

CJR-X Finalized: How are U.S. hospitals positioned for mandatory LEJR episodes of care?

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Educational Webinar Series



Today's Speakers



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Learning Objectives

After today's webinar, you'll understand:

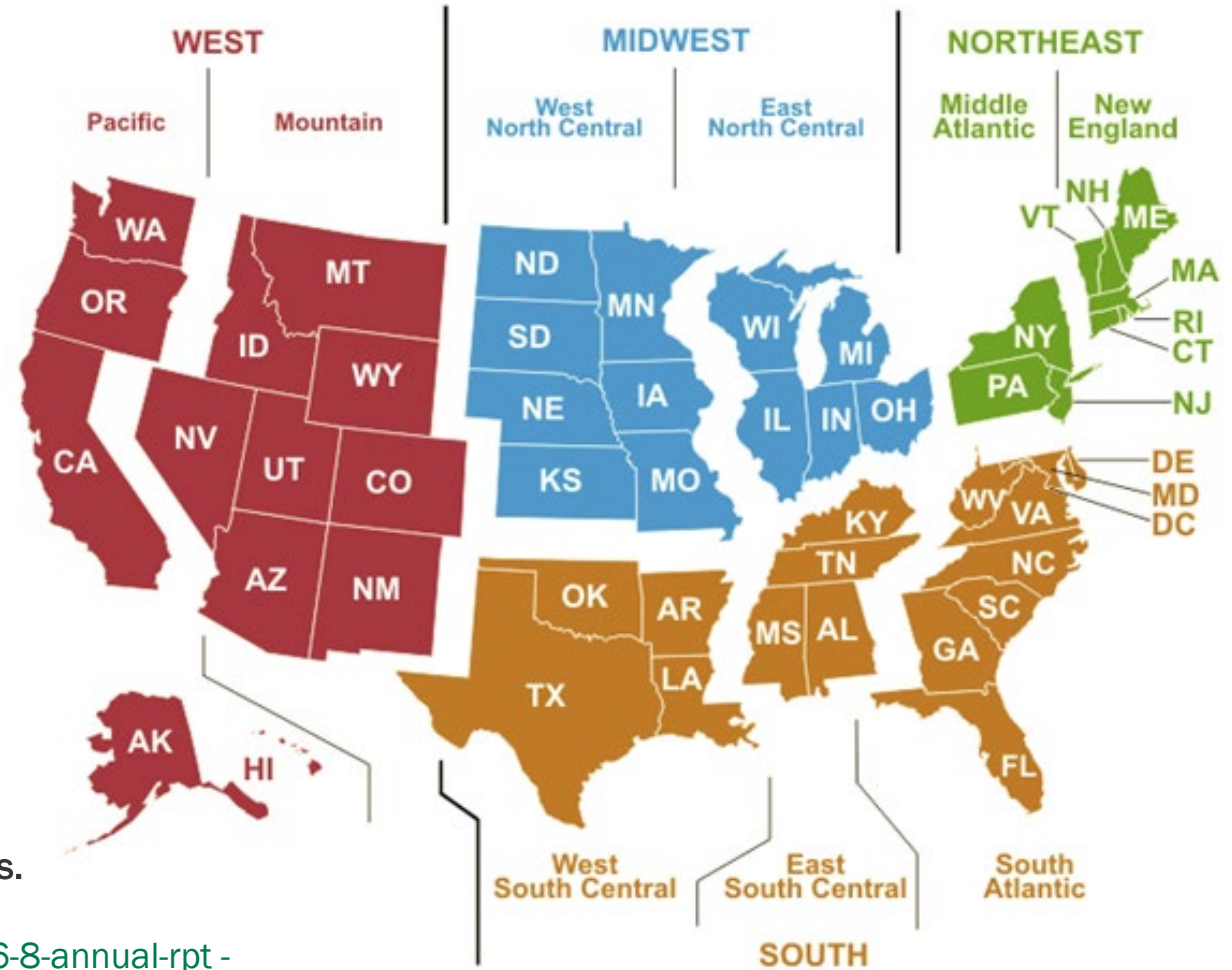
- the most important CJR-X model specifications;
- outstanding methodology gaps not yet addressed in rulemaking; and
- LEJR episode data trends on a national and regional level.

Disclaimers

- This is not an “explainer” webinar – not model all details will be covered.
- This webinar is meant to illustrate what CJR-X means in terms of participation, risk/opportunity and regional variation using data to the extent feasible.
- All analyses are derived using the Medicare Standard Analytic File (SAF) Limited Data Sets (LDS) and comply with CMS data privacy rules including the CMS Small Cell Size Suppression Policy.

U.S. Census Regions & Divisions

CMS will use
benchmark prices
based on U.S.
Census Divisions
in CJR-X



U.S. Energy Information Administration. U.S. Census Regions and Divisions.
Data from U.S. Census Bureau.

[https://www.cms.gov/priorities/innovation/data-and-reports/2026/cjr-py6-8-annual-rpt -](https://www.cms.gov/priorities/innovation/data-and-reports/2026/cjr-py6-8-annual-rpt-)

CJR-X Finalized: Phase II Expansion of CJR

Press Releases

Jul 31, 2026

CMS News: CMS Announces Nationwide Expansion of Proven Joint Replacement Program

[Hospitals](#)

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CMS Announces Nationwide Expansion of Proven Joint Replacement Program

The Centers for Medicare & Medicaid Services (CMS) is expanding an initiative to improve care coordination for hip, knee, and ankle replacements, ensuring providers work together from pre-surgery education through post-op recovery to promote a seamless patient care experience and optimal health outcomes.

CMS. CMS News: CMS Announces Nationwide Expansion of Proven Joint Replacement Program.

<https://www.cms.gov/newsroom/press-releases/cms-news-cms-announces-nationwide-expansion-proven-joint-replacement-program>

Minimal Changes to CJR-X in IPPS Final Rule

Criteria	CJR-X Specifications
Model Duration	To begin on January 1, 2028* (CY alignment)* → <u>no end date</u>
Participants	Acute care hospitals (by CCN) – 2,217 hospitals estimated for PY1
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, PPS-exempt cancer hospitals, CAHs, 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

*Reflects provisions that were updated in the FY 2027 IPPS Final Rule

Final CJR Evaluation Report

\$180 Million

Net Medicare Savings

CJR PY6 – PY8

Published September 28, 2026

LewinGroup. CMS Comprehensive Care for Joint Replacement Model Performance Year 6-8 Evaluation Report: Final Evaluation Report.

[https://www.cms.gov/priorities/innovation/data-and-reports/2026/cjr-py6-8-annual-rpt -](https://www.cms.gov/priorities/innovation/data-and-reports/2026/cjr-py6-8-annual-rpt-)



CMS Comprehensive Care for Joint Replacement Model: Performance Years 6–8 Evaluation Report

Final Evaluation Report



September 2026

Prepared for: Centers for Medicare & Medicaid Services

Submitted by: The Lewin Group, with GDIT and Telligen

Polling Question #1

- How is your organization approaching CJR-X data analytics? Select one response.
 - Internal IT resources
 - External partnership
 - Mix of internal and external resources
 - Undecided
 - Not applicable

Polling Question #2

- How confident are you in knowing your organization's opportunities to reduce Medicare episode spend? Select one response.
 - Not at all confident
 - Slightly confident
 - Moderately confident
 - Very confident
 - Extremely confident

CJR-X Specifications



...as told through data

Participant Inclusion/Exclusion Criteria

CJR-X Participant Definitions

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

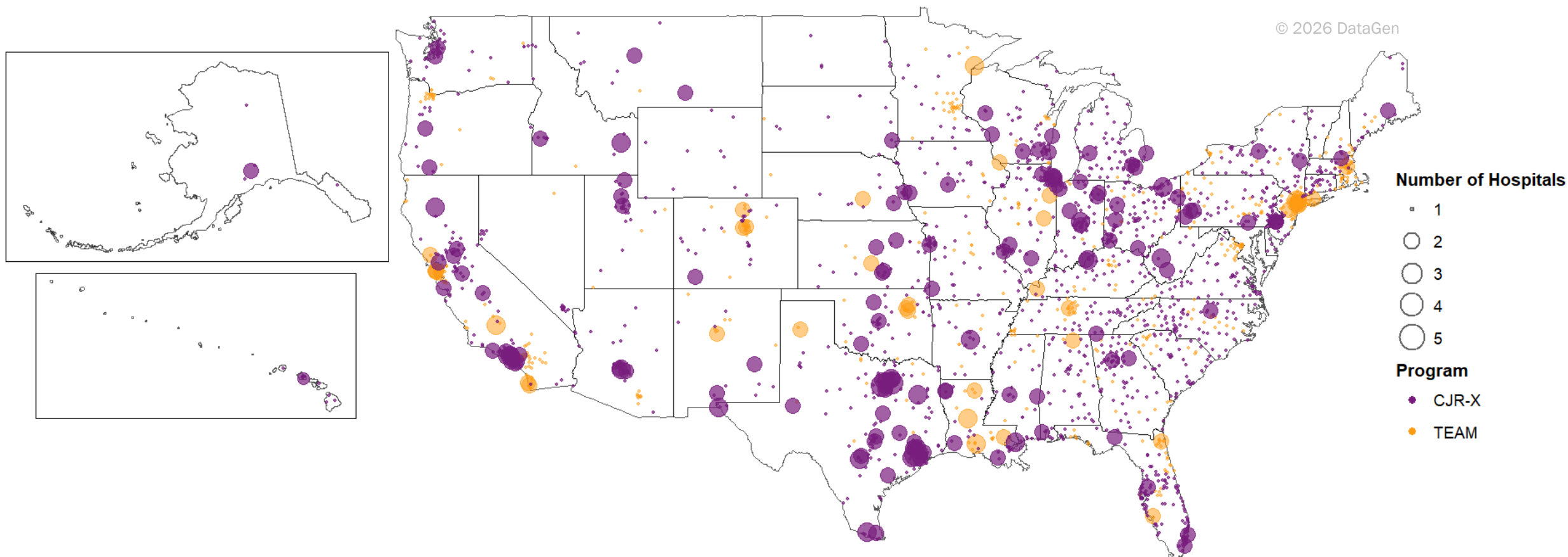
Excluded Hospitals

- Indian Health Service and Tribal Hospitals
- Hospitals participating in the Rural Community 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)

