**Response to Comments on the Burden Estimates for the FY 2024 IRF QRP Proposals\***

The FY 2024 IPPS/LTCH PPS Notice of Proposed Rulemaking (88 FR 26658) was published on May 1, 2023. In response to the NPRM, CMS received one comment related to the proposed burden estimate. CMS responded to those comments in the FY 2024 IPPS/LTCH PPS Final Rule that was published on August 28, 2023.

Comment: One commenter suggested that CMS’ burden estimates underestimated the burden on providers to complete the assessments, including the time it takes to conduct an interview, obtain a patient response, and change workflows to accomplish the collection. They also point to the burden of training and educating personnel, the burden on informatics to update paper-based facility forms and EMR builds increase the cost significantly. This commenter stated that it currently takes its members a minimum of 30 minutes to complete each LCDS V5.0 on admission and on discharge. However, they report that other members have estimated that it takes between 100 and 110 minutes to complete a full patient assessment, which is nearly three times more than the time CMS has estimated it takes to complete an assessment. This commenter also believes the data may be duplicative of other data captured in the medical chart, as well as being rarely relevant for ongoing training needs and facility-wide improvement efforts, and therefore takes time away from actual patient care without contributing to improved quality. Finally, this commenter also referenced a 2018 report by the General Accounting Office that found calculation errors and inconsistencies across documentation that led to underestimates of time cost.

Response: We appreciate the time and effort LTCHs invest in completing the LCDS. The LCDS is an evaluation and assessment tool and the data collected is directly relevant to patient care, such as hearing, speech, vision, cognition, mood, function, bladder and bowel function, pain, swallowing, nutrition, skin integrity, high-risk medications, special treatments and procedures, and ventilator status. Each of these data elements contributes to the development of a patient-centered plan of care. We also would like to point out that LTCHs have been collecting the data elements in the LCDS V5.0 since October 1, 2022, and our proposal to increase the data completion threshold does not increase the number of items an LTCH must collect at admission or discharge.

As the commenter pointed out in their example, the patient must be assessed and information gathered. After the patient assessment is completed, the LCDS is coded with the information and submitted to iQIES, and we want to remind LTCHs, that it is these steps (after the patient assessment) that the estimated burden and cost captures. The burden estimated is based on past LTCH burden calculations and represents the time it takes to encode the LCDS. Our assumptions for staff type were based on the categories generally necessary to perform an assessment, and subsequently encode it, which is consistent with past collection of information estimates. While we acknowledge that some LTCHs may train and utilize other personnel, our estimates are based on the categories of personnel necessary to complete the LCDS.

We continually look for opportunities to minimize burden associated with collection of the LCDS for information users through strategies that simplify collection and submission requirements. At the time we adopt new items, we ensure that all instructions and notices are written in plain language and provide step-by-step examples for completing the LCDS. We provide a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated LTCH QRP webpage houses multiple modes of tools, such as instructional videos, case studies, user manuals, and frequently asked questions which support understanding of the items collected on the LCDS generally, and these can be used by current and assist new users of the LCDS. We utilize a listserv to facilitate outreach to users, such as communicating timely and important new material(s), and we continue to use those outreach resources when providing training and information. We create data collection specifications for LTCH electronic health record (EHR) software with ‘skip’ patterns associated with the items used for LTCH QRP compliance to ensure the LCDS is limited to the minimum data required to meet quality reporting requirements. These specifications are available free of charge to all LTCHs and their technology partners. Further, these minimum requirements are standardized for all users of the LCDS assessment forms. Finally, we provide LTCHs with various resources to review and monitor their own performance on APU, and provide a free internet-based system through which users can access on-demand reports for feedback on the collection of the LCDS associated with their facility.