CJR-X: From Episode Rules to Rehabilitation Action

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Learning Outcomes

- Analyze how the CJR-X Model's scope, eligibility rules, and 90-day episode timeframe alter care delivery responsibilities across acute and postacute settings
- Analyze how regional target prices, risk adjustment, the 2% discount, the Composite Quality Score, and annual reconciliation determine a participant hospital’s opportunity for payment or obligation to repay Medicare
- Distinguish between the inpatient and outpatient CJR-X quality measures, and the operational practices that support complications, performance, patient experience, and patient-reported outcomes
- Apply patient-specific clinical and social risk information to select safe, cost-effective rehabilitation and postacute pathways for low-risk elective, moderate-risk elective, high-risk elective, and unplanned fracture episodes
- Construct a cross-continuum CJR-X readiness plan that defines the roles, data, care pathways, escalation processes, and performance expectations needed among hospitals, physicians, therapists, home health agencies, and skilled nursing facilities

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Course Roadmap: 70-Minute Lecture + 20-Minute Q&A

- **Chapter 1:** CJR-X: Scope and Financial Mechanics
- **Chapter 2:** Quality, Patients, and Clinical Pathways
- **Chapter 3:** From Rules to Action
- **Q&A:** Application to your setting

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Chapter 1

CJR-X: Scope and Financial Mechanics



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What CJR-X Is and Is Not

It Is

- A mandatory hospital-centered episode model
- Accountability for LEJR cost and quality
- A quality-adjusted retrospective reconciliation

It Is Not

- A single bundled check paid to every clinician
- A replacement for Medicare FFS billing
- Permission to reduce medically necessary care

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FY2027 Proposed Rule → Final Rule

Provision	Proposed Rule	Final Rule
Start date	October 1, 2027	January 1, 2028
Performance years	Aligned to the fiscal year	Aligned to the calendar year
Postdischarge accountability	—	Retain 90-day accountability
Quality performance periods	Use existing CMS schedules	Conform to the revised start date
TEAM overlap attribution	Propose attribution rules	Finalize without modification

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Who Participates?

Participant	An acute care hospital eligible for both IPPS and OPPS that initiates CJR-X LEJR episodes
Mandatory Nationwide Model	Most eligible hospitals in the 50 states, the District of Columbia, and US territories
Excluded	TEAM participants and hospitals located in Maryland; other exceptions as defined in the final rule
Clinicians	Not individually enrolled; therapists and other providers support episodes through care delivery and collaboration

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What Starts an Episode?

Inpatient Anchor

- Admission to an IPPS hospital for a qualifying LEJR procedure
- The episode begins with the anchor hospitalization
- Part A and B episode services are included, subject to exclusions

Outpatient Anchor

- Qualifying TKA or THA in a hospital outpatient department
- The episode begins with the anchor procedure
- An ASC procedure does not initiate a CJR-X episode

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CJR-X Anchor Codes

Setting	Code	Description
Inpatient MS-DRGs	469	Major hip/knee replacement or reattachment with MCC, or total ankle replacement
	470	Major hip/knee replacement or reattachment without MCC
	521	Hip replacement for hip fracture with MCC
	522	Hip replacement for hip fracture without MCC
Hospital Outpatient HCPCS	27130	Total hip arthroplasty
	27447	Total knee arthroplasty

- Outpatient claims use HCPCS codes, not DRGs
- Total ankle replacement is an inpatient anchor

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Accountability and Incentives

The Hospital is Accountable for the Total Episode Spending While All Providers Bill Medicare As Usual

The Acute Care Hospital

At-risk entity: accountable for the total episode cost and quality vs. the target price

Surgeons

Continue billing Medicare FFS (Part B)

Outpatient PT

Continue billing Medicare FFS (Part B)

