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CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISIONS TO THE LCDS V5.2
FOR THE COLLECTION OF DATA
PERTAINING TO
LONG-TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP)

OMB Control Number 0938-1163
CMS-10409

<u>SUPPORTING STATEMENT-PART A</u>
LCDS
FOR THE COLLECTION OF DATA PERTAINING TO
THE LTCH QRP

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Supporting Statement Part A

LCDS For the Collection of Data Pertaining to the Long-Term Care Hospital Quality Reporting Program

A. Background

The Centers for Medicare & Medicaid Services (CMS) is requesting approval of revisions to the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) Version 5.2 that will be effective October 1, 2026.

On May 2, 2024 the Centers for Medicare & Medicaid Services (CMS) published the Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) for Federal Fiscal Year (FY) 2024 proposed rule (89 FR 35934) which finalizes modifications to the collection of quality reporting data in the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). Specifically, CMS is proposing to collect four new items as standardized patient assessment data elements, modify one item collected as a standardized patient assessment data element, and remove one item from the LCDS. Per the proposed rule, CMS would require LTCHs to start collecting these new and modified assessment data using the LCDS Version 5.2 for LTCH patients beginning October 1, 2026. The LTCH PPS Proposed Rule is available here: https://www.federalregister.gov/documents/2024/05/02/2024-07567/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.

CMS is asking for approval of the LCDS Version 5.2, which would have an October 1, 2026 implementation date. The LCDS Version 5.1 will have a runoff period through September 30, 2026 and sunset when the LCDS Version 5.2 takes effect on October 1, 2026

1. Background of the LCDS in LTCHs

The LCDS is a uniform instrument used in every hospital certified as a LTCH under 42 C.F.R. 412.23(e) in the United States to assess resident condition. The LCDS serves two purposes:

(1) Collect data to inform care plans.
(2) To generate quality indicators to evaluate LTCHs and guide improvement interventions.

Regarding the LTCH QRP, **Table 1** lists the quality measures currently collected via the LCDS Version 5.1.

Table 1. Quality Measures Collected via the LCDS V5.1

Short Name	Measure Name & Data Source
LCDS	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Change in Mobility	Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
Compliance with SBT	Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
Ventilator Liberation	Ventilator Liberation Rate
TOH–Provider	Transfer of Health Information to the Provider Post-Acute Care (PAC)
TOH–Patient	Transfer of Health Information to the Patient Post-Acute Care (PAC)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percentage of Patients/Residents Who Are Up to Date

B. Justification

1. Need and Legal Basis

This instrument with its supporting manual is needed to permit the Secretary of Health and Human Services, and CMS, to implement Section 1886(m)(5) of the Social Security Act, as enacted by Section 3004 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). The statute authorizes the establishment of the LTCH QRP. The LTCH QRP was implemented in section VII.C. of the fiscal year (FY) 2012 IPPS/LTCH PPS final rule (76 FR 51743 through 51756)[1] pursuant to Section 3004 of the Affordable Care Act.[2] Beginning in FY 2014, LTCHs that fail to submit quality data to CMS were subject to a 2 percentage point reduction in their annual payment update.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113-185, enacted on Oct. 6, 2014), requires that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which LTCH providers are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of the such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use; for LTCHs, this requirement refers to the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS).

2. Information Users

The LCDS is used to collect data for the LTCH QRP. The LTCH QRP is authorized by section 1886(m)(5) of the Social Security Act (the Act), and it applies to all hospitals certified by Medicare as LTCHs. Under the LTCH QRP, the Secretary reduces the annual update to the LTCH PPS standard Federal rate for discharges for an LTCH during a fiscal year by 2 percentage points if the LTCH has not complied with the LTCH QRP requirements specified for that fiscal year. The IMPACT Act enacted new data reporting requirements for LTCHs. All of the data that must be reported in accordance with section 1899B(a)(1)(A) must be standardized and interoperable so as to allow for the exchange of the information among PAC providers and other providers and the use of such data in order to enable access to longitudinal information and to facilitate coordinated care.

