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CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISIONS TO THE LTCH CARE DATA SET (LCDS) V5.1
FOR THE COLLECTION OF DATA
PERTAINING TO
LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM

SUPPORTING STATEMENT-PART A

LTCH CARE DATA SET
FOR THE COLLECTION OF DATA PERTAINING TO
THE LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM

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Supporting Statement Part A

LTCH CARE Data Set 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 proposed revisions to the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) Version 5.0.

On May 1, 2023 the Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) (88 FR 26658) which proposes modifications to the collection of quality reporting data in the Long-term Care Hospital Quality Reporting Program (LTCH QRP). Per the NPRM, CMS proposes to require LTCHs to start collecting assessment data using LCDS Version 5.1 beginning October 1, 2024. The NPRM is available here: https://www.federalregister.gov/documents/2023/05/01/2023-07389/medicare-program-proposed-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals.

CMS is asking for approval of the LCDS Version 5.1, which would have an October 1, 2024 implementation date if the measures proposals are adopted.

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.

Table 1. Quality Measures Currently Collected via the LCDS

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)
Functional Assessment	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
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)

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 LCDS.

2. Information Users

The LTCH CARE Data Set 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/

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

[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.

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.

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), and Home Health Agencies (HHAs), and will be used by Skilled Nursing Facilities (SNFs) beginning in calendar year 2023.

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 information collection 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 considered whether the change impacts a significant number of small entities. Out of a total of 330 LTCHs, approximately 27 are considered small LTCHs (that is, less than 25 beds). The average number of assessment sets completed annually by each LTCH is 449 admission assessments and 451 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 CY 2021.

CMS requests authorization for LTCHs to use the updated LCDS for the submission of quality measure and standardized patient assessment data information. 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 for the purposes of measures calculation.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The FY 2024 IPPS/LTCH PPS Notice of Proposed Rulemaking (88 FR 26658) published on May 1, 2023, If the two new measure proposals (see B.1.a. and B.1.c.) and two measure removals (see B.1.b.) are adopted, LTCHs would begin collecting LCDS data using the LCDS V5.1 beginning with patients discharged October 1, 2024. This proposed rule can be found here: https://www.federalregister.gov/documents/2023/05/01/2023-07389/medicare-program-proposed-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals.

CMS informed the provider community on April 10, 2023 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-initiatives-patient-assessment-instruments/ltch-quality-reporting/ltch-quality-reporting-spotlight-announcements.

9. Payment/Gifts to Respondents

There will be no payments/gifts to respondents for the use of the LCDS.

10. Confidentiality

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

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 2024 IPPS/LTCH notice of proposed rulemaking, associated with the proposed collection of new information requirements for the LTCH QRP using the LCDS V5.1**.**

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 Adopt the Discharge Function Score Measure Beginning with the FY 2025 LTCH QRP

In the FY 2024 LTCH PPS Proposed Rule (88 FR 27140), CMS proposed to adopt the Discharge Function Score measure beginning with the FY 2025 LTCH QRP. This new measure would be calculated with existing data elements reported by LTCHs for other quality reporting purposes. As a result, the proposed adoption of this measure would have no effect on burden and costs for LTCHs.

b) Proposal to Remove the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure and the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure

In the FY 2024 LTCH PPS Proposed Rule (88 FR 27145), CMS proposed to remove the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure and the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure beginning with the FY 2025 LTCH QRP. LTCHs will no longer be required to submit data on these two measures beginning with patients discharged on October 1, 2023. While these measures are proposed for removal, some of the data elements used to calculate the measures would still be reported by LTCHs for other payment and quality reporting purposes. As a result, the estimated burden and cost for LTCHs for complying with requirements of the FY 2025 LTCH QRP will decrease. Specifically, we believe there will be a 0.01 hour decrease [(0.3 minutes per item x 2 items)/60 minutes] in clinical staff time to report data for each LCDS completed at admission and a 0.005 hour decrease [(0.3 minutes per item x 1 item)/60 minutes] in clinical staff time to report data for each LCDS completed for planned discharges.

