Coming Soon to an Acute Care Hospital Near You: CMS's Proposed Mandatory CJR-X Model

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The sequel to CMS's Comprehensive Care for Joint Replacement ("CJR") model is arriving in Fall, 2027. CMS has proposed the Comprehensive Care for Joint Replacement Expansion ("CJR-X") model, a new expansion to the CJR bundled payment model. Once finalized, CJR-X would be effective on October 1, 2027 and would be mandatory for all acute care hospitals, with few exceptions.

Previous CJR Model

CMS implemented the previous CJR model from April 1, 2016, to December 31, 2024.[i] The CJR model required bundled payments for lower extremity joint replacement care episodes, including hip, knee, and ankle replacements.[ii] By the end of the performance period, CJR was implemented in 324 hospitals in 34 designated metropolitan statistical areas.[iii] The CJR model held participating hospitals financially accountable for episodes of care, including the 90 days following discharge from inpatient hospitalization or the outpatient procedure.[iv]

CMS previously used two quality measures to evaluate participant quality: the THA/TKA Complications Measure and the Hospital Consumer Assessment of Healthcare Providers and Systems Survey.[v] The participants' composite quality score ("CQS") was linked to reconciliation payment under a pay-for-performance methodology in which participants were assigned a category and payment discount corresponding to performance quality.[vi] Participants' quality measure data was made publicly available annually.[vii] CMS established target pricing for the bundled payment model prospectively, taking into account historical spending and regional spending data.[viii] At the end of a performance year, the participant's actual spending for episodes was compared to the target price, and the participant received a reimbursement or owed a repayment to CMS.[ix]

Proposed CJR-X Model

Under the proposed rule, not only would CJR-X become effective in October, 2027, but it would be mandatory for all except for a limited few categories of acute care hospitals.[x] In particular, the facilities exempted from the mandatory rule would include Maryland hospitals, certain rural and critical access hospitals, and TEAM participants.[xi] Once the TEAM model ends on December 31, 2030, TEAM participants would be required to participate in the CJR-X model.[xii] Just like the original CJR, CJR-X covers lower extremity joint replacement care episodes,[xiii] which include the 90 days following

inpatient hospital discharge or the date of the outpatient procedure.[xiv] To address a concern that CJR-X participants might seek financial gain by delaying medically necessary care until after the 90-day episode window, CMS proposes to implement the same protective mechanism as it did under the CJR model. [xv] In particular, CMS will calculate the average total Medicare Part A and Part B expenditures in the 30-day period following each episode of care for all services covered under Medicare Part A and Part B for the Performance Year, regardless of whether the service would have been part of the CJR-X episode spending calculation.[xvi] Then, if the CJR-X Participant's average post-episode spending exceeds CMS' regional average threshold, the CJR-X participant would repay Medicare the amount that exceeds such a threshold. Importantly, consistent with the method applied in the CJR model, this amount would not be subject to the proposed stop-loss limits.[xvii]

CJR-X would use five quality measures to evaluate participants and determine their Composite Quality Score (CQS), a measure that impacts the target price that determines the CJR-X Participant's reconciliation or repayment amount.[xviii]

- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
- Hospital Visits Within 7 days of Hospital Outpatient Department (HOPD) Surgery
- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)
- Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS)
- Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO)-Based Performance Measure[xix]

These proposed measures include three new quality measures (RSCR, HOPD, and OAS CAHPS) that were not in the original CJR model. Beginning in 2029, participants' CQSs would be publicly reported with a 1-year lag to increase transparency and educate the public.[xx] Participants' CQSs would be linked to payment discounts under similar measures and categories as the original CJR model:

- "Excellent" – quality score greater than or equal to 17.1 would be eligible for a reconciliation payment if actual episode spending were less than the reconciliation target price and a 0.0% discount factor
- "Good" – quality score from 12.1 to 17.0 would be eligible for a reconciliation payment if actual episode spending were less than the reconciliation target price and a 1.0% discount factor
- "Acceptable" – quality score from 6.1 to 12.0 would be eligible for a reconciliation payment if actual episode spending were less than the reconciliation target price, but would not be eligible for a discount factor reduction
- "Below Acceptable" – quality score less than or equal to 6.0 would not be eligible for discount factor reduction or reconciliation payment[xxi]