In addition, the public/consumer is a data user, as CMS is required to make LTCH QRP data available to the public after ensuring that an LTCH has the opportunity to review its data prior to public display. Measure data is currently displayed on Long-Term Care Hospital Compare (LTCH Compare): https://www.medicare.gov/longtermcarehospitalcompare/

3. Use of Information Technology

CMS uses information technology to decrease the burden associated with data collection of the LCDS. This is accomplished through strategies that (1) streamline information and submission processes, (2) minimize costly documentation requirements, and (3) utilize information technology for improving communication.

First, CMS creates data collection specifications for LTCH electronic health record (EHR) software with ‘skip’ patterns to ensure the LCDS is limited to the minimum data required to meet quality reporting requirements and to calculate LTCH payment. 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. CMS also provides flexibility to LTCHs by giving them the option of recording the required data on a printed form and later transferring the data to electronic format or they can choose to directly enter the required data electronically to the CMS designated submission

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[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals’ FTE Resident Caps for Graduate Medical Education Payment, Federal Register/Vol. 76, No. 160, August 18, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf.

[2] Patient Protection and Affordable Care Act. Pub. L. 111-148. Stat. 124-119. 23 March 2010. Web. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

system, which is currently used by Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), Home Health Agencies (HHAs), and Skilled Nursing Facilities (SNFs).

Second, CMS has minimized costly documentation requirements by allowing LTCHs to electronically self-attest to the accuracy of the data in the LCDS prior to transmitting the LCDS, eliminating the need for supportive documentation to be submitted with the LCDS. CMS has also developed customized software that allows LTCHs to encode, store and transmit the LCDS data. The software is available free of charge on the CMS Website at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/ltch-technical-information. Additionally, the software delivers real-time warnings to the LTCH when the data is incomplete. LTCHs receive warnings when the data is accepted by the system but may be incomplete for purposes of quality reporting submission. LTCHs receive fatal warnings when the data collection form is not accepted by the system for any reason.

Third, we provide customer support for software and transmission problems encountered by the providers. LTCHs have the ability to self-select their preferred method of communication. For example, we have dedicated help desks to respond to questions about issues LTCHs may encounter with the software. We also offer LTCHs the ability to sign up for listservs that send out timely and important new information, reminders, and alerts via electronic mail related to the software. CMS has also established a website to assist providers with questions regarding the LCDS, at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/ltch-care-data-set-and-ltch-qrp-manual. This website publishes new information related to the LCDS, houses archived versions of the tool, and is available at all times to LTCHs.

4. Duplication of Efforts

This data collection for the LTCH QRP does not duplicate any other effort and the standardized information cannot be obtained from any other source. There are no other data sets that will provide comparable information on patients admitted to LTCHs.

5. Small Businesses

As part of our PRA analysis for an update of our existing approval, we again considered whether the change impacts a significant number of small entities. Out of a total of 329 LTCHs, approximately 30 are considered small LTCHs (that is, less than 25 beds).[3] The average number of assessment sets completed annually by each LTCH is 395 admission assessments and 398 discharge assessments (that is planned, unplanned, and expired), and is the same across all respondents based on the number of actual assessment sets completed by LTCHs in FY 2023.

CMS requests authorization for LTCHs to use the updated LCDS 5.2 for the submission of quality measure and standardized patient assessment data information proposed in the FY 2025 IPPS/LTCH PPS proposed rule. Provider participation in the submission of quality measure and standardized patient assessment data is mandated by Section 3004 of the Affordable Care Act and Section 1899B(c)(2)(A) of the IMPACT Act. Small business providers viewing the data collection as a burden can elect not to participate. However, if an LTCH does not submit the required data, this provider shall be subject to a 2 percentage point reduction in their annual payment update.

