Comprehensive Care for Joint Replacement Expanded (CJR-X) Model
What to Know & How to Prepare

August 11, 2026

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Today’s Learning Objectives

1

Understand the Model

Describe the key features & goals of the CJR-X Model.

2

Connect Cost & Quality

Explain how CJR-X aligns cost & quality performance across an episode of care & shifts accountability to hospitals.

3

Recognize Organizational Impact

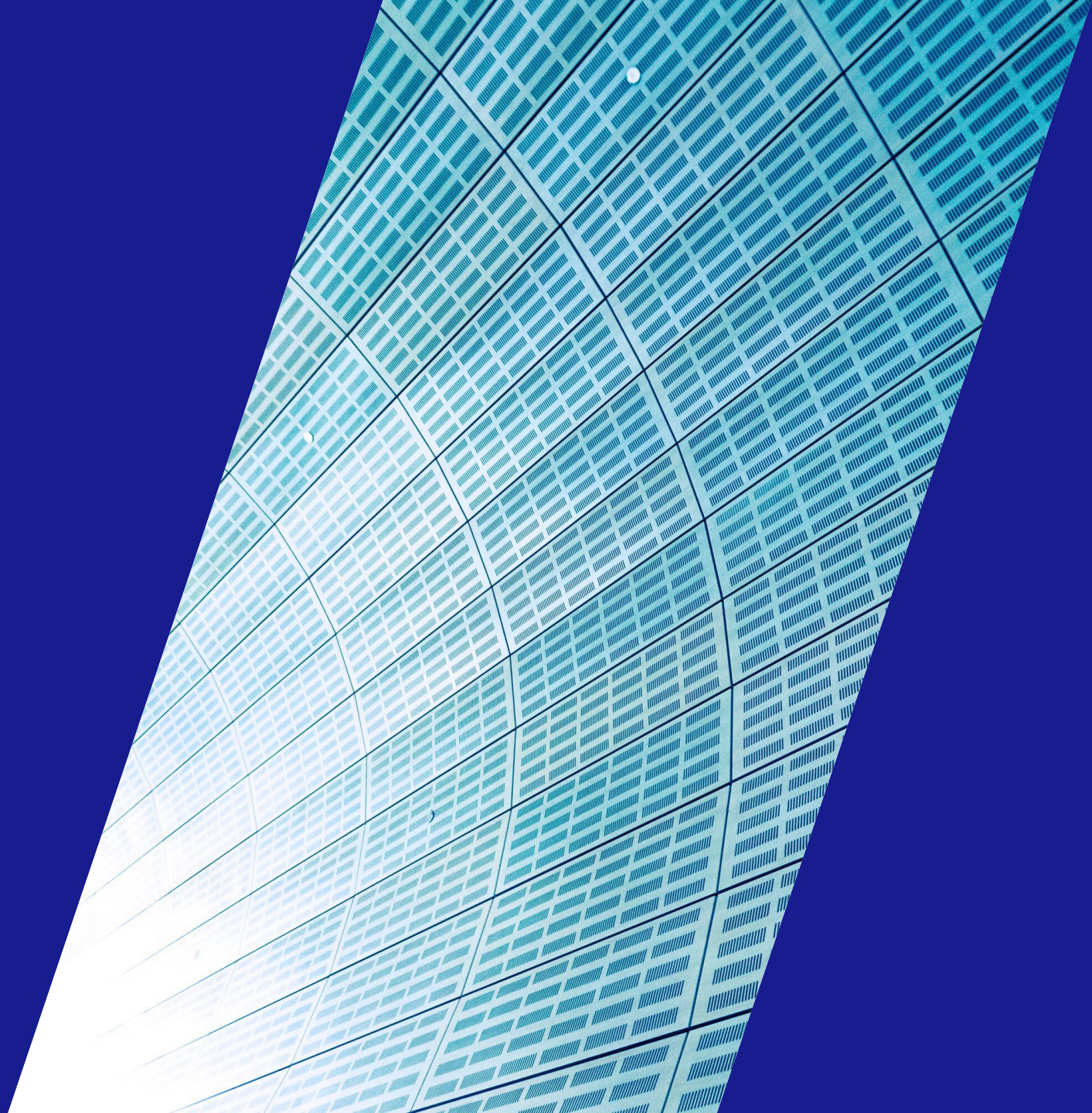
Recognize the potential organizational implications of participating in CJR-X, including impacts on performance, operations, & care delivery.

4

Prepare for Participation

Identify key considerations & early steps to help prepare for & succeed under the CJR-X Model.