**2,217 eligible
hospitals
identified for PY1**

CMS. CJR-X Participant List. Published October 5, 2026. <https://www.cms.gov/priorities/innovation/files/cjrx-participant-list.xlsx>

TEAM vs. CJR-X Participation

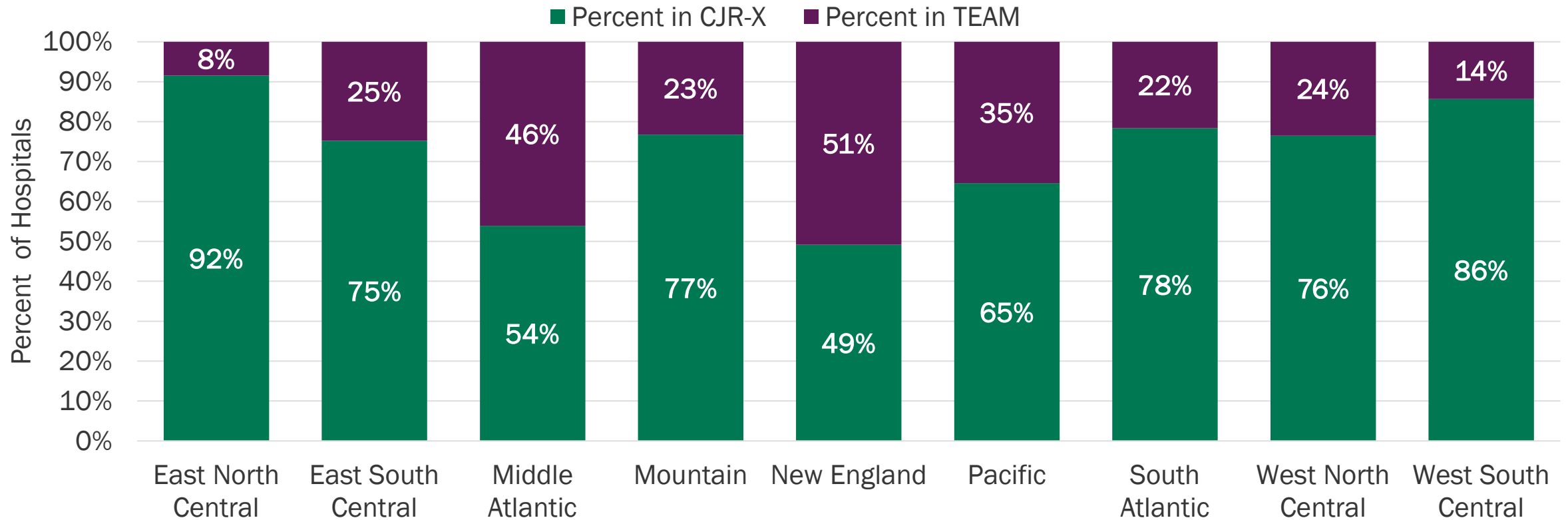


Map & Data Notes: U.S. territories are not displayed. Yellow markers indicate hospitals currently participating in TEAM. Purple markers indicate hospitals that will be subject to CJR-X. Data is derived from the Medicare SAF LDS (FY 2025) and CMS' TEAM PY1 Participation List.

Model Participation by Region

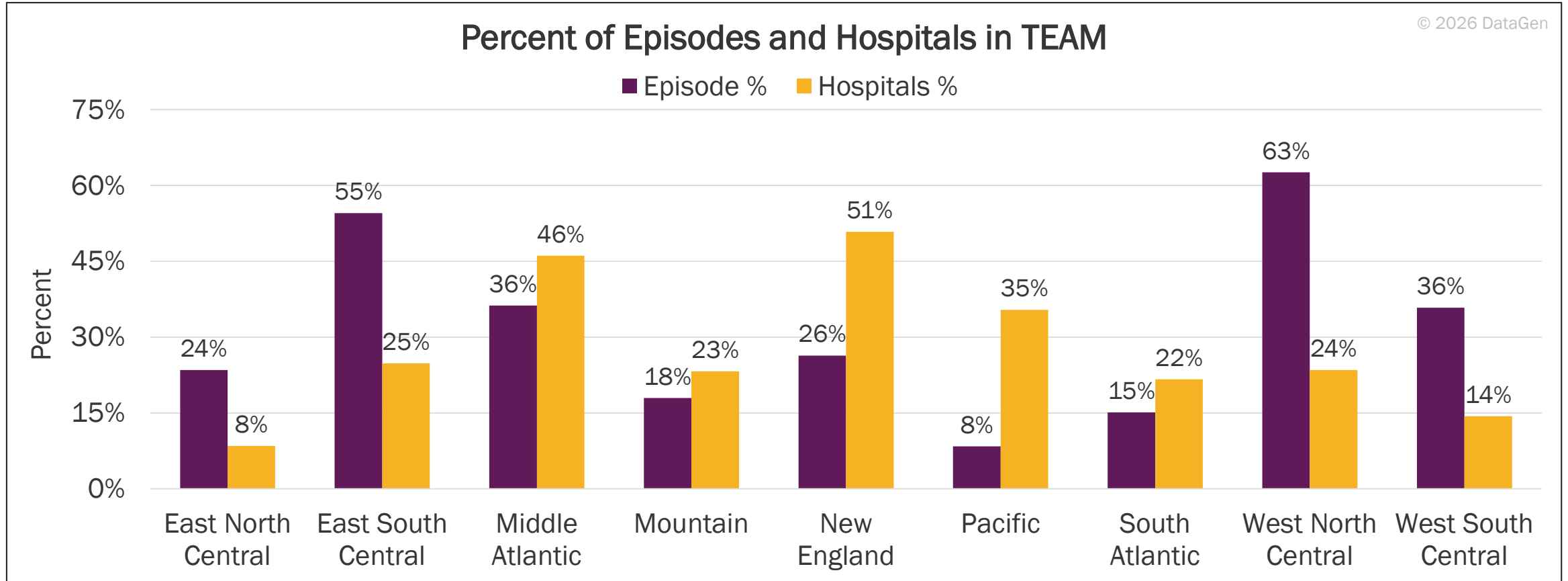
Anticipated CJR-X and TEAM Hospital Participation by Region

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Data Note: Data is derived from the CMS TEAM PY1 Participation List (Pub. Sep. 22, 2026) and the CMS CJR-X PY1 Participation List (Pub. Oct. 5, 2026).

TEAM Episode Penetration by Region



Data Note: Data is derived from the CMS TEAM PY1 Participation List (Pub. Sep. 22, 2026), the CMS CJR-X PY1 Participation List (Pub. Oct. 5, 2026), and the Medicare SAF LDS (FY 2025).

