

TEAM and CJR-X: How Universal Mandatory Risk Will Change VBC

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June 30, 2026

Why is this important now?

- Together, these payment models dramatically shift reimbursement
- They have significant economic impacts on hospitals and specialists
- They usher in a new focus on specialty care
- They are likely to change private health plan reimbursement too



WHY TRUST US TO TALK ABOUT THIS TOPIC?

WE'RE DEEP INTO IT.

MEASURE QUALITY & COST!

SUPPORT

ROJI EPISODES

SUPPORT PAYMT MODELS

BE SAFE UNDER RISK!

ANALYSIS

EXCELLENT AGGREGATED DATA!

TELLS THE STORY OF VALUE!

DEEP KNOWLEDGE

LEARN

DEEP RESEARCH HUB

DEEP DIVE ANALYTICS

TRENDS

RESEARCH ANALYTIC

ACCURACY

ROJI EPISODES

ROJI EPISODES

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What's Your Place in this Universe?



A. Participant in TEAM and at risk.



B. Participant in TEAM and not at risk.



C. We will be in CJR-X.

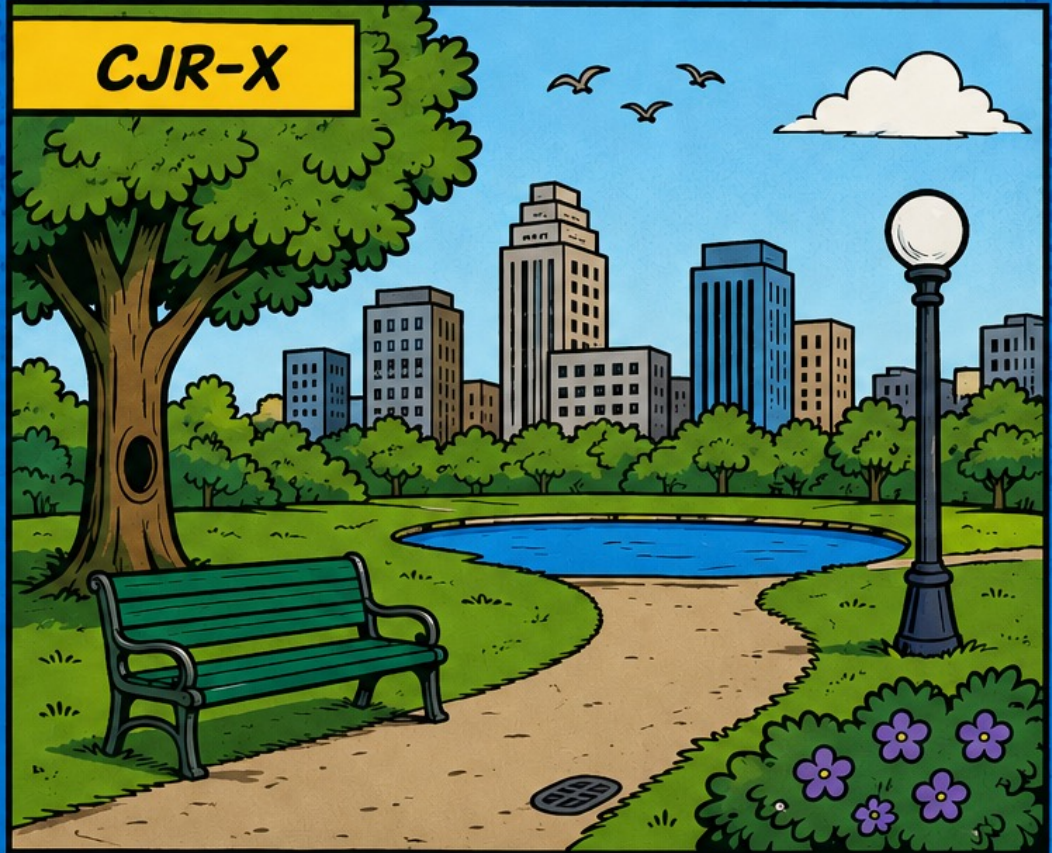
SPOT THE DIFFERENCE!

TWO PROGRAMS MAY BE SIMILAR...
BUT THEY'RE **NOT** THE SAME!

