

Medicare’s Mandatory Bundled Payment Models
New Jersey & Metro Philadelphia HFMA 50th Anniversary Annual Institute

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Today’s Learning Objectives

1

Understand the Models

Describe the key features & goals of Medicare’s bundled payment models.

2

Connect Cost & Quality

Explain how TEAM/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 TEAM/CJR-X, including impacts on performance, operations, & care delivery.

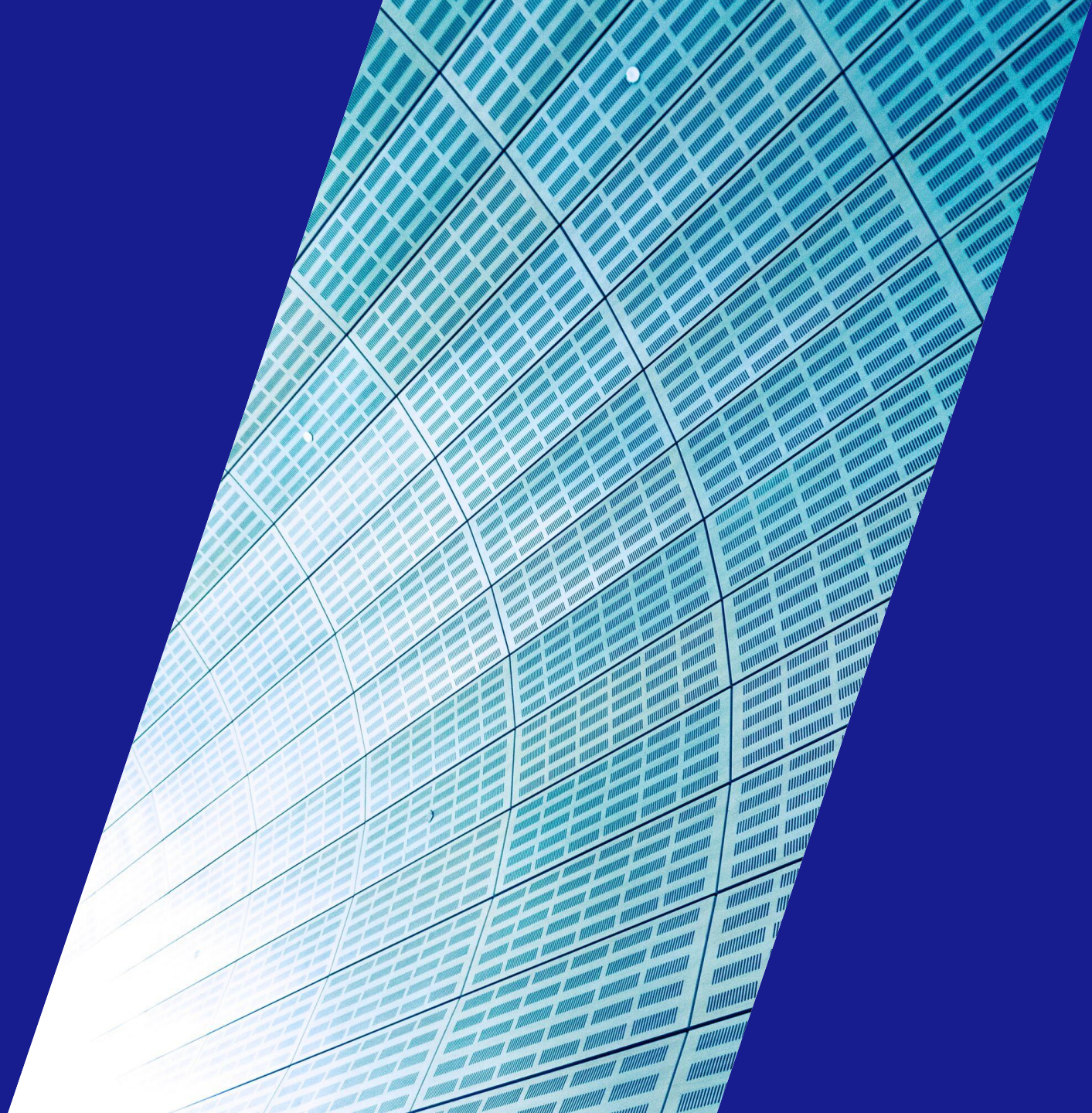
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Prepare for Downside

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

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Introductions



Meet the Presenter



Michael Wolford

Principal, Healthcare Consulting

P: 216.798.8593

michael.wolford@us.forvismazars.com

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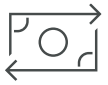
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Net Promoter Score®