Using data from calendar year 2021, we estimate 148,088 admissions and 111,251 planned discharges from 330 LTCHs annually. This equates to an estimated 785.88 total assessments per LTCH per year (148,088 + 111,251 / 330). As a result, we estimate a decrease of 1,480.88 hours in burden at admission for all LTCHs (0.01 hour clinical time at admission × 148,088 admissions), and a decrease of 556.26 hours in burden for planned discharges for all LTCHs (0.005 hour clinical time at discharge × 111,251 planned discharges). This equates to an estimated reduction in burden of 2,037.14 hours for all LTCHs (1,480.88 + 556.26) and an estimated reduction of 6.17 hours per LTCH per year (2037.14/ 330).

We believe the LCDS item affected by the proposed removal of the Application of Functional Assessment/Care Plan measure is completed by Occupational Therapists (OT), Physical Therapists (PT), Registered Nurses (RN), Licensed Practical and Licensed Vocational Nurses (LVN), and/or Speech-Language Pathologists (SLP) depending on the assessment and functional goal selected. Therefore, we averaged the national average for these labor types and established a composite cost estimate of $86.2085. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: OT 45 percent; PT 45 percent; RN 5 percent; LVN 2.5 percent; SLP 2.5 percent. For the purposes of calculating the costs associated with

the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates.[3] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 1.

Table 1. U.S. Bureau of Labor and Statistics' May 2021 National Occupational Employment and Wage Estimates.

Occupation title	Occupation code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse (RN)	29-1141	$39.78	$39.78	$79.56
Licensed Vocational Nurse (LVN)	29-2061	$24.93	$24.93	$49.86
Speech Language Pathologist (SLP)	29-1127	$41.26	$41.26	$82.52
Physical Therapist (PT)	29-1123	$44.67	$44.67	$89.34
Occupational Therapist (OT)	29-1122	$43.02	$43.02	$86.04

We estimate that the total cost would be reduced by $175,618.353 for all LTCHs annually ($86.2085/hr composite hourly rate x 2,037 hours), or $532.1768 per LTCH annually ($175,618.353 total reduction/330 LTCHs) based on the proposed removal of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure and the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure.

Burden Hours and Cost Calculation for LCDS V5.0 for the FY 2025 LTCH QRP:

Average number of LTCHs in U.S. in 2022	330
Average number of LCDS admission assessments submitted per each LTCH for the FY 2025 LTCH QRP	448.75
Average number of LCDS planned discharge assessments submitted per each LTCH for the FY 2025 LTCH QRP	337.12
Average number of LCDS admission assessments submitted for all LTCHs for the FY 2025 LTCH QRP	148,088
Average number of LCDS planned discharge assessments submitted for all LTCHs for the FY 2025 LTCH QRP	111,251
Decrease in Hours for each LTCH annually resulting from the proposed removal of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure beginning with the FY 2025 LTCH QRP	(6.17)
Decrease in Hours for all LTCHs annually resulting from the proposed removal of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure beginning with the FY 2025 LTCH QRP	(2,037.135)
Change in Annual Cost for each LTCH for the FY 2025 LTCH QRP	($532.1768)
Change in Annual Cost for all LTCHs for the FY 2025 LTCH QRP	($175,618.353)

c) Proposal to Adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure

In the FY 2024 LTCH PPS Proposed Rule (88 FR 27146), CMS proposed to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure beginning with the FY 2026 LTCH QRP. As a result, the estimated burden and cost for LTCHs for complying with requirements of the FY 2026 LTCH QRP will be increased.

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

Specifically, we believe that there will be a 0.005 hour increase (0.3 minutes per item x 1 item) in clinical staff time to report data at discharge per patient stay.

Using data from calendar year 2021, we estimate 148,965 discharges from 330 LTCHs annually, resulting in 451 discharge assessments per LTCHs. This equates to an increase of 744.825 hours for all LTCHs (148,965 x 0.005 hrs) and 2.26 hours per LTCH 744.825 hours / 330 LTCHs). We believe the LCDS item affected by the proposed COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure is completed by Registered Nurses (RN) and Licensed Practical and Licensed Vocational Nurses (LVN). Therefore, we averaged the national average for these labor types and established a composite cost estimate of $64.71. 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 data collection requirements, we used the mean hourly wages for these staff, accounting for overhead and fringe benefits. These amounts are detailed in Table 1.