Participant Risk

Upside/Downside Risk Begins PY 1

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

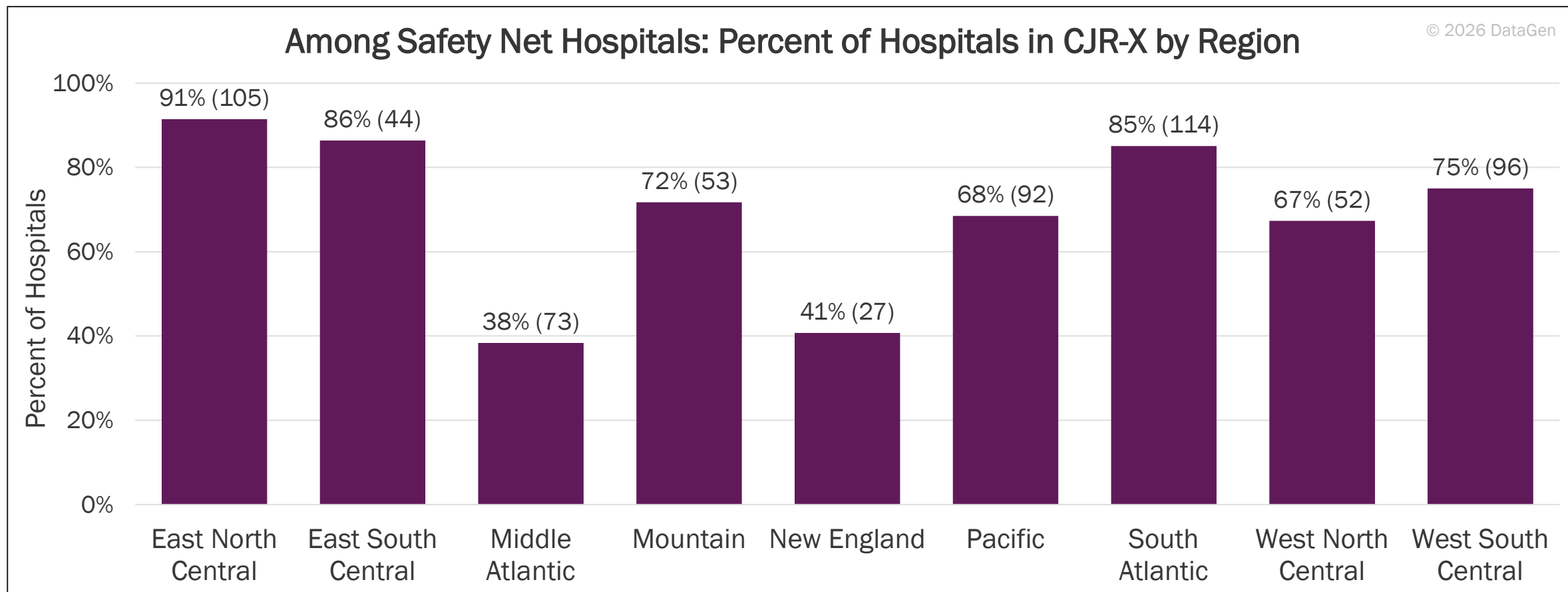
Low-volume hospitals are not reconciled
(<31 episodes in 3-year baseline)

Participants Eligible for 5% Stop-Loss

Rural Hospitals	• Hospitals designated as rural under §412.64 or located in a rural census tract under §412.103(a)(1).
Medicare Dependent Hospitals (MDH)	• Hospitals rurally located with 100 or fewer beds and $\geq 60\%$ of inpatient days or discharges from Medicare patients.
Sole Community Hospitals (SCH)	• Hospitals designated as the sole source of inpatient hospital services reasonably available to patients in a defined geographic area.
Safety Net Hospitals	• Hospitals that fall in the top 25th percentile within its region for the percent of FFS LEJR inpatient episodes provided to dually eligible beneficiaries during the applicable baseline period.

 **Important!** CMS defines and treats “rural hospitals” differently in CJR-X than in CJR. Also note, CJR-X and TEAM have different “safety net hospital” definitions.

Among Safety Net Hospitals: Percent in CJR-X



Data Notes: Data is derived from the Medicare SAF LDS (FY 2025). Counts represent the number of eligible safety net hospitals in the region using CJR-X's definition. Percents represent the number of safety net hospitals in region that will be participating in CJR-X.

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

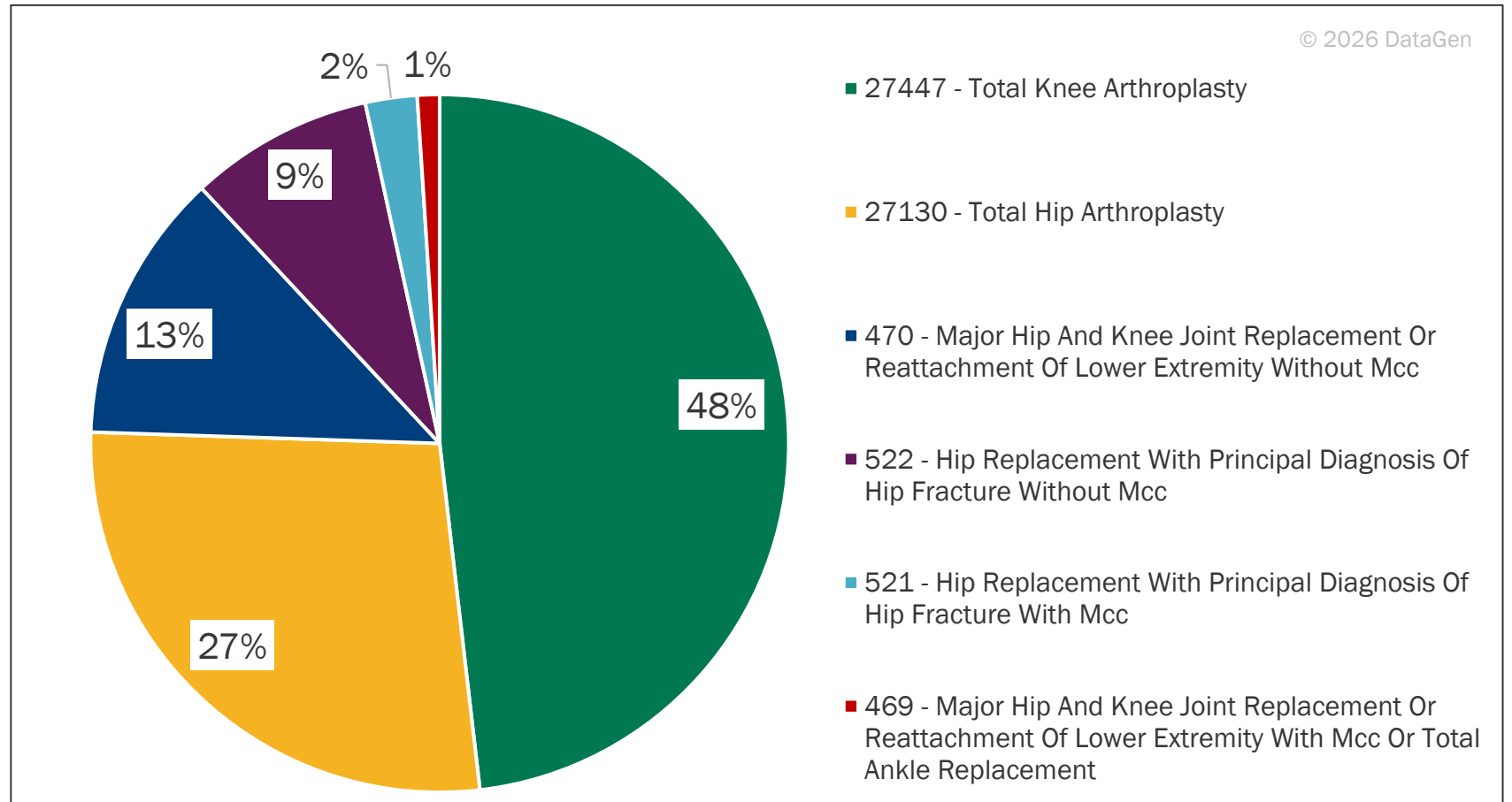
Episode end = 90 days after the episode start date

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

Episode Distribution

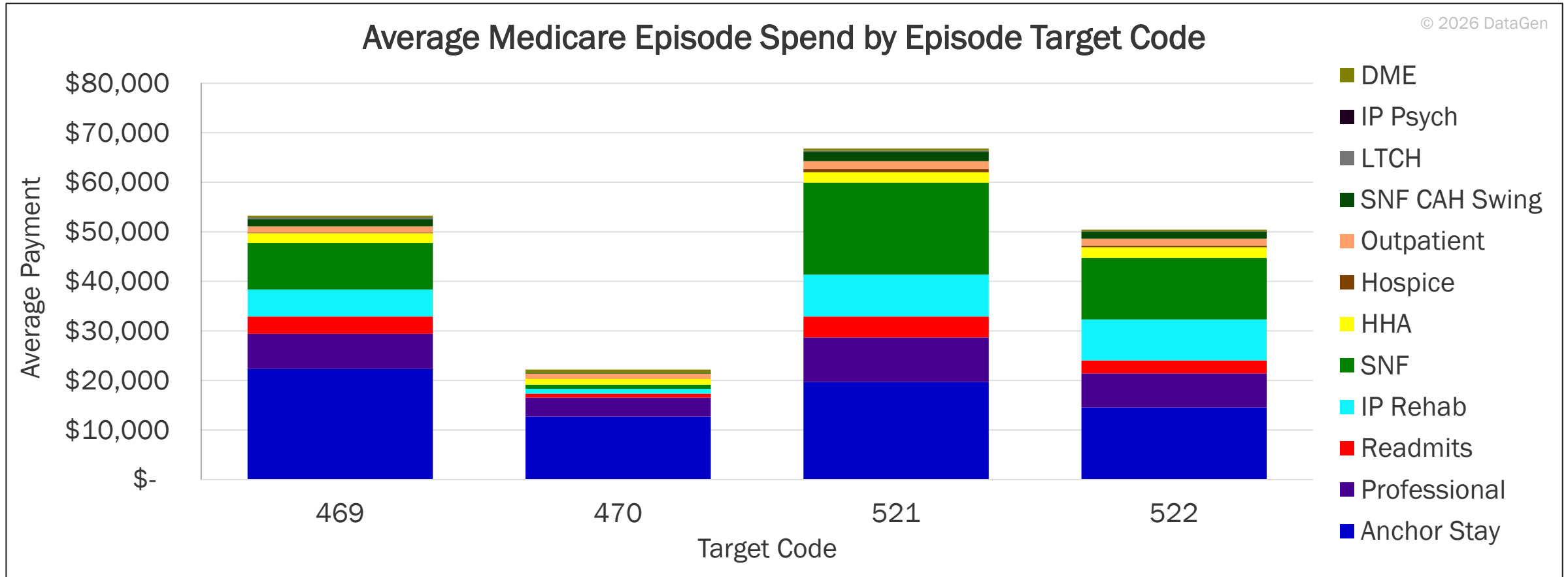
88% of LEJR episodes are for trigger codes 27447, 27130 & 470