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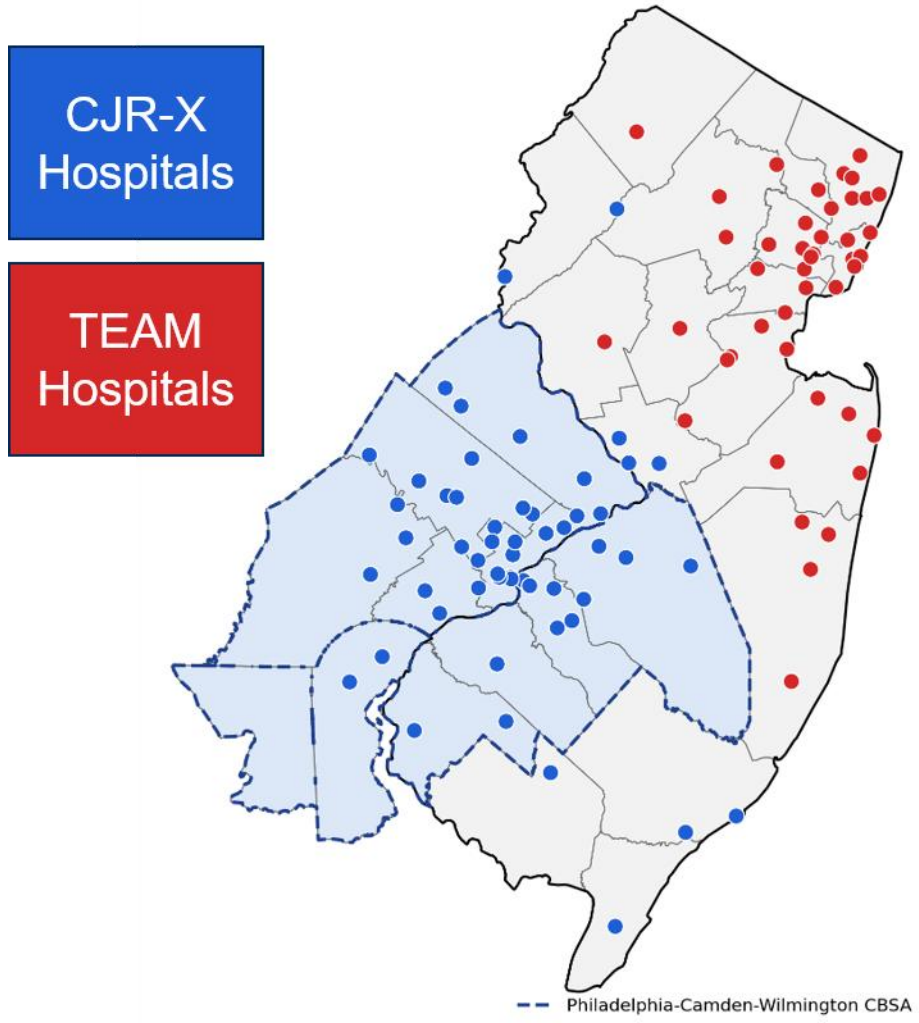
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TEAM & CJR-X

Two Models covering New Jersey

TEAM	CJR-X
Transforming Episode Accountability Model	Comprehensive Care for Joint Replacement Expanded Model
44 hospitals in New Jersey (red dots)	All other hospitals
Started 2026	Starts 2028
Mandatory	Mandatory
5 surgery types	Just lower-extremity joint replacement



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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

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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

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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
- Expansion to ASCs as early as 2028

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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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Target Price Calculation

