American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 9, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

*Submitted Electronically*

***RE: CMS–1849–P Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes***

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model. We are submitting separate comments on the agency's proposed changes to the inpatient and long-term care hospital prospective payment systems (PPSs).

Hospitals and health systems are eager to advance value-based care arrangements that improve quality, enhance patient outcomes and make health care more affordable. **The AHA and its members support continued innovation in Medicare payment models that align incentives, promote coordinated care and reward prevention and wellness. While we appreciate CMS' efforts to expand the reach of value-based models, we believe that mandatory participation in the CJR-X Model would present significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign.** A phased or voluntary approach would better support success, allowing organizations to build the infrastructure and partnerships needed to achieve shared savings and improved outcomes.

The CJR-X Model, as proposed, includes design elements that would make it difficult for hospitals to be successful under the model. To optimize the effectiveness of CJR-X in terms of how to best transform care delivery through improved care coordination and financial accountability, hospitals must have the necessary tools to succeed and appropriately balance risk versus reward. Specifically, we urge the agency to adopt the following changes to the model in the final rule:

- Make Participation Voluntary. A voluntary pathway to participation would provide a stronger foundation for hospitals to succeed in the model. **We urge CMS to give all hospitals the choice to participate in CJR-X.** At a minimum, the agency should allow certain categories of hospitals to opt in to the model voluntarily, including those that have participated in bundled payment models and other alternative payment models (APMs), as well as rural, Medicare-dependent, sole community and safety-net hospitals (referred to as "special designation hospitals" herein).
- Create a Glide Path to Risk. CJR-X is the first expanded nationwide mandatory model for hospitals, and as such, a higher bar for introducing downside risk should be set. **We recommend that year one of CJR-X be a data-sharing period only, followed by at least two years of no downside risk for all participants as well as upside-only risk for special designation hospitals for the model's entire duration.**
- Eliminate the Discount Factor. A discount factor is not sustainable for a mandatory expanded nationwide model of indefinite duration. This is even more true considering how extensively bundling for joint replacements has already been tested. **Therefore, CMS should not finalize any discount factor for CJR-X. If the agency were to adopt a discount factor, it should be set well below 2% and phased out entirely after three years.**
- Address the Ratchet Effect. A discount factor combined with annual rebasing of regional target prices means that CJR-X has the potential to be nothing more than a payment cut for hospitals nationwide. **We urge CMS to adopt policies to mitigate the ratchet effect of the model that, as proposed, would make continued savings unachievable for hospitals. In addition to no discount factor, the timeframe for rebasing should be extended to, at most, once every ten years.**
- Increase the Low-volume Threshold. A low-volume threshold of 31 cases, as proposed, would fail to ensure that hospitals have enough cases to integrate changes in care delivery and determine if they had an impact based on statistical significance. **We urge CMS to substantially increase the low-volume threshold to ensure statistical significance and effectively mitigate potential impacts of outliers and volatility in cases.**
- Revise the Maximum Stop-loss Limit. The maximum stop-loss limit should be phased in gradually over a period of at least five years. Additionally, it should be

no more than 10% for most CJR-X participants and 2.5% for special designation hospitals (to the extent they are subject to downside risk at all).

- Modify the Quality Measures Set. The quality performance aspects of CJR-X should fairly and appropriately reflect relevant care. We have conceptual concerns with some of the proposed measures that we urge CMS to consider and monitor for unintended consequences, as, for most of these measures, it is the first time they are being deployed as part of a pay-for-performance model.
- Waive Applicable Fraud and Abuse Laws. We urge CMS to waive applicable provisions of the Physician Self-Referral Law, the Anti-Kickback Statute and the Beneficiary Inducements Civil Monetary Penalty Law so that organizations can form the financial arrangements necessary to implement CJR-X.
- Extend Medicare Program Waivers to Support Care Delivery. We urge CMS to give providers maximum flexibility to place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals through additional waivers of Medicare program requirements.

The changes we recommend would help facilitate hospitals' success in providing quality care to Medicare beneficiaries, achieving savings for the Medicare program and pursuing an opportunity for reward that is commensurate with the risk they are assuming. We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Robyn Tessin, AHA director of payment policy, at rtessin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Abe Sutton
Director, Center for Medicare and Medicaid Innovation

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## BACKGROUND

The CJR Model was a mandatory alternative payment model tested by the Center for Medicare and Medicaid Innovation (CMMI) from 2016 through 2024 for certain hospitals in selected Metropolitan Statistical Areas. The model was designed to improve care for Medicare beneficiaries undergoing lower extremity joint replacement (LEJR) performed in the inpatient or outpatient setting. CMS proposes to expand CJR to all eligible hospitals nationwide based on its evaluation results indicating the model successfully reduced spending without reducing quality of care and the Secretary of Health and Human Services' determination that the model has met the statutory requirements for expansion.

## PARTICIPATION

CJR-X would begin on Oct. 1, 2027. CMS proposes that all acute care hospitals located in the 50 states, the District of Columbia and the U.S. territories and that are paid under both the inpatient and outpatient PPSs would be required to participate, except for hospitals participating in the Transforming Episode Accountability Model (TEAM) and those located in Maryland. The agency notes that hospitals participating in TEAM would be required to participate in CJR-X when TEAM ends or in the event they no longer meet the criteria for inclusion in TEAM.

### Mandatory Participation

We are concerned that many hospitals are not in a position to support the investments necessary to transition to a mandatory bundled payment approach for one of the most common surgical procedures in the Medicare patient population. **We urge CMS to give all hospitals the choice to participate in CJR-X.** We have particular concerns over mandatory participation for certain categories of hospitals, as outlined below, due to, for example, their safety net or other special designation status as well as prior participation in LEJR bundles.