Introductions



Meet the Presenters

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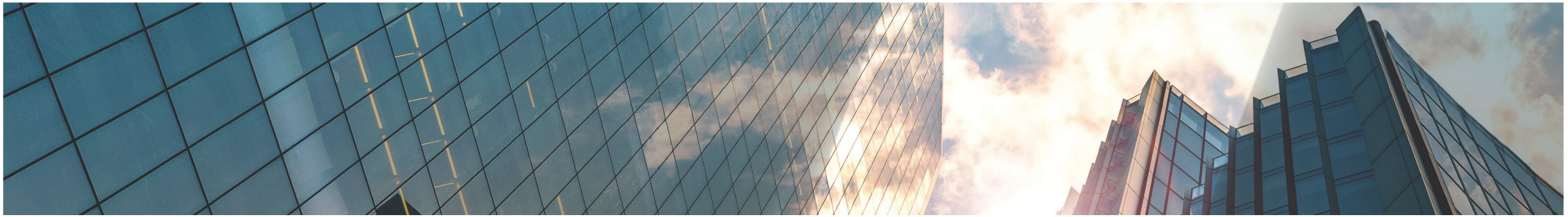

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89

Net Promoter Score®

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CJR-X Overview

How Did We Get Here?
Progression From CJR to CJR-X

2016	**CJR Launches: Inpatient Only**	Mandatory in 67 MSAs; episode defined by MS-DRG 469/470 alone—no outpatient procedures
2018	**Scaled Back**	Mandatory participation narrowed to 34 MSAs; episode definition unchanged
2019	**Target Pricing Change**	Hospital-specific target pricing moved to 100% regional target pricing
2020	**DRG Refinement**	CMS splits hip fracture cases into new MS-DRG 521/522; episode definition updated to track the new codes
2021	**Outpatient Added**	TKA (27447) & THA (27130) added after removal from the Inpatient Only list, priced site-neutral with inpatient DRGs without MCC; risk adjustment expanded (age, dual-eligibility, comorbidities), PY 6 target prices established using CY 2019 data instead of rolling three-year window
2024	***December 31, 2024:*** **CJR Ends**	8 performance years complete; $112.7M net savings in PY 6–7
2028	***January 1, 2028:*** **CJR-X Begins**	Carries forward CJR's DRGs & site-neutral outpatient pricing with no phased-in upside only in PY 1; composite quality scoring methodology to determine discount factor; adopts TEAM's target pricing & risk methodology; nationwide, ~2,500 hospitals

CJR-X: Comprehensive Care for Joint Replacement Expanded

Fast Facts

CJR-X is a mandatory, nationwide expansion of the original Comprehensive Care for Joint Replacement (CJR) Model.

Participants

- All IPPS hospitals unless they are already participating in TEAM; Maryland hospitals also excluded
- TEAM participants will begin CJR-X in 2031

Patient Population

- Medicare FFS only
- Patients can overlap with other models, *e.g.*, MSSP
- Beneficiaries must receive notification of hospital's participation in CJR-X prior to discharge

Risk Exposure

- Two-sided risk in all years for all participants
- ±20% risk for most hospitals (some may qualify for ±5% risk)

Episode Structure

- 90-day total cost of care episodes, includes Parts A & B
- Revenue cycle undisrupted

Target Price Calculation

- Starting point for all targets is multistate regional history
- Significant adjustments for patient characteristics & acuity (age group, social risk, specific HCCs)

Quality Measures

- Five measures in three domains
- Poor quality scores could disqualify hospital from earning bonuses

Key Changes in the 2027 IPPS Final Rule

What CMS locked in—and what it weighed but set aside—for the CJR-X Model

Finalized by CMS

- **Start Delayed to January 1, 2028**
  A three-month push from the proposed October 1, 2027 launch, giving hospitals more runway to prepare.
- **Calendar-Year Alignment**
  Performance and baseline years now follow the calendar year instead of the fiscal year.
- **Direct CJR-X vs. TEAM Comparison**
  Calendar alignment lets CMS compare LEJR episodes across both models on equal footing.
- **Seamless TEAM-to-CJR-X Handoff**
  When TEAM ends in 2030, its hospitals roll into CJR-X with no transitional “stub” year.

Considered—Not Finalized

- Making the model voluntary rather than mandatory
- An upside-only first performance year, mirroring TEAM
- Phasing in downside risk gradually over three years
- Phasing in mandatory participation over time
- Exempting safety-net, Medicare dependent, small rural, sole community, and essential access hospitals
- Adding outpatient total ankle arthroplasty to the model

CJR-X vs. CJR vs. TEAM: How the Models Compare

CJR-X pairs TEAM's risk adjustment approach with CJR's 90-day structure, requiring two-sided risk from Day 1, nationwide.