TEAM



CJR-X



CAN YOU FIND
THE **7** DIFFERENCES?

1. SIZE
2. SCOPE
3. DURATION

4. EPISODE WINDOW
5. QUALITY
6. 2ND EPISODE

7. ATTRIBUTION

ROJI HEALTH INTELLIGENCE



TEAM Episodes and Definitions

Coronary Artery
Bypass Graft (IP)

Major Bowel
Procedure (IP)

Lower Extremity
Joint Replacement
(IP/OP)

Surgical Hip and
Femur Fracture
Treatment (IP)

Spinal Fusion
(IP/OP)

- Procedural episodes
- Anchor discharge +30 days
- IPPS + OPPS hospitals at risk, collaboration allowed
- Standard CMS reimbursement, reconciled to a calculated target price
- 188 CSBAs -Nationwide, not "national"
- Active through 2030

TEAM Participation Tracks

Track 1

Upside Only

Stop-G/L: 10%/0%

Track 2

Two-Sided

Stop-G/L: 5%/5%

Track 3

Upside Only

Stop-G/L: 20%/20%

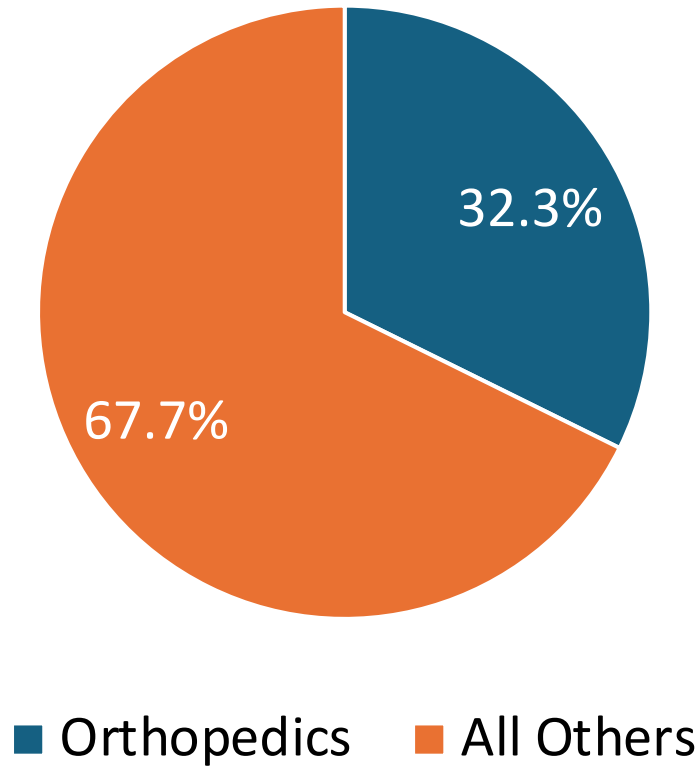
Photo by Martin Blan
on Unsplash

Hospital Type	PY1 (2026)*	PY2 (2027)	PY3 (2028)	PY4 (2029)	PY5 (2030)
Safety Net Hospital	May select Track 1 or 3	May select Track 1, 2, or 3			May select Track 2 or 3
Rural Hospital, MDH, SCH, or EACH	May select Track 1 or 3	May select Track 2 or 3			
All Other Hospital Types	May select Track 1 or 3	Must select Track 3			

<https://www.cms.gov/files/document/team-participation-tracks-fact-sheet.pdf>

Why Complicate Things?

Medicare Procedures 2000-2022



<https://pubmed.ncbi.nlm.nih.gov/40801367/>

- CJR Model Success
 - 324 hospitals in 34 MSAs
 - Active from 2016 to 2024
 - \$112 million saved, 2021-2023
- Expansion in size and scope
 - Outpatient LEJRs (No DRG)
 - Mandatory nationwide

CJR-X Scope

- National, excluding TEAM (2030) and Maryland (2027)
- Exclusively orthopedics
- Inpatient and Outpatient
- Hospital bears risk
- Anchor discharge +90 days
- No proposed end date