Voluntary Participation Would Support Hospital Success. Hospitals are committed to innovative payment approaches that reward better care, improve patient outcomes and lower the overall cost of care delivery. **While we commend CMS' intention to accelerate the transition to value-based care, mandatory participation in CJR-X would create real barriers, particularly for hospitals that do not have the scale, capital or operational capacity to support significant transformation efforts. A voluntary pathway to participation would provide a stronger foundation for success, giving organizations the flexibility to build needed capabilities and progress toward achieving savings and improved patient outcomes.**

Voluntary participation is particularly important because hospitals currently face the competing demands of multiple mandatory CMMI models, especially health systems with multiple locations. As a field, hospitals must contend with not only TEAM, but also

the Increasing Organ Transplant Access Model and the Ambulatory Specialty Model that is mandatory for their employed physicians and practitioners. Further, while the Wasteful and Inappropriate Service Reduction Model is voluntary for participating technology companies, hospitals in selected states are forced to adhere to its prior authorization and prepayment medical review requirements.

These concurrent obligations present significant operational and resource challenges, particularly for health systems with multiple hospitals and clinicians participating in different models simultaneously. Each model carries distinct rules, reporting requirements and compliance obligations, increasing administrative burden and introducing the potential for misaligned or conflicting incentives. Moreover, participation across multiple models complicates efforts — both for providers and CMS — to evaluate the effectiveness of specific interventions and determine which approaches are successful.

**In addition, although we support CMS adopting successful model design elements at a greater scale across Medicare, we question how much value remains to be gained from LEJR bundled payment models.** As discussed below in the Pricing and Payment Methodology section, CJR-X would require participation from hospitals even if they previously participated in CJR and Bundled Payments for Care Improvement Advanced (BPCI-A) and reasonably have little further cost savings to achieve. Specifically, due to the ratchet effect over time, many organizations have squeezed as much cost savings and quality improvement out of LEJR bundles as they can. Thus, they would now simply be taking a payment cut when participating in this model. In addition, our analysis shows that the majority of costs in CJR-X episodes are incurred during the anchor hospitalization or procedure, for which reimbursement is already paid on a bundled basis, leaving few opportunities for savings by participants.

Voluntary participation in CJR-X also would be appropriate given the historic financial pressures that hospitals and health systems continue to face. Indeed, according to the Medicare Payment Advisory Commission (MedPAC) March 2026 report to Congress, inpatient PPS hospitals' aggregate Medicare margins were a staggering *negative* 12.1% in FY 2024, and the median margins of even relatively efficient hospitals were *negative* 1%. Furthermore, MedPAC reported that 18 hospitals closed in the last fiscal year, exceeding the number of hospital openings.[1] As such, many hospitals may not be in a position to make the infrastructure investments necessary to be successful in CJR-X, nor absorb potential losses.

Finally, we are concerned that safety-net hospitals and those serving higher proportions of dual-eligible (DE) and low-income subsidy (LIS) beneficiaries in particular may not have the infrastructure and resources necessary to succeed under this model. Our

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[1] https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf

analysis shows that hospitals treating higher complexity and underserved patient populations in LEJR episodes perform categorically worse under CJR-X. Specifically, when we divided hospitals into quintiles based on the difference between their regional target price and spending per episode, we found that hospitals in the highest spending quintile included a disproportionate share of safety-net hospitals and served a disproportionate share of DE or LIS patients (see Table 1).

**Table 1. Distribution of Hospital Characteristics for LEJR Episodes by Quintile: Safety-net, DE and LIS**

| | Number of Hospitals | Number of Episodes | Average Episode Spending | Average Target Price | Difference Between Target and Spending | Percent Safety-net | Percent Patients DE | Percent Patients LIS |
|---|---|---|---|---|---|---|---|---|
| Highest Spending Quintile | 407 | 69,050 | $33,835 | $29,093 | -$4,742 | 45.2% | 11.5% | 12.7% |
| 2nd Quintile | 408 | 177,066 | $27,359 | $25,296 | -$2,064 | 31.6% | 6.0% | 7.0% |
| 3rd Quintile | 407 | 211,082 | $24,961 | $24,329 | -$632 | 32.2% | 5.6% | 6.6% |
| 4th Quintile | 408 | 247,519 | $23,618 | $24,163 | $544 | 28.9% | 5.3% | 6.2% |
| Lowest Spending Quintile | 408 | 159,487 | $22,750 | $24,652 | $1,901 | 38.7% | 5.3% | 6.4% |
| **Total** | **2,038** | **864,204** | **$25,369** | **$24,920** | **-$449** | **35.3%** | **6.1%** | **7.0%** |

Source: AHA analysis of FY 2023-2025 Medicare claims data.

As such, we are extremely concerned that mandatory participation could contribute to a downward financial spiral for these organizations, which would have even fewer funds to invest in APMs, let alone targeted interventions to benefit their patients and communities. This could in turn lead to even larger losses under the model, eventually resulting in decreased access to care and widening disparities for underserved populations.

**Participant Exclusions**

Exclusion of TEAM and Maryland Hospitals. **We support CMS' proposal to exclude hospitals participating in TEAM and those located in Maryland from CJR-X. However, we disagree that TEAM hospitals should be required to participate in CJR-X when TEAM ends or in the event they no longer meet the criteria for inclusion in TEAM.** These hospitals will have already implemented care redesign for LEJR episodes and achieved efficiencies under an even shorter 30-day episode timeframe in TEAM. Many TEAM hospitals may be unable to achieve further savings or quality of care improvements with LEJR episodes, and thus they should be given the choice to opt in to CJR-X.

Voluntary Opt-in for CJR and BPCI-A Participants. CJR-X would mandate participation from hospitals that participated in CJR and BPCI-A, even though they have likely exhausted opportunities to reduce spending associated with LEJR procedures. As mentioned above regarding TEAM hospitals, many of these organizations have already captured achievable efficiencies for LEJR episodes. As a result, mandating their participation in CJR-X would set them up for failure and would effectively translate into a permanent payment cut on these procedures. Thus, we urge CMS to allow CJR and BPCI-A participant hospitals to choose whether to participate in CJR-X.

Voluntary Opt-in for Hospitals Participating in Other APMs. Hospitals participating in other APMs also should be allowed to voluntarily opt in to CJR-X. The staffing and resources required for one hospital to participate in multiple APMs are significant, particularly if they are being implemented at the same time. **There also is the potential for organizations to be penalized in multiple models for the same cases and measures because, aside from TEAM, model interactions are not accounted for in the CJR-X proposal.** Some examples are noted below.

*Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Hospital Participants.* Hospitals that participate in AHEAD already will be undergoing significant organizational change and redesign of care pathways for all of their clinical areas, including LEJR. Measuring these episodes twice would be inappropriate and untenable. In addition, the AHEAD and CJR-X performance periods would overlap, and it would be difficult to discern which model interventions would be responsible for changes in outcomes.

*IOTA Model Hospital Participants.* The mandatory IOTA Model began on July 1, 2025, for kidney transplant hospitals in selected areas. Again, implementation of complex payment models requires significant time, resources and staffing on the part of hospital participants. With a six-year performance period, IOTA hospitals could be implementing multiple models at the same time (for example, IOTA, TEAM and AHEAD, not to mention any other voluntary models).

*Accountable Care Organization (ACO) Hospital Participants.* ACO models are intended to hold organizations accountable for aggregate healthcare expenditures and population health outcomes for an attributed population. Requiring ACO participants to also participate in CJR-X could result in duplication of effort, as ACOs already support episode management post-discharge and redirection of resources.

Voluntary Opt-in for Special Designation Hospitals. As previously mentioned, rural, Medicare-dependent, sole community and safety-net hospitals have less infrastructure and resources available to implement a mandatory bundled payment model. They also would be disproportionately at risk for losses under CJR-X because of the more medically complex patient populations they serve. As such, these organizations should have the flexibility to opt in to CJR-X.

## GLIDE PATH TO RISK

If CMS chooses to proceed with CJR-X as a mandatory model, a more gradual introduction to risk is necessary to position hospitals for success. **Specifically, we recommend that year one of CJR-X be a data-sharing period only, followed by at least two years of no downside risk for all participants as well as upside-only risk for special designation hospitals for the model's entire duration.** Collectively, these policies would create a glide path to prevent risk from being applied too quickly for hospitals that are not ready for APM participation and would shield the most financially vulnerable hospitals from harmful payment cuts under the model.

A Data-sharing Year Would Help Hospitals Prepare. Although CJR-X would be mandatory for nearly all hospitals nationwide, the vast majority did not participate in CJR, and many have no prior experience with bundled payment models. Those who did participate in CJR or other APMs may have struggled to succeed due to factors largely outside of their control, such as limited financial and other resources to invest in care redesign, as well as more complex patient populations.

Hospitals need adequate time to prepare for model participation, including time to incorporate adjustments to their operations and workflows as necessary. For example, they need to:

- Educate staff and clinicians about the CJR-X Model.
- Analyze claims data to understand episode spending.
- Build relationships with physicians and post-acute care providers.
- Negotiate and execute financial arrangements with physicians and post-acute care providers.
- Develop and implement the use of documents to meet CMS' proposed beneficiary notification requirements.
- Create protocols to identify CJR-X patients upon admission.
- Create protocols to determine if potential CJR-X patients meet all of CMS' inclusion criteria (for example, ensure they are not eligible for Medicare based on end-stage renal disease).
- Create protocols to identify canceled episodes.
- Create protocols to ensure notification materials are shared with appropriate beneficiaries.
- Examine and modify discharge planning protocols.
- Create systems to track and monitor beneficiaries throughout the episode.

**To enable hospitals to succeed in CJR-X, particularly those that are new to bundled payments, we recommend that year one of the model be a data-sharing period only, with no financial impact on participants.** Specifically, for the first year, CMS should make appropriate beneficiary-identifiable claims data and regional

aggregate data available to participants regarding beneficiaries who may initiate an episode and be attributed to them in the model as proposed. However, episodes would not actually be initiated, and there would not be financial consequences under the model for participants. Such a policy would provide a valuable learning opportunity for hospitals as they receive data feeds from CMS, analyze how they would perform under the model and make necessary adjustments to their protocols and processes. By allowing participants to test out specific interventions without the pressures of financial risk, CMS would help to ensure they are better positioned to achieve savings, improve quality of care and move towards a successful model.

Downside Risk Should Be Phased in After at Least Two Years. If CJR-X remains a mandatory model as proposed, we recommend that after the initial data-sharing year, there are at least two years of no downside risk for all participants. Extensive precedent exists for a phase-in period for risk in other CMMI models and value-based payment programs. **As the first expanded nationwide mandatory model for hospitals, CJR-X should set a higher bar for introducing downside risk.** In addition, a Government Accountability Office report found that mandatory participation could negatively impact patient care and financial sustainability if participants are not able to leave the model.[2] It also found that mandatory participation could impact organizations' ability to support other voluntary models for which they may be better equipped. Introducing downside risk too quickly in CJR-X would only exacerbate these negative effects of mandatory participation.

Special Designation Hospitals Should Not Be Subject to Any Downside Risk. In addition, downside risk should not apply to rural, Medicare-dependent, sole community and safety-net hospitals ("special designation hospitals") for the model's entire duration. Indeed, CMS' own report from December 2025 examines the particular challenges that safety-net hospitals experienced participating in CJR.[3] Specifically, it found that safety-net hospitals were overrepresented among hospitals with the highest per-episode repayments to Medicare. It found that they performed fewer but more complex LEJR procedures, served a higher percentage of fracture patients and performed a lower percentage of outpatient LEJR procedures compared to non-safety-net hospitals. Additionally, it found that safety-net hospitals often served patient populations with substantial medical needs, including chronic conditions, as well as nonmedical needs that could have affected patients' ability to manage their health and treatment. **These findings demonstrate that when special designation hospitals are forced to participate in APMs, there is no level playing field for their success. Therefore, it would be highly risky to subject them to downside risk in CJR-X.**

**BENEFICIARY NOTIFICATIONS**

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[2] https://www.gao.gov/assets/gao-19-156.pdf

[3] https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-safety-net-hospital-exp-rpt

CMS proposes certain beneficiary inclusion criteria for CJR-X and would require participant hospitals to provide written notification to each CJR-X beneficiary of their inclusion in the model. The notification would have to include specific information about the model and be provided prior to discharge from the anchor hospitalization or procedure. The agency also proposes that CJR-X collaborators would have to provide written notice to beneficiaries regarding their sharing arrangement with the participant hospital when the beneficiary first receives an item or service from the CJR-X collaborator during an episode. The agency states that it considered requiring these notifications only during the years when both TEAM and CJR-X are implemented or, alternatively, not requiring these notifications at all for CJR-X.