These codes capture hip and knee episodes that are likely “Elective”



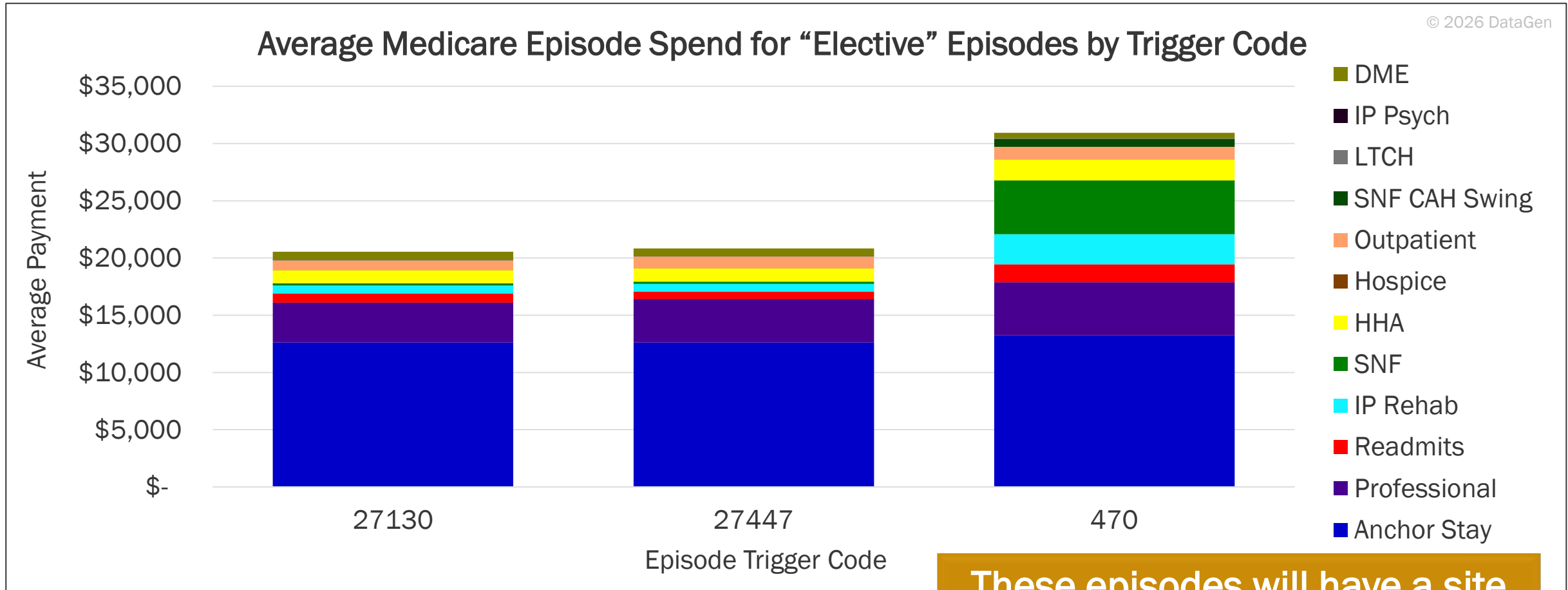
Data Note: Data is derived from the Medicare SAF LDS (FY 2025).

Episode Spend by Target Code



Data Notes: Target Code 470 represents likely elective episodes triggered by MS-DRG 470, HCPCS 27447 & HCPCS 27130 (which will have a site neutral target price). Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

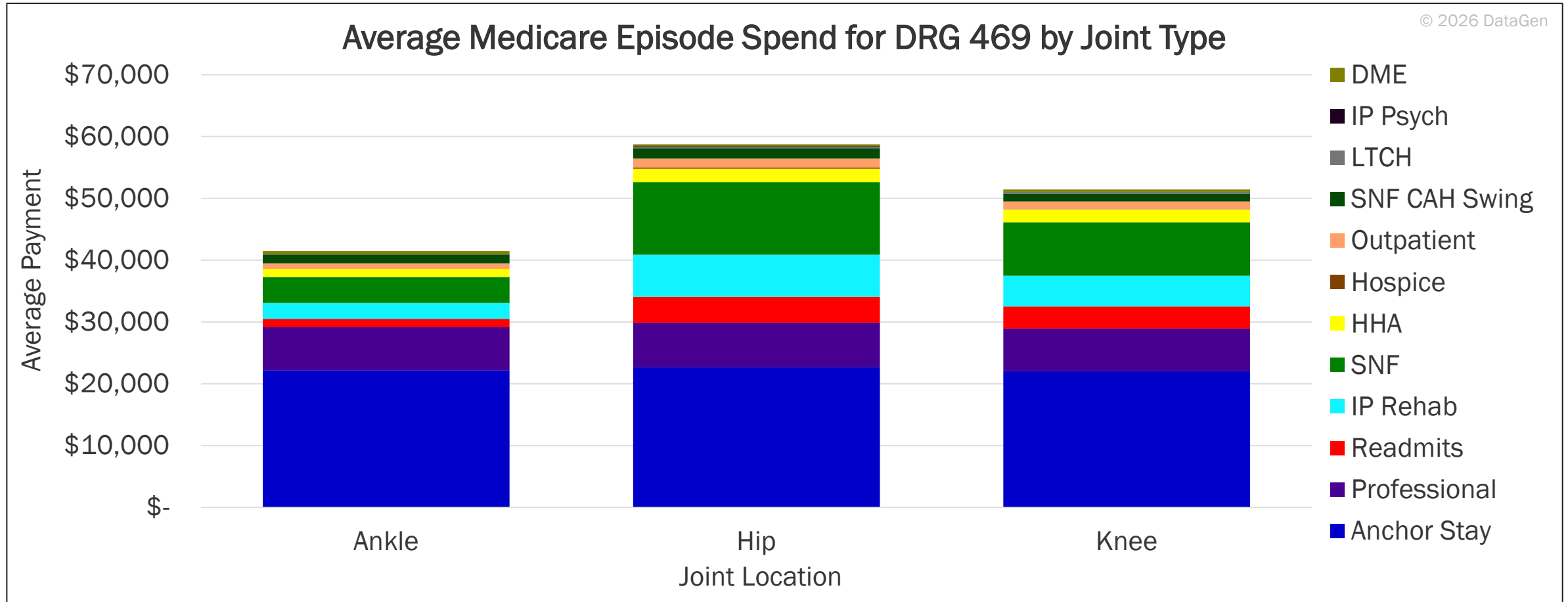
Episode Spend for “Elective” Trigger Codes



Data Note: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

These episodes will have a site neutral target price!

Episode Spend for DRG 469 by Joint Location



Data Note: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

Staged Joint Procedures

Joints in both legs (hips or knees) are replaced during two separate operations

<1.5% of LEJR Episodes ▪ \$13,500 Cost Difference

CJR	TEAM	CJR-X ★
First episode is canceled; second anchor procedure begins a new episode	First episode is retained; second anchor procedure is treated as a readmission	CMS stated its intent to follow CJR but <u>did not</u> finalize a policy

 This policy issue is deferred for future rulemaking.

Target Price Methodology

Participants will receive for each MS-DRG/HCPCS episode type:



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 ($\pm 3\%$ cap) and Normalization Factor ($\pm 5\%$ cap).