IP Major Joint Replacement w/MCC

IP Major Joint Replacement w/o MCC

IP Hip Replacement, Hip Fx w/MCC

IP Hip Replacement, Hip Fx w/o MCC

OP Total Knee Arthroplasty

OP Total Hip Arthroplasty

Shared Inclusions and Exclusions

Included Costs/Svcs

- Physicians' Svcs
- IP/OP Hospital (incl OR)
- IP Psych Facility
- Long-Term Care Hospital
- IP/OP Rehab (inc SNF, HHA)
- OP Therapy
- Clinical Lab
- DME
- Hospice
- Most Part B Drugs

Excluded Costs/Svcs

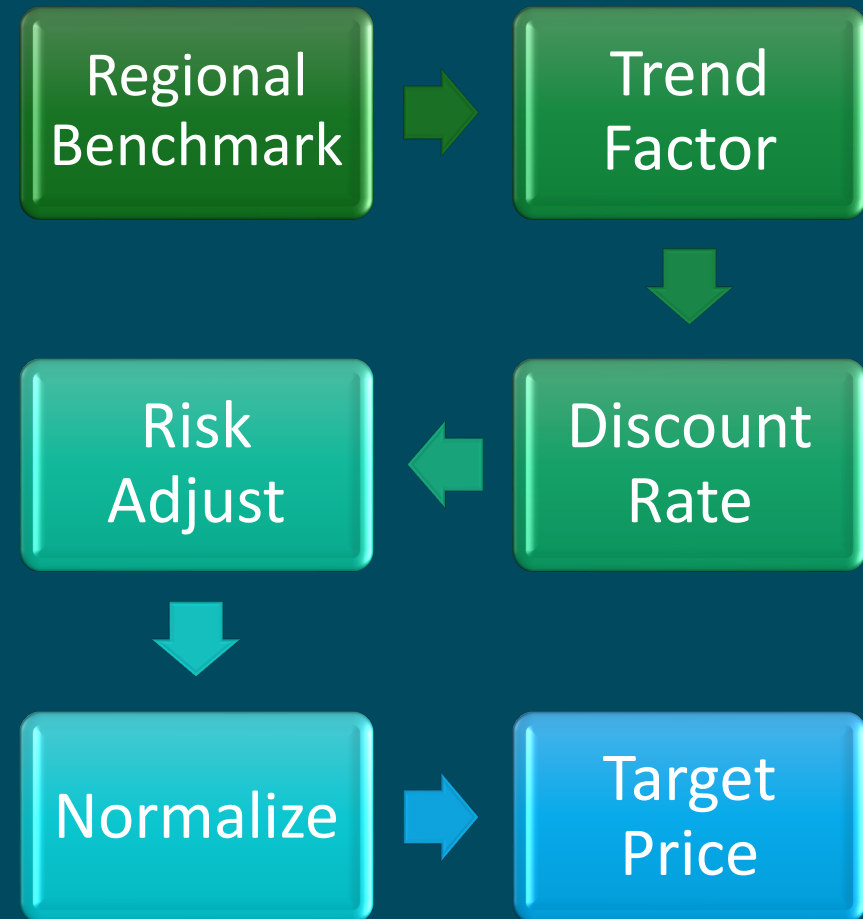
- Oncology
- Trauma
- Transplants
- Ventricular Shunts
- Disorders of the eye
- Pregnancy
- Birth
- Newborns
- Specified Part B Drugs

Wild Cards

- 2nd Episode within 1st Window
 - ReAdmit in TEAM
 - Not answered in CJR-X
- 3-day pre-costs if OP Px becomes IP Px (CJR-X)
- No OP TAA in CJR-X
- 180-day pre-attribution criteria in TEAM

Additional TEAM and CJR-X Overlap

- Target Pricing Methodology
- Stop-Gain/Loss 20% (w/o desig.)
- SN, Rural, MDH, SCH, EACH protection
- Collaboration, Waivers
- ACO Participation, APM Chance
- Quality Measurement
- Beneficiary Notification, Risk



TEAM and CJR-X Distinctions

	TEAM	CJR-X
Episode Length	Anchor disch. +30d	Anchor disch. +90d
1-Side	1-3 years	None
Quality Score	Single score	IP and OP scores
CQS & Recon.	CQS applied to recon \$	CQS determines <u>any</u> recon \$