**The AHA is concerned that the administrative burden that these notifications would create for hospitals outweighs any minimal informative value they might provide in an expanded model.** CJR-X participant hospitals and their collaborators would have to invest significant time and resources to develop these notifications, educate staff and clinicians on their use, incorporate them into work flows to ensure they are provided timely to beneficiaries and regularly update the notification documents. Additionally, patients already receive a substantial volume of information in connection with their hospital stay or procedure, including notifications and disclosures mandated under federal and state laws. We are concerned that requiring additional notifications under CJR-X would only contribute to the paperwork overload patients may experience at a critical transition point in their care, and may cause important clinical instructions or payment information to be overlooked. An expanded nationwide mandatory model like CJR-X is equivalent to a permanent program, making it unnecessary to inform beneficiaries that they are part of a model test. Indeed, CMS chose not to require beneficiary notifications in another recently expanded model, the Expanded Home Health Value-Based Purchasing (HHVBP) Model. This model began in 2022, and like CJR-X, participation is mandatory for all Medicare-certified home health agencies in the 50 states, the District of Columbia and the U.S. territories. **As such, we urge CMS to follow the precedent set by the Expanded HHVBP Model and not require beneficiary notifications in CJR-X.**

## EPISODES OF CARE

CMS proposes that an episode of care would include all Medicare Parts A and B items and services (except those specifically excluded) furnished to a CJR-X beneficiary beginning on the date of admission for an anchor hospitalization or procedure and ending 90 days later. Episodes would be triggered by certain Medicare-severity Diagnosis-related Groups (MS-DRGs) and Healthcare Common Procedure Coding System (HCPCS) codes. The agency proposes that episodes would include inpatient hip, knee and ankle replacement procedures and hospital outpatient hip and knee replacement procedures.

### Included and Excluded Items and Services

The agency proposes that an episode would include physicians' services, hospital inpatient and outpatient services, post-acute care, clinical labs, durable medical equipment, drugs and biologics, and hospice. Items and services that are clinically unrelated to an LEJR procedure would be excluded, such as certain categories of diagnoses, new technology add-on payments, outpatient PPS transitional pass-through payments for medical devices, hemophilia clotting factors and certain high-cost drugs and biologics as well as low-volume drugs.

**We recommend that CMS further clarify what constitutes unrelated items and services for a CJR-X episode.** For example, the proposed rule states that certain categories of diagnoses, such as oncology, trauma medical admissions, organ transplant, ventricular shunts, diseases and disorders of the eye, pregnancy and childbirth, and HIV, would be excluded, but these are very broad categories. **Therefore, we urge the agency to identify specific diagnoses for exclusion.** We also recommend that CMS assess whether additional exclusions are warranted, particularly for non-elective and emergent episodes, which present fundamentally different clinical profiles and resource demands than elective joint replacement procedures. Additionally, LEJR procedures are highly unlikely to be clinically related to a beneficiary's election of the hospice benefit; therefore, hospice services should be excluded from the episode.

We urge CMS to consider taking a different approach to included and excluded services in bundled payment models in the future. That is, instead of delineating services that should be excluded, the agency could focus on which services should be included. There are infinite permutations of unrelated services a patient can have in an episode. If CMS instead focused on procedures and complications that could arise from the procedure itself as a starting point, it would likely arrive at a more appropriate list.

Additionally, certain services were not addressed in the proposed rule. These include prescheduled inpatient/outpatient services (for example, glaucoma surgery) and critical care transport. For rural and geographically remote areas, critical care transport often requires high-cost air ambulance services, which may inappropriately and adversely impact hospitals' episode spending if included. **CMS also should exclude these services.**

**Patient Transfers**

Under CJR-X, CMS proposes to treat hospitalizations for hospital-to-hospital transfers discretely; that is, they may result in an episode being initiated depending on each hospital's participation in the model and the MS-DRGs involved.

We appreciate that like CJR, if both hospitals are in CJR-X and treat the same patient for a LEJR procedure, then the anchor hospitalization would be linked to the initial hospitalization (that is, a separate anchor hospitalization would not be initiated at the receiving hospital). **However, we urge CMS to ensure that, as in previous models, if the patient's discharge MS-DRG from the receiving hospital is not an episode**

**trigger under CJR-X, the episode should be canceled.** These episodes are atypical but can adversely impact spending in a significant way.

We also have concerns that the proposed transfer policy does not account for the fact that transfer episodes inherently will be extremely costly and may affect hospitals differently due solely to their capabilities and patient populations. For example, smaller community hospitals may transfer cases more frequently to allow their most complicated patients to receive the most appropriate care at larger, tertiary hospitals. They should not be penalized for doing so. **Therefore, to avoid inappropriately penalizing hospitals for transferring patients, we recommend that CMS exclude the amount paid to the initial admitting hospital when calculating target prices and actual episode spending. Doing so would help put all hospitals on a more level playing field and encourage the best provision of care.**

## QUALITY MEASURES AND SCORING

In CJR-X, CMS proposes to assess performance on five measures currently used in the hospital Inpatient Quality Reporting (IQR) or Outpatient Quality Reporting (OQR) programs. They include:

- Hospital-level Risk-Standardized Complication Rate 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 (HCAHPS) Survey
- Outpatient and Ambulatory Surgery (OAS) CAHPS Survey
- Hospital-Level THA/TKA Patient Reported Outcome-based Performance Measure (PRO-PM)

The AHA appreciates that CMS proposes to use measures for which hospitals already report data through the IQR and OQR to reduce data reporting burden and align quality performance across CMS programs, rather than creating novel, unfamiliar and untested measures of performance solely for use in CJR-X. The disadvantage of relying upon existing IQR measures, though, is that three of the five measures above are not specific to LEJR episodes; the HCAHPS and OAS CAHPS survey-based measures and the Hospital Visits within 7 Days of HOPD Surgery apply to much broader patient populations (in the case of HCAHPS and OAS CAHPS, to patients across all service lines, surgical or not). This means that the weight of these measures may be disproportionate to their actual relevance to hospital performance on LEJR procedures — for example, CMS proposes that performance on the patient experience measures contribute 40% toward the composite quality score, but that performance may be more reflective of other care provided by the hospital than of joint replacement care. In addition, because the HCAHPS survey is also used to evaluate performance in the Hospital Value-based Purchasing program, its influence toward payment adjustments

will be compounded. We request that CMS provide insight into how it can ensure that the quality performance aspects of CJR-X fairly and appropriately reflect relevant care.

