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CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISIONS TO THE LCDS V5.3
FOR THE COLLECTION OF DATA
PERTAINING TO
LONG-TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP)

OMB Control Number 0938-1163
CMS-10409

SUPPORTING STATEMENT-PART A

LCDS

FOR THE COLLECTION OF DATA PERTAINING TO

THE LTCH QRP

Table of Contents

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 April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) displayed the Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) for Federal Fiscal Year (FY) 2026 proposed rule. The proposed rule, published in the Federal Register on April 30, 2025,[1] proposes modifications to the collection of quality reporting data in the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). Specifically, CMS is finalizing the removal of four items as standardized patient assessment data elements, and the modification of one item collected as a standardized patient assessment data element. While these items are being removed from the LCDS before being implemented on the October 1, 2026 version, we have previously accounted for the burden associated with these items under OMB Control Number 0938-1163. We are also proposing to remove the Patient/Resident COVID-19 Vaccine data item (O0350) from the expired LCDS assessment, effective October 1, 2026. If finalized as proposed, LTCHs will no longer be required to collect and submit data on this item for patients who expire in the LTCH, beginning with patients admitted on October 1, 2026. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page

In addition, we are modifying two items. Item A1250 Transportation will be modified to item A1255 Transportation. Item A0800. Gender will be modified to A0810. Sex to be consistent with EO 14168 *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*.

CMS is asking for approval of the LCDS Version 5.3, which will 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 5.3 takes effect on October 1, 2026. The LCDS version 5.2, which was previously approved on 12/27/24, will not be implemented and will be superseded by LCDS Version 5.3.

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

[1] FY 2026 IPPS/LTCH PPS proposed rule (90 FR 18002) https://www.federalregister.gov/d/2025-06271

Short Name	Measure Name & Data Source
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)[2] pursuant to Section 3004 of the Affordable Care Act.[3] 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 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/

[2] 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.

[3] 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.

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 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 330 LTCHs, approximately 17 are considered small LTCHs (that is, less than 25 beds).[4] The average number of assessment sets completed annually by each LTCH is 394 admission assessments and 397 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 2024.

CMS requests authorization for LTCHs to use the updated LCDS 5.3 for the submission of quality measure and standardized patient assessment data information proposed in the FY 2026 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

[4] Public display version of the FY 2026 IPPS/LTCH PPS proposed rule: https://public-inspection.federalregister.gov/2025-06271.pdf

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 will require the LCDS Admission and LCDS Discharge assessments to be conducted more than once during a patient's stay.

SPD 15 Implementation Update

We support implementing the latest SPD-15 directive.

For the FY/CY 2027 Rulemaking seasons, we intend to discuss our plans to implement Figure 3, the minimum categories with the expectation to implement in our 5 PAC Programs. The implementation of this standard sooner would be a significant burden for the following reasons—

- Existing patient assessment instruments (PAIs) collect information on patients' race and/or ethnicity using an earlier standard. By statute, all PAIs must propose the data items, including race/ethnicity via notice and comment rulemaking. This means that to add the race/ethnicity from SPD 15, we would need to propose the time, place, and manner of adding the SPD 15 race/ethnicity in each of its rules.
- While we have begun preliminary conversations with our Information Systems Group (ISG) colleagues for implementation following rulemaking, adoption of this standard (like any new work) requires adequate time for vendors, States, other CMS components, and federal agencies to implement updates to their respective systems, databases, finder files, etc.
- We need to allow for the 12-month period allotted prior to implementation of any updates and related trainings to the assessment tools and technical data specifications, our various data bases, and impacted reports. We plan to incorporate the Race and Ethnicity Question with Minimum Categories only (no examples or write-ins) (as shown in Figure 3 of the Federal Register posting).
    - With the very long list of race/ethnicity options, it may be more difficult to administer the longer version by PAC staff, especially to an older and sicker Medicare-aged population. This version of the question aligns with current versions used on the PAC patient assessment instruments. The minimum categories reduce provider burden and patient/resident/family confusion since the staff must read the questions to the patient/resident for their response. We also need to consider the translations for patients who need staff to ask the questions in a language other than English. Based on testing from other write-in considerations, we have proven that we cannot use the data. Aside from spelling issues and how many write-ins should be allowed, we seek inter-operability, and write-ins do not allow for it. Further, the current data lacks sufficient N to include sub-groups at the facility level. Therefore, we roll-up the data to the Minimum Categories. Currently, we can only show white and non-white to represent some PAC data. The increased burden to staff would be significant to implement other than the Minimum Categories and not improve the data quality. Additionally, to make statements about the data will require roll-up to the Minimum Categories since we do not use the examples or write-ins due to the small Ns. We could include the examples in our manuals as guidance, but due to the high burden and confusion would use the Minimum Categories in the assessment instruments.

8. Federal Register/Outside Consultation

The FY 2026 IPPS/LTCH PPS Notice of Proposed Rulemaking published on the Federal Register public inspection desk on April 11, 2025, and published in the Federal Register on April 30, 2025.[5] CMS invited public comment on the proposed burden estimate.

CMS informed the provider community on April 11, 2025 as the rule went 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).