Dimension	CJR (2016–2024)	TEAM (2026–2030)	★ CJR-X (2028+)
1 **Episode Length**	90 days	30 days	**90 days**
2 **Episode Scope**	LEJR only (hip & knee, no ankle)	5 categories: LEJR, SHFFT, CABG, Spinal Fusion, Major Bowel	**LEJR only: hip & knee (IP & OP); ankle (IP only)**
3 **Risk Structure**	Upside-only PY 1, then flat	Two-sided for Tracks 2/3; Track 1 is upside-only	**Two-sided from Day 1—no glide path**
4 **Financial Protections**	Ramped 5%→20% (PY 2–5); 3%→5% safety-net/rural	10% (Track 1); 5% (Track 2, safety-net/rural); 20% (Track 3)	**20% most hospitals; 5% safety-net/rural—full risk in PY 1**
5 **Risk Adjustment**	Basic clinical adjustment (primarily fracture status & episode type)	Advanced patient- & hospital-level adjustment using HCCs, demographics, social risk, disability, & utilization history	**Comprehensive—same methodology as TEAM**
6 **Participation**	Mandatory in 34 MSAs (approx. 320 hospitals)	Mandatory in 188 CBSAs (approx. 700 hospitals)	**Mandatory nationwide (~2,500 hospitals)**
7 **Model Timing**	2016–2024	2026–2030	**Begins January 1, 2028; no end date**

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Why Does CJR-X Matter?

CMS has signaled **continued movement toward mandatory, two-sided financial risk for providers.**

Hospitals that meet applicable cost and quality criteria may be eligible for financial incentives; CJR-X also includes unique waivers & provider alignment opportunities.

Episodic strategies **support service line goals**, while also advancing other existing value-based & total-cost-of-care models like ACOs.

The Urgency of CJR-X

61%

Proportion of hospitals in 2023 that paid CMS a penalty for CJR

January 2028

Model start date; deadline to have operational requirements in place

$725M

Projected Medicare savings, PY 1–PY 5

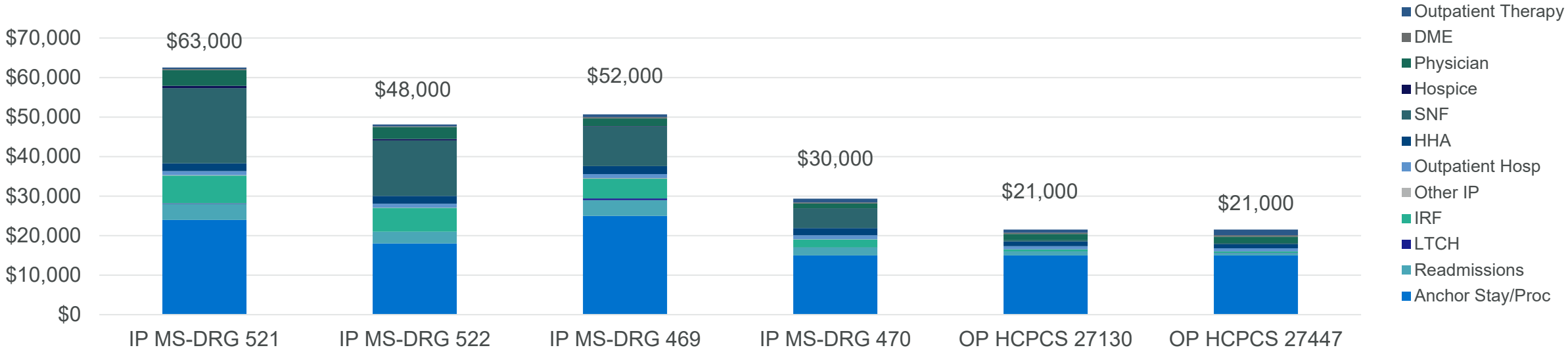
Two-Sided Risk

Starting Year 1 for all participants

Episode Group & Definitions

Episode Type	MS-DRG/HCPCS Code(s)
Inpatient Triggers: MS-DRG (4 codes)	
Major Hip & Knee Joint Replacement Procedures	MS-DRG 469 (w/MCC), MS-DRG 470 (w/out MCC); *includes Ankle Replacement*
Hip Fracture Procedures	MS-DRG 521 (w/MCC), 522 (w/out MCC)
Outpatient Triggers: HCPCS (2 codes) *Ankle Not Included*	
Total Knee Arthroplasty (TKA)	HCPCS 27447: billed via OPPS (HOPD)
Total Hip Arthroplasty (THA)	HCPCS 27130: billed via OPPS (HOPD)

Average Episode Expenditures by MS-DRG/HCPCS



Illustrative figures for discussion purposes only; derived from sample region.

Target Price Calculation

Regional Target Pricing

1

Regional Benchmark

Target prices are established at the U.S. Census Division level.