In addition, we have conceptual concerns with some of these measures outlined below that we urge CMS to consider and monitor for unintended consequences as, for most of these measures, it is the first time they are being deployed as part of a pay-for-performance model.

OAS CAHPS. This OQR/ASCQR measure is the outpatient complement to the HCAHPS survey measure. HOPDs and ambulatory surgical centers (ASCs) have been required to administer the survey since Jan. 1, 2025; it was previously voluntary. The performance period for the measure is one calendar year and requires at least 100 completed surveys.

The AHA has long supported the use of rigorously designed surveys of patient experience of care, and we have engaged with CMS, the Agency for Healthcare Research and Quality and several other stakeholders on work to improve CAHPS surveys. We have concerns about the reliability of the data produced by the OAS CAHPS survey. The CAHPS program already includes multiple, and potentially overlapping, survey tools. Correct attribution of performance results for HOPDs is challenging because two existing CAHPS surveys — the Clinician/Group CAHPS (CG-CAHPS) and the Surgical CAHPS — capture closely related information. These surveys evaluate providers on several issues, including access to appointments, physician communication with patients, courtesy of office staff and follow-up on testing results. This means that outpatient surgical patients may receive three separate but similar surveys for exactly the same care episode. CMS itself listed these and other issues in its rationale to delay implementation of the OAS CAHPS survey and related measures in previous rules, but did not provide a solution to the issue before moving forward with mandatory application of the OAS CAHPS survey. In the CY 2022 OPPS Final Rule that finalized the mandatory adoption of the OAS CAHPS, the agency simply stated that “we believe that patients are able to respond to OAS CAHPS survey questions, and that those responses are reliable based on our prior experiences collecting voluntary data for public reporting since CY 2016,” and provided a link to the agency’s provider data homepage. Yet the agency does not provide any specific data demonstrating OAS CAHPS reliability. We agree that the survey and topics addressed by the related measures are important, but **we ask CMS to provide evidence of the survey’s reliability before it requires survey administration.**

In addition to general conceptual concerns with the OAS CAHPS survey, we have practical concerns about its use in CJR-X. Specifically, hospitals would need at least 100 completed OAS CAHPS surveys to receive a score; otherwise, the hospital’s performance would automatically be assigned to the 50th percentile. Because Patient Experience contributes 40% of the Composite Quality Score, the influence of a lack of patient experience surveys may be outsized.

Hospital-Level THA/TKA PRO-PM. This measure evaluates whether patients report improvements in their self-assessed pain and function following their THA/TKA. It uses data collected on standardized tools prior to and following THA/TKA procedures along with risk variable data, and there are multiple data collection time periods and data submission deadlines. The performance period for the measure is one year beginning July 1 and requires at least 25 patient cases.

The measure is mandatory in the IQR as of July 1, 2025, but is voluntary in the OQR and ASCQR until calendar year 2028. CMS states that "the inpatient measure provides an overall reflection of hospital performance related to LEJR care and can appropriately be used to infer quality of care for outpatient episodes," and thus the agency would only use the IQR measure in CJR-X at this time. In the future, CMS may propose to include the OQR measure as well through notice-and-comment rulemaking.

The measure was used on a voluntary basis in the original CJR model and was the first PRO-PM to be part of the IQR program. While the AHA agrees with the value of PRO measures for hospital quality improvement, this measure is incredibly complex in terms of the data elements required for reporting and the timelines for data collection. The voluntary reporting period for this measure is ongoing as of this proposed rule; while mandatory data collection has begun, reporting will not begin until July 1, 2026. We have not yet seen results from the voluntary reporting period and thus do not know of the feasibility and usefulness of this measure on a national scale; indeed, participation in the voluntary period has been low, so there may not be meaningful results from this trial period.[4]

Anecdotally, hospitals that did participate in voluntary reporting have shared that post-operative data collection is challenging for several reasons. First, the post-operative window is extremely wide, ranging from 300 to 425 days after the surgery date. Patients are frequently lost to follow-up (LTFU) in this time, and even those patients who remain interested in submitting additional information are more likely to do so at their physician's office than at the hospital. By setting the data completion threshold (that is, the percentage of complete data submissions for which hospitals can provide both pre- and post-operative results for the same patient) at 50%, CMS acknowledges that a significant proportion of patients may be LTFU; however, this threshold is still too high, as studies suggest that matched pair rates are generally less than 33%.[5] This rate also differs by setting: Studies demonstrate that inpatient Medicare THA patients have substantially lower one-year PRO-PM completion rates and require more resource-intensive active methods for follow-up than patients who underwent their THA in the outpatient setting.[6] Because CMS proposes to use a weighted average of inpatient and

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[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC12152723/
[5] https://pubmed.ncbi.nlm.nih.gov/40216276/
[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC12634202/

outpatient volume to calculate the composite quality score, this would compound the influence of unreliable measure performance.

These voluntary participants have noted additional challenges with data collection and submission, including around the lack of clarity about required data elements as well as their formatting and reporting. Our members have reported that the CMS website for submitting data will reject uploaded documents frequently due to various formatting issues, requiring painstaking review of data to ensure there are no extra spaces or noncompliant date formats and re-uploading of required files. Because this proposed rule has been issued prior to the end of the voluntary reporting period, it is unclear whether these issues are solvable with the measure as currently specified or if CMS has a strategy to address the issues before measure performance influences target pricing in CJR-X. **For this reason, we recommend that CMS reconsider the use of the THA/TKA PRO-PM both in IQR and CJR-X at this time.**

**Composite Quality Score.** CMS proposes calculating CJR-X participants' reconciliation payments for LEJR episodes based on their quality performance for the performance year. To link performance and payment, CMS would calculate an overall quality performance score based on the weighted sum of performance scores on the five measures proposed above. Scores for each measure would be calculated based on the participant's performance compared to the national distribution of performance for IPPS hospitals; each participant would receive a certain number of points for each measure that is associated with the decile of its measure performance. If a participant does not meet the required minimum number of patient cases during the performance period for a measure, it would be assigned to and receive the score for the 50th percentile of performance.

