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1	N/A	3	N/A	Table 1-1 COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	Table 1-1 COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date**	Added the following footnote: ** - This QM will be publicly reported in January 2026, retired with the April 2026 public reporting update, and retired from iQIES reports as of January 2026.
3	N/A	7	N/A	• M0100_ASSMT_REASON: Reason for assessment • M0150_Current_Payment_Sources • PRVDR_ID: Facility internal ID • STATE_CD: State abbreviation • EFCTV_DT: Effective date of the assessment • iQIES_PTNT_ID: Unique patient ID • ASSESSMENT_ID: Unique OASIS assessment ID • ASSESSMENT_DT: Assessment completion date	• M0100_RSN_FOR_ASMT_CD: Reason for assessment • CCN: CMS Certification Number • EFCTV_DT: Effective date of the assessment • STATE_PTNT_ID: iQIES Patient Identifier •M0030_STRT_CARE_DT: Start of Care Date • HHA_ASMT_ID: Unique OASIS assessment ID • M0090_ASMT_CMPLT_DT: Assessment completion date	Updated the OASIS items needed to create an episode to account for payer source and refinements to episode creation process to address multiple assessment start dates in a narrow time windows.
3	N/A	7	N/A	OASIS assessments are transmitted to the National Submissions Database residing on a secure database server maintained by CMS. Quality episodes are constructed by including only assessments with Medicare or Medicaid payers, matching up assessments for each individual served by a home health agency, sorting those assessments by effective date, then pairing up assessments that mark the beginning and end of a quality episode. During this process, a unique patient ID (iQIES_PTNT_ID) and ASSESSMENT_ID are assigned to each assessment. Quality episodes for which either the beginning or end assessment is missing, or for which assessments are out of sequence, are not included. Quality episodes2F are not created for patients who meet the following OASIS data collection exclusions, and generic exclusions for OASIS-based measures: patients who 1) do not have as a payment source Medicare (traditional fee-for-service, Medicare (HMO/managed care/Advantage plan), Medicaid (traditional fee-for-service), or Medicaid (HMO/managed care); 2) are less than 18 years old at start or resumption of care; 3) are receiving only maternity services; or 4) are receiving personal care, homemaker, or chore services only. When working with assessment records from the National Submissions Database, the unique home health agency ID is a combination of the two position STATE_CD and PRVDR_ID, and the unique patient ID is a combination of STATE_CD and iQIES_PTNT_ID.	Quality episodes are constructed by matching up assessments for each person served by a home health agency, sorting those assessments by start of care date and effective date, and then pairing up assessments that mark the beginning and end of a quality episode. Quality episodes for which either the beginning or end assessment is missing, or for which assessments are out of sequence, are not included.	Revised the description of the episode creation process.
3	3.1	8		N/A	Section 3-1: Transition to All-Payer OASIS	Added new section outlining transition to all payer data submission

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					Assessments: CMS is mandating OASIS data collection and submission for all patients regardless of payer (a.k.a. all-payer sources beyond Medicare/Medicaid) effective 1/1/2025, with a voluntary phase-in period of 1/1/2025 – 6/30/2025. Starting on 7/1/2025, the OASIS-based Patient-Related Characteristics Reports will report data for all payers. Accordingly, OASIS assessments that do NOT have a Current Payment Source (M0150) value of (1 Medicare fee-for-service, 2 Medicare Advantage, 3 Medicaid fee-for-service OR 4 Medicaid managed care) will be new under the all-payer requirements. These OASIS assessments, which are paid through sources other than Medicare or Medicaid, will fall in the: 1) Voluntary all-payer period if they have a Date Assessment Completed (M0090_ASMT_CMPLT_DT) between 1/1/2025 and 6/30/2025 associated with the start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"), and 2) Mandatory all-payer period if they have a Date Assessment Completed (M0090_ASMT_CMPLT_DT) starting 7/1/2025 associated with the start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"). Additionally, for any assessments with M0100 Reason For Assessment OTHER THAN 01 "Start of Care" that do NOT have a Current Payment Source (M0150) value of [1 Medicare fee-for-service, 2 Medicare Advantage, 3 Medicaid fee-for-service OR 4 Medicaid managed care] and do NOT have a matching start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"), the M0030 Start of Care Date reported on the assessment will be used to determine whether the assessment falls in the voluntary or mandatory periods. Note: The OASIS-based quality measures in the Home Health Quality Reporting Program will continue to report data only for Medicare fee-for-service, Medicare Advantage (Medicare managed care),	and what is implemented during the voluntary and mandatory submission time period.