Home Health

Continue billing Medicare under HH PPS

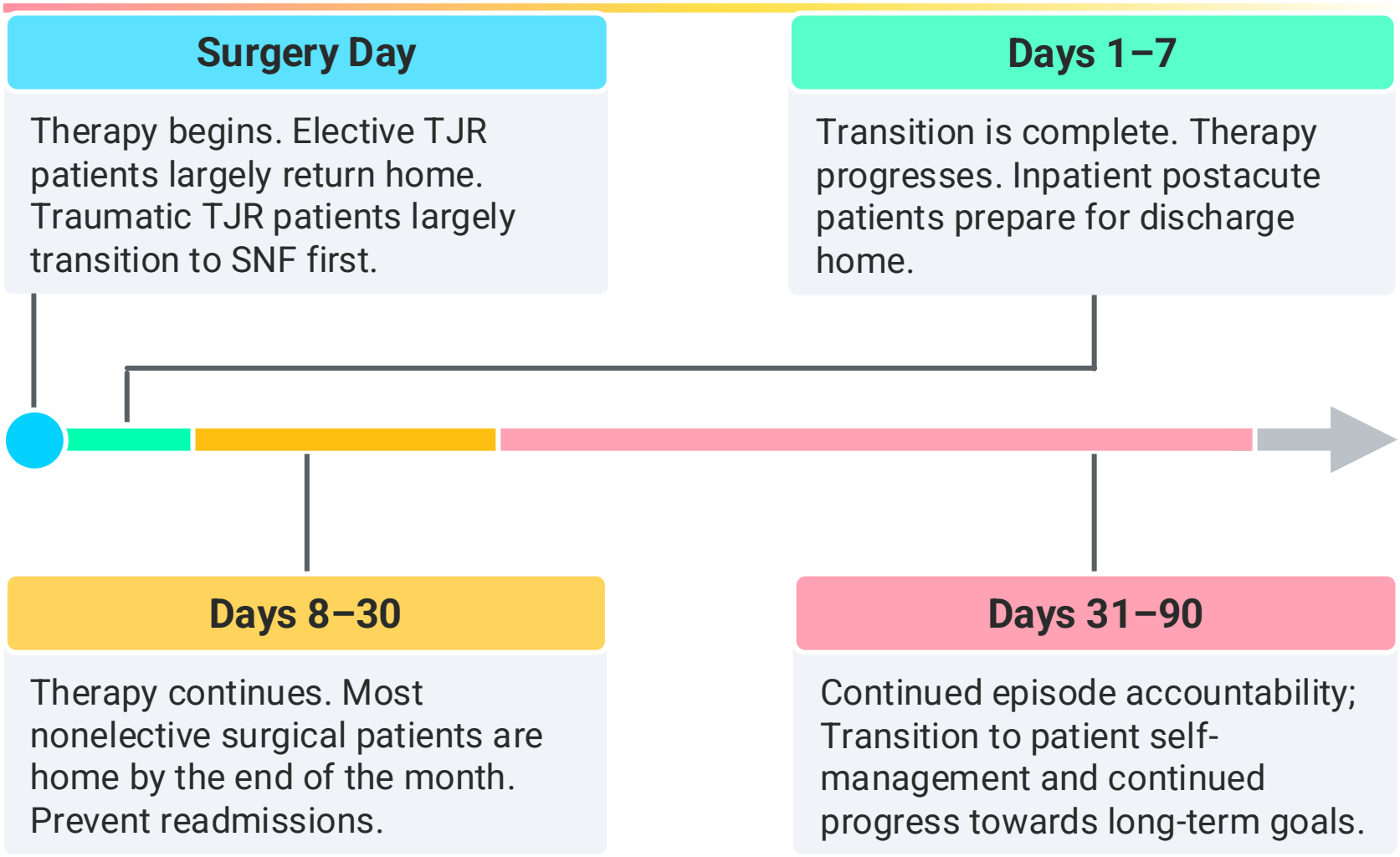
SNFs/Postacute

Continue billing Medicare FFS

Alignment happens by contract: Hospitals use gainsharing / collaborator agreements to share savings (and, in some designs, downside) with physicians and postacute partners, but CMS's financial relationship stays with the hospital

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Elective Hip and Knee Recovery Has Moved to HOPD and Recovery at Home



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What Spending Is in the Episode?

