CJR-X is Coming: The Proposed National Mandatory Expansion of CJR

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Educational Webinar Series

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Learning Objectives

After today's webinar, you'll understand:

- upcoming CJR-X Model requirements that may impact hospitals nationwide;
- key differences from CJR and TEAM; and
- methodological gaps, operational challenges, and potential financial exposure.

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Medicare APM Analytics

DataGen APM Experience

Accountable Care Models			Bundled Payment Models				Primary Care Transformation	Medicaid Models	State-based Models	
MSSP	REACH	KCC	BPCI/ BPCIA	CJR	OCM/ EOM	TEAM	PCF	InCK	MD TCOC	AHEAD

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CJR-X Announced: Phase II Expansion of CJR

Press Releases Apr 10, 2026

CMS to Improve Patient Care Experience and Lower Costs for Hip, Knee, and Ankle Replacements

Administration Innovation models Payment Rules

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CMS to Improve Patient Care Experience and Lower Costs for Hip, Knee, and Ankle Replacements

Proposed Expansion Would Improve Care, Lower Costs for Medicare Beneficiaries

CMS. Comprehensive Care for Joint Replacements Expanded (CJR-X) Model Press Release.
https://www.cms.gov/newsroom/press-releases/cms-improve-patient-care-experience-lower-costs-hip-knee-ankle-replacements

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Polling Question #1

- Has your organization participated in a bundled payment arrangement? Select one response.
  - Yes, voluntary
  - Yes, mandatory
  - Yes, both voluntary & mandatory
  - No
  - Not applicable

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Polling Question #2

- **What challenges are you most concerned about if required to participate in a mandatory model? Choose all responses that apply.**
  - Stakeholder buy-in
  - Internal education
  - Care delivery improvement
  - Data & analytics
  - Building partnerships
  - Model compliance

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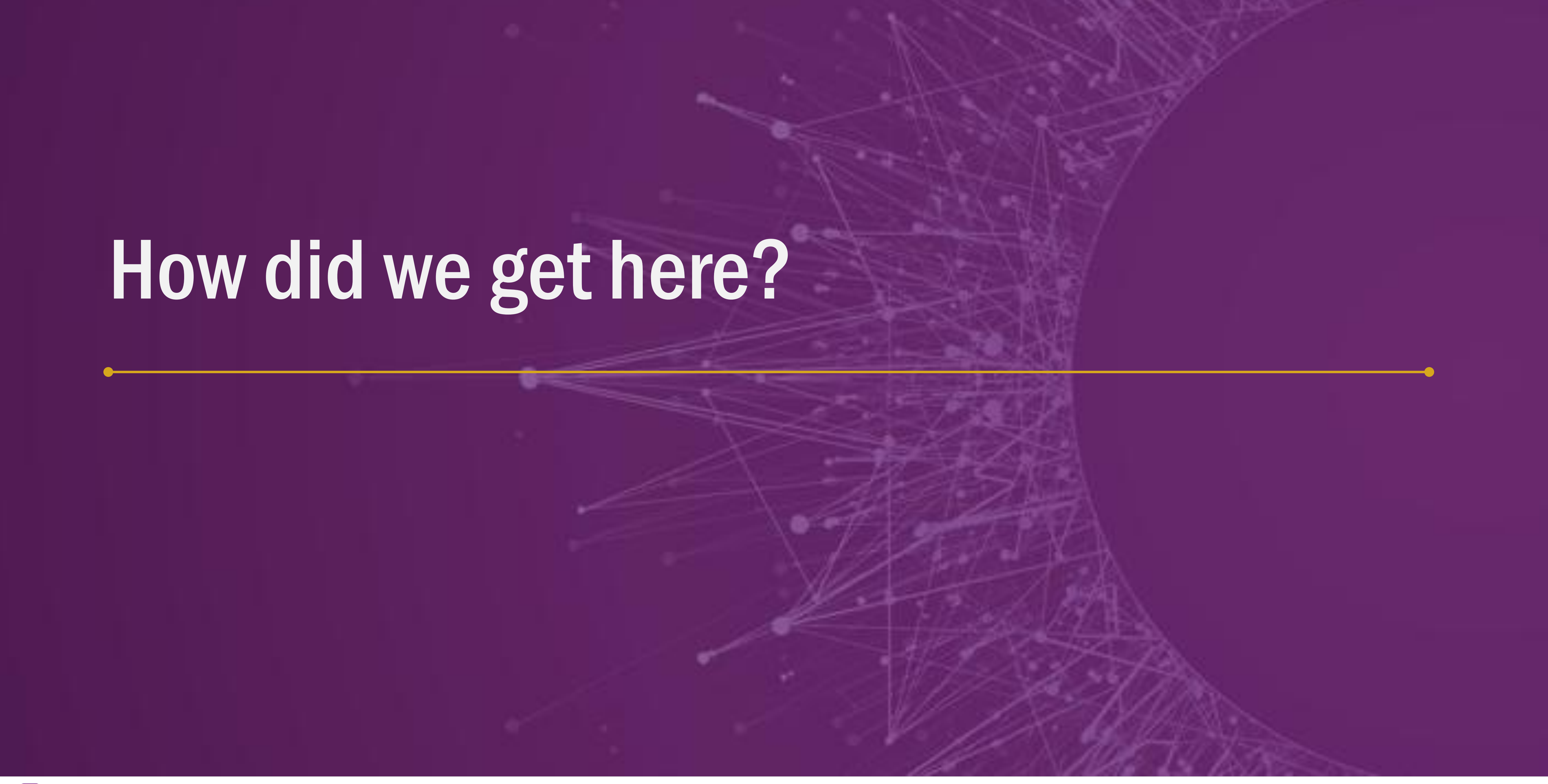