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					Medicaid, and Medicaid managed care. All-payer submissions will not affect current risk adjustment calculations.	
3	3.2	8	N/A	The process of building quality episode-level records is as follows: 1. Keep only assessments in which the current payment sources for home care (M0150) includes any one of the following responses (Medicare fee-for-service, Medicare Advantage (Medicare managed care), Medicaid, or Medicaid managed care)): a. Response 1 – Medicare (traditional fee-for-service), or b. Response 2 – Medicare (HMO/managed care/Advantage plan), or c. Response 3 – Medicaid (traditional fee-for-service), or d. Response 4 – Medicaid (HMO/managed care). 2. Keep only assessments related to start of care (SOC), resumption of care (ROC) after an inpatient facility stay, or end of care (EOC) discharge from home health care, including discharge due to death, or admission to inpatient facility for 24 hours or for reasons other than diagnostic testing (with or without discharge from home health care)13F : a. SOC: M0100_ASSMT_REASON = 01 b. ROC: M0100_ASSMT_REASON = 03 c. EOC: M0100_ASSMT_REASON = 06, 07, 08, or 09 3. Sort assessments by PRVDR_ID, iQIES_PTNT_ID, STATE_CD in descending order based on EFCTV_DT (i.e., latest to earliest assessment). 4. For each set of assessments having the same combination of PRVDR_ID, iQIES_PTNT_ID, STATE_CD, step through the assessments to find the latest assessment with M0100_ASSMT_REASON = 06, 07, 08, or 09.4F 5. If an assessment with M0100_ASSMT_REASON = 06, 07, 08, or 09 is found before an assessment with M0100_ASSMT_REASON = 01 or 03 is found, discard the episode being built and start over with step #3. 6. If no assessment with M0100_ASSMT_REASON = 01 or 03 is found before the assessments for this patient are exhausted, discard the episode being built.	Section 3-2: Steps for Creating Quality Episodes: The process of building quality episode-level records is as follows: 1. Keep only assessments related to start of care (SOC), resumption of care (ROC) after an inpatient facility stay, or end of care (EOC) discharge from home health care, including discharge due to death, or admission to inpatient facility for 24 hours or more: a. SOC: m0100_rsn_for_asmt_cd = 01 b. ROC: m0100_rsn_for_asmt_cd = 03 c. EOC: m0100_rsn_for_asmt_cd = 06, 07, 08, or 09 2. Group assessments by CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT (M0030 Start of Care Date). Further sort assessments within those groups in ascending order by EFCTV_DT and m0100_rsn_for_asmt_cd. 3. Maintaining the sort order defined in Step 2, for each group of assessments having the same combination of CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT, step through the assessments to find pairs of assessments that define a quality episode: 1) a SOC assessment followed by an EOC assessment; or 2) a ROC assessment followed by an EOC assessment. 4. Within CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT: a. If an EOC assessment is found before a SOC or ROC assessment is found, discard the EOC assessment and start over with step #3. 5. CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT: a. If no EOC assessment is found after a SOC or ROC assessment, discard the SOC assessment and start over with step #3. 6. CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT: a. When an EOC assessment following a SOC or ROC is found, the episode is complete. Start over with step #3 until all assessments within CCN, STATE_PTNT_ID, and M0030_STRT_CARE_DT are either	Revised the steps for creating quality episodes to account for scenarios in which there are multiple assessments in a short time window. Updated the process of accounting for all payer data submission during the voluntary and mandatory time window.

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				7. When an assessment with M0100_ASSMT_REASON = 01 or 03 is found, the episode is complete. 8. Create an episode of care record with the following attributes: • PRVDR_ID • iQIES_PTNT_ID • STATE_CD • Current_Payment_Sources • ASSESSMENT_ID_1: Assessment ID of the SOC or ROC assessment • ASSESSMENT_ID_2: Assessment ID of the EOC assessment • EFCTV_DT_1: Effective date of the SOC or ROC assessment • EFCTV_DT_2: Effective date of the EOC assessment	paired or discarded. 7. Keep all assessments, regardless of payer source. Specifically, with the transition to all-payer OASIS assessments, consider the following: a. Submission requirements for OASIS assessments paid by Medicare or Medicaid are unchanged. Keep all OASIS assessments paid by Medicare or Medicaid, regardless of Date Assessment Completed (M0090_ASMT_CMPLT_DT). b. OASIS assessments that are NOT paid by Medicare or Medicaid (i.e., are only paid by other payers) may be submitted as of 1/1/2025. i. This includes: assessments with Current Payment Sources for Home Care (M0150) that do NOT include any of the following responses: 1. Response 1 – Medicare (traditional fee-for-service), or 2. Response 2 – Medicare (HMO/managed care/Advantage plan), or 3. Response 3 – Medicaid (traditional fee-for-service), or 4. Response 4 – Medicaid (HMO/managed care). ii. OASIS assessments that do NOT have a Current Payment Source (M0150) value of (1 Medicare fee-for-service, 2 Medicare Advantage, 3 Medicaid fee-for-service OR 4 Medicaid managed care) fall in the voluntary all-payer period if they have a Date Assessment Completed (M0090_ASMT_CMPLT_DT) between 1/1/2025 and 6/30/2025 associated with the start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"). iii. OASIS assessments that do NOT have a Current Payment Source (M0150) value of (1 Medicare fee-for-service, 2 Medicare Advantage, 3 Medicaid fee-for-service OR 4 Medicaid managed care) fall in the mandatory all-payer period if they have a Date Assessment Completed (M0090_ASMT_CMPLT_DT) starting 7/1/2025 associated with the start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"). iv. Otherwise, for any assessments meeting the following criteria, the M0030 Start of	

