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Client Alert: Centers for Medicare & Medicaid Services Finalize Comprehensive Care for Joint Replacement Expanded, a Mandatory Nationwide Bundled Payment Model for Joint Replacement Care

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On July 31, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1849-F), which establishes a new, mandatory nationwide bundled payment model for lower extremity joint replacement procedures, known as the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model. Beginning January 1, 2028, most acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) will be financially accountable for the cost and quality of hip, knee, and ankle replacement episodes of care, from the surgery through 90 days of recovery. CMS projects CJR-X will save the Medicare program approximately $725 million, building on the demonstrated cost savings of its predecessor, the original CJR Model. This alert summarizes what hospital administrators, in-house counsel, and

health system executives need to know about CJR-X, with a particular focus on the physician alignment strategies hospitals should begin developing now.

Background

CJR-X is not an entirely new concept. The original Comprehensive Care for Joint Replacement Model held participating hospitals in a select number of metropolitan markets financially accountable for the cost and quality of hip, knee, and inpatient ankle replacement episodes from 2016 until the model ended on December 31, 2024. Based on that model's demonstrated savings, CMS has concluded the approach is ready for nationwide use and, for the first time, will apply it to essentially all hospitals paid under the IPPS rather than a limited set of test markets.

Key Provisions

The CJR-X Model applies to lower extremity joint replacements: hip and knee replacements performed in either the inpatient or the hospital outpatient setting, and ankle replacements performed in the inpatient setting. Each episode begins with the qualifying surgery and continues for 90 days after discharge or the outpatient procedure, capturing nearly all related Medicare Part A and Part B spending, including the hospital stay, physical therapy, and follow-up visits. Participation is mandatory for most hospitals paid under both the IPPS and the Outpatient Prospective Payment System (OPPS). CMS has exempted hospitals participating in the Transforming Episode Accountability Model, hospitals located in Maryland, and hospitals not paid under both prospective payment systems.

As under the original model, CMS will set a target price for each episode type and compare it to a hospital's actual spending after each performance year. Hospitals that spend below target may earn a reconciliation payment, while those that exceed it may owe money back to CMS. Critically, CMS has built the CJR-X Model around a quality first principle: a hospital must meet a minimum composite quality score before it can receive any reconciliation payment, regardless of how much it saved on cost. Fortunately for compliance and quality teams, the composite score draws on measures hospitals already report through CMS's existing Hospital Inpatient Quality Reporting and Outpatient Quality Reporting Programs, including complication rates, patient experience surveys, and patient reported outcomes. Hospitals can put this existing quality infrastructure to immediate use by treating quality monitoring and cost management as a single operational effort, rather than parallel workstreams, when preparing to perform joint replacement care cost effectively under the model.

Physician Alignment: What's Old Is New Again

Hospitals have long used physician co-management and service line management arrangements, particularly in orthopedics, to align surgeon compensation with quality and efficiency goals. The original CJR Model permitted participating hospitals to enter into sharing arrangements with physicians and other collaborators to make gainsharing and alignment payments tied to quality and cost performance. CMS's experience with the original model suggests that the CJR-X Model may support a similar collaborative and payment-sharing framework for lower extremity joint replacement care. In that sense, what is old is new again: existing co-management structures may be the most efficient starting point for hospitals once CMS finalizes CJR-X's collaborator and payment-sharing provisions.

Any revived co-management or gainsharing arrangement should be built with the Stark Law's value-based enterprise exceptions in mind (an underused resource in the hospital-physician contracting space). Physician gainsharing and co-management arrangements have traditionally had to satisfy Stark Law exceptions requiring compensation to be fair market value and set in advance, without regard to the volume or value of referrals. CMS's 2020 final rule, modernizing the physician self-referral regulations, created three new exceptions for compensation paid under a value-based arrangement between a value-based enterprise and its participants, expressly relieving those arrangements of the traditional fair market value and set-in-advance requirements. See 42 C.F.R. Section 411.357(aa). Hospitals structuring physician alignment arrangements for the CJR-X Model should evaluate whether forming a value-based enterprise with their physicians and other collaborators, and structuring compensation under one of these risk-tiered exceptions, offers a more flexible and durable compliance path than relying solely on traditional compensation exceptions with their inherent limitations.

Practical Implications for Hospitals

- Confirm exposure now. Hospitals that furnish inpatient or outpatient hip, knee, or ankle replacements and are paid under both the IPPS and the OPPS should assume they will be required to participate absent a specific exemption.
- Inventory physician and post-acute relationships. Identify the surgeons, hospitalists, and post-acute providers whose cooperation will be needed to manage cost and quality across the 90-day episode.
- Revisit or build a value-based enterprise. Evaluate whether a value-based enterprise structured under the Stark Law's value-based arrangement exceptions can support gainsharing, co-management, or other alignment arrangements with CJR-X collaborators.
- Put existing quality data to work. Use current Hospital Inpatient Quality Reporting Program and Outpatient Quality Reporting Program data and dashboards to assess current performance on CJR-X's composite quality measures before the model's financial consequences take effect.
- Track TEAM interaction. Hospitals currently participating in the Transforming Episode Accountability Model, which runs through December 31, 2030, should confirm how and when their obligations will transition to the CJR-X Model.
- Monitor CMS guidance. Watch for CMS's forthcoming CJR-X operational guidance and any fraud and abuse waivers, which CMS has not yet finalized for the model.

The CJR-X Model will be the first mandatory, nationwide test of an episode-based Medicare payment model, and it is likely to shape how CMS structures future bundled payment initiatives. Hospitals should begin preparing now by assessing their operational, financial, and physician alignment strategies.

If you have questions about how the CJR-X Model will affect your organization, please contact Mara Rendina at mrendina@shumaker.com, Kate Crawford at kcrawford@shumaker.com, or a member of Shumaker's Health Law Service Line.

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