How did we get here?

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Medicare Bundled Payment Evolution

Year & Model	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	End
ACE																			2012
BPCI																			2018
CJR*																			2024
OCM																			2022
EPM*																			-
BPCIA																			2025
RO*																			-
EOM																			2028
TEAM*																			2030

*mandatory model

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Brief CJR History

2016

- Model began Apr. 1st for ~800 hospitals located in 67 MSAs

2018

- Feb. 1st: rural, low-volume, and hospitals in 33 MSAs have option to exit the model
- Mandatory participation reduced to hospitals located in 34 MSAs

2020

- Model flexibilities introduced due to COVID-19 public health emergency
- Hip fracture MS-DRGs implemented Oct. 1st (already part of adjustment)

2021

- CJR 3-year extension began Oct. 1st for mandatory hospitals only (324 hospitals)
- Inclusion of OP episodes and target price methodology changes implemented

2024

- End of model on Dec. 31st

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LEJR Site of Service Shifts

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"Elective" Lower Extremity Joint Replacement Procedure Volume by Site of Service

Inpatient Hospital Setting
Outpatient Hospital Setting
Ambultory Surgical Center Setting

Procedure Volume

140,000
120,000
100,000
80,000
60,000
40,000
20,000
-

TKA removed from IPO List
THA removed from IPO List & ASCs begin TKAs
ASCs begin THAs

2017 Q1, 2017 Q2, 2017 Q3, 2017 Q4, 2018 Q1, 2018 Q2, 2018 Q3, 2018 Q4, 2019 Q1, 2019 Q2, 2019 Q3, 2019 Q4, 2020 Q1, 2020 Q2, 2020 Q3, 2020 Q4, 2021 Q1, 2021 Q2, 2021 Q3, 2021 Q4, 2022 Q1, 2022 Q2, 2022 Q3, 2022 Q4, 2023 Q1, 2023 Q2, 2023 Q3, 2023 Q4, 2024 Q1, 2024 Q2, 2024 Q3, 2024 Q4, 2025 Q1, 2025 Q2, 2025 Q3

IP MS-DRG = 470 (excludes fractures prior to 2020 Q4)
OP/ASC CPTs = 27447 & 27130

Derived from CMS SAF LDS Files

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CJR 7th Evaluation Report Findings