TEAM QMs	CJR-X QMs
HW All-Cause ReAdmit	THA/TKA Comp. Rate
Pt Safety/Event comp.	Hosp. 9d post-OP Surg
THA/TKA PRO-PM	Hospital CAHPS
Falls (PY2-5)	OP AS CAHPS
Resp. Failure (PY2-5)	THA/TKA PRO-PM
MR w/Surg Comp (PY2-5)	
Info Transfer PRO-PM (PY3-5)	

Impacts of TEAM and CJR-X Together





Near-Universal Risk for LEJRs
performed at hospital IP & OP

Hospitals w/Orthopedic
Centers

Free-standing surg centers
excluded

Implementation Short

TEAM-CJR-X DUALITH

Near-Universal Risk: Market Issues

- LEJRs in hospital outpatient centers 35% higher cost than at free-standing surgical centers
- Surgical practices not in deep hospital alignments could evade risk-sharing alignment agreements with hospitals
- Patients prefer to get home if feasible
- Likely to affect growth of ASCs and possibly larger movement of surgeries away from hospital OP

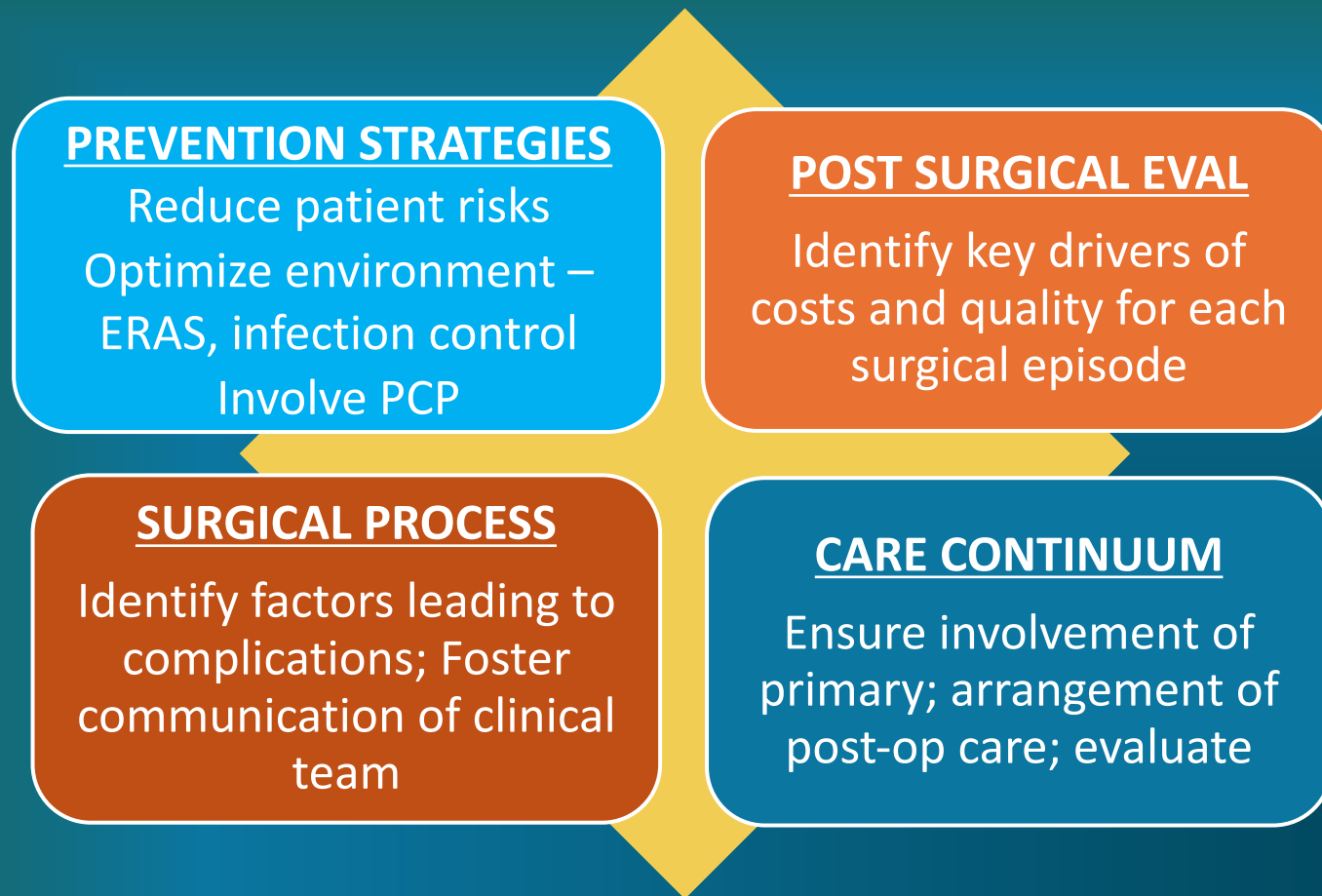
Strategic Failures From Risk + Short Window: Deferring the Costs Problem