- Medicare Part A and Part B items and services associated with the episode are generally included
- The final rule specifies exclusions and adjustments, including certain unrelated services and add-on payments
- Claims continue to flow through existing Medicare payment systems
- CMS later compares aggregated episode spending with reconciliation target prices

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Target Prices: A Benchmark, Not a Patient Bill

Build the Benchmark

- Three-year regional baseline
- Prospective trend and normalization
- Episode type and region

Adjust and Reconcile

- Beneficiary and hospital risk adjustment
- 99th-percentile high-cost outlier cap
- Preliminary 2% discount
- Quality-adjusted discount at reconciliation

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Risk Adjustment: Fairness Across Patients and Hospitals

Beneficiary Factors	HCC count, age bracket, economic risk, disability, prior postacute care, and specified clinical conditions
Hospital Factors	Bed size and safety net adjustment
Clinical Implication	Accurate history, assessment, and discharge planning make complexity visible
Guardrail	Risk adjustment supports comparison; it never replaces individualized goals

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Reconciliation: From Performance to NPRA

Six Months After the Performance Year

- Aggregate reconciliation target prices
- Aggregate adjusted episode spending
- Subtract spending from target prices
- Apply CQS/discount factor
- Apply stop-gain, stop-loss, and outlier rules
- Issue reconciliation report and payment or repayment

- One formal reconciliation per performance year
- Monthly claims data feeds support monitoring
- Quality data comes through existing CMS programs
- Final payment can be positive or negative

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A Simple Reconciliation Example

- Aggregated reconciliation target prices: $10,000,000
- Adjusted performance-year episode spending: $9,700,000
- Pre-quality difference: $300,000 positive
- Quality adjustment: depends on CQS tier
- Final result: subject to the final rule’s limits and eligibility rules

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Financial Guardrails

Quality-Adjusted Discount

CQS	Discount
≥17.1	0%
12.1–17.0	1%
6.1–12.0	2%
≤6.0	2%, and no reconciliation payment eligibility

Limits and Protections

- Most participants: ±20% stop-gain/stop-loss
- Specified rural, safety net, MDH, and SCH categories: 5% loss cap
- 99th-percentile high-cost outlier cap
- Fewer than 31 baseline episodes: no target / no reconciliation eligibility

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Chapter 1 Summary

- CJR-X is mandatory for most eligible hospitals and begins January 1, 2028
- Four inpatient MS-DRGs and two hospital outpatient HCPCS codes initiate episodes
- The episode covers the anchor event and 90 days after discharge
- Target prices, risk adjustment, quality, and reconciliation work together

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Chapter 2

Quality, Patients, and Clinical Pathways

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The CQS Is a Quality Gate

Inpatient Composite	Outpatient Composite	Weight
Complication rate	Hospital visits within seven days	**50%**
HCAHPS	OAS CAHPS	**40%**
THA/TKA PRO-PM	THA/TKA PRO-PM*	**10%**

*Inpatient and outpatient are the same

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What Is Measured?

- Inpatient complication measure: risk-standardized complication rate following elective primary THA/TKA
- Outpatient utilization measure: hospital visits within seven days of HOPD surgery
- Inpatient experience: HCAHPS; outpatient experience: OAS CAHPS
- Patient-reported outcome: hospital-level THA/TKA PRO-PM
- Measures are drawn from existing CMS reporting programs; CJR-X does not require duplicate quality submissions

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Inpatient and Outpatient Quality Measures

	Quality Measure	What It Captures	Weight
Inpatient	Total hip arthroplasty (THA) / total knee arthroplasty (TKA) complications	Risk-standardized rate of mortality, myocardial infarction, pneumonia, sepsis, pulmonary embolism, bleeding, infection, and mechanical failure within 90 days of inpatient THA/TKA	50%
	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)	Patient perceptions of hospital experience (communication with nurses/doctors, discharge info, cleanliness, overall rating)	40%
	THA/TKA patient-reported outcome performance	Patient-reported functional outcomes following hip/knee replacement	10%
Outpatient	Hospital visits within seven days of hospital outpatient department surgery (OP-36)	Unplanned ED visits, observation stays, and inpatient admissions within seven days of outpatient THA/TKA	50%
	Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS)	Patient experience with outpatient/ ambulatory surgery	40%
	THA/TKA patient-reported outcome performance	Patient-reported functional outcomes following hip/knee replacement	10%