CMS would establish target pricing for each participant prospectively based on the episode type and hospital's geographic region.[xxii] Pricing would be adjusted retrospectively based on the episode, performance year, and any quality-based discount above.[xxiii] CJR-X would include stop-loss and stop-gain limits on the total amount a participant would owe as repayment or receive as a reconciliation payment to avoid unmanageable risks and to prevent lesser care.[xxiv]

CJR-X would also allow financial sharing arrangements with key suppliers and providers (collaborators) to align financial incentives and support quality care.[xxv] Participants would remain the sole risk-bearing entity under CJR-X, but participants could share upside risks and downside risks with CJR-X collaborators.[xxvi] Any financial sharing arrangements must comply with applicable fraud and abuse laws, payment and coverage requirements, and record-keeping requirements for any CMS evaluation, monitoring, compliance, and enforcement activities.[xxvii] Both the participant and any CJR-X collaborator's compliance programs must have oversight over any financial sharing arrangements to provide a program integrity safeguard.[xxviii] The participant's board or governing body would be responsible for oversight of the participant's participation, financial arrangements, gainsharing and alignment payments, and beneficiary incentives.[xxix]

CMS expects to make a determination that the Federal Antikickback safe harbor for CMS-sponsored model arrangements will be available to protect renumeration in the following way for the following types of arrangements, so long as the arrangements meet all of the safe harbor requirements: 1) gainsharing and alignment payments supplied as part of sharing arrangements; and 2) distribution payments supplied as part of distribution and downstream distribution arrangements.

As in the original CJR model, CMS also expects to waive certain Medicare program requirements to provide flexibility, including certain post-discharge home visits during the episode, telehealth restrictions, and the 3-Day Skilled Nursing Facility rule. [xxx] CMS specifically requested comments on possible waivers which would allow participants flexibility to improve care and reduce unnecessary spending.[xxxi]

Conclusion

The proposed CJR-X model represents a shift away from voluntary bundled payment models and a trend toward mandatory bundled payments. Public comment on the proposed rule closed on June 10, 2026. If you have any questions or need further guidance regarding CMS's proposed CJR-X model, please contact Mary Malone.

[i] Centers for Medicare and Medicaid Services, *Comprehensive Care for Joint Replacement Model*, CMS.Gov (last visited June 15, 2026), https://www.cms.gov/priorities/innovation/innovation-models/cjr.
[ii] *Id.*
[iii] *Id.*
[iv] *Id.*
[v] Centers for Medicare and Medicaid Services, *Overview of CJR Quality Measures*, CMS.Gov (last visited June 15, 2026), https://www.google.com/goto?url=CAESeQHuR6pNIi4lddhfUGYF5FpiCYXQ7Zv8Iljc3LwLPRr6ehrpN9g-YoOIfDbphiGLrD4wlQtQ21tSxFgs7YaMc0oUwL9J3_rtGpBJcMxG6fRb3yPDvZuaWXnJnxis2-Mzoc8tOZiFYB4SyNny-Sum4DOAVPQVOdTmFug=
[vi] *Id.* at 10.

[vii] *Id.* at 16.
[viii] Centers for Medicare and Medicaid Services, *Comprehensive Care for Joint Replacement Model*, CMS.Gov (last visited June 15, 2026), https://www.cms.gov/priorities/innovation/innovation-models/cjr.
[ix] *Id.*
[x] Payment System Policy Changes, Requirements for Quality Programs, & Other Policy Changes, 91 Fed. Reg. 19764-75 (Apr. 10, 2026).
[xi] *Id.* at 19675.
[xii] *Id.*
[xiii] *Id.* at 19678.
[xiv] *Id.* at 19680.
[xv] *Id.* at 19702.
[xvi] *Id.*
[xvii] *Id.*
[xviii] *Id.* at 19686-87.
[xix] *Id.* at 19682.
[xx] *Id.* at 19686.
[xxi] *Id.* at 19700-01.
[xxii] *Id.* at 19692.
[xxiii] *Id.* at 19690-91.
[xxiv] *Id*. at 19702.
[xxv] *Id.* at 19704.
[xxvi] *Id.* at 19705.
[xxvii] *Id.* at 197705-06.
[xxviii] *Id.* at 19706.
[xxix] *Id.* at 19706-07.
[xxx] *Id.* at 19714.
[xxxi] *Id*.