- Delay / Defer Strategy: Election to go upside-risk only in Year 1. This leaves no lead time in 2027, when under risk.
- Benchmark Numbers Strategy: Reliance on aggregate benchmark data to support beliefs of costs below threshold. Failure to examine problems from an episode perspective leaves providers vulnerable.
- Low-Hanging Fruit Strategy: Go after SNFs first, since use is correlated with higher readmissions.

Real Cost Drivers in Joint Replacements

1. Infections – either periprosthetic or surgical site
2. Medical complications – DVTs, PE
3. Joint stiffness and mechanical problems
4. Dislocations
5. Pre-existing conditions: smoking, osteoporosis, metabolic diseases

Strategic and Holistic Approach to Near-Universal Risk



How PCPs and ACOs Fit in TEAM and CJR-X

Care Flow and Change (TEAM & CJR-X)

- Pre-surgical patient risk assessment
 - Anesthesia type, risks, history
 - IP vs OP and facility protocols
 - Environmental assessment
- Incorporating updated guidelines (e.g. ERAS)
- Discharge w/PCP referral (TEAM req)
- Data-driven rehab referral network
- Defined post-procedure responsibilities



Collaboration/Sharing Agreements

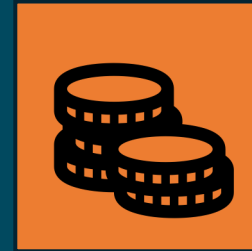


Scope and Purpose

Formal arrangements between Hospital Participants and other providers

Promotes coordination, process improvement, decreased complications

Beneficiary notification and freedom of choice reminder

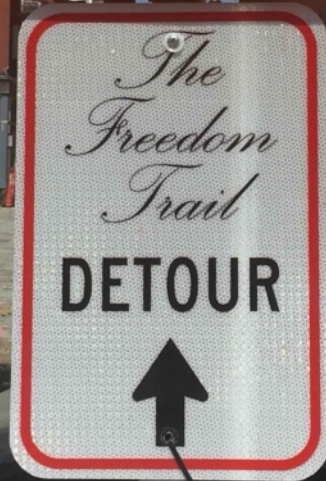


Financial Ramifications

Specialists need facilities to perform, but facility needs specialist revenue

For a stake, ACOs/groups need Sharing Arrangements w/participating hospital

Individual payments require Distribution Agreement w/ACO or group



Limited Agreement Freedom

- Agreement "must haves"
 - Obligations of each party
 - Management/staffing info
 - Gainsharing \$ terms (paid by participant)
 - Alignment \$ terms (paid to participant)
 - All payments tied to quality (not volume)



Benefits of ACO + TEAM/CJR-X

Bi-directional referral network

- Post-procedure assignment
- High-performing specialists
- Improved patient experience
- Facilitate hospital/specialist dialogue