CMS, 2026b

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Percentiles Become Points

Relative Performance on Key Measures

Percentile	Points
≥90th	Highest points
50th–90th	Points rise in 10-percentile bands
30th–50th	Lowest score band
<30th	0 points

- CMS accounts for whether a higher or lower result is better
- Compared with hospitals nationwide
- Minimum case/survey thresholds
- CQS capped at 20 points

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Low Volume

- At least 25 eligible cases for complication, outpatient-visit, and PRO-PM measures
- At least 100 completed surveys for each patient-experience measure; these are broader hospital surveys
- Too few cases or surveys: CMS assigns that measure the 50th percentile points
- Separate payment rule: Fewer than 31 CJR-X baseline episodes means no target prices or reconciliation that year

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PRO-PM: The Patient's Voice

Collect

- Baseline function and symptoms
- Patient goals and expectations
- Explain the measure and support completion

Act

- Review reported pain and function
- Escalate unexpected change
- Use patient-reported information in shared decisions

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Clinical Guardrail: Function, Safety, and Choice

- Prevent avoidable complications through evidence-informed mobility, education, and escalation
- Match discharge setting to clinical need, support, and patient preference, not a financial target alone
- Document goals, barriers, response to treatment, and the reason for transitions
- Use shared decision-making when progress is slower or risk changes

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Patient Profile: The Pathway Is a Clinical Decision

Patient

- 72 y/o after TKA
- COPD and low-income subsidy
- Two flights of stairs
- Daughter works days
- Wants to recover at home

Team Question

- What must be true for a safe home plan?
- What is the escalation trigger?
- How will the next setting know the plan?
- How will patient preference be documented?

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Six Levers of a High-Performing Episode

Plan the Trajectory Before the First Transition

- Elective joints: plan recovery at home before surgery with the patient and caregiver
- Post-op: mobilize early and repeatedly as clinically appropriate
- Route to the least restrictive setting that safely meets medical, functional, and support needs
- SNF: reserve for genuine daily skilled need; set milestones and a projected home transition
- Nonelective joints: identify medical, cognitive, functional, and social support needs immediately
- Follow through: keep the hospital navigator connected with the patient and caregiver across settings

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Discharge Site: Match Need, Not Habit

Home Pathways

- Home health: for a homebound patient needing intermittent skilled nursing or therapy
- Part B outpatient therapy: furnished at home or in a clinic; no homebound requirement
- Services may be sequenced from home health to outpatient therapy as needs change

Institutional Postacute Care

- SNF: daily skilled care that cannot be delivered safely at home; often used for higher-risk or non-elective patients
- IRF: rare for routine elective joints; for select patients requiring intensive interdisciplinary rehabilitation and medical oversight
- For either setting, planning for a safe return to the community starts on admission

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Handoffs Must Match the Next Setting

To SNF or IRF

- Procedure, date, laterality, diagnoses, comorbidities, active medical issues, functional prognosis
- Medication reconciliation, anticoagulation, wound/dressing, pain plan, and recent clinical findings
- Weight-bearing/precautions, mobility, ADLs, cognition, equipment, and assistance level
- Follow-up, red flags, escalation contact, milestones, and expected home plan

To Home Health or Outpatient

- Procedure details, therapy order/protocol, precautions, wound, pain, and medication concerns
- Baseline/current function, stairs, home setup, caregiver availability, and equipment
- First visit scheduled, transportation/access plan, goals, and milestones
- Red flags and escalation contact, with receipt and patient teach-back confirmed

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Chapter 2 Summary

- The CQS combines outcomes, patient experience, and PRO-PM
- Elective home planning, early mobility, and risk-based destination decisions shape the episode
- Nonelective patients require immediate assessment of medical, functional, cognitive, and support needs
- Reliable handoffs differ by receiving setting and protect medically necessary care

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Chapter 3

From Rules to Action

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What Experienced Episode Hospitals Do Differently