2

Three-Year Baseline

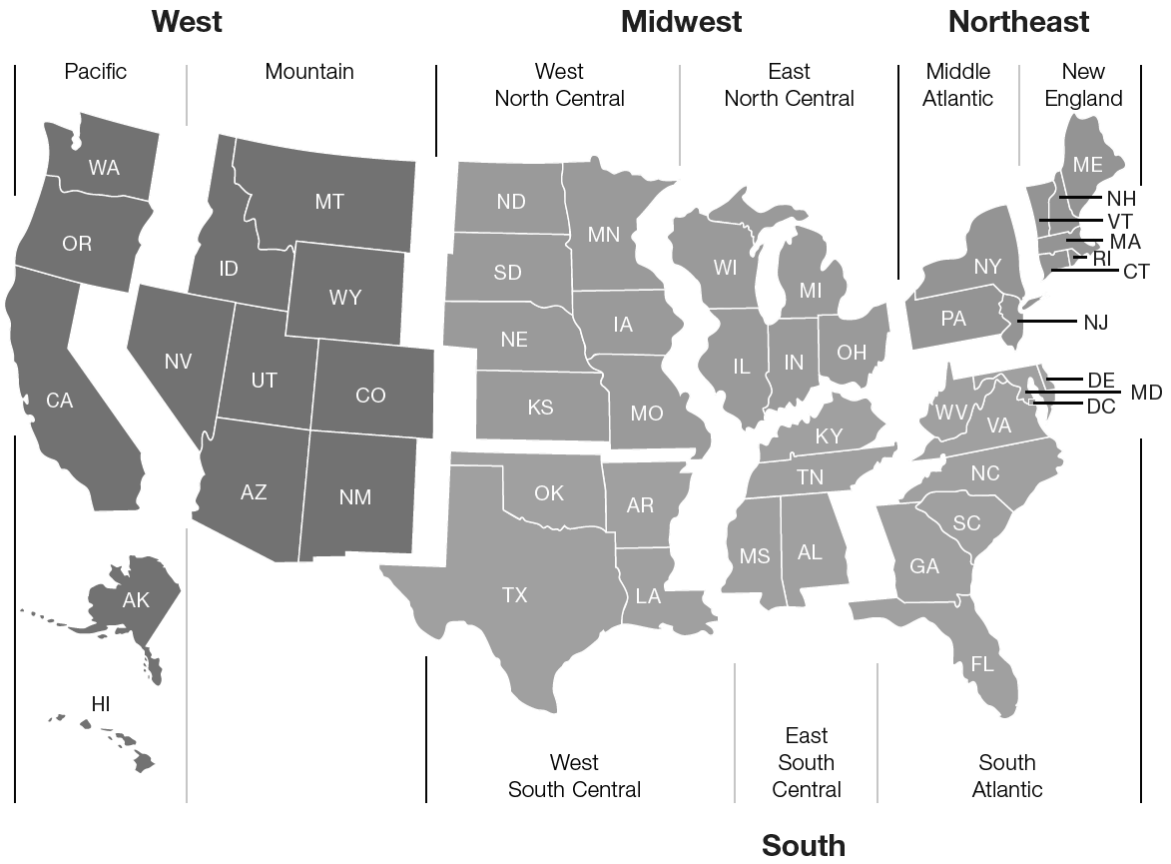
Based on Medicare fee-for-service episode spending across all hospitals in the region during the three years prior to the performance year.

3

Same Starting Line

Every hospital in a region starts from the same DRG/HCPCS benchmark, regardless of historical spending.

U.S. Census Divisions[1]



1. U.S. Energy Information Administration

Target Price Calculation

HCC Look-Back: HCCs documented by any provider in the 180 days preceding the episode count toward the target price.

How the Target Price Is Built

Regional Benchmark 1

Benchmark price for the DRG/HCPCS episode type in the census region (three-year baseline).

Baseline Weights
Year 3: 50% • Year 2: 33% • Year 1: 17%

Site-Neutral Targets 2

Site-neutral targets applied for certain HCPCS/DRG combinations within LEJR episode group.

Risk & Patient Adjustment 3

Hospital-level (bed size, safety-net), beneficiary-level (age, HCC count, social risk), and episode-group specific variables.

CMS Discount 4

Up to 2.0% CMS discount factor applied to all benchmarks (reduced from 3.0% in the original CJR Model).

Sample Target Price Calculation

For illustrative purposes only using hypothetical figures

$18,975	×	1.173	×	0.85	×	1.02	×	0.98	=	$18,911
Regional Price		**Patient/Hospital** Specific Adjustment		**Normalization** Factor		**Trend** Factor		**CMS** Discount		**Target Price**

Retrospective Adjustment: Target price can be adjusted by up to ±3% retrospectively.