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)*
- Procedure

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

***HCCs are identified in the 180 days prior to the episode start date.**



Baseline & Performance Years

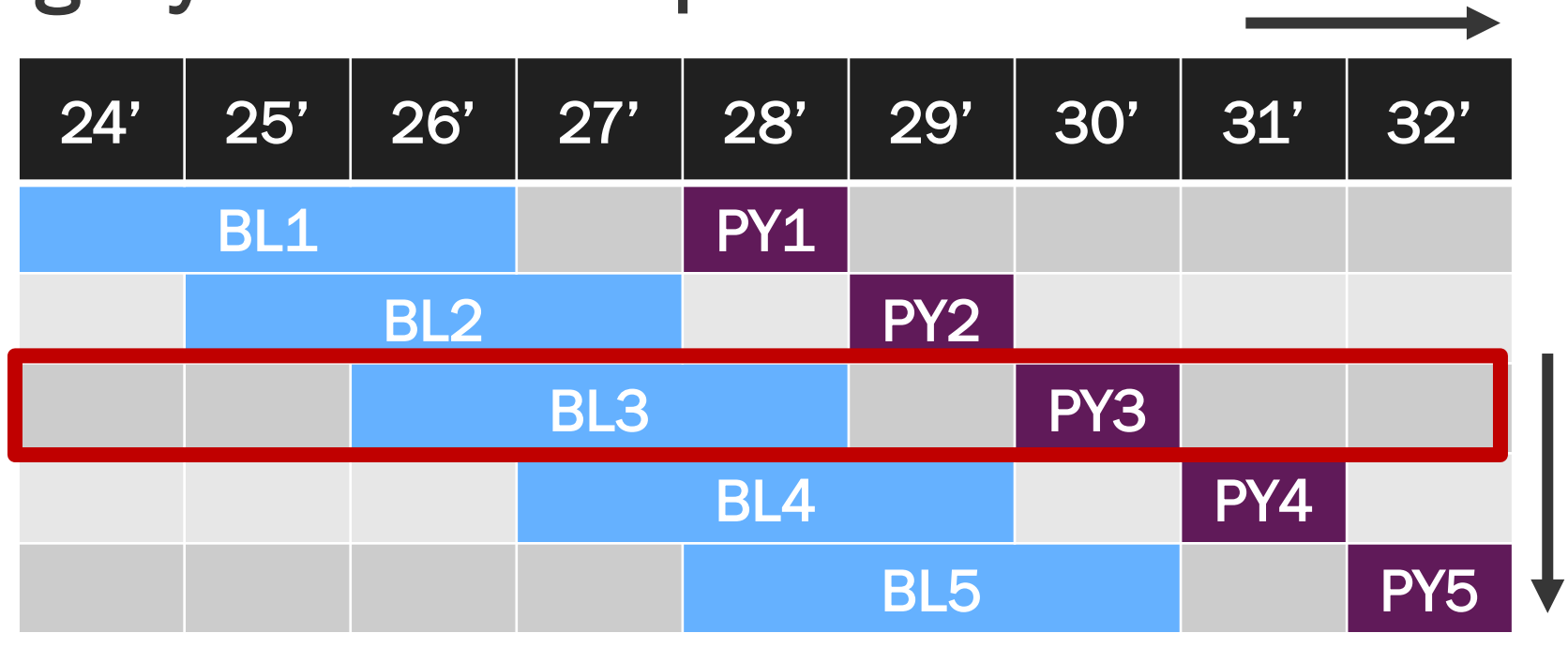
Regional benchmark prices are set using a rolling 3-year baseline period.

Baseline Weighting:

Year 1 = 17%

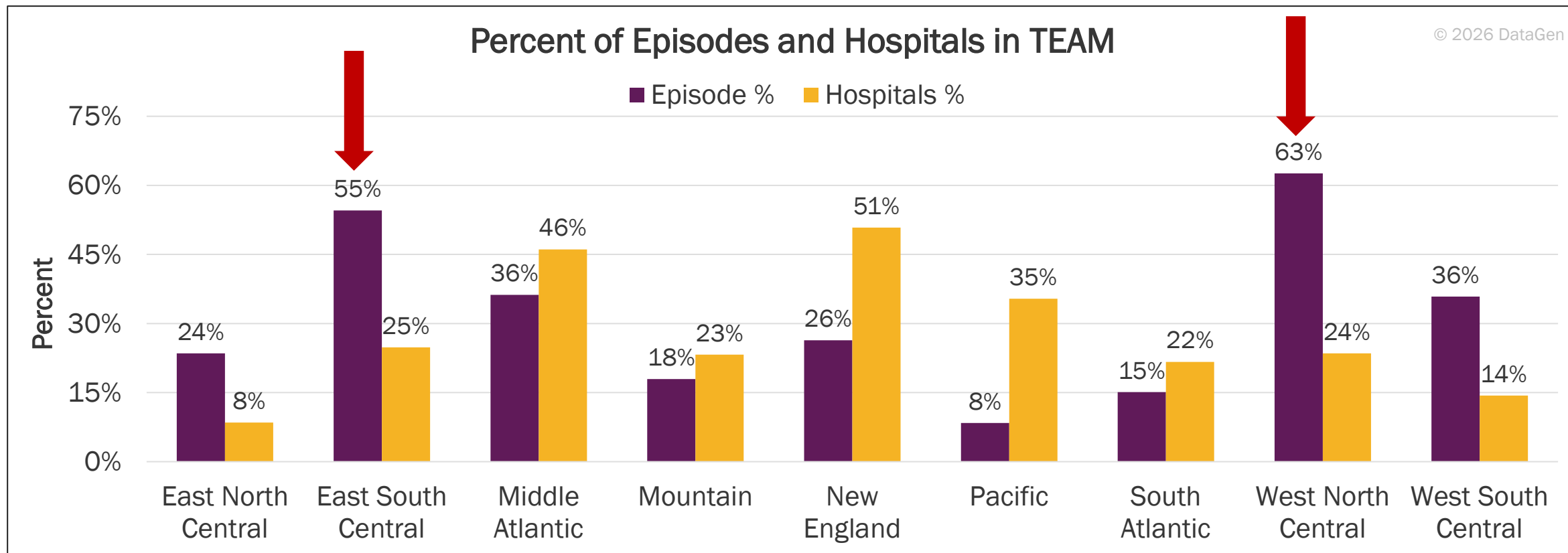
Year 2 = 33%

Year 3 = 55%



The first CJR-X PY with a baseline period fully overlapping TEAM PYs

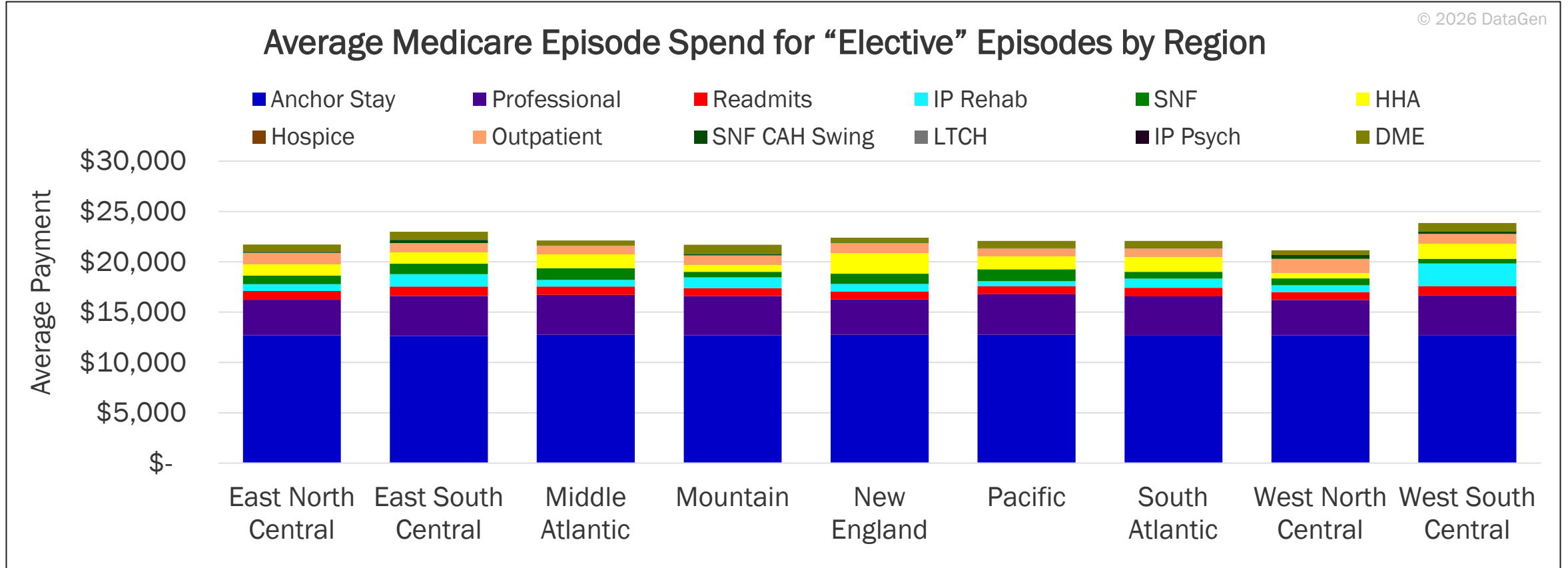
TEAM Episode Penetration by Region



Regions with a greater percent of TEAM LEJR episodes may feel the “race to the bottom” effect earlier than others.

Data Note: Data is derived from the CMS TEAM PY1 Participation List (Pub. Sep. 22, 2026), the CMS CJR-X PY1 Participation List (Pub. Oct. 5, 2026), and the Medicare SAF LDS (FY 2025).

Episode Spend for “Elective” by Region



Data Notes: Target Code 470 represents likely elective episodes triggered by MS-DRG 470, HCPCS 27447 & HCPCS 27130 (which will have a site neutral target price). Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

Quality Measures

Quality Measure	CMIT ID#	Applied 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.