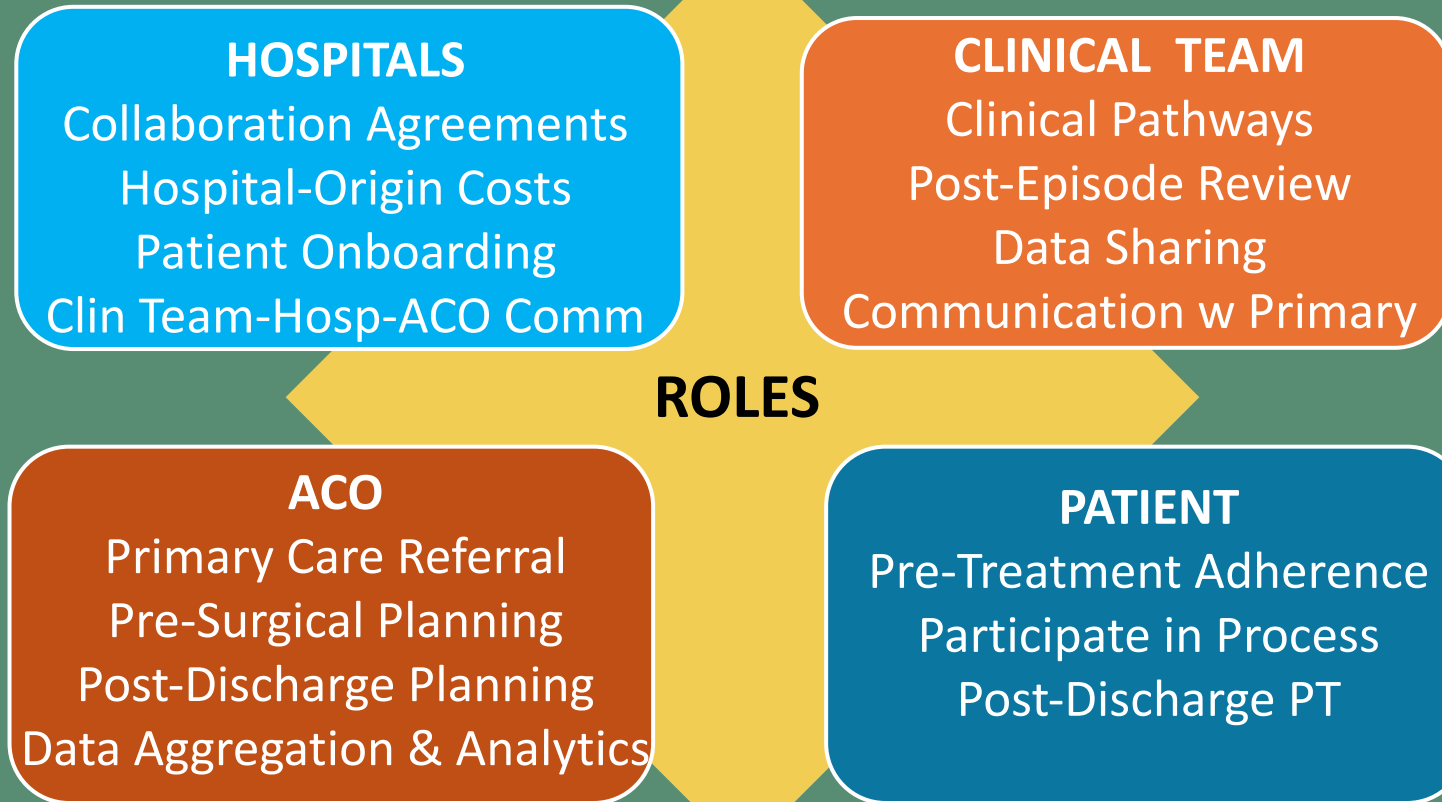
ACO Support for TEAM and CJR-X

- Technical infrastructure for episode platform
 - Hospital + Practice + CMS claims = 360° episode view
 - Delivers actionable info needed for improvement
 - Promotes provider buy-in for quality initiatives
 - Improved care produces savings – both entities benefit

The Success Formula for Team & CJR-X: Roles + Processes + Data



Empower Stakeholders by Defining Key Roles



Prevention: Patient pre-surgical readiness; Infection control; blood management, ERAS