[5] FY 2026 IPPS/LTCH PPS proposed rule (90 FR 18002) https://www.federalregister.gov/d/2025-06271

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 2026 IPPS/LTCH proposed rule, associated with the proposed collection of new information requirements for the LTCH QRP using the LCDS V5.3**.** 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) Assessing Burden of Information Collection

In the FY 2026 IPPS/LTCH PPS proposed rule[6] we proposed the removal of four items from the LCDS Version 5.3:

- R0310. Living Situation
- R0320A. and R0320B. Food
- R0330. Utilities

We are also proposing to remove the Patient/Resident COVID-19 Vaccine Status item (O0350) from the LCDS form used for patients who have expired.

Finally, we are modifying two items on the LCDS. Item A0800. Gender will be modified to A0810. Sex, and item A1250 Transportation will be modified to item A1255 Transportation. We estimate no burden change for these item modifications.

Overall, we estimate a decrease in the total burden related to the LCDS Version 5.3, if the policies proposed for the LTCH QRP in the FY 2026 IPPS/LTCH PPS proposed rule are finalized.

Estimate of the Burden: Using data from fiscal year 2024, we estimate 130,050 admission assessments from 330 LTCHs annually and 394 admission assessments per LTCH. This equates to a decrease of 2,634 hours in burden for all LTCHs (-0.020 hour x 130,050 admissions for removal of the SDOH items) + (-0.005 x 6,503 expired assessments for removal of the COVID-19 vaccination item). We believe the LCDS items affected by the proposal to remove four 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

[6] Public display version of the FY 2026 IPPS/LTCH PPS proposed rule: https://public-inspection.federalregister.gov/2025-06271.pdf

estimate of $70.10. 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 2023 National Occupational Employment and Wage Estimates.[7] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 2.

Table 2. 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	$41.38	$41.38	$82.76
Licensed Practical /Vocational Nurse (LPN/LVN)	29-2061	$28.72	$28.72	$57.44

We estimated that the total cost will decrease by $184,643.40 for all LTCHs annually ($70.10 x -2,601 hours for four items on admission) + ($70.10 x -33 hours for one item on the expired assessment), or $559.53 per LTCH annually ($184,643.40 total decrease/330 LTCHs) based on the proposed removal of four items on the admission assessment and proposed removal of one item on the expired assessment.

Burden Hours and Cost Calculation for LCDS V5.3 for the FY 2028 LTCH QRP:

Average number of LTCHs in U.S. in FY 2023	330
Average number of LCDS admission assessments submitted per each LTCH in FY 2023	394
Average number of LCDS expired assessments submitted per each LTCH in FY 2023	20
Average number of LCDS admission assessments submitted for all LTCHs in FY 2023	130,050
Current Hours for each LTCH annually resulting from the LTCH QRP proposed changes to LCDS submissions	-2634
Decrease in Hours for each LTCH annually resulting from the proposal to remove four standardized patient assessment data elements and to remove the Patient/Resident COVID-19 item from the Expired Assessment	-8
Change in Annual Cost for each LTCH for the FY 2028 LTCH QRP	$559.53
Change in Annual Cost for all LTCHs for the FY 2028 LTCH QRP	$184,643.40

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.

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

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 $427,464. The annual cost is $117,962.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33% effort for 3 years, or $142,488. The annual cost is $46,465

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

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 3 years at 142,488 annually)	$ 427,464
GS-14 Federal Employee (33% X 3 years at $46,465 annually)	$ 142,488
Total Cost to Federal Government	**$3,444,952**

15. Changes to Burden

As a result of the FY 2026 IPPS/LTCH proposed rule proposed the collection of quality reporting data, the total burden associated with each LCDS submission will decrease by 0.025 hours per LCDS, 8 hours per LTCH and 2,634 hours for all LTCHs. We estimate a decrease in the amount of time it will take to complete a single LCDS Version 5.3 as compared to the previously approved package. If finalized, the burden will decrease from 86 minutes to 84.5 minutes beginning October 1, 2026.

Since the approval of the LCDS V5.2, The number of LTCHs submitting assessments has not changed and remains at 330. LTCHs are submitting approximately 130,050 admission assessments, and 6,503 expired assessments. As a result of these changes, we estimate an overall decrease in burden hours for LTCHs. Specifically, the burden hours will decrease by 2,634 hours [187,735 hours – 185,101 hours].

We estimate the average cost per each LCDS submission beginning with the FY 2028 QRP to be $98.72 [((0.704 hrs/admission assessments) + (0.704 hrs/expired assessments)) x $70.10/hour]. Therefore, we estimate there will be a decrease in average annual cost to all LTCHs for reporting quality data of $184,643.40 (-2,634 hours in burden for all LTCHs x $70.10 composite wage (see Table 2)). We estimate there will be a decrease in average annual cost to each LTCH for reporting quality data of $559.53 ($184,643.40 / 330 LTCHs).

Previous Cost Burden for all LTCHs per year	$12,260,963.87
New Cost Burden for all LTCHs per year	$12,076,320.47

16. Publication/Tabulation Dates

For the changes to the LCDS Version V5.3 related to the LTCH QRP, the proposed rule went on display on the Federal Register Public Inspection website on April 11, 2025 and was published in the Federal Register on April 30, 2025.

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

Final LTCH CARE Data Set Version 5.3Admission Item Set
Final LTCH CARE Data Set Version 5.3 Expired Item Set
Final LTCH CARE Data Set Version 5.3 Planned Discharge Item Set
Final LTCH CARE Data Set Version 5.3 Unplanned Discharge Item Set