They Redesign the Full Journey, Not Only the Surgery

- Educate patients and caregivers before elective surgery; set home-recovery expectations
- Assess medical and social risk and form a preliminary discharge plan before admission
- Standardize pain, mobility, and discharge practices; ambulate on the day of surgery
- Use “Why not home?” while matching the plan to safety and individual need
- Use navigators to monitor patients, appointments, barriers, and red flags after discharge
- Build SNF/HHA relationships with explicit pathway, quality, LOS, and data expectations

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CJR-X Expands Accountability Beyond the Surgery

Traditional Encounter-Based Journey

- The surgery and immediate quality outcomes dominate attention
- Each setting optimizes its own visit or stay
- Postdischarge problems may surface only through an ED visit or readmission
- PAC use may follow customary patterns and local availability

CJR-X Episode-Accountable Journey

- Risk, support, and home planning are addressed early
- The hospital follows spending and quality through 90 days
- Destination choice and partner performance are actively managed
- Missed milestones and red flags trigger earlier intervention

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Who Is on the Hospital Care Team?

At the Bedside

- **Surgeon/APP:** procedure, surgical plan, weight-bearing/precautions, clinical leadership
- **Nursing:** pain, wound, medications/anticoagulation, mobility reinforcement, education
- **PT/OT:** function, mobility/ADLs, equipment, home safety, discharge recommendation, caregiver training

Across the Episode

- **Case management / social work:** options, coverage, patient choice, transportation, and support needs
- **Episode navigator/coordinator:** handoff, appointments, PAC tracking, escalation, and 90-day follow-through
- **Anesthesia, hospitalist, and pharmacy:** pain, comorbidity optimization, and medication reconciliation

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SNF Performance Can Move an Episode off Target

Medicare Pays SNFs Per Day, so the Length of Stay Must Be Closely Managed

- Each additional SNF day adds episode spending
- Readmissions, ED visits, wounds, falls, and medication problems add cost and harm
- CJR evaluation: SNF stays fell by 2.3 days more than controls, reducing SNF payments
- Use a joint pathway with mobility/ADL milestones and wound, pain, and anticoagulation standards
- Set the projected home date and barriers on admission—not at the end of the stay
- Have the hospital navigator follow progress and intervene when the trajectory deviates

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CJR-X Reshapes Incentives for Every Partner in the Episode

Stakeholder	Shift Under CJR-X	Gap to Close
Orthopedic surgeon, employed or independent	The hospital needs the surgeon involved in planning and follow-up across the episode	Agree on recovery plan, presurgical optimization, postsurgical communication
Hospital PT/OT, acute care	Early mobility and functional assessment help determine a safe discharge plan	Send the next team the patient's actual mobility, true prior level of function, equipment needs, caregiver training needs
Case manager or episode navigator	Help optimize the episode with least restrictive next site of care and establishing goals and expectations	More active role in considering care outside the hospital
Hospital outpatient PT/OT	Therapy may continue within the hospital system after a short stay or outpatient procedure	Offer timely appointments and report functional progress or setbacks to the surgical team

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CJR-X Reshapes Incentives for Every Partner in the Episode (cont.)

Stakeholder	Shift Under CJR-X	Gap to Close
Community outpatient PT/OT	May be in home or in clinic and replace home health, may include telehealth or hybrid care	Direct to outpatient will require close collaboration with the discharge planning team
Home Health	May begin the day of discharge from the hospital	Start within 24 hours of discharge ideally; transition to OP in home or clinic as soon as possible
Skilled Nursing Facilities	Some patients need daily skilled care before they return home, especially after a traumatic total joint replacement	Transition home following Medicare guidelines closely; as soon as skilled care can be provided intermittently, transition to home health or outpatient PT

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Collaborator Arrangements: Stay Inside the Guardrails

- CJR-X collaborators may include ACOs, physician groups, nonphysician practitioners, and therapy group practices as defined in the final rule
- Sharing arrangements must be written, tied to CJR-X activities, and include quality of care criteria
- Participants submit financial arrangements lists and clinician engagement lists on the cadence CMS specifies
- Route any proposed arrangement through compliance and legal review