6. Less Frequent Collection

We need to collect the data on the LCDS at the required frequency (that is, at admission and at discharge from the LTCH) in order to calculate any possible payment penalty under the LTCH QRP. According to the LTCH QRP requirements, LTCHs are required to submit this data to CMS on a quarterly basis in order to calculate the quality measures adopted under the LTCH QRP and to obtain standardized patient assessment data.

7. Special Circumstances

There are no special circumstances that would require the LCDS Admission and LCDS Discharge assessments to be conducted more than once during a patient's stay.

[3] FY 2025 IPPS/LTCH PPS Proposed Rule; 89 FR 36638; Table IV.

8. Federal Register/Outside Consultation

The FY 2025 IPPS/LTCH PPS Notice of Proposed Rulemaking (89 FR 35934) published on May 2, 2024, and can be found here: https://www.federalregister.gov/documents/2024/05/02/2024-07567/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.

CMS informed the provider community on April 10, 2024 as the rule went out on public display. A reference to the announcement can be found on the LTCH QRP webpage found here https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-quality-reporting-spotlight-announcements.

a) Consideration of Burden of Information Collection Requests

CMS continually looks for opportunities to minimize burden associated with collection of the LCDS for information users through strategies that (1) simplify collection and submission requirements, (2) improve LCDS comprehension, and (3) enhance communication, navigation, and outreach, (4) minimize learning costs, and (5) provide flexible time frames for data submission.

First, interviews are conducted with information users before new items are introduced. The interviews provide valuable evidence in order to ensure the item(s) are precise and result in meaningful information.

Second, improving LCDS comprehension is a priority. A number of strategies are used, including standardizing the collection instructions across all LTCHs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the LCDS. Human-centered design best practices are used, such as prioritizing key communication in headings, text boxes, and bold text. Close attention is paid to the amount of information required in the forms so that only the necessary data is collected on the LCDS.

Third, CMS looks for opportunities to improve communication with users and conducts outreach. CMS provides 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 LCDS, and can be used by current and assist new users of the LCDS. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), as well as reminders and alerts related to the LCDS completion. Finally, CMS provides 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.

Fourth, CMS is aware of the learning costs that LTCHs may incur when new data collection is required. CMS provides multiple free training resources and opportunities for LTCHs to use, reducing the burden to LTCHs in creating their own training resources. These training resources include live training, online learning modules, tip sheets, and/or recorded webinars and videos. Having the materials online and on-demand gives LTCHs the flexibility to use the materials in a group setting or on an individual basis at times that work for them.

Fifth, CMS allows up to 4.5 months for LTCHs to submit all data required in this information collection, providing ample time for data submission. CMS acknowledges that some small providers may experience difficulties complying with data collection requirements, and having additional time may reduce the stress and anxiety LTCH providers may experience.

9. Payment/Gifts to Respondents

There will be no payments/gifts to respondents for the use of the LCDS. If an LTCH fails to comply fully, CMS may withhold (in full or in part) or reduce Medicare payment to the LTCH.

10. Confidentiality

The system of records (SOR) establishes privacy stringent requirements. The LCDS SOR Notice (SORN) (09-70-0539) was published in the Federal Register on February 6, 2013 (78 FR 8536). A SORN modification notice was published in the Federal Register on February 14, 2018 (83 FR 6591).

CMS has also provided, as part of the current Manual, a section that addresses in writing statements of confidentiality consistent with the Privacy Act of 1974. All patient-level data is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. The data collected is protected and held confidential in accordance with 20 CFR 401.3. Data will be treated in a confidential manner, unless otherwise compelled by law.

11. Sensitive Questions

There are no sensitive questions on the LCDS.