$112.7 Million

Net Medicare Savings

CJR Model Performance Years 6 & 7
(10/01/2021 to 12/31/2023)

Statistically Significant
Quality of Care Maintained

Lewin Group. Comprehensive Care for Joint Replacement Model Evaluation: Executive Summary, Seventh Evaluation Report.
https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-ar-exec-sum

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Proposed CJR-X Methodology

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Model Highlights

Criteria	CJR-X Specifications
Model Duration	To begin on October 1, 2027 → no end date
Participants	Acute care hospitals (by CCN) – about 2,000 hospitals
Participation	Mandatory for all hospitals paid IPPS & OPPS performing LEJR procedures TEAM hospitals will roll into CJR-X after 12/31/2030 Some exclusions (i.e., Maryland, CAHs, REHs, etc.)
Patients	Medicare beneficiaries with Part A & B coverage, non-ESRD
Clinical Episodes	90-day episodes of care for IP and OP LEJR procedures
Discount Factor	0-2% depending on quality performance
Quality	THA/TKA Complications (RSCR), Hospital Visits 7-Days Post-HOPD, HCAHPS Survey, OAS CAHPS Survey, and THA/TKA Patient-Reported Outcomes Performance Measure

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Participant Inclusion/Exclusion Criteria

CJR-X Participant Definitions

- Acute care hospitals
- Paid IPPS <u>and</u> OPPS
- Located in any of the 50 states, D.C., or other U.S. Territories

Excluded Hospitals

- Indian Health Service and Tribal Hospitals
- Hospitals participating in the Rural Communicty Hospital Demonstration
- Critical Access Hospitals
- Rural Emergency Hospitals
- TEAM participant hospitals (until TEAM ends in 2030)
- Maryland hospitals (may be considered in future rule making after 2027)

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Participant Volume

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Hospital Count

200
150
100
50

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Note: 50 States & D.C. are displayed only. Other U.S. territories are not displayed but will also be subject to CJR-X, if finalized.

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Episode Specifications

Setting	Code	Procedure
IP	469	Major joint replacement w/ MCC
IP	470	Major joint replacement w/out MCC
IP	521	Hip replacement w/ hip fracture w/MCC
IP	522	Hip replacement w/ hip fracture w/o MCC
OP	27447	Total knee arthroplasty
OP	27130	Total hip arthroplasty

IP total ankle arthroplasty (MS-DRG 469) included in CJR-X.
OP total ankle arthroplasty (HCPCS 27702) excluded — tested in TEAM only.

Anchor hospital = The acute care hospital that initiates the episode and bears accountability

Triggering event = The inpatient discharge MS-DRG or outpatient procedure HCPCS code that initiates the episode

Episode start = Inpatient discharge date or outpatient procedure date

Episode end = 90 days after the episode start date

All Medicare FFS Part A & B payments are included as part of the episode's expenditures, with some exclusions.

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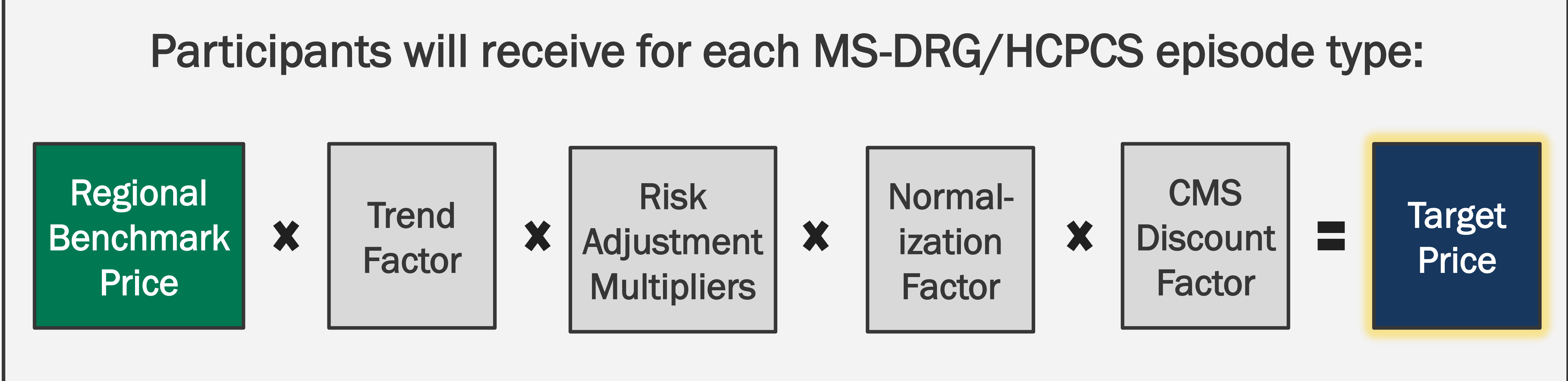
Target Price Methodology