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Risk Adjustment

CJR-X Episode Risk-Adjustment Factors & LEJR HCCs

CJR-X episodes are risk-adjusted for:

1. **Hospital Bed Size**
   & Safety-Net Adjuster
2. **Anchor Procedure Type**
   Ankle • Partial or Total Hip/Knee Arthroplasty
3. **Disability**
   Original Reason for Medicare Enrollment
4. **Prior Post-Acute Care Use**
   History Within Look-Back Window
5. **Patient Characteristics**
   Age • Dual Eligibility • Social Risk
6. **LEJR HCCs (180 Days Prior)**
   Count of HCCs + Specific HCCs Correlated to LEJR

HCCs Correlated to LEJR Procedures

Oncology

- HCC 17: Cancer metastatic to lung, liver, brain & other organs; AML (except promyelocytic)

Cognitive & Mental Health

- HCC 125/126/127: Dementia (severe/moderate/mild)
- HCC 151: Schizophrenia
- HCC 155: Major depression (moderate/severe)

Cardiovascular

- HCC 224: Acute on chronic heart failure
- HCC 225: Acute heart failure
- HCC 226: Heart failure (except end-stage)
- HCC 238: Specified heart arrhythmias
- HCC 267: DVT & pulmonary embolism

Renal

- HCC 326: Chronic kidney disease, Stage 5
- HCC 327: CKD, severe (Stage 4)

Metabolic

- HCC 36: Diabetes w/severe acute complications
- HCC 37: Diabetes w/chronic complications
- HCC 48: Morbid obesity

Neurological

- HCC 199: Parkinson & basal ganglia disease
- HCC 253: Hemiplegia/hemiparesis

Respiratory

- HCC 280: COPD, interstitial & other chronic lung disorders

Skin & Musculoskeletal

- HCC 383: Chronic skin ulcer (except pressure)
- HCC 402: Hip fracture/dislocation

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CJR-X Quality Measures

Quality measures will be linked to financial gains & losses in CJR-X. CMS proposes five measures in three domains.

Complications	Domain Weight: 50%
Inpatient: Hospital-Level RSCR Following Elective Primary THA &/or TKA (CMIT ID #350)	
Outpatient: Hospital Visits Within 7 Days of HOPD Surgery (CMIT ID #344, OP-36)*	

Patient Experience	Domain Weight: 40%
Inpatient: HCAHPS Survey (CMIT ID #338)*	
Outpatient: OAS CAHPS Survey (CMIT ID #162)*	

Patient-Reported Outcomes	Domain Weight: 10%
Inpatient & Outpatient: Hospital-Level THA/TKA PRO-PM (CMIT ID #1618)	

*Measure includes CJR-X & non-CJR-X patients

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CJR-X Quality Measures

Point Values for Quality Measures

Performance Percentile	RSCR THA/TKA (#350)	Hosp. Visits 7d HOPD (#344)	HCAHPS (#338)	OAS CAHPS (#162)	THA/TKA PRO-PM (#1618)
>90th	10.00	10.00	8.00	8.00	2.00
≥80th & <90th	9.25	9.25	7.40	7.40	1.85
≥70th & <80th	8.50	8.50	6.80	6.80	1.70
≥60th & <70th	7.75	7.75	6.20	6.20	1.55
≥50th & <60th	7.00	7.00	5.60	5.60	1.40
≥40th & <50th	6.25	6.25	5.00	5.00	1.25
≥30th & <40th	5.50	5.50	4.40	4.40	1.10
<30th	0.00	0.00	0.00	0.00	0.00

- Overall CQS = weighted average of inpatient & outpatient composite quality scores, capped at 20 points.
- Weighting reflects each hospital's proportion of inpatient vs. outpatient episode volume.
- Performance assessed against national distributions; hospitals without reportable values default to the 50th percentile.
- Quality improvement points are not included; CJR-X emphasizes absolute performance only.

Quality-Adjusted Discount Factor

A hospital's CQS determines both its eligibility for reconciliation payment & its effective discount factor.

CQS Impact on Reconciliation Payment Eligibility & Discount Factor

CQS	CQS Category	Eligible for Reconciliation Payment	Discount Factor
CQS ≤6.0	Below Acceptable	**No**	2.0%
CQS ≥6.1 & ≤12.0	Acceptable	**Yes**	2.0%
CQS ≥12.1 & ≤17.0	Good	**Yes**	1.0%
CQS ≥17.1	Excellent	**Yes**	0.0%

CJR-X Reconciliation Calculation Examples

"Acceptable" Quality

- Regional Benchmark Price: $22,000
- Discount factor: 2.0% (CQS ≥6.1 & ≤12.0)
- Reconciliation target price: $22,000 x 0.98 = $21,560
- Actual episode spend: $20,500
- NPRA: $21,560 – $20,500 = **$1,060 paid to the hospital**