Regional Target Pricing

1

Regional Benchmark

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

2

Three-Year Baseline

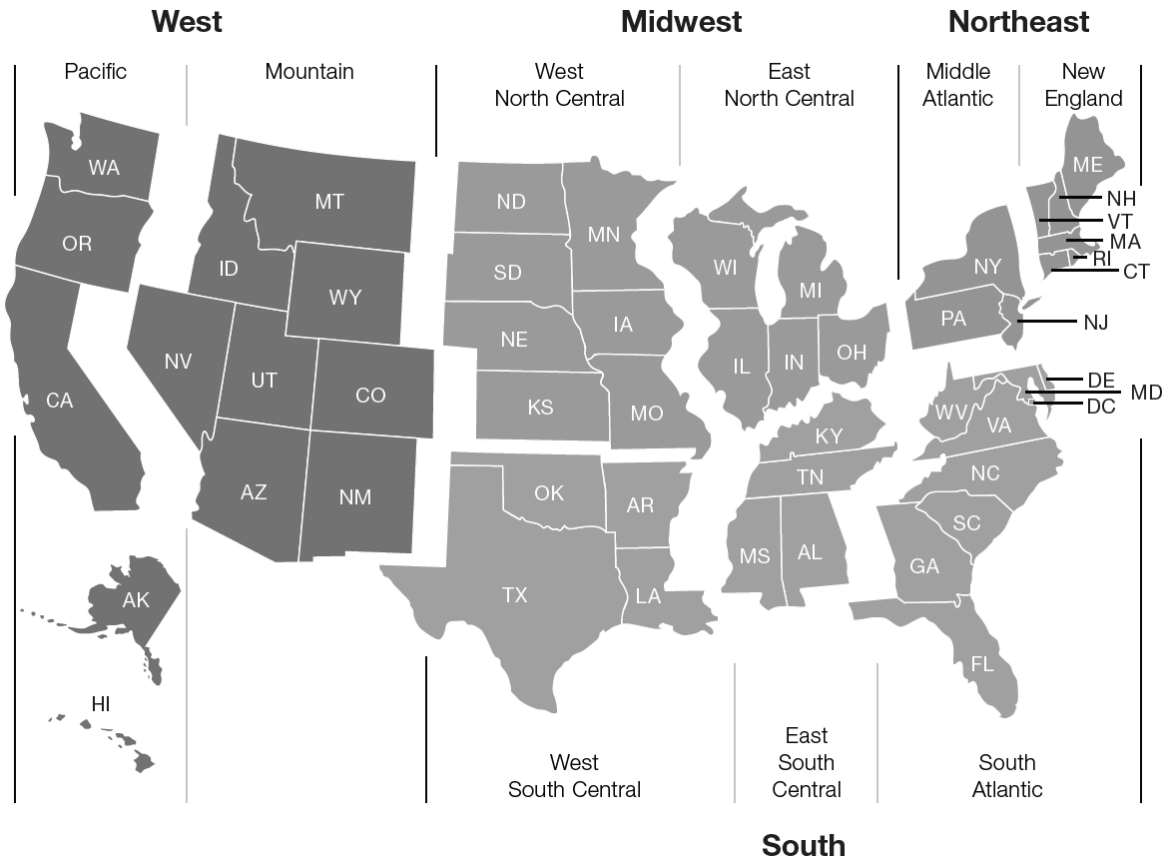
Based on Medicare fee-for-service episode spending across all hospitals in the region during the three years prior to the performance year.

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

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Target Price Calculation

180 **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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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**

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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: $4,400,000

5% Stop-Gain	5% Stop-Loss	20% Stop-Gain	20% Stop-Loss
$220,000	($220,000)	$880,000	($880,000)
Reduced risk participants	Reduced risk participants	Standard participants	Standard participants

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TEAM Overview



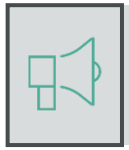
TEAM Overview

Traditional Medicare FFS Duration: 1/1/2026 – 12/31/2030	Hospitals required to participate were selected based on geographic regions	Current BPCI-A & CJR participants could have opted to participate if their region was not selected	Inpatient stay + 30-day total cost of care episodes, incl. Parts A & B; revenue cycle undisrupted
Graduated risk through three participation tracks, with 0% downside risk moving up to 5% or 20% in subsequent years*	5 surgical episode groups (inpatient & outpatient settings)	Target prices will be set at the regional level for each DRG/HCPCS with additional adjustments	Patients attributed to a Medicare ACO are still included in TEAM
Quality measures will be linked to financial gains and losses	One financial reconciliation per model year	Participants are required to screen patients for health-related social needs (HRSN) and include referral to primary care in discharge planning	Gainsharing is allowed

*Some participants will qualify for a 5% downside risk cap

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Model Requirements
Beneficiary Notification



Beneficiary notification – Attributed beneficiaries must receive written notification of the hospital's participation in TEAM

Letter Template

CMS has provided TEAM participants with a standardized template available now on the participant portal.

Timing of Notification

The notification letter must be delivered during the anchor stay or procedure.

Method of Delivery

TEAM participants may share hardcopy templates or share the templates electronically with TEAM beneficiaries. Acceptable forms of electronic distribution include email and providing the notification through a patient portal (e.g. MyChart).

Documentation Requirements

Participants must retain documentation that the letter was provided.

Beneficiary Responsibilities

TEAM beneficiaries are not required to sign or acknowledge receipt of the notification letter.