Episodic Data Analysis: Find key drivers of costs for each surgical episode



CREATE KEY PROCESSES TO SUPPORT BETTER PATIENT OUTCOMES

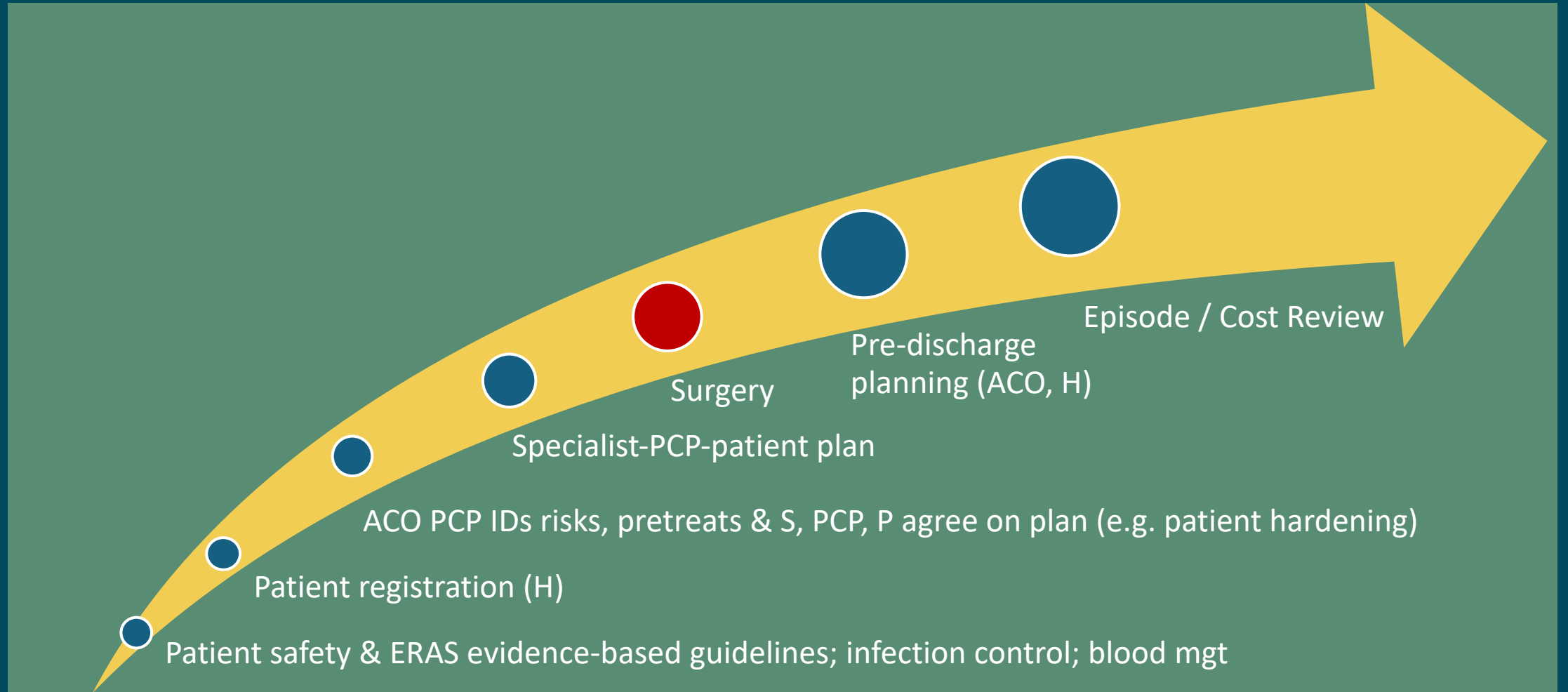
Hospital / Clinical Teams: Team-based efforts to reduce risks; data and episode sharing



Care Continuum: Pre-surgical PCP appt; planning post-op care



Engineer Process for Interventions at Each Point



How to See Cost Drivers / Variation

1. Aggregated Data:

- EHR from all sources: Primary, Specialty, Hospital
- Claims data
- Lab data r imported as PDF into EHR

2. Curate data into TEAM/CJR-X and standardized Episodes that compare

3. Episode analytics to reveal the detail



Image by Daniel Schuh on Unsplash

Foreseeable Directions from TEAM-CJR-X



Image by Bram van Oost on Unsplash

Specialty Care will Move to Episodic Payments



Image by Andy Holmes on Unsplash

- The path and 3 payment models exist (TEAM, CJR-X, ASM)
- The Bundled Payments Care Initiative (BPCI) laid the groundwork for a long list of procedures to come next, but it will be volume/dollar impact-based
- TEAM / CJR-X is likely to be a continued pattern where cost variation is high.
- Other procedures/conditions have single models.