"Excellent" Quality

- Regional Benchmark Price: $22,000
- Discount factor: 0.0% (CQS ≥17.1)
- Reconciliation target price: $22,000 x 1.00 = $22,000
- Actual episode spend: $20,500
- NPRA: $22,000 – $20,500 = **$1,500 paid to the hospital**

Risk Structure

CJR-X applies two-sided risk to all participants starting Performance Year 1

NO upside-only option in PY 1 • Risk limits vary based on hospital classification

Reduced Risk — Safety-Net • Rural • MDH • SCH • EACH

5%

Stop-Gain/Stop-Loss

- Two-sided risk starting PY 1 (2028)
- Stop-gain/stop-loss capped at 5% of aggregate reconciliation target prices
- Reduced exposure protects vulnerable providers

Full Exposure — All Other CJR-X Participants

20%

Stop-Gain/Stop-Loss

- Two-sided risk starting PY 1 (2028)
- Stop-gain/stop-loss capped at 20% of aggregate reconciliation target prices
- Full symmetric risk/reward exposure

CJR-X Risk Exposure Scenario

Annual Volume: 200 episodes • Total Program Size: $4,434,176

5% Stop-Gain	5% Stop-Loss	20% Stop-Gain	20% Stop-Loss
$217,159	($217,159)	$868,635	($868,635)
Reduced risk participants	Reduced risk participants	Standard participants	Standard participants

Assessing Your Readiness

Assessing Your Current Performance & Readiness

CJR-X has no upside-only transition period—assessment needs to happen before January 1, 2028, not after.

1

Where Do You Stand Today?

Review your organization's LEJR claims:
episode volume, spend by category, & current discharge patterns.

2

How Do You Compare?

Benchmark cost, quality, & post-acute utilization against regional & regionally efficient peers.

3

What's Your Risk Exposure?

Model your target price under CJR-X's methodology to estimate PY 1 financial exposure before go-live.

4

Where Are the Gaps?

Identify specific cost, quality, & post-acute gaps to close before mandatory participation begins.

Why this is different from TEAM: TEAM hospitals had a full performance year of upside-only risk to learn the model. CJR-X hospitals are financially at risk from the very first episode—there is no equivalent trial period.

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How to Prepare for CJR-X

Now
Current State Assessment

Purpose: Assess your current performance in CJR-X episodes & areas for improvement to develop strategies for the model.

- Financial Projections
- Risk Adjustment/Stratification
- Care Setting Optimization
- Provider Alignment/Intelligence
- Discharge Planning
- Coordination of Care
- Outcomes Management
- Quality Measure Results
- Model Requirement Readiness

2026–2027
Implementation Planning

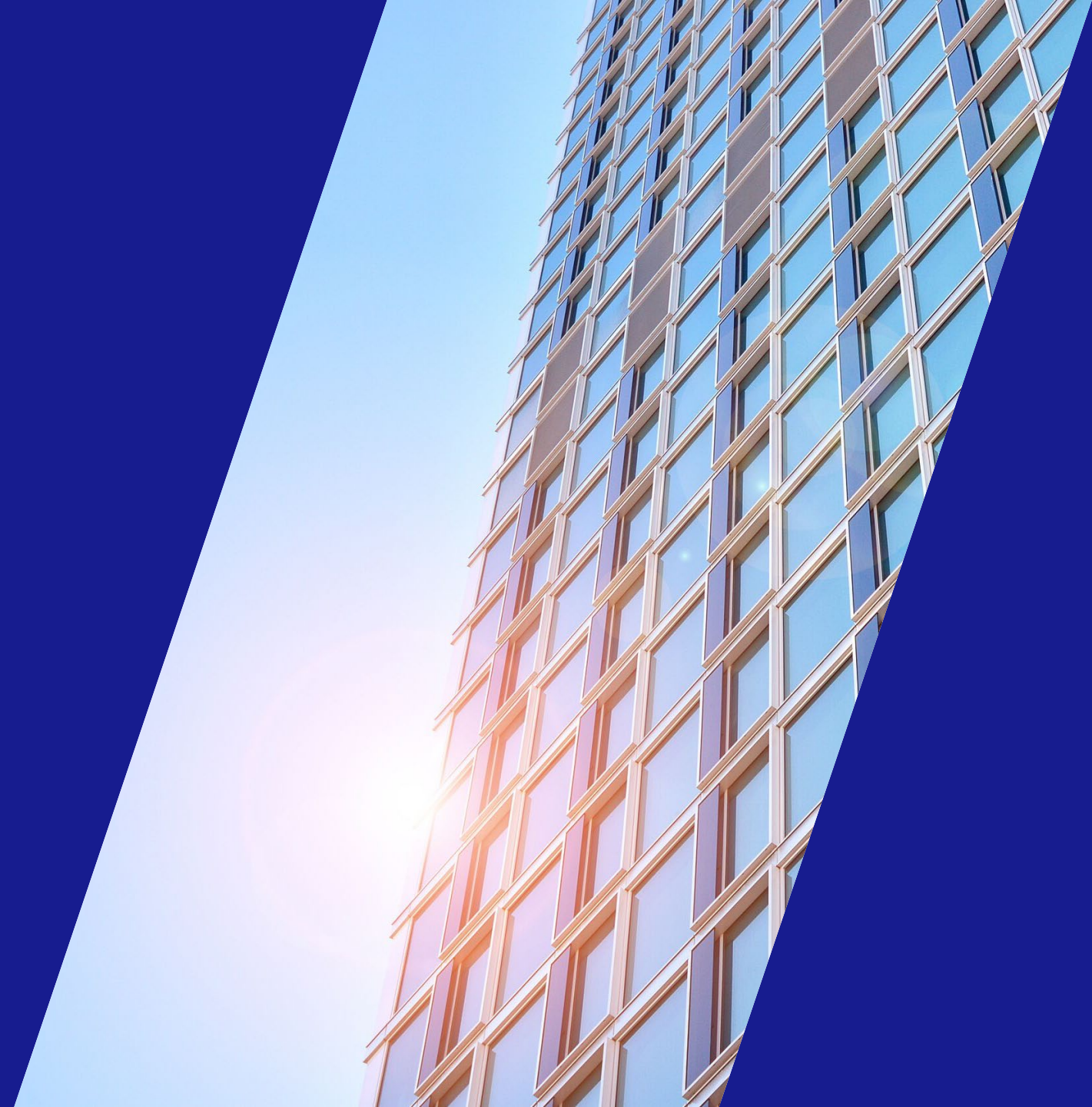
Purpose: Implement strategies to improve performance in areas identified in current state assessment & comply with model requirements.

