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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
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SUPPORTING STATEMENT-PART A

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 5.3 that will be effective October 1, 2026.

On April 14, 2026, the Centers for Medicare & Medicaid Services (CMS) displayed the Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) for Federal Fiscal Year (FY) 2027 proposed rule.[1] This rule proposes modifications to the collection of quality reporting data in the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). Specifically, CMS is proposing the removal of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the LTCH QRP, effective with the FY 2028 LTCH QRP. If finalized as proposed, LTCHs will no longer be required to collect and submit data on the Patient/Resident COVID-19 Vaccine data item (O0350) item beginning with patients admitted on October 1, 2026.

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 The LCDS version 5.2, which was previously approved on 12/27/24, will not be implemented and will be superseded by LCDS Version 5.3.

Background of the LCDS in LTCHs

The LCDS is a uniform instrument used in hospitals certified as a LTCH under 42 C.F.R. 412.23(e) in the United States to assess patient conditions. 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

[1] https://www.federalregister.gov/documents/2026/04/14/2026-07203/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and

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/

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

[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.

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. 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/long-term-care-hospital. 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 318 LTCHs, approximately 31 are considered small LTCHs (that is, less than 25 beds).[4] The average number of assessment sets completed annually by each LTCH is 359 admission assessments and 359 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 2025.

CMS requests authorization for LTCHs to use the revised 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 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.

[4] Public display version of the FY 2027 IPPS/LTCH PPS proposed rule: https://www.federalregister.gov/public-inspection/current

We intend to discuss our plans to implement Figure 3, the minimum categories with the expectation to implement in our 5 PAC Programs prior to the September 28, 2029 deadline.[5] 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 databases, 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 in the Federal in April 14 2026 (91 FR 19312).[6] CMS invited public comment on the proposed burden estimate.

CMS informed the provider community in April 2026 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

In alignment with Executive Order 14192 title "Unleashing Prosperity Through Deregulation" (January 21, 2025), CMS continues to look for ways to balance the statutory requirement for data collection in the LTCH QRP with the burden that such data collections may have on LTCH.

[5] OMB Announcing Timeline Extensions for SPD 15 Implementation. Accessed March 22, 2026. https://spd15revision.gov/content/spd15revision/en/news/2025-09-26-bulletin.html

[6] FY 2027 IPPS/LTCH PPS proposed rule. https://www.federalregister.gov/documents/2026/04/14/2026-07203/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and

CMS has taken steps 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, and (4) minimize learning costs.

First, during the measure selection process, interviews are conducted with information users before new measures or items are introduced. The interviews provide valuable evidence to ensure that any addition to the LCDS is precise and results 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, removing this cost 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.

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 2027 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 may incur a higher cost than was estimated, while some LTCHs may 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) Assessment of Burden of Information Collection

CMS routinely assesses data collection for the LTCH QRP, given the statutory requirements for quality measurement. CMS continues to evaluate the assessment items to consider appropriate removal of items that are not required for quality measure calculation, risk adjustment, or other aspects of the QRP.

In the FY 2027 IPPS/LTCH PPS proposed rule we proposed the removal of two measures to meet the requirements of Executive Order 14192 title "Unleashing Prosperity Through Deregulation" (January 21, 2025). We propose removal of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, effective with the FY 2028 LTCH QRP. While this burden reduction is not accounted for under this PRA, we account for the burden reduction for the LTCH QRP in the FY 2027 IPPS/LTCH PPS proposed rule.[7] We also propose removal of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the LTCH QRP, effective with the FY 2028 LTCH QRP. We would also remove the Patient's COVID-19 vaccination is up to date" item (O0350) from the LCDS form used at the time of planned or unplanned discharge, as soon as is practicable, effective October 1, 2028. However, LTCHs would no longer be required to complete this item effective October 1, 2026, with the LCDS Version 5.3.

Overall, we estimate a decrease in the total burden related to the revised 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 FY 2025 data, we estimate an annual total of 102,590 discharges from 318 LTCHs for an annual decrease of 512.95 hours (102,590 x 0.005 hour) for all LTCHs. For each LTCH, we estimate an annual burden decrease of 1.61 hours (512.95 hours/318 LTCHs). We believe that data collection would be completed equally by a Registered Nurse (RN) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN). However, LTCHs determine the staffing resources necessary.

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 2024 National Occupational Employment and Wage Estimates. To account for other indirect costs and fringe benefits, we doubled the hourly wage. We established a composite cost estimate using our adjusted wage estimates. The composite estimate of $78.16/hr was calculated by weighting each adjusted hourly wage equally (that is, 50 percent) [($61.68/hr × 0.5) plus ($94.64/hr × 0.5) = $78.16]. These amounts are detailed in **Table 2**.[8]

[7] Public display version of the FY 2027 IPPS/LTCH PPS proposed rule: https://www.federalregister.gov/public-inspection/current

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

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	$30.84	$30.84	$61.68
Licensed Practical /Vocational Nurse (LPN/LVN)	29-2061	$47.32	$47.32	$94.64

Given 0.005 hours at $78.16 per hour, we estimate the total cost will decrease annually by $40,092.17 for all LTCHs ($78.16 x 512.95 hours), or an annual decreased cost of $126.08 for each LTCH.

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

Average number of LTCHs in U.S. in FY 2025	318
Average number of LCDS discharge assessments submitted for all LTCHs in FY 2025	102,590
Decrease in hours for each LTCH annually resulting from the LTCH QRP proposed changes to LCDS submissions	-512.95
Decrease in hours for each LTCH annually resulting from the proposal to remove the Patient/Resident COVID-19 item	-1.61
Change in Annual Cost for each LTCH for the FY 2028 LTCH QRP	-$126.08
Change in Annual Cost for all LTCHs for the FY 2028 LTCH QRP	-$40,092.17

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) 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 $365,355, or $121,785 annually.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33% effort for 3 years, or $143,913, or $47,971 annually.

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 $121,785 annually)	$ 365,355
GS-14 Federal Employee (33% X 3 years at $47,971 annually)	$ 143,913
Total Cost to Federal Government	**$3,384,268**

15. Changes to Burden

As a result of the FY 2027 IPPS/LTCH proposed rule, the total burden associated with each LCDS submission for the collection of quality reporting data will decrease by 0.005 hours per LCDS, 1.61 hours per LTCH and 512.95 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.

Since the approval of the LCDS V5.3, the number of LTCHs submitting assessments has changed to 318. LTCHs are submitting approximately 102,590 planned and unplanned discharge assessments. As a result of these changes, we estimate an overall decrease in burden hours for LTCHs. Specifically, the burden hours will decrease by 513 hours [185,101 hours – 184,588].

We estimate there will be a decrease in average annual cost to all LTCHs for reporting quality data of $40,092.17 (-512.95 hours in burden for all LTCHs x $78.16 composite wage (see **Table 2**)). We estimate there will be a decrease in average annual cost to each LTCH for reporting quality data of $126.08 ($40,092.17 / 318 LTCHs).

Previous Cost Burden for all LTCHs per year	$12,076,320.47
New Cost Burden for all LTCHs per year	$12,036,228.30

16. Publication/Tabulation Dates

For the changes to the LCDS Version V5.3 related to the LTCH QRP, the proposed rule went on display in the Federal Register website in April 2026.

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
LTCH CARE Data Set Crosswalk