As referenced above in regard to the OAS CAHPS survey, the AHA is concerned that the minimum number of cases to be eligible for a score on the measures does not align with the low-volume threshold. To trigger CJR-X episodes for a performance year (PY), a hospital not only must perform at least 31 LEJR episodes during the applicable three-year baseline period, but also must have a minimum of 25 patient cases for three of the measures and 100 for the CAHPS-based measures during the performance period (which is generally one year, with the exception of the RSCR measures, which is two). It is conceivable that hospitals with lower volumes in general could meet the volume threshold to trigger CJR-X episodes while not meeting the minimum case thresholds for multiple measures. Thus, a composite quality score could be informed not by actual performance, but instead by automatic assignment to the 50th percentile. It is unclear from the proposed rule whether CMS has investigated this possibility and the magnitude of participating hospitals that may be affected; we would encourage the agency to do so prior to finalizing the model as proposed. In addition, as detailed below, we urge CMS to finalize a higher low-volume threshold; doing so would help address this issue as well.

**Improvement Score.** The original CJR Model rewarded participants for quality improvement. CMS does not propose to include a policy that provides CJR-X

participants with quality improvement points, because the agency believes the model is structured to "emphasize absolute quality performance…rather than short-term year-over-year changes that may reflect random variation or changes in case mix." **The AHA respectfully disagrees with this conclusion and encourages CMS to include quality improvement points in its scoring methodology.** CJR-X being a mandatory, permanent, national model means it would include far more than the 324 hospitals in 34 MSAs that participated in the original model; the variety of new participants would be such that many hospitals (particularly those with lower volumes and susceptible to the issues with small numbers outlined above) may never be able to achieve scores associated with positive payment reconciliation. Other value-based purchasing programs include points for improvement as an incentive for those hospitals to focus on significant short-term improvements despite a comparable lack of resources or volumes. CJR included such an improvement incentive, and CMS suggests that CJR resulted in improved outcomes and quality of care. Thus, it is incongruous to suggest that including points for improvement would not result in substantive enhancements in quality. CMS can more highly value absolute quality performance by adopting a methodology like that used in the skilled nursing facility (SNF) VBP program, where hospitals can earn "achievement" points for meeting certain advanced benchmarks or "improvement" points for better outcomes versus a baseline.

## PRICING AND PAYMENT METHODOLOGY

### Baseline Period for Benchmarking

To calculate benchmark prices for episodes, CMS proposes to use three years of baseline episode spending trended forward to the most recent year of the baseline period, such that baseline year one and two spending would be expressed in baseline year three dollars. The agency proposes to weight episode spending from baseline year one at 17%, baseline year two at 33% and baseline year three at 50%. The three-year baseline period would be rolled forward to determine prices for each PY. CMS would group episodes from the baseline period into four different episode types and calculate separate benchmark prices for each region, resulting in 36 episode-type/region-level benchmark prices.

**We are concerned that this proposed approach for benchmarking would cause a ratchet effect for participating hospitals where they are effectively penalized for achieving past savings.** By rebasing the target price annually and weighting the most recent baseline year more heavily, hospitals would be more likely to experience diminishing returns over time and be forced to compete against their own best performance. **We urge CMS to weight each baseline year equally and extend rebasing timelines.** Indeed, while the agency has rebased prices annually for certain limited duration model tests (referred to as "Phase 1" models under section 1115A of the Social Security Act), this is not an appropriate policy choice for an expanded model. CJR-X has no fixed end point and could continue indefinitely. In other words, it is essentially a permanent payment program for LEJR episodes that would be imposed on

almost all hospitals nationwide. Annual rebasing would mean that target prices eventually would reach a level where it is no longer possible to achieve savings. **Combined with a 2% discount factor, this annual rebasing approach is not sustainable for a permanent mandatory program and would amount to a payment cut for hospitals.**

In contrast, under the Long-term Enhanced ACO Design (LEAD) Model, CMS chose not to rebase benchmarks for the model's entire 10-year duration. The agency stated that such a policy was designed to offer a predictable pathway toward sustainable long-term benchmarks and savings.[7] Specifically, it said that, "[t]o ensure that these [savings] opportunities are durable, LEAD will not rebase benchmarks, making the model appealing to both higher-spending ACOs seeking room to improve and lower-spending ACOs seeking a longer runway to sustain and build on their success." **This same reasoning applies even more so in a mandatory nationwide model like CJR-X.** Specifically, an extended timeline for rebasing would help to ensure that hospitals with limited or no prior experience in value-based care have a chance to improve and those who previously participated in bundled payment models are not penalized for their past success. **As such, we recommend that CMS use a similar rebasing approach for CJR-X as it has for a voluntary model like LEAD. Specifically, the agency should rebase, at most, once every 10 years.**

**Trend Factors**

CMS proposes to apply a prospective trend factor to the benchmark price for an episode to inflate it from the baseline period to the current PY. During the annual reconciliation process, the agency proposes to apply a retrospective trend factor, which would be capped at +/– 3%, to the reconciliation target price to account for actual changes in spending patterns during the PY. CMS states that this proposed methodology would be similar to the approach used in TEAM.

We appreciate that these proposals include guardrails that may help limit wide variation between preliminary and reconciliation target prices. As TEAM implementation continues, we urge CMS to continually evaluate whether these guardrails are sufficient to ensure target prices are accurate, stable and predictable for participants. Moreover, in light of the ratchet effect perpetuated by annual rebasing and a discount factor, it is incumbent upon the agency to build in additional safeguards for CJR-X to ensure target prices do not trend too low. **We recommend that CMS evaluate whether any administratively set components of target prices are needed to protect participants from the ratchet effect in both CJR-X and TEAM.** While the agency has incorporated administrative benchmark policies (such as the Accountable Care Prospective Trend) in some of its ACO models to mitigate the ratchet effect, they have

[7] https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf

proved challenging to implement and had unintended consequences for participants. CMS should conduct a robust analysis of the administratively set components of pricing in the ACO context and apply lessons learned before considering whether similar policies would be appropriate for CJR-X and TEAM.