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					Care Date reported on the assessment will be used to determine whether the assessment falls in the voluntary or mandatory periods. The criteria for this categorization are as follows: 1. M0100 Reason For Assessment OTHER THAN 01 "Start of Care" [inclusive of M0100 Reason For Assessment values of 03 "Resumption of Care," 04 "Recertification," 05 "Other Follow-up," 06 "Transfer to Inpatient Facility and Not Discharged from Agency," 07 "Transfer to Inpatient Facility and Discharged from Agency," 08 "Death at home," and 09 "Discharge from Agency"] AND 2. Do NOT have a Current Payment Source (M0150) value of [1 Medicare fee-for-service, 2 Medicare Advantage, 3 Medicaid fee-for-service OR 4 Medicaid managed care] AND 3. Do NOT have a matching start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"). v. There should be no OASIS assessments that are not paid by Medicare or Medicaid with a Date Assessment Completed (M0090_ASMT_CMPLT_DT) value of 12/31/2024 or prior. 1. Our understanding of all-payer policy is that whether an assessment falls into the voluntary period (1/1/2025-6/30/2025) or mandatory period (7/1/2025 and on) is determined by the Date Assessment Completed (M0090_ASMT_CMPLT_DT) as documented in the start of care assessment (M0100: Reason For Assessment = 01 "Start of Care"). However, we are aware of some assessments in the OASIS Assessment data on the CMS Centralized Data Repository (CDR) that have an M0090_ASMT_CMPLT_DT value documented in the start of care assessment of prior to 1/1/2025. Our understanding is that those assessments are not eligible for inclusion under all-payer policy. 8. Create an episode of care record with the following attributes: • CCN • STATE_PTNT_ID • STATE_CD_1 • M0150: Current Payer Sources • ASSESSMENT_ID_1: Assessment ID of	

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					the SOC or ROC assessment • ASSESSMENT_ID_2: Assessment ID of the EOC assessment • EFCTV_DT_1: Effective date of the SOC or ROC assessment • EFCTV_DT_2: Effective date of the EOC assessment	
4	1	N/A	12	Table 4-1 reflected 2024 public reporting refresh dates.	Updated Table 4-1 to reflect January 2025-October 2026 public reporting dates and corresponding data report impacts.	Updated data to reflect more recent public reporting examples.
4	2	N/A	13	Table 4-2 reflects 2024-2025 iQIES report calculation dates	Updated Table 4-2 to reflect 2025 and 2026 report calculation dates.	Updated data to reflect more recent iQIES report calculation time frames.
4	3	N/A	14	Table 4-3 reflects 2025-2026 Provider Preview Report dates	Table 4-3 reflects 2026-2027 Provider Preview Report dates	Updated data to reflect more recent iQIES report calculation time frames
6	3	N/A	19	N/A	The updated risk adjustment model results in Appendix A are based on CY2024 episodes and calculated in CY 2025. They will be implemented for quality episodes with SOC/ROC completion dates starting January 1, 2026.	Added language to describe the latest risk adjustment result time frame.
Appendix	Table A-1	38	N/A	Gender	Sex	Updated Appendix Table A-1 to replace "Sex" with any description of "Gender" in the risk adjustment model table.
Appendix	Table A-2	49	N/A	N/A	Revised Table A-2: Summary of Number of Risk Factors and Model Fit Statistics	Table A-2 was updated to add 2026 risk adjustment model statistics based on only OASIS-E1 items to the other active risk adjustment models.
Appendix	Table A-3	51-57	N/A	N/A	Revised Table A-3: Estimated Coefficients	Table A-3 was updated to reflect new estimated coefficients based on data available with the transition to OASIS-E1 and usage of Hierarchical Condition Categories