12. Burden Estimates (Hours & Wages)

In this section, we provide burden estimates, provided in the FY 2025 IPPS/LTCH notice of proposed rulemaking, associated with the proposed collection of new information requirements for the LTCH QRP using the LCDS V5.2**.** Since the establishment of the LCDS, CMS has calculated programmatic burden accounting for the time and cost it takes an LTCH to encode the LCDS, prepare the data for electronic submission, and transmit the data to CMS. Our estimates of time to complete new items is based on past LTCH burden calculations, and our assumptions for staff type are based on the categories generally necessary to collect this data, and subsequently encode it. However, individual providers determine their own processes to collect the information and the staffing resources necessary to collect it. We acknowledge that some LTCHs will incur a higher cost than was estimated, while some LTCHs will incur a lower cost.

We note that the burden associated with the measures and data elements related to the IMPACT Act of 2014 have been exempt from the PRA. Section 1899B(m) and the sections referenced in section 1899B(a)(2)(B) of the Act exempt modifications that are intended to achieve the standardization of patient assessment data.

a) Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning with the FY 2028 LTCH QRP

In the FY 2025 IPPS/LTCH PPS Proposed Rule (89 FR 36345 to 36350), CMS proposes to require LTCHs to report the following four new items to be collected as standardized patient assessment data elements in the LCDS under the Social Determinants of Health (SDOH) category under the LTCH QRP: one item for Living Situation; two items for Food; and one item for Utilities. CMS is also proposing to modify one of the current items collected as standardized patient assessment data under the SDOH category. LTCHs would be required to report these data with respect to admission of all patients, regardless of payer, discharged beginning October 1, 2026. As a result, the estimated burden and cost for LTCHs for complying with requirements of the FY 2028 LTCH QRP will increase. Specifically, we believe there will be 0.015 hour increase in clinical staff time to report data per patient stay.

Functional Description of the items: The proposed new items and modified item are collected at admission to the LTCH. The Living Situation item asks “What is your living situation today?” The proposed response options are: (1) I have a steady place to live; (2) I have a place to live today, but I am worried about losing it in the future; (3) I do not have a steady place to live; (7) Patient declines to respond; and (8) Patient unable to respond. The first proposed Food item states, “Within the past 12 months, you worried that your food would run out before you got money to buy more.” The second proposed Food item states, “Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.” We propose the same response options for both items: (1) Often true; (2) Sometimes true; (3) Never True; (7) Patient declines to respond; and (8) Patient unable to respond. The proposed Utilities item asks, “In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?” The proposed response options are: (1) Yes; (2) No; (3) Already shut off; (7) Patient declines to respond; and (8) Patient unable to respond. The proposed Transportation item asks, “In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?” The proposed response options are: (0) Yes; (1) No; (7) Patient declines to respond; and (8) Patient unable to respond. A draft of what the proposed new and modified items will look like can be found in the Downloads

section of the LTCH CARE Data Set and LTCH QRP Manual webpage and readers can view it at *https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-care-data-set-ltch-qrp-manual*.

Evaluation of the need for the items: Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect standardized patient assessment data elements with respect to other categories deemed necessary and appropriate. Accordingly, we finalized the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42578 through 42581), and defined SDOH as the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health.[4] According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30-55% of health outcomes.[5] This is a part of a growing body of research that highlights the importance of SDOH on health outcomes. Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjustors or in future quality measures. Our ability to perform these analyses and to make adjustments relies on existing data collection of SDOH items from PAC settings. The SDOH items we are proposing to adopt as standardized patient assessment data elements under the SDOH category in this proposed rule were also identified in the 2016 NASEM report[6] or the 2020 NASEM report[7] as impacting care use, cost, and outcomes for Medicare beneficiaries. The items have the capacity to take into account treatment preferences and care goals of patients and their caregivers, to inform our understanding of patient complexity and SDOH that may affect care outcomes, and ensure that LTCHs are in a position to impact through the provision of services and supports, such as connecting patients and their caregivers with identified needs with social support programs.