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Beneficiary Incentives and Choice

Protect Choice

- Provide the required beneficiary notification
- Explain that Medicare coverage and provider choice remain
- Hospitals may recommend preferred providers while preserving patients' freedom to choose another qualified provider

Use Safeguards

- Follow waiver and incentive conditions
- Document the patient's needs and preferences
- Monitor for premature discharge or delayed care

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SNF and Home Health Partners

Skilled Nursing Facilities

- CMS overall, inspection, staffing, and quality ratings—plus short-stay measures
- Joint volume, LOS, discharge to community, rehospitalization, and ED use
- Weekend clinical/therapy capacity; wound and medication capability
- Timely data sharing, escalation, and adherence to the agreed joint pathway

Home Health Agencies

- CMS Quality of Patient Care and Patient Survey stars
- Timely start, mobility/transfer outcomes, medication management, preventable hospitalization
- Geographic/weekend capacity and first-visit reliability
- Joint pathway, rapid escalation, and transition to Part B therapy

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Flexibilities: Use Them to Solve Patient Problems

- Telehealth, remote communication, and other flexibilities may support access when clinically appropriate and permitted
- Flexibility is not a shortcut around assessment, documentation, consent, or patient preference
- Build exception pathways for transportation, language, caregiver, housing, and digital access barriers
- Check the current CMS and payer guidance before operationalizing a flexibility

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Readiness Checklist

Before Launch or Refresh	Done
Identify the participant hospital and the executive sponsor	☐
Map inpatient and outpatient pathways	☐
Confirm quality and data cadence	☐
Define handoff and escalation standard work	☐
Review collaborator/engagement documentation	☐
Test beneficiary notification	☐
Run a mock case and reconciliation review	☐
Start with one pathway	☐
Measure one patient-defined outcome	☐
Expand after reliability is visible	☐

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Case: Two Pathways, One Patient Goal

Inpatient Pathway

- Discharged to home with outpatient PT
- Daughter helps in the evenings
- Transportation is unreliable
- Need a contingency plan

Outpatient Pathway

- Same-day HOPD TKA
- Needs equipment and pain education
- Ride must be confirmed
- First follow-up must be visible

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The First 72 Hours in the SNF

Arrival to 6 Hours	Verify medications, anticoagulation, wound/dressing, pain plan, weight-bearing/precautions, and red flags; close information gaps the same day; start therapy with evaluation. Ideally, the hospital navigator has shared a communication form, so they have the patient starting point.
By 24 Hours	Fully assess mobility, ADLs, cognition, falls, and pain; begin appropriate mobility and confirm follow-up. Discuss therapy prognosis, confirm hand-off information from navigator, and initial discharge plan based on prognosis, goals, and support that will be in place.
By 48 Hours	Team, patient, and caregiver set milestones and a projected home date; address equipment, home, and support barriers; update the hospital navigator; establish care partner first training to occur by day 5.
By 72 Hours	Compare progress with the plan, adjust treatment or medical management, pre-arrange the next setting, and escalate deviations before avoidable ED use.

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Chapter 3 Summary

- Experienced episode hospitals redesign the journey before, during, and after surgery
- The surgeon, nursing, PT/OT, case management, and navigator each own distinct work
- SNF length of stay and PAC quality can materially change episode spending and outcomes
- Partner standards, fast handoffs, and first 72-hour execution protect the patient trajectory

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Course Summary

- Episode: identify the inpatient or outpatient anchor and the 90-day window
- Quality: connect outcomes, experience, PRO-PM, and the CQS
- Trajectory: plan elective recovery, identify nonelective support needs, and match the site of care to the patient
- Execution: use reliable handoffs, an interdisciplinary hospital team, and accountable PAC partners

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What to Do Monday Morning

- Map current discharge destinations separately for elective and nonelective joints
- Review what the next setting actually receives in the hospital handoff
- Compare SNF and home health partners on quality, access, LOS, readmissions, function, and escalation reliability
- Choose one transition defect and bring the patient’s story to the interdisciplinary team

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Thank You

- CJR-X is a payment model
- Better recovery is the work

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