excess bad debt depending on each hospital's interpretation of the S10 instructions.

With an inability to align Adaptive data to HCRIS benchmarking data, the potential for misinforming the analyses and conclusions drawn is high. Additionally, there were several metrics proposed in the metrics workbook that would simply not be achievable from Cost Report data, for example numbers 27-29. The Medicare cost report does not include any payor mix data. The only payor information is for Medicare and Medicaid, so any attempt at commercial price would be impossible. Even then not all hospitals need to report Medicaid charge information. Any attempt to reconcile with Adaptive data will be mixing apples and oranges and therefore, the potential across these metrics for the data to be measured against an inappropriate benchmark is high which can have negative outcomes for both the regulated and regulator. Extending the work on comparative analysis metrics and corresponding peer groups or benchmarks beyond March 31, 2024, will not allow sufficient time to perform the appropriate level of scrutiny and achieve the level of validation for inclusion in the 2025 process.

- **Cost Report/HCRIS Data to Benchmark Interface:** As was evidenced during the last budget cycle, organizational structures matter in how costs are reported within a cost report. For example, CAH, stand-alone vs. CAH, system-affiliated, can have very different data results and thus, require different peer groups within which the benchmark would be applied. Some hospitals employ physicians, and some do not, all of which has cost implications the exist within the base data. HCRIS data should never be considered a reliable comparison tool between hospitals (in and outside of VT) because Cost Reports aren't necessarily comparative across peers due to the differences in how hospitals/systems are set up and report hospital and home office level

expenses, some hospitals employ their medical staff others do not as well as other differences. These implications also permeate how hospitals report labor data. With a condensed interactive schedule this year between the VAHHS workgroup and the GMCB staff, this work has not been undertaken and the capacity to explore alignment of Cost Report data with the suggested benchmark or find better options for benchmarks has been limited. If the goal is an evidenced-based, data-driven, process the potential across these metrics for the data to be measured against an inappropriate benchmark is high which can have negative outcomes for both the regulated and regulator. Extending the work on comparative analysis metrics and corresponding peer groups or benchmarks beyond March 31, 2024, will not allow sufficient time to perform the appropriate level of scrutiny and achieve the level of validation for inclusion in the 2025 process.
Data: With the evidence-based, data-driven process being new, we encourage and recommend standardization and agreement on calculations of data and benchmarks. As evidenced in the sections above there is much variety that often does not align appropriately. Early in this process we supplied a template that would aid in capturing the important components of data, along with how the data point is calculated. That example is also attached separately.

- **Caveats:** As outlined in the example template provided by VAHHS to help comprehend the collection, calculation and validation of various data, metrics, and benchmarks to be utilized in this process, caveats are essential to understanding the value of a particular piece of data as it is to be applied. We recommend that for every data point, and corresponding metric and benchmark that appropriate caveats be considered to illuminate potential shortcomings of a particular data point. That said, caveats should not be utilized to explain away potential underlying data issues as outlined around the HCRIS benchmark proposal.
- **Delivery Dates:** In Section II, subsection A and B, so named 'Methodology for Establishing Hospital Peer Groups' and 'Key Performance Metrics' the 2025 Budget Guidance notes that these areas of the guidance will be available at some point between the March 31 release of the budget guidance and the July 1 submission date for 2025 Hospital Budget materials. This does not allow hospitals the time to consider, analyze, vet, factor, and articulate a response to the outcomes of such important budget details for their July 1 budget submission requirements per the budget guidance. These materials and the information contained therein, are an integral part of the GMCB's evidence-based, data-driven budget process and should be published in correspondence with the 2025 Budget Guidance by March 31, 2024, in accordance with Hospital Budget Rule 3.0.
  Otherwise, what happens if errors are identified in the data or benchmark after the conclusion of the Budget Guidance process on March 31, 2024? Do such metrics and benchmarks continue to be applied to the process anyway only to generate erroneous results? Are they removed from the process and when? At what point, post March 31 would hospitals be notified that certain GMCB approved metrics and benchmarks cannot be validated and are to be removed from the guidance materials and discharged from application in the 2025 Budget process?

Vermont Association of Hospitals and Health Systems

Hospital Budget Guidance FY2025 Peer Group Summary and Recommendations

VAHHS recommendations for peer group refinement

Remove duplicate hospitals and hospitals missing from the 2021 cost report from the peer group.

Expand peer group for more accurate comparison: The size of the respective peer groups may be too small to compare against the Vermont cohorts. Expanding the peer group to include more hospitals reduces noise and improves stability of the peer group over time.

Align peer groups more closely Vermont hospital characteristics: The composition of the peer groups doesn't match some of the most important aspects of what makes Vermont's hospital system unique. Peer groups should be similar to Vermont hospitals in their rural vs urban designations, their larger network affiliations (or lack of affiliations), and their non-profit status.

Additional Peer Group Questions (placeholder as more questions come up)

- Is there more detail on the methodology and data sources used to create the peer groups?

Duplicates in the File

There are three hospitals that are duplicated in the file. Differences between duplicate records are noted in red text.