Estimate of the Burden: Using data from fiscal year 2023, we estimate 130,050 admission assessments from 329 LTCHs annually and 395 admission assessments per LTCH. This equates to an increase of 2,116.55 hours in burden for all LTCHs [(0.020 hour x 130,050 admissions) minus (0.005 x 96,890 planned discharges)] for a total of 187,735 hours for all LTCHs. We believe the LCDS items affected by the proposal to collect four new items and modify one item are completed by Registered Nurses (RN) and Licensed Practical and Licensed Vocational Nurses (LVN). Therefore, we averaged the national median for these labor types and established a composite cost estimate of $65.31. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: RN 50 percent and LVN 50 percent. For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates.[8] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 1.

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[4] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs. June 28, 2020. Available at: *https://aspe.hhs.gov/reports/second-report-congress-social-risk-medicares-value-based-purchasing-programs*.

[5] World Health Organization. Social determinants of health. Available at: *https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1*.

[6] Social Determinants of Health. Healthy People 2020. *https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health*. (February 2019).

[7] National Academies of Sciences, Engineering, and Medicine. 2020. Leading Health Indicators 2030: Advancing Health, Equity, and Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25682.

[8] https://www.bls.gov/oes/current/oes_nat.htm.

Table 1. U.S. Bureau of Labor and Statistics' May 2022 National Occupational Employment and Wage Estimates.

Occupation title	Occupation code	Median Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse (RN)	29-1141	$39.05	$39.05	$78.10
Licensed Practical /Vocational Nurse (LPN/LVN)	29-2061	$26.26	$26.26	$52.52

We estimate that the total cost would increase by $138,231.88 for all LTCHs annually [($78.10 x (2,116.55 hours)/2)] + [($52.52 x (2,116.55 hours)/2)], or $420.16 per LTCH annually ($138,231.88 total increase/329 LTCHs) based on the proposal to require LTCHs to report four new items to be collected as standardized patient assessment data elements in the LCDS and to modify one of the current items collected as standardized patient assessment data under the SDOH category.

Burden Hours and Cost Calculation for LCDS V5.2 for the FY 2028 LTCH QRP:

Average number of LTCHs in U.S. in FY 2023	329
Average number of LCDS admission assessments submitted per each LTCH in FY 2023	395
Average number of LCDS planned discharge assessments submitted per each LTCH in FY 2023	294
Average number of LCDS admission assessments submitted for all LTCHs in FY 2023	130,050
Average number of LCDS planned discharge assessments submitted for all LTCHs for the in FY 2023	96,890
Current Hours for each LTCH annually resulting from the LTCH QRP requirement for LCDS submissions	640.55
Increase in Hours for each LTCH annually resulting from the proposal to require LTCHs to report four new items to be collected as standardized patient assessment data elements and to modify one of the current items collected as standardized patient assessment data under the SDOH category	6.43
Change in Annual Cost for each LTCH for the FY 2028 LTCH QRP	$420.16
Change in Annual Cost for all LTCHs for the FY 2028 LTCH QRP	$138,231.88

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The Department of Health & Human Services (DHHS) will incur costs associated with the administration of the LTCH QRP including costs associated with the IT system used to process LCDS submissions to CMS and analysis of the data received.

CMS has engaged the services of an in-house CMS contractor to create and manage an online reporting/IT platform for the LCDS. This contractor works with the CMS Center for Clinical Standards and Quality, Division of Post-Acute and Chronic Care (DCPAC) in order to support the IT needs of multiple quality reporting programs. When LTCHs transmit the data contained within the LCDS to CMS it is received by this contractor. Upon receipt of all data sets for each quarter the contractor performs some basic analysis which helps to determine each provider's compliance with the reporting

requirements of the LTCH QRP. The findings are communicated to the LTCH QRP lead in a report. Contractor costs include the development, testing, roll-out, and maintenance of the software that is made available to LTCHs free of charge providing a means by which LTCHs can submit the required data to CMS.