Will Private Health Plans Adopt Derivative Payment Models?

Yes, but without the formulas, etc.

Plans are likely to take an average CMS payment and apply a multiplier in negotiations with providers.

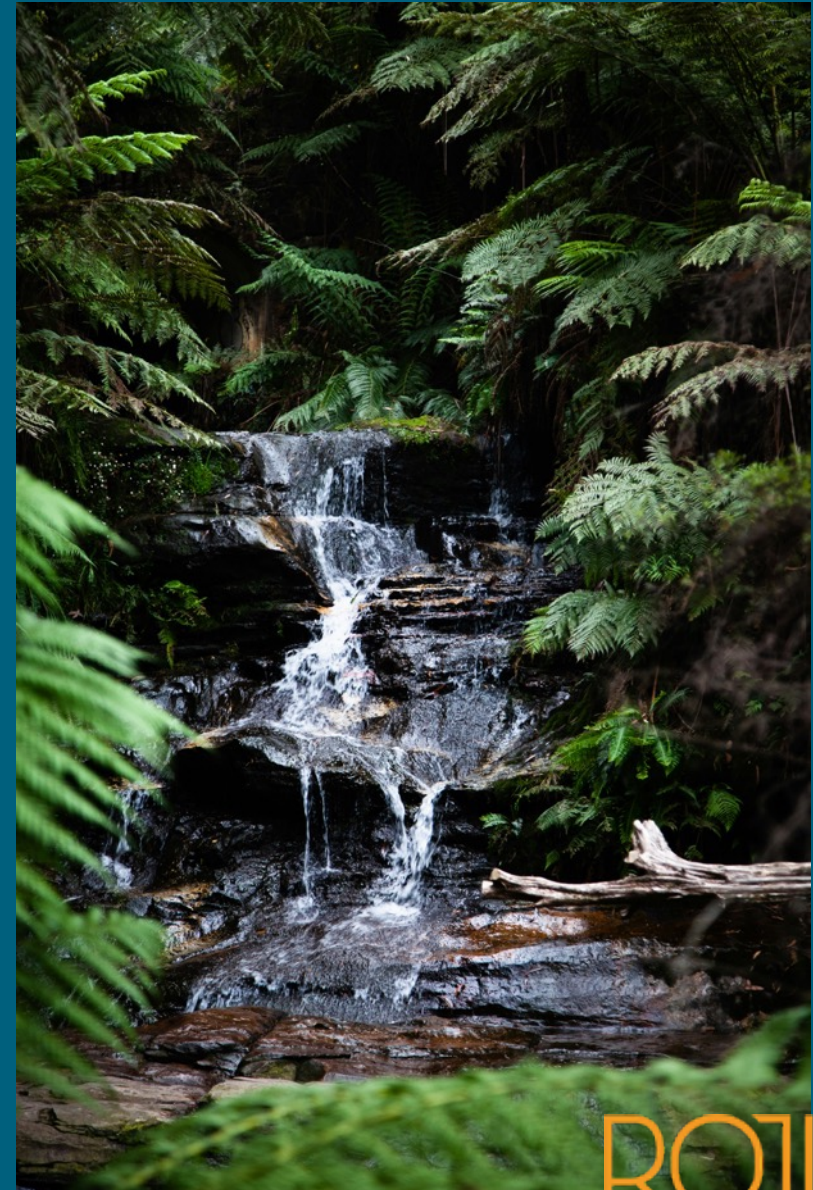


Image by Deleece Cook on Unsplash

Other TEAM Surgeries Likely Not to Expand Soon



Image by Joe Pohle on Unsplash

- CABG is a toss-up – its high cost makes it a target
- More likely: gradual increased use of alternatives (robotic bypass, PCI)

Whatever the scenario...

If you need to get into action on TEAM or CJR-X, we are here to help. Call us for the knowledge and customized technology-based services to support you.

Contact us: info@rojihealthintel.com or hush@rojihealthintel.com .

Questions and Answers

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Thank You!

Roji Health Intelligence LLC

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