The Preliminary Target Price will use a Prospective Trend Factor and a Prospective Normalization Factor and will not account for Risk Adjustment Multipliers.

The Final Target Price will use a Retrospective Trend Factor (±3% cap) and Normalization Factor (±5% cap).

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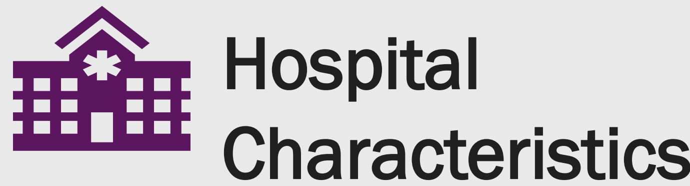
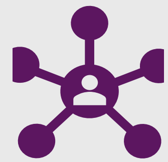
Risk Adjustment Strategy



Hospital Characteristics

- Bed size
- Safety net status



Beneficiary Economic Risk

- Full dual eligibility status
- Qualification for Part D low-income subsidy
- Community deprivation index (CDI)

Beneficiary Characteristics

- Age group
- Disability as reason for initial enrollment
- Prior PAC use
- Institutional LTC
- HCC count
- Specific HCCs (21 in 180-day lookback)
- Procedure

Note: Risk adjustments will be calculated for each MS-DRG/HCPCS episode type.

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Quality Measures

Quality Measure	CMIT ID#	Setting	Weight
Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	350	IP	50%
Hospital Visits Within 7 Days of Hospital Outpatient Department (HOPD) Surgery	344	OP	
Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)	338	IP	40%
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS)	162	OP	
Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO)-Based Performance Measure	1618	IP & OP	10%.

A Composite Quality Score (CQS) will determine reconciliation payment eligibility and the CMS discount factor applied.

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Reconciliation

Annual reconciliation:

- Data cut 6 months after the end of the performance year
- Low-volume hospitals not reconciled (<31 episodes in 3-year baseline)
- Payments and repayments are made as a one-time lump sum

CMS calculations include:

- Application of risk adjusters
- Final retrospective trend and normalization factors
- Quality score adjustments
- Stop loss/gain limits

If Episode Expenditures < Target Amount → Positive NPRA (savings)
If Episode Expenditures > Target Amount → Negative NPRA (losses)

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Participant Risk

5% Stop-Loss

- Rural hospitals
- Medicare-dependent hospitals
- Sole community hospitals
- Safety-net hospitals

20% Stop-Loss

- All other hospitals

20% Stop-Gain for all hospitals

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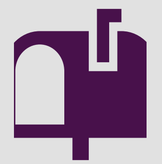
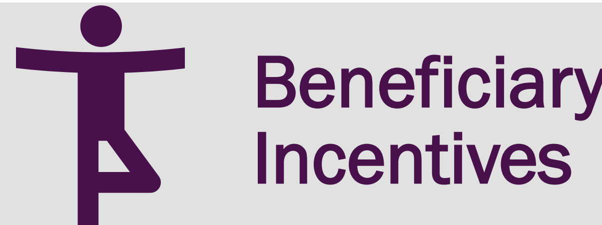
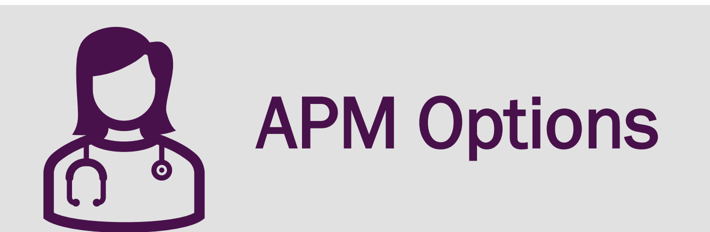
Additional Model Aspects