- Patient Optimization
- Site-of-Care Shift
- Post-Acute Utilization
- Quality Improvement

2028 & Beyond
Ongoing Monitoring

Purpose: Track performance & identify areas for improvement across the care continuum.

Critical Success Factors



What Separated High vs. Low Performers

Capabilities that drove performance in the original CJR Model

High performance reflected disciplined execution across surgeons, pathways, post-acute networks, & data infrastructure.

High-Performing Organizations

- Surgeon alignment around standard pathways
- Preferred post-acute network strategy
- Reliable care management infrastructure
- Transparent data to identify variation
- Cross-functional accountability

Common Readiness Gaps

- Limited surgeon engagement
- Weak post-acute oversight
- Fragmented discharge planning
- Delayed or incomplete episode data
- Variation not managed in real time

Executive Takeaway
Capabilities that once differentiated high performers are now table stakes.

Identify Sources of Financial Risk
Financial risk & margin opportunity in CJR-X

A focused set of levers can significantly influence upside or downside.

Primary Cost Drivers

- Post-acute utilization patterns
- Length-of-stay variation
- Discharge destination mix
- Additional hospital admissions
- Episode management consistency

Where Risk Emerges

- Post-acute utilization
- Avoidable inpatient days
- Inconsistent post-discharge management
- Avoidable readmissions
- Limited visibility into variation

Priority Areas for Intervention

- Target resources toward greatest impact drivers
- Right-setting post-acute discharge strategy
- Reduced variation in care pathways
- Managing high risk episodes
- Targeted management of high-cost episodes

Executive Takeaway
A small number of levers will determine most of the upside—or downside.

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Operating Model for CJR-X Success
Moving from program management to 90-day episode ownership

CJR-X readiness may benefit from a deliberate operating model shift.

1

Governance

- Define one accountable owner for the 90-day episode
- Executive oversight across finance, operations, & clinical
- Set issue escalation & performance review rhythms

2

Clinical Model Evolution

- Preoperative optimization
- Standardized discharge planning
- Home-first care model when clinically appropriate
- Pathways that reduce avoidable variation

3

Cross-Continuum Execution

- Real-time data visibility
- Post-discharge care management
- Active management of SNF, home health, & readmission risk
- Closed-loop feedback to surgeons & care teams

Operating model maturity

Executive Takeaway
Operating model changes may help support CJR-X readiness.

Why Quality Matters More Than Most Hospitals Expect
CQS can influence how much financial performance is ultimately realized

Cost efficiency creates the opportunity; quality performance helps protect the value of that opportunity during reconciliation.

Why Quality Can Get Overlooked

Preparation often concentrates on target price performance, post-acute spend, LOS, & utilization management—because those levers are visibly tied to episode cost.

Why That Creates Risk

Poor CQS performance can reduce the quality adjustment & limit the amount of savings a hospital ultimately realizes.