Reconciliation

Annual reconciliation:

- Data is cut about 6 months after the end of the performance year
- Low-volume hospitals are not reconciled
- 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 to discount factor 
- Stop loss/gain limits

If Episode Expenditures < Target Amount → **Positive NPRA (savings)**

If Episode Expenditures > Target Amount → **Negative NPRA (losses)**

Impact of CQS

CQS Score (Max = 20)	CQS Category	Eligible for Recon. Payment?	Discount Factor
≤ 6.0	Below Acceptable	No	2.0%
6.1 – 12.0	Acceptable	Yes	2.0%
12.1 – 17.0	Good	Yes	1.0%
≥ 17.1	Excellent	Yes	0.0%



Scenario 1:

\$100M benchmark, +\$2.5M variance

CQS Category	NPRA
Below Acceptable	\$0
Acceptable	\$0.5M
Good	\$1.5M
Excellent	\$2.5M

Scenario 2:

\$100M benchmark, +\$1M variance

CQS Category	NPRA
Below Acceptable	-\$1M
Acceptable	-\$1M
Good	\$0
Excellent	\$1M

Scenario 3:

\$100M benchmark, -\$1M variance

CQS Category	NPRA
Below Acceptable	-\$3M
Acceptable	-\$3M
Good	-\$2M
Excellent	-\$1M

What is missing? Update Factors

Regional
Benchmark
Price

×

Trend
Factor

×

Risk
Adjustment
Multipliers

×

Normal-
ization
Factor

×

CMS
Discount
Factor

=

Target
Price

What we know:

- No release of MS-DRG or APC updates factors during the PY
- Will be accounted for at time of reconciliation

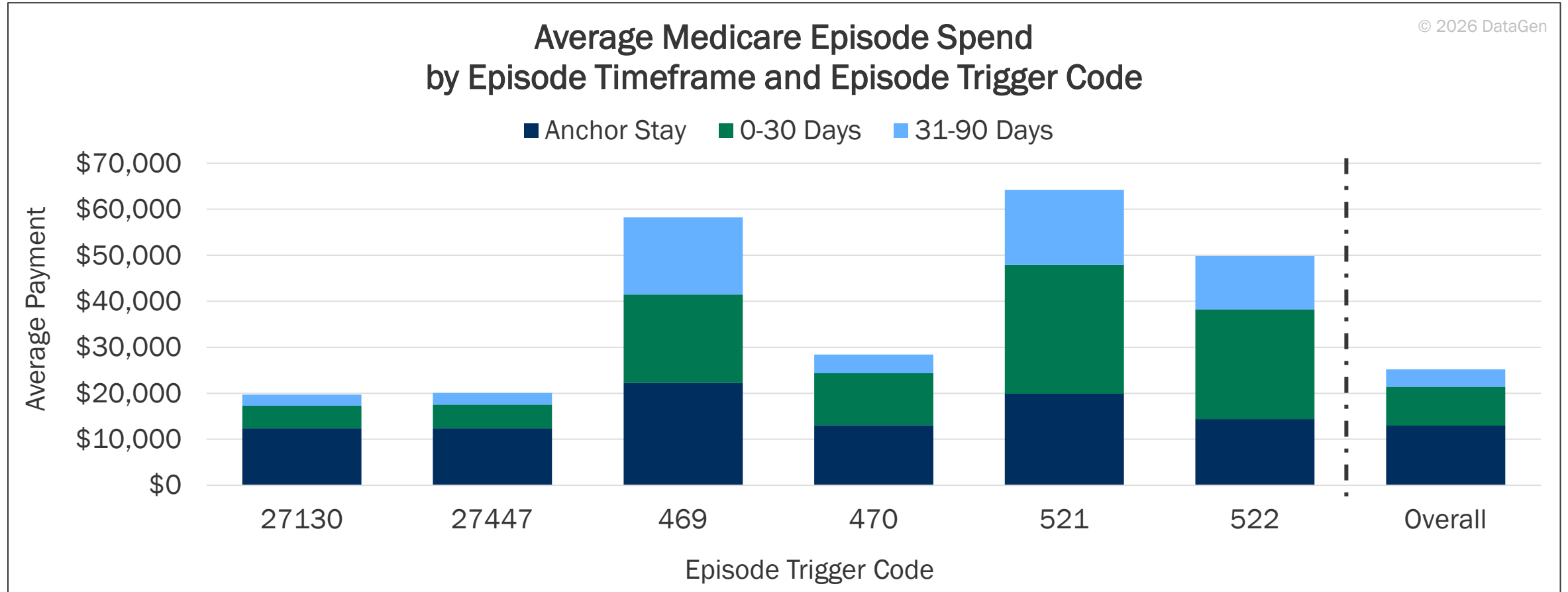
What we don't know:

- Exact method/placement in the final target price calculation
- CMS deferred to reconciliation specifications to be released

Additional LEJR Trends to Know

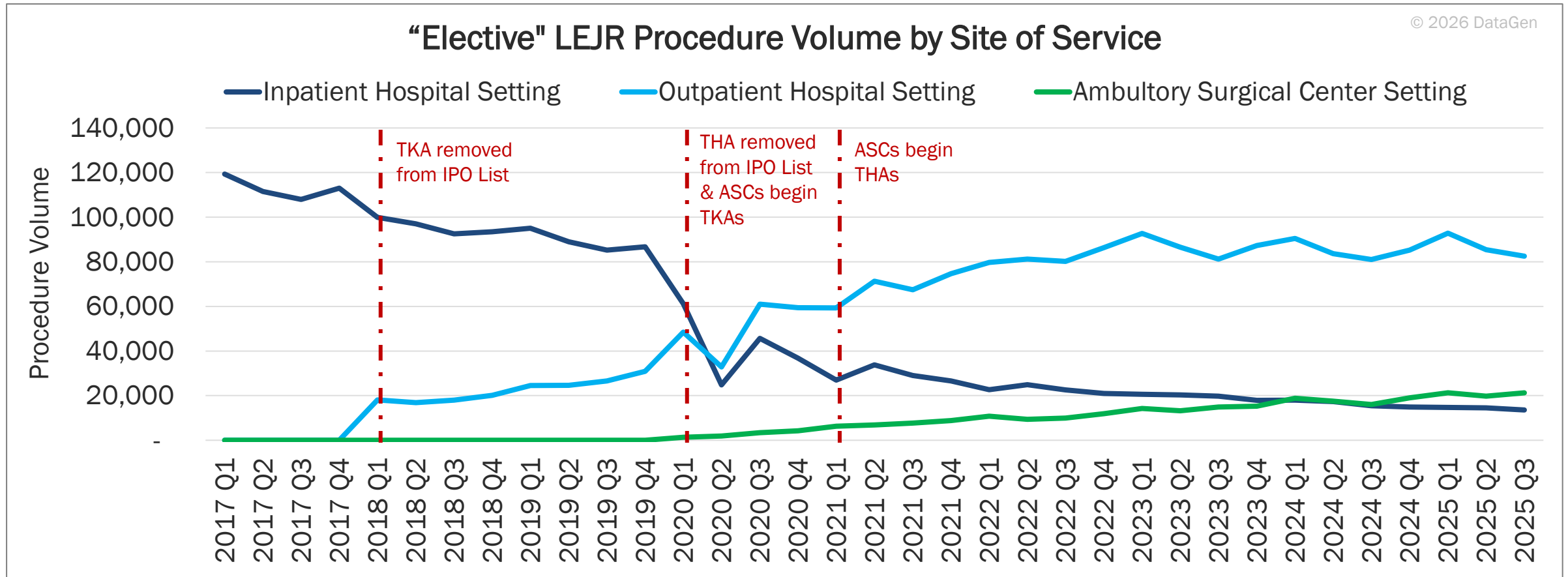
A decorative background featuring a complex network graph with numerous nodes and connecting lines, rendered in a light purple color. A solid yellow horizontal line spans the width of the slide, positioned below the title.