We estimate that the total cost would be increased by $48,197.63 for all LTCHs annually ($64.71 composite hourly rate x 744.825 hours), or $146.05 per LTCH annually ($48,197.63 total reduction/330 LTCHs) based on the proposed adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.

We have included the full LCDS burden in this PRA package.

Burden Hours and Cost Calculation for LCDS V5.1 for the FY 2026 LTCH QRP:

Average number of LTCHs in U.S. in 2022	330
Average number of LCDS discharge assessments submitted per each LTCH for the FY 2026 LTCH QRP	451.41
Average number of LCDS discharge assessments submitted for all LTCHs for the FY 2026 LTCH QRP	148,965
Increase in Hours for each LTCH annually resulting from the proposed adoption of the COVID-19 Vaccine: Patients/Residents Who Are Up To Date measure	2.26
Increase in Hours for all LTCHs annually resulting from the proposed adoption of the COVID-19 Vaccine: Patients/Residents Who Are Up To Date measure	744.83
Change in Annual Cost for each LTCH for the FY 2026 LTCH QRP	$146.05
Change in Annual Cost for all LTCHs for the FY 2026 LTCH QRP	$48,197.63

As a result of the FY 2024 IPPS/LTCH NPRM proposed modifications to the collection of quality reporting data, the total burden associated with each LCDS submission would decrease by 0.01 hours per LCDS, 3.92 hours per LTCH and 1,292.31 hours for all LTCHs. However, the new overall cost burden for all LTCHs per year has increased due to changes in the number of LTCHs and the volume of LCDS submissions. This is described in more detail in Section 15.

Previous Cost Burden for all LTCHs per year	$9,370,641.00
New Cost Burden for all LTCHs per year	$17,667,319.92

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 $336,315.
- GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33% effort for 3 years, or $132,368.

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	$ 750,000
Data analysis contractor	$1,000,000
Provider training & help desk contractor	$1,000,000
GS-13 Federal Employee	$ 112,105
GS-14 Federal Employee	$ 44,122
Total Annual Cost to Federal Government	**$2,906,227**

15. Changes to Burden

We estimate an overall 0.01 hour decrease in the amount of time it would take to complete a single LCDS V5.1 as a result of these proposed changes. Additionally, since the approval of the LCDS V5.0, new information demonstrates there have been a reduction in the number of LTCHs submitting LCDSs and an increase in the total number of LCDSs submitted across all LTCHs (see Table 3).

Since the approval of the LCDS V5.0, there are 85 fewer LTCHs submitting assessments (415 – 330). Since the approval of the LCDS V5.0, LTCHs are submitting approximately 45,620 more admission assessments (148,088 – 102,468) and 46,497 discharge assessments (148,965- 102,468) across all LTCHs, resulting in an increase of 138.24 (45,620 / 330) admission assessments and 140.9 (46,497 / 330) discharge assessments per LTCH. As a result of these changes, we estimate an overall increase in burden hours for LTCH. Specifically, the burden hours will increase by 65,549.5 hours [(0.711592 hours per LCDS x 297,053 assessments) – 145831].

Table 3. Change in number of LTCHs and LCDS submissions since approval of the LCDS V5.0

	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 LCDS V5.0	415	102,468	246.91	102,468	246.91	145,831
Proposed Collection of LCDS V5.1	330	148,088	448.75	148,965	451.41	211,380.5

We estimate the average cost per each LCDS submission beginning with the FY 2025 QRP to be $59.48 ($17,667,319.92 / 297,053 assessments). Therefore, we estimate there would be an increased average annual cost to all LTCHs for reporting quality data of $5,479,119.16 [(45,620 x $59.48) + (46,497 x $59.48)]. We also estimate there would be an increased average annual cost to each LTCH for reporting quality data of $16,603.39 ($5,479,119.16 / 330).

16. Publication/Tabulation Dates

For the proposed changes to the LCDS Version V5.1 related to the LTCH QRP, the proposed rule was published in the Federal Register on May 1, 2023 (88 FR 27154). The draft LCDS Version V5.1 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 – LTCH CARE Data Set V 5.1 Item