Waivers



Beneficiary notification





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Comparison of Key Features

Note: Displayed comparisons focus on cross-model differences. Common features across all three models are not listed. This list is not inclusive of all model differences.

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Participation Overview

Dimension	CJR 3-YR Extension	TEAM	CJR-X
Program Years/ Duration	PY6–8 (2021–2024) 3-year ext. (Plus 5 PYs prior) – CY alignment	Started Jan 1, 2026; 5 years (PY1–5, 2026–2030) – CY alignment	Proposed start: Oct 1, 2027 – FY alignment
Participants	Acute care hospitals paid IPPS	Acute care hospitals paid both IPPS and OPPS	Acute care hospitals paid both IPPS and OPPS, excludes TEAM hospitals through 2030
Mandatory locations	34 selected MSAs (originally 67)	188 selected CBSAs	Nationwide, excludes Maryland*
Rural exclusion	Yes	No	No
Rural definition	Located in rural area, rural census tract, reclass. as rural, or designated rural referral center	Located in rural area or located in rural census tract	Located in rural area or located in rural census tract

*Maryland hospitals may be considered in future rule making after 2027

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TEAM vs. CJR-X Participation

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Number of Hospitals
1
2
3
4
5
Program
CJR-X
TEAM

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*Note: U.S. territories are not displayed. Yellow markers indicate hospitals currently participating in TEAM. Purple markers indicate hospitals that may be subject to CJR-X, if finalized.

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CJR-X with Prior CJR 3-YR Ext. Experience

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Number of Hospitals
1
2
3
4
5

CJR Experience
No Prior CJR
Prior CJR

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*Note: U.S. territories are not displayed and hospitals currently participating in TEAM are not displayed.
Yellow markers indicate hospitals that may be subject to CJR-X who did not participate in the CJR 3-year extension.
Purple markers indicate hospitals that may be subject to CJR-X who did participate in the CJR 3-year extension.

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Episode Definition & Beneficiaries

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
Episode categories	LEJR only (IP & OP)	LEJR (IP & OP), CABG, Major Bowel, SHFFT, Spinal Fusion (IP & OP)	LEJR only (IP & OP)
OP total ankle arthroscopy	Not included (on inpatient only list until 2021)	Included (HCPCS 27702)	Not included
Episode length	90 days post-discharge	30 days post-discharge	90 days post-discharge
Subsequent qualifying procedure	First episode canceled; new episode begins	First episode retained; second anchor treated as readmission in first episode	Not explicitly addressed in proposed rule – silent on this scenario
Beneficiary eligibility	Part A & B; Medicare primary payer; non-ESRD; not enrolled in MA or any managed care plan during episode	Part A & B; Medicare primary payer; non-ESRD; not enrolled in MA or any managed care plan during episode *All criteria also apply to 180 days prior to episode trigger	Part A & B; Medicare primary payer; non-ESRD; not enrolled in MA or any managed care plan during episode

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LEJR 30-Day vs. 90-Day Accountability

Anchor Stay | 0-30 Days | 31-90 Days

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Average Medicare Episode Spend