DCPAC also retains the services of a separate contractor for the purpose of performing a more in-depth analysis of the LTCH quality data, as well as the calculation of the quality measures, and for future public reporting of the LTCH quality data. Said contractor is responsible for obtaining the LTCH quality reporting data from the in-house CMS contractor. They will perform statistical analysis on this data and prepare reports of their findings, which will be submitted to the LTCH QRP lead.

DCPAC retains the services of a third contractor to assist with provider training and help desk support services related to the LTCH QRP.

In addition to the contractor costs, the total includes the cost of the following Federal employees:

- GS-13 (locality pay area of Washington-Baltimore-Northern Virginia) at 100% effort for 3 years, or $353,886. The annual cost is $117,962.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33% effort for 3 years, or $139,395. The annual cost is $46,465

The estimated annual cost to the federal government is as follows:

Item	Cost
CMS in-house contractor – Maintenance and support of IT platform that Supports the LCDS	$ 875,000
Data analysis contractor	$1,000,000
Provider training & help desk contractor	$1,000,000
GS-13 Federal Employee (100% x 1year)	$ 117,962
GS-14 Federal Employee (33% x 1 year)	$ 46,465
Total Cost to Federal Government	**$3,039,427**

15. Changes to Burden

As a result of the FY 2025 IPPS/LTCH proposed rule proposals for the collection of quality reporting data, the total burden associated with each LCDS submission would increase by 0.015 hours per LCDS, 6.43 hours per LTCH and 2,116.55 hours for all LTCHs.

Since the approval of the LCDS V5.1, new information demonstrates a change in both the number of LTCHs and the number of LCDS's completed per LTCH. As illustrated in **Table 3,** the number of LTCHs submitting assessments has decreased from 330 to 329. LTCHs are also submitting approximately 18,038 fewer admission assessments and 17,970 fewer discharge assessments across all LTCHs, resulting in a decrease of 54.82 (18,038 / 329) admission assessments and 54.62 (17,970 / 329) discharge assessments per LTCH. As a result of these changes, we estimate an overall decrease in burden hours for LTCHs. Specifically, the burden hours will decrease by 23,646 hours [211,381 hours – 187,735 hours.

Table 3. Change in number of LTCHs and LCDS submissions since approval of the LCDS V5.1

	Number of LTCHs	Number of Admission LCDS Across All LTCHs	Number of Admission LCDS per LTCH	Number of Discharge LCDS Across All LTCHs	Number of Discharge LCDS Across per LTCH	Burden Hours
Approved Collection of LCDS V5.1	330	148,088	448.75	148,965	451.41	211,381
Proposed Collection of LCDS V5.2	329	130,050	395.29	130,995	398.16	187,735

We estimate the average cost per each LCDS submission beginning with the FY 2028 QRP to be $93.94 [((0.719166667 hrs/admission assessments) + (0.719166667 hrs/discharge assessments)) x $65.31/hour]. Therefore, we estimate there would be an increased average annual cost to all LTCHs for reporting quality data of $138,231.88 (2,116.55 hours in burden for all LTCHs x $65.31composite wage (see Table 2)). However, due to the changes in both the number of LTCHs and the number of LCDS's completed per LTCH, we estimate there would be a decreased average annual cost to each LTCH for reporting quality data of $90,967.43 ($29,928,283.8 / 329).

Previous Cost Burden for all LTCHs per year	$17,667,319.92
New Cost Burden for all LTCHs per year	$12,260,963.87

16. Publication/Tabulation Dates

For the changes to the LCDS Version V5.2 related to the LTCH QRP, the proposed rule was published in the Federal Register on May 2, 2024 (89 FR 36351 to 36352). The draft LCDS Version V5.2 can be found here: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/ltch-care-data-set-and-ltch-qrp-manual.

17. Expiration Date

The OMB expiration date will be displayed on all disseminated data collection materials.

18. Certification Statement

There are no exceptions to the certifications statement.

Appendices:

Appendix A

Draft LTCH CARE Data Set Version 5.2 Admission Item Set
Draft LTCH CARE Data Set Version 5.2 Expired Item Set
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