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CMS Finalizes Mandatory Nationwide Bundle for Joint Replacement

On July 31, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2027 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS final rule.[1] Alongside a 2.3% increase to IPPS payment rates, the rule finalizes the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model, the first episode-based payment model that Medicare will require most acute care hospitals nationwide to join.[2] Beginning January 1, 2028, CJR-X will hold participating hospitals financially accountable for the cost and quality of lower extremity joint replacement (LEJR) episodes for a period of 90 days beyond discharge. This Health Capital Topics article reviews the finalized model, the revisions CMS made in response to public comment, and the questions the model raises for hospitals and for the physicians and post-acute providers who treat their patients.

From CJR to CJR-X

CMS established the original CJR Model in a 2015 final rule, which required hospitals in 67 randomly selected metropolitan statistical areas (MSAs) to accept accountability for LEJR episodes beginning April 1, 2016.[3] CMS later extended the model for three additional performance years and revised its episode definition and pricing methodology; the model concluded on December 31, 2024.[4] CMS reported that the model produced approximately $112.7 million in net savings to Medicare in 2021 through 2023, while quality of care held steady.[5]

CJR-X is not the only mandatory Medicare value-based payment model concerning LEJR episodes. In the FY 2025 IPPS final rule, CMS established the Transforming Episode Accountability Model (TEAM), a mandatory model that began January 1, 2026 and runs through December 31, 2030 for hospitals located in selected core-based statistical areas.[6] TEAM covers five surgical episode categories, including LEJR, and measures spending over a 30-day post-discharge window.[7] Because CMS excluded TEAM participants from CJR-X, joint replacement care furnished to Medicare beneficiaries will soon fall under two mandatory episode models with different accountability periods and different pricing methodologies, depending on where the hospital is located.

Scope and Participation

CJR-X applies nationwide to acute care hospitals paid under both the IPPS and the Outpatient Prospective Payment System (OPPS).[8] Three groups are exempt from the model: hospitals participating in TEAM; hospitals in Maryland, which operates under a statewide all-payer model; and providers not paid under both prospective payment systems, a category that includes critical access hospitals and rural emergency hospitals.[9]

Episodes begin with an anchor inpatient admission assigned to Medicare Severity Diagnosis Related Group (MS-DRG) 469, 470, 521, or 522, or with an outpatient hip or knee arthroplasty billed under Healthcare Common Procedure Coding System (HCPCS) code 27130 or 27447, and run through the 90 days following discharge.[10] Episodes capture related Medicare Part A (hospital) and Part B (physician) spending across that window, including post-acute care, readmissions, and physician services.

CJR-X also notably includes outpatient procedures. CMS removed total knee arthroplasty from the Medicare inpatient-only (IPO) list in 2018 and total hip arthroplasty in 2020, and a substantial share of joint replacement volume has since migrated to hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs).[11] Anchoring episodes in both settings prevents hospitals from shedding accountability through site-of-service decisions, although procedures performed in freestanding ASCs remain outside the model.

To support care redesign, CMS will waive certain Medicare payment requirements for CJR-X episodes, including the requirement of a three-day inpatient stay before a covered skilled nursing facility (SNF) admission, and restrictions that would otherwise limit post-discharge home visits and telehealth services.[12]

Pricing, Risk, and Quality

CMS will set preliminary, prospective target prices at a regional level, applying trend and normalization factors, MS-DRG and Ambulatory Payment Classification (APC) update factors, and risk adjustment.[13] The most significant methodological departure from the original CJR model is the expansion of risk adjustment from three variables to 29.[14] The finalized adjusters include hospital bed count, the hospital's share of dually eligible beneficiaries, patient age, disability status, procedure

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type, prior post-acute care use, chronic condition count, and 21 Hierarchical Condition Category flags.[15]

CMS will reconcile actual episode spending against target prices annually. A hospital whose spending falls below its target may receive a reconciliation payment, and a hospital whose spending exceeds the target may owe a repayment. Quality performance modulates that calculation. CMS finalized five quality measures:

(1) The hospital-level risk-standardized complication rate following elective primary total hip and total knee arthroplasty;
(2) Hospital visits within seven days of outpatient surgery;
(3) The Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
(4) The Outpatient and Ambulatory Surgery CAHPS survey; and
(5) A patient-reported outcome-based performance measure for hip and knee arthroplasty.[16]

Those measures combine into a composite quality score that adjusts the discount factor applied at reconciliation, and a hospital that fails to meet a minimum composite score cannot earn any reconciliation payment.[17]

CMS also finalized protections for providers with a limited ability to absorb downside risk. Safety net hospitals serving a high proportion of dually eligible beneficiaries, geographically rural hospitals, Medicare-dependent small rural hospitals, and sole community hospitals receive a 5% stop-loss limit (which caps a hospital's downside exposure, meaning these hospitals will never owe CMS more than 5% of those target prices for the performance year, however far actual spending runs above the benchmark), and the rule adopts separate pricing policies for low volume hospitals.[18]

Changes from the Proposed Rule and Industry Response

The most visible change between the proposed and final rule concerns timing. CMS had proposed an October 1, 2027 start date, which would have aligned the first performance period with the federal fiscal year.[19] Hospitals and trade associations objected that the timeline left too little room to build the analytic and care management infrastructure the model requires, and CMS moved the start to January 1, 2028, placing performance periods on a calendar-year basis.[20] The model's structure otherwise emerged from the comment process largely intact.

Hospital groups continue to question mandatory participation itself. The American Hospital Association argued that flexibility remains critical because some hospitals lack the scale or the financial capacity to make the investments episode accountability demands, and the Federation of American Hospitals objected to the imposition of a one-size-fits-all model as uncompensated care burdens rise.[21]

Implications for Providers

Because CJR-X episodes run 90 days past discharge, the model reaches well beyond the operating room. Post-acute utilization drove much of the savings attributed to the original CJR Model, and hospitals facing repayment exposure have an incentive to shift discharges from institutional post-acute care toward home health and self-care, to narrow referral networks to preferred SNFs, and to manage readmissions more closely. SNFs and home health agencies in markets that have not previously faced episode-based scrutiny may see referral volume and case mix change accordingly.

The model also raises familiar questions about physician alignment. A hospital bearing episode risk cannot influence implant selection, surgical technique, or discharge planning without the cooperation of the orthopedic surgeons who make those decisions, and gainsharing and co-management arrangements are the customary vehicles for securing it. Legal counsel observed that hospitals have long used orthopedic co-management arrangements to tie surgeon compensation to quality and efficiency, and that those existing structures may offer the most efficient starting point for CJR-X once CMS finalizes the model's collaborator and payment-sharing provisions.[22] Arrangements that distribute model savings to physicians remain subject to the federal Anti-Kickback Statute and Stark Law, and compensation under those arrangements must be consistent with Fair Market Value and Commercially Reasonable. The value-based enterprise exceptions CMS adopted in 2020 relieve qualifying arrangements of the Fair Market Value and set-in-advance requirements.[23] CMS and the Office of Inspector General (OIG) jointly waived certain fraud and abuse requirements for the original CJR Model, but CMS has not yet finalized comparable waivers for CJR-X.[24]

Conclusion

CJR-X marks a shift in the CMS Innovation Center's approach to episode payment. Earlier models tested voluntary participation, or mandatory participation confined to selected geographies. Together with TEAM, CJR-X makes episode accountability a default condition of Medicare participation for most hospitals that perform joint replacements, and it does so for a procedure group that has already moved substantially into the outpatient setting.

Whether the model reproduces at national scale the savings CMS observed under CJR remains an open question. The original model operated in 67 MSAs among hospitals with meaningful joint replacement volume, and its results may not transfer to hospitals with thinner volume, fewer post-acute alternatives, and less analytic capacity. CMS has built stop-loss protections and expanded risk adjustment to address that concern. The first reconciliation results, which will not arrive until 2029, will indicate how well those protections perform.

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