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Model Requirements
Primary Care Referral



Referral to primary care provider – Referral to a primary care provider prior to discharge from the hospital/outpatient surgical facility must be provided to all beneficiaries

Where to Document the Referral?

Referrals must be documented as part of hospital discharge planning to ensure continuity of care.

What Constitutes a Referral?

CMS defines a referral as a "request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition." The referral must be made prior to discharge from the anchor hospitalization or procedure. Scheduling an appointment is not necessary and there is no requirement for the referral to result in a completed visit.

Broad Definition of Primary Care

CMS broadly defines primary care to include various services like office visits with a PCP or other physician, home health, skilled nursing, long-term care, emergency department services, and nursing home, boarding home, domiciliary, or custodial care medical services.

Prioritizing Established Primary Care Relationships

If the patient has an established primary care provider as documented on admission, referrals should be directed to that provider. If the patient does not have an established PCP, referral to any provider of primary care is sufficient.

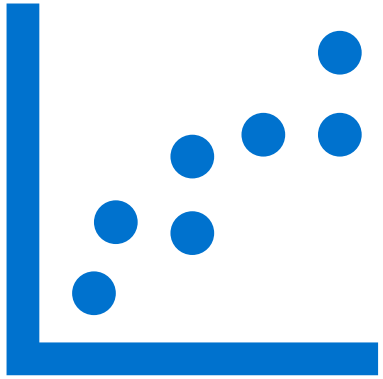
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Why Preparing for TEAM Matters
… and the time to act is now!



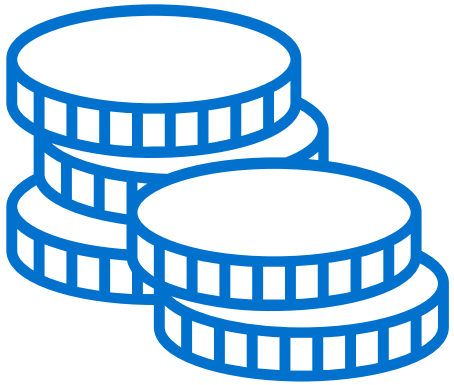
Mandatory means mandatory



CMS data is complex and lacks benchmarks



Pace of change and implementation matters



CMS projects netting $481M over five-year model

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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 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?

CJR-X risk will start quickly, and TEAM risk starts in less than 90 days.

4

Where Are the Gaps?

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

Why CJR-X is different from TEAM: TEAM hospitals are in the middle of a full performance year with 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.



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What TEAM hospitals should know

How do your KPIs compare to others?

On paper, are your patients sicker or healthier than they used to be?

What is causing outliers to be extremely expensive?

Where is care variation occurring?

What are your TEAM financial results to date?

Which post-acute providers provide the most efficient, coordinated care?