LEJR 30-Day vs. 90-Day Accountability



Data Note: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

LEJR Site of Service Shift

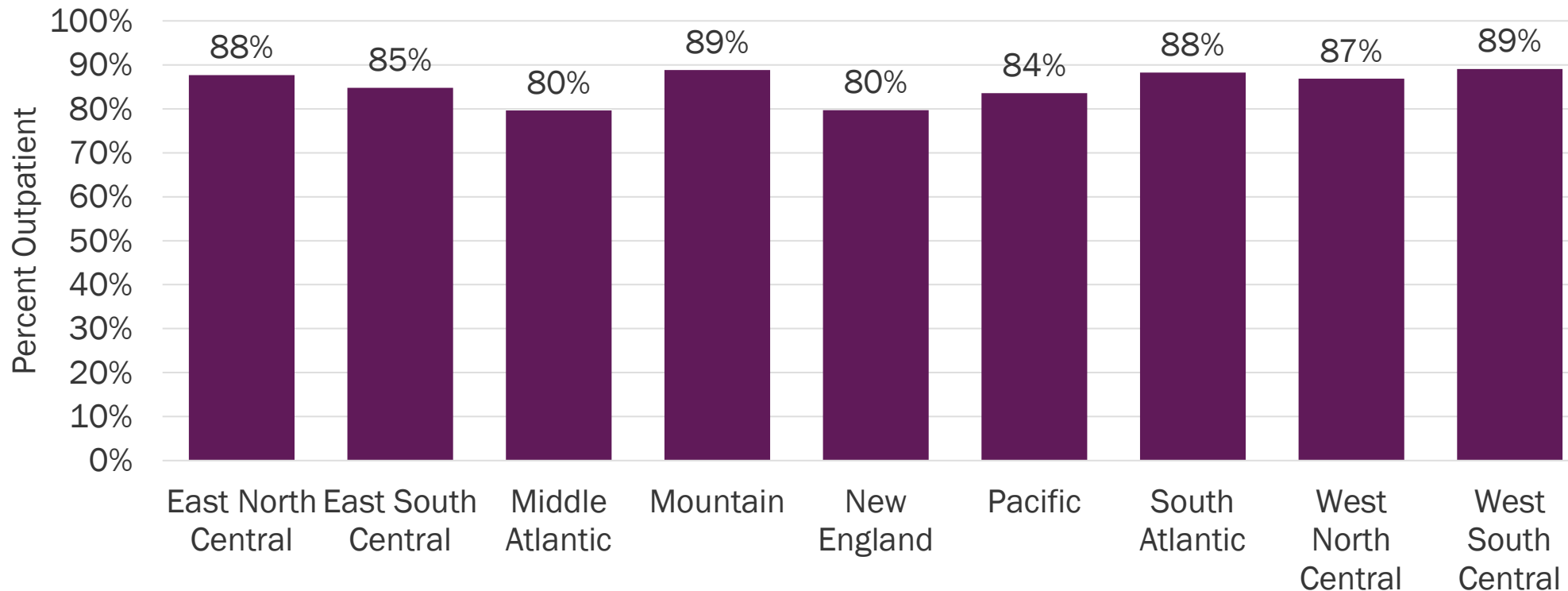


Data Notes: Likely elective episodes shown on this graph are triggered by MS-DRG 470, HCPCS 27447 & HCPCS 27130 and have fractures excluded prior to 2020 Q4. Data is derived from the Medicare SAF LDS (2027 Q1 to 2025 Q3).

Elective LEJR Site of Service by Region

“Elective” LEJR Episodes – Percent Outpatient by Region

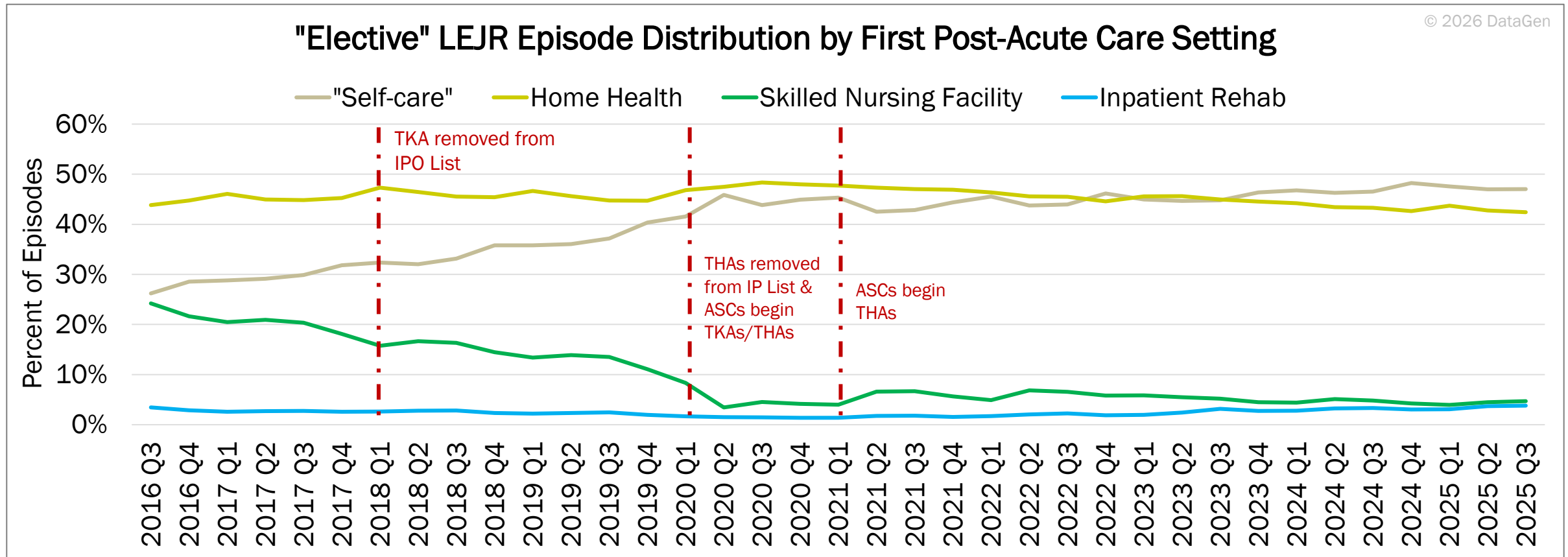
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IP Anchor is
≤\$1,000
more
expensive
than an
OP Anchor

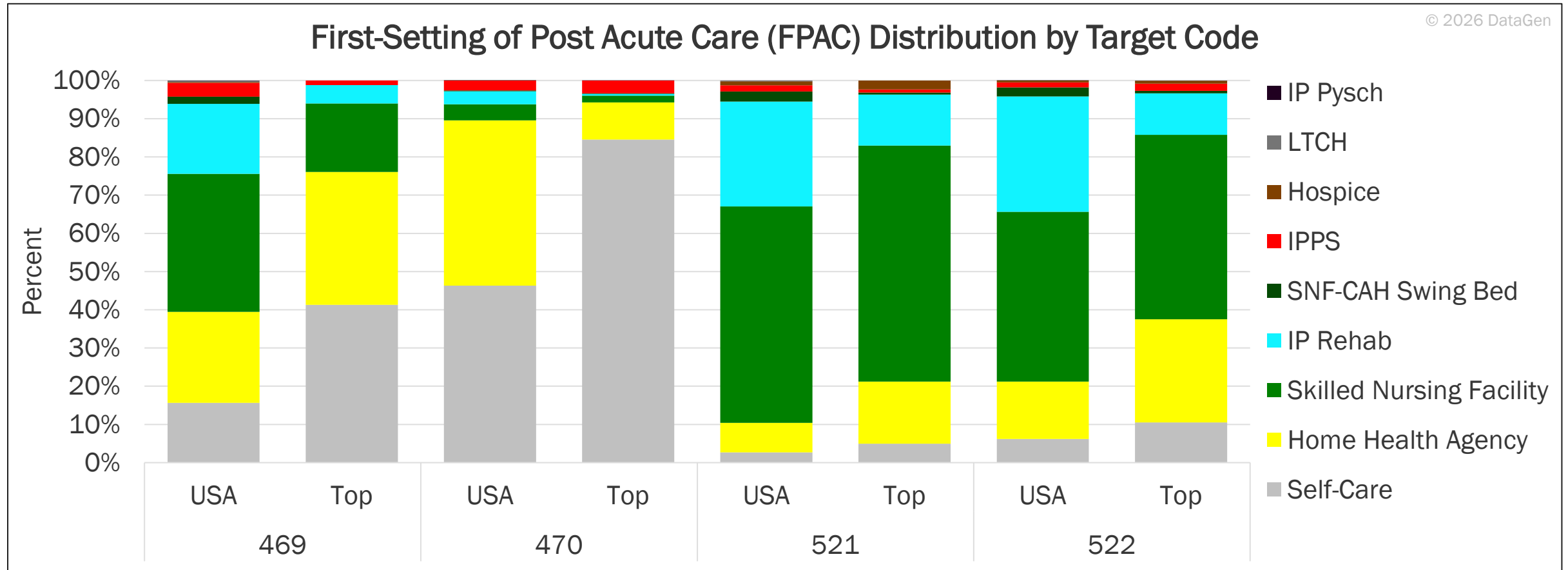
Data Notes: Likely elective episodes are triggered by MS-DRG 470, HCPCS 27447 & HCPCS 27130 (which will have a site neutral target price). Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