**Regional Target Prices**

CMS proposes to construct target prices for each episode type and region based on 100% regional data, consistent with the approach used in TEAM and the later years of CJR. **We appreciate that this approach was intended to mitigate hospitals having to compete against their own best performance. However, it is not sufficient, and we recommend additional protections as well as policies to support organizations disproportionately serving medically complex populations.**

Hospitals that achieve savings should not be penalized in subsequent PYs by having their success make future savings more difficult to achieve. To be clear, no matter the adjustments CMS makes, programs that are designed to achieve savings for the Medicare program year after year will see diminishing returns over time. This fact is particularly relevant for an expanded, mandatory model of indefinite duration like CJR-X. Providers in low-spending areas will first begin to encounter such limited opportunities for additional gains in efficiency, but eventually, the agency will no longer be able to continue decreasing target prices without putting the quality of care at risk. We are particularly concerned about hospitals that previously participated in CJR and BPCI-A, as they will be immediately impacted by diminishing returns.

**Therefore, we urge the agency to instead use the higher of the national or regional historical episode spending in calculating the target price. To be clear, even this policy will be of limited value in a mandatory model that is nationwide and indefinite.** But it would at least help ensure that appropriate incentives are provided to participants in both high- and low-spending areas and mitigate the impacts of regional variation that have been seen in other models. **We also recommend that CMS apply a prior savings adjustment to target prices to account for savings that participants have achieved in past years, as well as a regional efficiency adjustment to recognize participants with historically lower spending than their region. Additionally, target prices should be adjusted for historically higher-spending participants who may need additional time to implement care redesign before they will be able to achieve savings.** CMS has included these types of adjustments in other long-term or permanent programs, such as LEAD and the Medicare Shared Savings Program, to ensure their continued stability and sustainability for participants. This strongly underscores the need for similar adjustments in a permanent nationwide mandatory model like CJR-X to ensure that target prices are set fairly and participants have a real opportunity for success.

We also urge CMS to further stratify target prices to account for clinical complexity, as discussed below in the Risk Adjustment section. For example, at a minimum, target

prices should be adjusted based on fracture status, patient frailty, whether the anchor procedure was inpatient or outpatient, and whether the case was elective or emergent. Without an adequate risk adjustment to account for these factors, target prices would not adequately reflect the full spectrum of clinical complexity.

**Finally, safety-net hospitals and other hospitals serving a higher proportion of underserved beneficiaries should have a separate target price methodology.** As discussed above in the Participation section, safety-net hospitals and those serving higher proportions of DE and LIS beneficiaries in LEJR episodes perform categorically worse under CJR-X (see Table 1). Regional target prices inclusive of all provider types would adversely impact these organizations. Indeed, by lumping all provider types together, the model as proposed ignores the complexity of patients served by organizations like rural and safety-net hospitals.

**Risk Adjustment and Normalization**

For CJR-X, CMS proposes to use the same risk adjustment methodology and variables that are used in TEAM. Specifically, the agency proposes to risk-adjust target prices at the hospital level using hospital bed size and safety-net risk adjustment factors. It also would risk-adjust at the beneficiary level with an 180-day lookback period using hierarchical condition categories (HCCs) count, age bracket and beneficiary economic risk adjustment factors, as well as certain conditions or HCCs.

**The proposed 180-day lookback period is insufficient because it is too short and occurs prior to the anchor hospitalization or procedure. As such, it does not account for the breadth of chronic conditions supported by physician documentation that a patient may have.** Specifically, it would not account for conditions that are included only on the claim and related documentation for the anchor hospitalization or procedure and not on other prior claims. We conducted an R-squared analysis using the risk adjustment variables proposed for CJR-X to determine whether models with or without the anchor hospitalization/procedure in the lookback period explained a greater degree of variation. R-squared analysis assesses the “goodness of fit” of a regression model, or how well variation in a regression is explained by independent variables. Our analysis shows that including the anchor hospitalization/procedure in the lookback period explains more variation through higher R-squared values. Specifically, including the anchor hospitalization/procedure in the lookback period results in an R-squared value of 0.5497, whereas excluding it yields a lower R-squared value of 0.5443.

Furthermore, we found that spending on LEJR episodes increases linearly with the number of beneficiary HCC, complications or comorbidities, or major complication or comorbidity flags. It is therefore imperative to the creation of a fair and accurate model that the risk adjustment methodology appropriately captures the patient’s clinical history. **As such, we urge CMS to include the anchor hospitalization or procedure in the lookback period. In addition, we urge the agency to implement a longer lookback**

**period of at least 12 months for consistency with its other models, such as BPCI-A.**

Although we commend CMS for proposing a significantly more robust risk adjustment methodology for CJR-X than the CJR Model, opportunities for improvement remain. **Specifically, we recommend expanding the methodology to better account for clinical complexity by including additional risk adjustment variables, such as emergent versus elective procedures, inpatient versus outpatient episode initiators, fracture versus non-fracture status, and patient frailty.** For example, our analysis shows that participant performance on episode spending is significantly affected by whether an LEJR procedure is emergent or scheduled and whether it is inpatient or outpatient. When we divided hospitals into quintiles based on the difference between their regional target price and spending per episode, we found that hospitals in the highest spending quintile had a higher proportion of patients admitted through the emergency department (ED) or for trauma (see Table 2). In addition, hospitals with a higher proportion of outpatient anchor procedures consistently performed better on episodes (see Table 2).