Canton-Potsdam Hospital in Potsdam, NY:

CLASS	STATE	LOCATION	CASES	DAYS	SV. INDEX	GROSS REVENUE
Critical Access	NY	Potsdam	979	5,459	1.6654	$85M
Mid-Community	NY	Potsdam	4,450	20,896	1.3949	$226M

Exeter Hospital in Exeter, NH:

CLASS	STATE	LOCATION	CASES	DAYS	SV. INDEX	GROSS REVENUE
Mid-Community	NH	Exeter	4,570	21,720	1.5593	$258M
Small Rural	NH	Exeter	4,570	21,720	1.5592	$258M

Johnson Hospital/Johnson Memorial Hospital in Stafford Springs, CT:

CLASS	STATE	LOCATION	CASES	DAYS	SV. INDEX	GROSS REVENUE
Critical Access	CT	Stafford Springs	1,228	4,453	1.4015	$78M
Small Rural	CT	Stafford Springs	1,278	4,433	1.4051	$78M

Vermont Association of Hospitals and Health Systems

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Peer Group Comparisons Against Vermont Cohort

CRITICAL ACCESS PEER GROUP

The Critical Access Hospital (CAH) peer group is comprised of 18 hospitals from Connecticut, Maine, Massachusetts, New Hampshire, and Pennsylvania. Vermont hospitals included in this group are Copley, Gifford, Grace Cottage, Mt. Ascutney, North Country, NVRH, Porter, and Springfield.

	Peer Group	**Vermont Hospitals**
Number of Hospitals	18	8
CCN Type	15 CAH 3 STH	All CAH
Network affiliation	11 network affiliated 6 independent 1 government	2 network affiliated 6 independent
Type of Control	16 voluntary nonprofit 1 voluntary nonprofit-church 1 governmental	All voluntary nonprofit
Rural/Urban	15 rural 3 urban	All rural

MID-COMMUNITY PEER GROUP

The Mid-Community group is comprised of 22 hospitals from Connecticut, Maine, Massachusetts, New Hampshire, Pennsylvania, and Rhode Island. Vermont hospitals included in this group are CVMC and RRMC.

	Peer Group	**Vermont Hospitals**
Number of Hospitals	22	2
CCN Type	All STH	All STH
Network affiliation	17 network affiliated 5 independent	1 network affiliated 1 independent
Type of Control	19 voluntary nonprofit 1 governmental 2 proprietary corporation	All voluntary nonprofit
Rural/Urban	10 rural 12 urban	All rural

SMALL RURAL PEER GROUP

The Small Rural group is comprised of 20 hospitals from Connecticut, Maine, Massachusetts, New Hampshire, and Pennsylvania. Vermont hospitals included in this group are Brattleboro Memorial, NMC, and SVMC.

	Peer Group	**Vermont Hospitals**
Number of Hospitals	20	3
CCN Type	19 STH	All STH

	1 unknown*	
Network affiliation	All network affiliated	2 independent 1 network affiliated
Type of Control	16 voluntary nonprofit 1 voluntary nonprofit church 2 proprietary corporation 1 unknown*	All voluntary nonprofit
Rural/Urban	7 rural 12 urban 1 unknown*	All rural

*1 hospital does not appear on the 2021 CMS cost report. When researching this hospital, this hospital merged with another hospital several years ago. It's not clear how this hospital arrived on the peer group list.

ACADEMIC MEDICAL CENTER PEER GROUP

The Academic Medical Center (AMC) group is comprised of 8 hospitals from Connecticut, Maine, Massachusetts, New Hampshire, and Pennsylvania. UVM Medical Center is the only hospital in this group.

	Peer Group	**Vermont Hospitals**
Number of Hospitals	8	1
CCN Type	All STH	All STH
Network affiliation	All network affiliated	All network affiliated
Type of Control	7 voluntary nonprofit 1 voluntary nonprofit church	All voluntary nonprofit
Rural/Urban	5 rural 3 urban	All urban

Measure: EBITDA Margin	
Definition:	EBITDA stands for Earnings, Before, Interest, Taxes, Depreciation, and Amortization. The EBITDA margin is a measure of a company's operating gains as a percentage of revenue. EBITDA margins allows for a comparison of one company's real performance to the performance of others in the same industry.
Numerator:	Earnings before interest + depreciation + taxes +amortization
Denominator:	Total Revenues
Data Source:	Hospital Income Statement
Benchmarking/Measure Source:	XXXX e.g. Other Mid-sized hospital in Northern New England
Data and Benchmarking Reporting Period(s) Comparison:	e.g. FYE XXXX vs. FYBudget XXXX
Eligible Reporting Facilities:	All Vermont Community Hospitals
Data Collection:	Hospital submission to (GMCB) Adaptive Data Base
Caveats:	EBITDA is a non-GAAP financial measure, meaning it does not follow Generally Accepted Accounting Principles.
	Data and benchmarking comparison periods could cause slight variations when comparing a backwards-looking fiscal year vs. a forward-looking budget year and operational changes that may reside within.
Understanding EBITDA:	Although important to the overall finances of a business, EBITDA strips away interest, depreciation, taxes, and amortization to focus solely on operating activity and cash flow.
	EBITDA makes it easy to compare relative operational gains of two or more companies of different sizes in the same industry.
	EBITDA can also be helpful when gauging the effectiveness of a company's cost-cutting efforts, therefore the higher a company's EBITDA margin, the lower its operating expenses are in relation to total revenues.

NOTE: Might want to add "HOW TO measurement" e.g. Median 25th-75% Low is good, high needs improvement, etc.

	Do we want to add a space that would outline whether this was being anlayzed as a historical trend vs. a given year?
Other >>>>>	
Logic >>>>>>>>>>>	Both GMCB and Hospitals should be able to attain and comprehend both the source data and the benchmarking measure for ability calculate the measure and compare it to its benchmark and draw relative conclusions from that information.
Other >>>>>>>>>>>	Caveats should be thorough, comprehendible, and fully discussed, this should include ineligible facilities if the data and/or benchmarks are not applicable. Eligible facilities should be thoroughly outlined in the event certain data points are not attainable and/or benchmarks are not applicable to specific facilities or hospital groups.
	The benchmarking source and calculation of the benchmark should be vetted and understood by all parties with any potential variance to the data point outlined in the Caveats section.