LEJR FPAC Shift



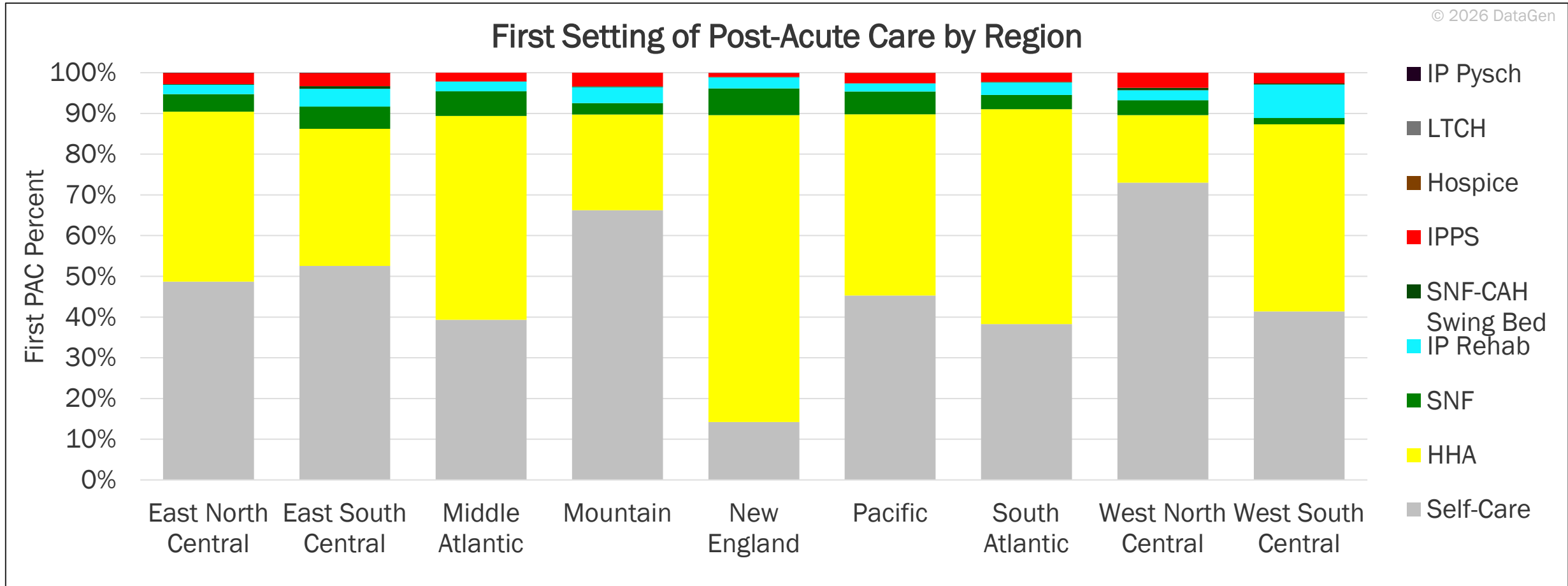
Data Notes: Likely elective episodes shown on this graph are triggered by MS-DRG 470, HCPCS 27447 & HCPCS 27130 (which will have site neutral target prices) and have fractures excluded prior to 2020 Q4. Data is derived from the Medicare SAF LDS (2016 Q3 to 2025 Q3). FPAC represents the First Post-Acute Care Setting after the anchor stay/visit.

FPAC % Benchmarks by Target Code



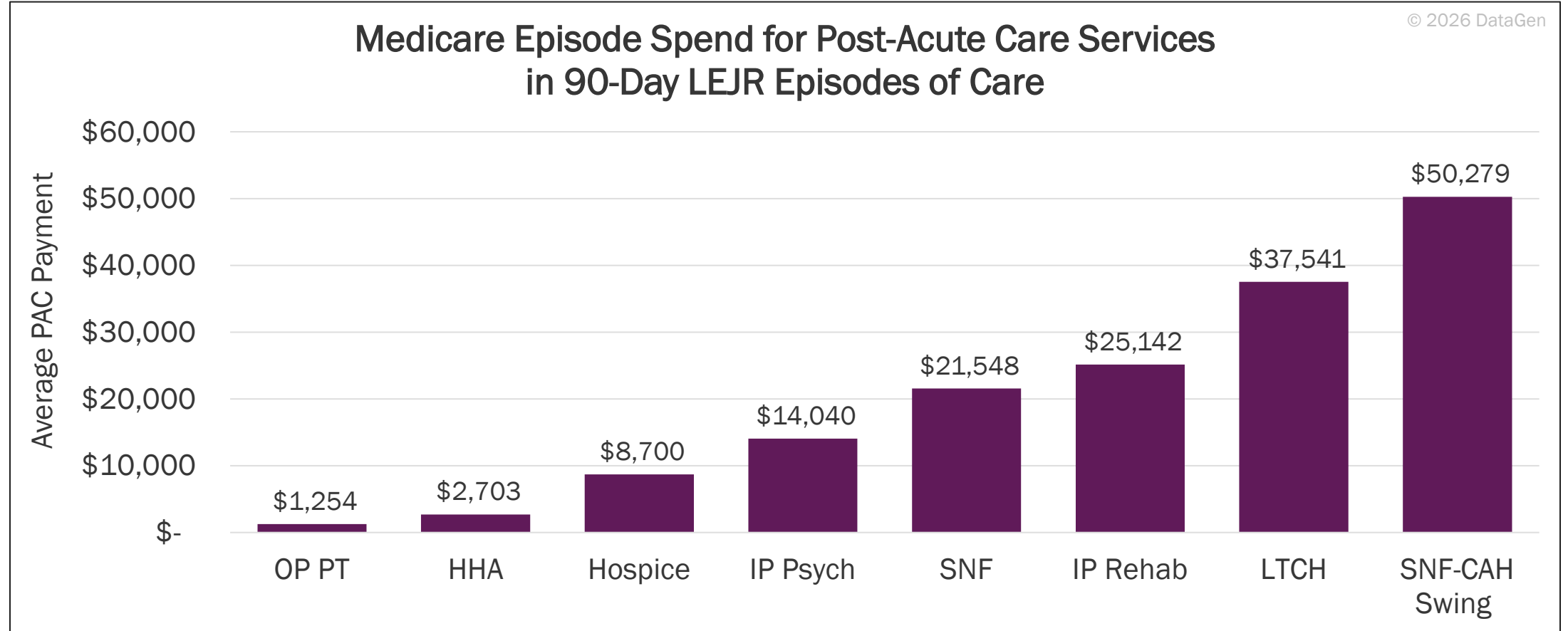
Data Notes: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4). FPAC represents the First Post-Acute Care Setting after anchor stay/visit. Top represents the highest volume hospitals (20%) with lowest average Medicare episode spend (10%).

FPAC Distribution by Region



Data Notes: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4). FPAC represents the First Post-Acute Care Setting after anchor stay/visit.

Medicare Cost for Post-Acute Care Services

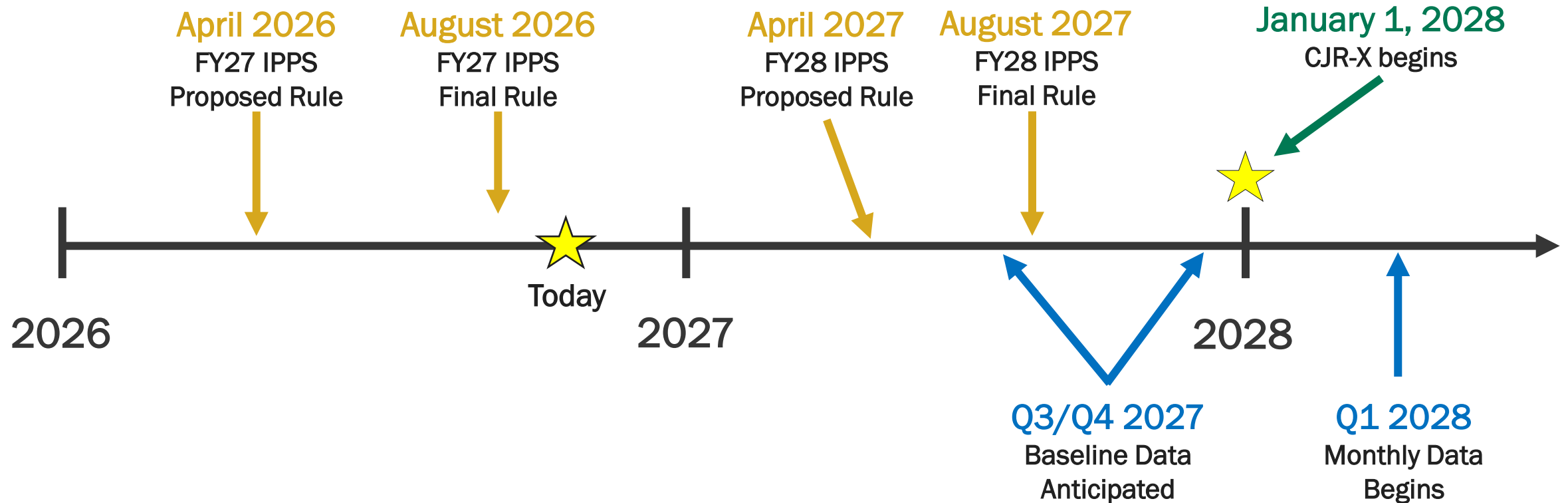


Data Notes: Data is derived from the Medicare SAF LDS (2024 Q4 to 2025 Q4).

Final Remarks



Timeline



Follow CMS Communications Closely

- ✓ Participant List → Published Oct. 5, 2026
- ✓ Hospital Points of Contact → Open Now
- ✓ Data Request Attestation (DRA) Form
- ✓ Data Sharing Agreement (DSA)
- ✓ Clinician Engagement Lists (CEL)
- ✓ Financial Arrangement Lists (FAL)
- ✓ FY 2028 IPPS Rulemaking

Questions & Answers

Stop by our VBCExhibitHall.com Virtual Booth



Thank you.

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