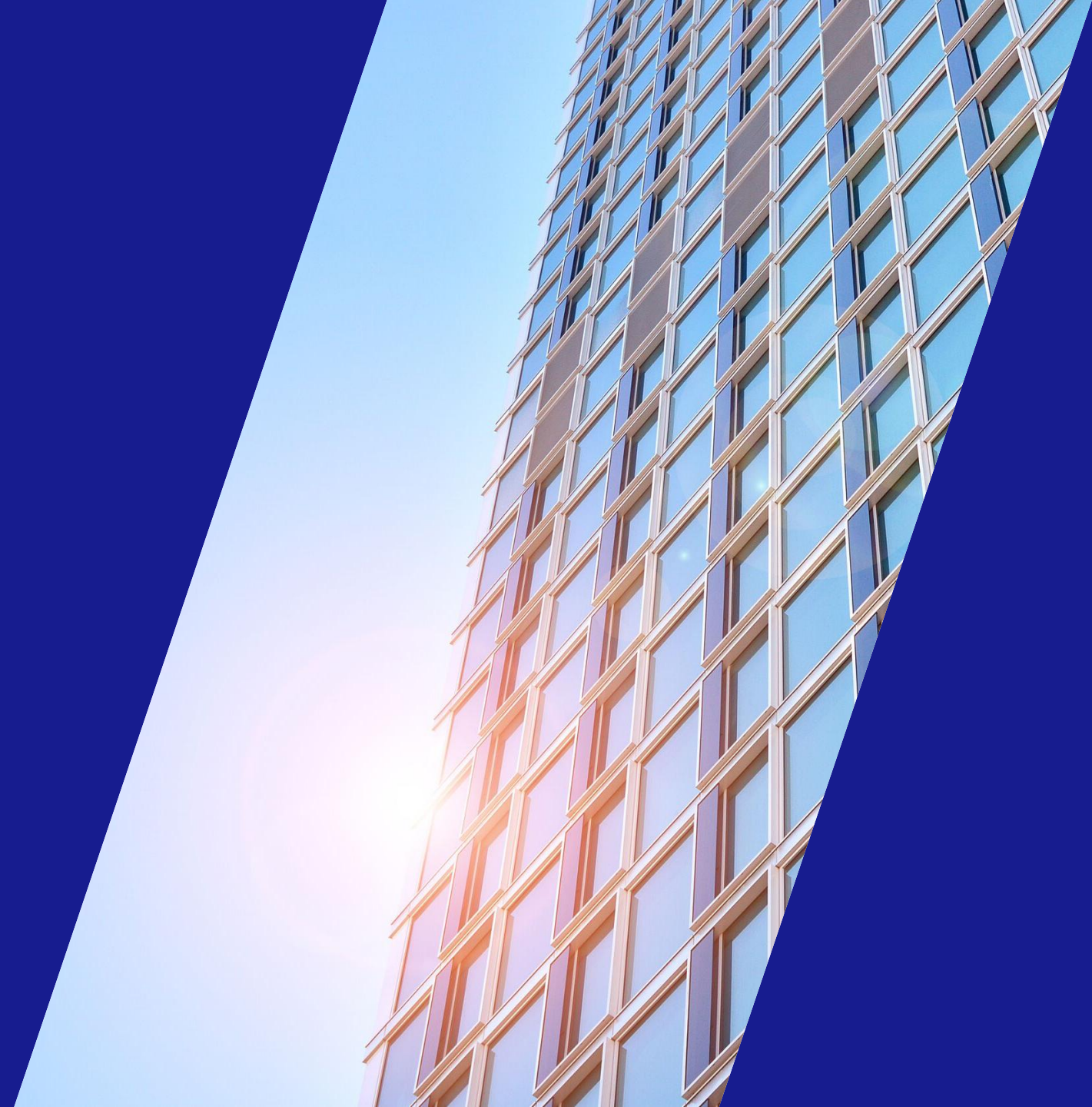
Which surgeons are best aligned to TEAM goals?

What is our compliance with PCP referral and BNL requirements?

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Critical Success Factors



What Separated High vs. Low Performers

Capabilities that drove performance in prior models

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.

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

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

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

1

Governance

- Define one accountable owner for the 30/90-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 TEAM performance and CJR-X readiness.



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CJR-X: 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

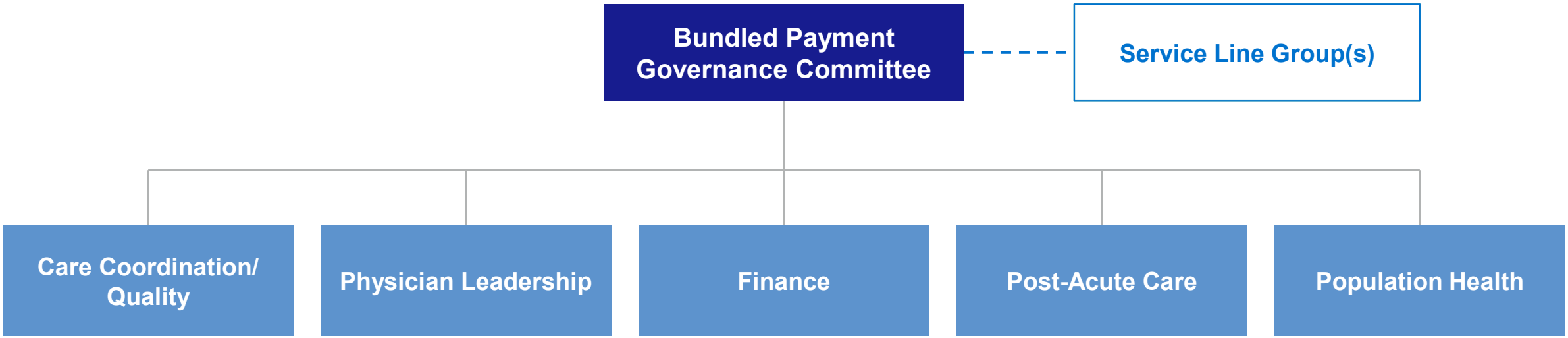
Recommended CJR-X Governance

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.



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If You Do Only Four Things
Priority actions for bundle success and 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 bundle performance management.

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Contact

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Questions?

Michael Wolford
Principal, Healthcare Consulting
P: 216.798.8593
michael.wolford@us.forvismazars.com

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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.

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