What Leaders Should Manage

Treat quality as an integrated financial lever—not a separate clinical scorecard or year-end reporting exercise.

Financial Reality

Strong Cost Performance + Weak Quality

- Reduced quality adjustment
- Reconciliation value at risk
- Savings may not fully translate to margin

Strong Cost Performance + Strong Quality

- Maximum quality opportunity
- Improved reconciliation outcome
- Greater realized margin opportunity

Executive Takeaway
Managing cost may create savings opportunities. Managing quality may help preserve reconciliation value.

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Practical Next Steps

Governance Structure

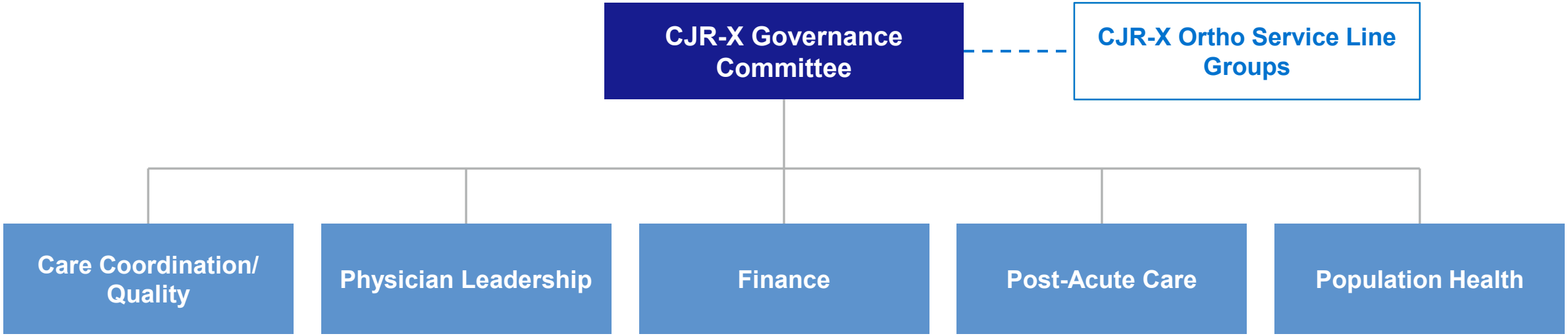
Recommended CJR-X Governance

Governance Committee

Senior leaders meet monthly to review performance data, identify improvement opportunities, & engage service lines to execute improvement strategies.

Service Line Groups

Administrative, clinical, & physician leaders engage every other month or as needed to review service-line-specific data & implement action steps directed by the committee.



If You Do Only Four Things
Priority actions for CJR-X readiness

Organizations may benefit from prioritizing key readiness actions rather than addressing all areas at once.

1 Build Data, Analytics, & Quality Infrastructure

- Establish baseline episode cost & utilization analytics
- Ingest claims data & monitor performance after go-live
- Create transparent dashboards to identify variation & trends
- Assess readiness to report required quality measures

Action Focus:
Data, Analytics, & Quality Readiness

2 Redesign Discharge as a Financial Strategy

- Patient-centered discharge planning
- Intentional PAC utilization management
- Reduced avoidable PAC variation

Action Focus:
Post-Acute Optimization

3 Align Surgeons to Standardized, Risk-Based Pathways

- Reduced clinical variation
- Shared accountability for episode outcomes
- Data-driven behavior reinforcement

Action Focus:
Physician Alignment

4 Establish a Single Owner of the 90-Day Episode

- Clear accountability across the continuum
- Connected finance, clinical, & operational decisions
- Performance monitoring beyond discharge

Action Focus:
Governance & Accountability

Prioritize these four actions in the first 90–180 days to establish visible, accountable, repeatable CJR-X performance management.

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Wrap-Up

What health systems need to know as CJR-X moves toward January 1, 2028

1

Mandatory & nationwide, starting January 1, 2028

~2,500 hospitals will be accountable for hip & knee replacement episodes (inpatient & outpatient), plus inpatient-only ankle replacement.

2

CJR-X introduces immediate two-sided risk from Day 1

CJR-X pairs TEAM's comprehensive risk adjustment with CJR's 90-day episode—but applies two-sided risk immediately, with no upside-only glide path.

3

There is no grace period—assess readiness now

Benchmark your current cost, quality, & post-acute performance against regional peers before January 2028, not after.

4

A small number of levers drive most of the outcome

Post-acute utilization, length of stay, discharge destination, & rehospitalizations concentrate most of the risk—managing them well is now table stakes, not a differentiator.

5

If you do only four things, do these

Develop a data infrastructure plan, redesign discharge as a financial strategy, align surgeons to standardized pathways, & name a single owner of the 90-day episode.

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Contact

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Questions?

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