Home Health Line Tool

Medicare Spending Per Beneficiary explained

Beginning in 2026, CMS hopes to more closely tie Medicare costs with reimbursement by adding a new measure to Home Health Value-Based Purchasing (HHVBP) using the Medicare Spending Per Beneficiary (MSPB) data. It was one of several changes detailed in the 2026 Home Health Prospective Payment System proposed rule. (*HHL 7/14/25*)

The claims-based MSPB was added to the Home Health Quality Reporting Program in 2017, but has not been tied to reimbursement until now. "Explicit measurement of costs of care will allow recognition of agencies that provide high-quality care at a lower cost," CMS stated in the proposed rule.

"If this is not something that an agency has been monitoring, providers need to go look at their scores on Care Compare and start working with their financial teams or advisors to put in place methods to measure, monitor and improve," says Angela Huff, senior manager at Forvis Mazars in Springfield, Mo.

HHVBP: Proposed 2026 measure values

Measure	Proposed 2026 weights
OASIS-based	
Improvement in dyspnea	7.00%
Improvement in management of oral medications	11.00%
Discharge Function Score	15.00%
Improvement in bathing	3.50%
Improvement in upper body dressing	1.75%
Improvement in lower body dressing	1.75%
Claims-based	
Within-stay potentially preventable hospitalization	15.00%
Discharge to community	15.00%
Medicare spending per beneficiary	**10.00%**
HHCAHPS-based	
Overall agency rating	10.00%
Willingness to recommend	10.00%

Scoring

The final agency score collects two years of data, looking at Medicare spending for most Part A and Part B services during the episode of care, as well as up to 30 days after the end of the treatment period.

An agency's score is its average risk-adjusted Medicare cost per beneficiary divided by the national median for all home health providers. A score higher than "1" means the agency is associated with Medicare costs greater than the national average, while agencies scoring lower than "1" are responsible for Medicare costs that are less than the national average.

Scoring example:

1. The total spend attributed to the home health stay is $1,000, whereas the predicted cost through risk adjustment was that the patient would require $900 of services in that time. CMS divides the actual cost by the expected cost, or $1,000/$900 = 1.1.
2. CMS takes the average across all of the agency's episodes for the two-year timeframe. For example, let's say that the provider has four patients and the ratio for each episode is 1.1, 0.8, 1.3 and 1.2. That means the average is 1.1.
3. The agency's average is then multiplied by the average spending for all home health agencies. So, if the average Medicare spending for all home health periods is $5,000, that amount is multiplied by the agency's 1.1 average. The result, $5,500, is the agency's MSPB amount.
4. The agency's amount is divided by the national median MSPB amount. If the national median is $4,000, CMS divides that amount into $5,500, or $5,500/$4,000 =1.375. That is the provider's MSPB score and is publicly reported on Care Compare. This indicates the provider's Medicare spending is higher than the national average.

How it's presented on Care Compare

How much Medicare spends on an episode of care at this agency, compared to Medicare spending across all agencies nationally	1.375
• *Higher (lower) ratios means that the agency spends more (less) on an episode of care than the Medicare national average*	National average: 1.00

Risk adjustment variables

- **Dozens of diagnosis codes.** Examples: Those for HIV/AIDS, lung cancer, diabetes, coma, congestive heart failure and more.
- **Select interactions.** Examples: A disabled patient with drug/alcohol dependence.
- **Patient indicators.** Examples: End-stage renal disease or hospice care.
- **Age.** Broken up into five-year increments.
- **Clinical case mix category.** Examples: A prior home health admission.
- **Intensive care stays and prior hospitalization**. Broken up into length of stay.

30 days post-discharge

MSPB cost determinations include hospitalizations, outpatient visits and other medical care during the 30-day period after discharge. This makes it crucial to monitor patient progress through check-ins post-discharge. (*HHL 5/5/25*)

Source: CMS measure specifications, 2026 Home Health Prospective Payment System proposed rule