$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0

27130 | 27447 | 469 | 470 | 521 | 522 | Overall

Episode Trigger Code

Derived from CMS SAF LDS Files

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Risk Exposure

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
Financial risk structure	Two-sided risk from PY6 20% stop-loss/gain	- Track 1: Upside only (all PY1); safety net hospitals PY1-3 - Track 2: 5% stop-loss/gain for safety net, rural, MDH, SCH only (PY2-5) - Track 3: 20% stop-loss/gain (all PY1-5)	Two-sided risk from PY1 - 20% stop-loss/gain for most hospitals - 5% stop-loss/gain for safety net, rural, MDH, SCH
Safety net hospital definition	None	Exceeds 75th percentile nationally for percent of dual-eligible beneficiaries OR Part D LIS-eligible beneficiaries *Binary, either criterion qualifies	Top 25th percentile in region for percent of FFS LEJR IP episodes to dual-eligible beneficiaries *Binary, single criterion
Low volume hospitals	<20 PY1 BL episodes – removed from model	<31 BL episodes — included; downside risk waived for that episode category	<31 BL episodes — excluded from reconciliation; re-enters as baseline rolls

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Target Price Construction

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
Baseline period	1 yr, rolled annually	3 yrs + 2 trend yrs, rolled annually. Weighted 17/33/50%	3 yrs, rolled annually. Weighted 17/33/50%
Discount	0-3% (dependent on CQS)	2% for LEJR	0-2% (dependent on CQS)
Trend factor approach	Fully retrospective market trend factor at reconciliation only	Prospective trend factor (linear regression across all baseline yrs + 2 trend yrs) + retrospective trend factor capped ±3% at reconciliation	Prospective trend factor in preliminary target price + retrospective trend factor capped ±3% at reconciliation
Normalization factor	Reconciliation only	Prospective in preliminary target price; final normalization capped ±5% at reconciliation	Prospective in preliminary target price; final normalization capped at ±5% at reconciliation
APC/MS-DRG payment rule changes	Setting-specific update factors applied to preliminary target prices during PY	Prospective in preliminary target price; final normalization capped ±5% at reconciliation	Incorporated at reconciliation, no participant visibility in PY

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Risk Adjustment

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
Provider characteristics	None	Hospital bed size category and safety net status	Hospital bed size category and safety net status
Beneficiary characteristics	Age range	Age range and disability status	Age range and disability status
Beneficiary economic risk	Dual eligibility	Dual eligibility, Part D LIS eligibility, community deprivation index (Binary, any criterion qualifies)	Dual eligibility, Part D LIS eligibility, community deprivation index (Binary, any criterion qualifies)
Comorbidities	HCC count	HCC count and 21 individual HCC flags	HCC count and 21 individual HCC flags
Other clinical information	None	Prior PAC use and joint procedure	Prior PAC use and joint procedure

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Quality Measurement

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
Measure set	RSCR (THA/TKA complications), HCAHPS, voluntary THA/TKA PRO submission	Hybrid HWR, PSI-90 (PY1), THA/TKA PRO-PM, Falls (PY2-5), Resp. Failure (PY2-5), ISCMR (PY2-5), Info. Transfer PRO-PM (PY3–5)	RSCR, Hosp. Visits w/in 7 days HOPD Surgery, HCAHPS, OAS CAHPS, THA/TKA PRO-PM (mandatory)
Outpatient measures	None	Info. Transfer PRO-PM (PY3–5 outpatient LEJR and spinal fusion)	Hosp. Visits w/in 7 days HOPD + OAS CAHPS
CQS structure	Single composite: complications 50%, patient experience 40%, PRO 10%	Single composite tied to reconciliation via quality performance adjustment	Separate IP and OP composites, volume-weighted blend. Same domain weights as CJR
Improvement pts.	Yes — 2-decile imp. rewarded	No — absolute achievement only	No — absolute achievement only
Quality to payment link	CQS determines discount factor adj. & recon. eligibility	CQS adjustment applied to recon. amount, based on risk track	CQS determines discount factor adj. & recon. eligibility
CQS baseline	Fixed historical baseline	Proposed sliding historical BL	Not specified — likely sliding hist.

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Reconciliation

Dimension	CJR 3-YR Ext.	TEAM	CJR-X
PY assignment	Anchor admit date	Anchor discharge date	Anchor discharge date
Recon. timing	Annual; April 1 claims cutoff	Annual; July 1 claims cut off	Annual; April 1 claims cutoff
Wage factor/ dollar conversion	Converted to real dollars at recon. using geographic wage factor from IPPS wage index	Target prices and recon. amts remain in standardized dollars throughout — no conversion	Converted to real dollars at recon. using geographic wage factor from IPPS wage index
ACO overlap	Concurrent allowed except ENHANCED track MSSP	All ACO tracks allowed — both retain savings independently	All ACO tracks allowed — both retain savings independently
Financial arrangements	Yes — collaborators can share reconciliation payments	Yes — collab. can share savings derived from recon. pmt. amts, internal cost savings, or both	Yes — collab. can share savings derived from recon. pmt. amts, internal cost savings, or both
Alignment payments cap	50% aggregate; 25% per non-ACO collaborator	50% aggregate; 25% per non-ACO collaborator; 50% per ACO collaborator	50% aggregate; 25% per non-ACO collaborator; 50% per ACO collaborator

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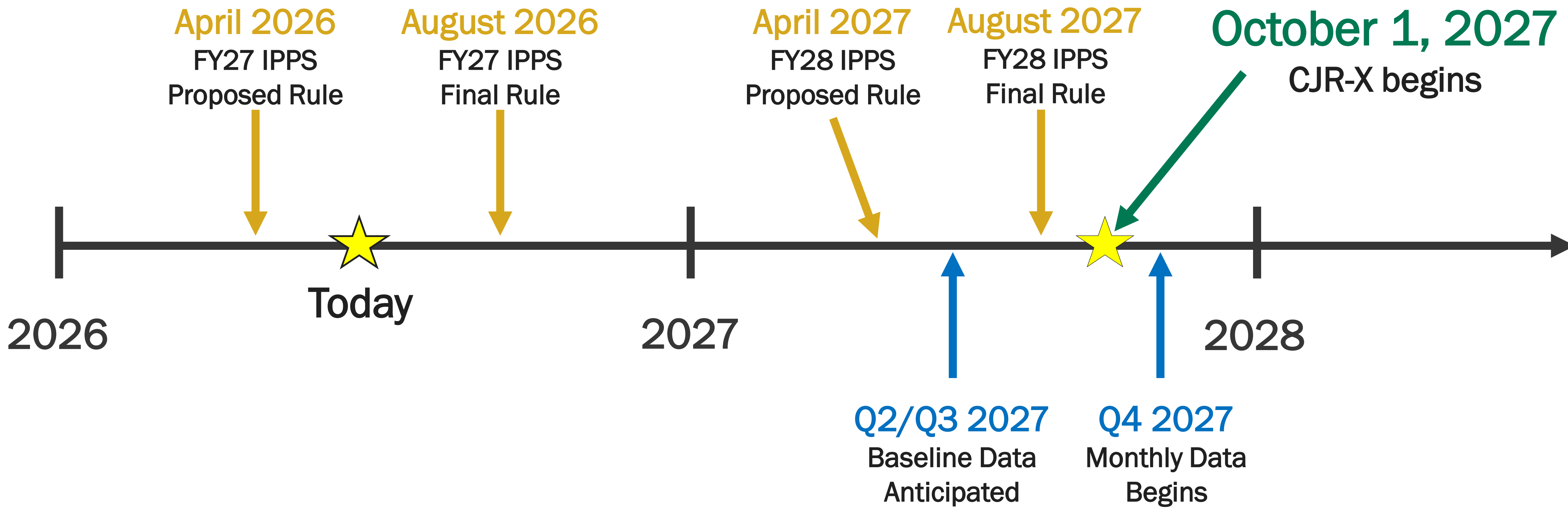
Timeline



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Appendix

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Bundled Payment Model Reference

- ACE = Medicare Acute Care Episode Demonstration
- BPCI = Bundled Payments for Care Improvement Initiative
- CJR = Comprehensive Care for Joint Replacements Model
- OCM = Oncology Care Model
- EPM = Episode Payment Model
- BPCIA = Bundled Payments for Care Improvement Advanced Model
- RO = Radiation Oncology Model
- EOM = Enhancing Oncology Model
- TEAM = Transforming Episode Accountability Model
- CJR-X = Comprehensive Care for Joint Replacements Expanded Model

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