**Table 2. Distribution of Hospital Characteristics for LEJR Episodes by Quintile: Admission Source and Outpatient Anchor Procedure**

| | Number of Hospitals | Number of Episodes | Average Episode Spending | Average Target Price | Difference Between Target and Spending | Percent Episodes ED or Trauma Admission | Percent Episodes OP Anchor Procedure |
|---|---|---|---|---|---|---|---|
| Highest Spending Quintile | 407 | 69,050 | $33,835 | $29,093 | -$4,742 | 18.8% | 53.9% |
| 2nd Quintile | 408 | 177,066 | $27,359 | $25,296 | -$2,064 | 10.5% | 71.3% |
| 3rd Quintile | 407 | 211,082 | $24,961 | $24,329 | -$632 | 8.2% | 75.9% |
| 4th Quintile | 408 | 247,519 | $23,618 | $24,163 | $544 | 7.9% | 78.0% |
| Lowest Spending Quintile | 408 | 159,487 | $22,750 | $24,652 | $1,901 | 9.1% | 78.5% |
| **Total** | **2,038** | **864,204** | **$25,369** | **$24,920** | **-$449** | **9.6%** | **74.3%** |

Source: AHA analysis of FY 2023-2025 Medicare claims data.

We further analyzed episodes where patients were admitted through the ED or for trauma (see Table 3) as well as episodes triggered by an inpatient or outpatient anchor procedure (see Table 4). As shown below, episode spending for these different types of cases varies to a staggering degree and should be accounted for in CMS' risk adjustment methodology.

**Table 3. Episode Spending for LEJR Based on Admission Source**

| Admission Source | Number of Hospitals | Number of Episodes | Average Episode Spending | Average Target Price | Difference Between Target and Spending |
|---|---|---|---|---|---|
| ED/Trauma | 1,867 | 82,869 | $51,638 | $50,304 | -$1,334 |
| Other | 1,995 | 781,335 | $22,583 | $22,227 | -$355 |

Source: AHA analysis of FY 2023-2025 Medicare claims data.

**Table 4. Episode Spending for LEJR Based on Anchor Procedure**

| Anchor Procedure | Number of Hospitals | Number of Episodes | Average Episode Spending | Average Target Price | Difference Between Target and Spending |
|---|---|---|---|---|---|
| Inpatient | 2,014 | 222,332 | $38,780 | $35,666 | -$3,115 |
| Outpatient | 1,911 | 641,872 | $20,724 | $21,198 | $474 |

Source: AHA analysis of FY 2023-2025 Medicare claims data.

Additionally, CMS proposes that a prospective normalization factor would be constructed using the full baseline period and adjusted up to +/– 5% at reconciliation based on the observed case mix. **We are concerned that this normalization factor has the potential to negate the risk adjustment and, in fact, exceed the risk adjustment, as has been the case in previous iterations of bundled payment models. As such, we recommend that CMS cap the normalization factor to, at a minimum, not exceed the risk adjustment.**

**Discount Factor**

The proposed rule would apply a 2% discount factor to CJR-X benchmark prices. Although a 3% discount factor was used in the CJR Model, the agency states it would not be sustainable for an expanded model and could result in more price ratcheting over a longer time horizon. CMS also states that it considered but is not proposing lower discount factors, including 1.5%, 1% or no discount factor.

We appreciate CMS' recognition that a discount factor could exacerbate the ratchet effect in an expanded model. **However, a 2% discount factor is much too aggressive, especially for a mandatory, expanded, indefinite model and in the context of other CJR-X model design features such as annual rebasing. The opportunity to achieve savings under mandatory, expanded, indefinite models like CJR-X is not the same as in CJR or other Phase 1 models; rather, it is much less. The discount factor combined with annual rebasing means that CJR-X has the potential to be nothing more than a payment cut for hospitals nationwide.**

Indeed, based on our analysis, 53% of episode spending in CJR-X would be accounted for by the anchor hospitalization or procedure. This is extremely problematic. Hospitals cannot decrease the anchor hospitalization or procedure payment amount, leaving them with limited opportunity to achieve efficiencies and meet, let alone reduce spending below, the proposed 2% discount factor.

Hospitals' ability to decrease episode spending in CJR-X is even further constrained by their past participation in previous models. LEJR episodes were included in both CJR and BPCI-A. Each of these models ran for an extended term of eight PYs. Many of the hospitals that participated in these two predecessor models have already produced as much cost savings as they possibly could in LEJR episodes. **We urge CMS to consider the potential impact on quality of care if hospitals are forced to wring additional savings from LEJR episodes to ensure spending comes in below the discounted amount.** Further, as discussed above, the collective savings hospitals achieved on LEJR through care redesign under CJR and BPCI-A would be reflected in CJR-X's regional benchmark prices.

Additionally, CMS states that it proposes a 2% discount factor for CJR-X because it is the discount applied to LEJR episodes in TEAM. However, this is not an appropriate comparison. TEAM is a five-year Phase 1 model test that includes only a subset of hospitals. In contrast, CJR-X would be an expanded model of indefinite duration in which nearly all hospitals nationwide must participate. We continue to believe that the range of discount factors used in TEAM (1.5%-2% depending on the episode category) is too high even for a Phase 1 model. But if the same 2% discount factor used in a five-year model like TEAM is applied every year in perpetuity for CJR-X, episode spending would have to be reduced to below $0 to continue to achieve savings.

We urge CMS to provide hospitals with a fair opportunity to achieve enough cost savings to garner a reconciliation payment. **Specifically, we recommend that CMS not finalize any discount factor for CJR-X. If the agency were to adopt a discount factor, it should be set below 2% and phased out entirely after three years.**

**High-cost Outlier Cap**

The proposed rule would cap episode spending for both the baseline period and PY at the 99th percentile of spending for the episode type, region and baseline year. **Although we agree that high-cost spending caps are necessary to protect hospitals from the adverse effects of cases with unexpected and severe complications on episode spending, evidence from the CJR Model suggests that the 99th percentile does not sufficiently capture outliers.** The CJR Model originally capped individual episode costs at two standard deviations above the mean. However, CMS later changed the cap to the 99th percentile, which was too high and did not capture the prevalence of severe complications. **We urge CMS to use its initial CJR**

**policy and set outlier spending thresholds at two standard deviations above the mean.**

**Low-volume Hospitals**

CMS proposes that low-volume hospitals, defined as those with fewer than 31 LEJR episodes performed during the three-year baseline period, would not receive a target price or trigger CJR-X episodes for a PY. As the baseline period shifts forward each year, a hospital potentially could meet the volume threshold and trigger CJR-X episodes for a subsequent PY.

**A low-volume threshold is a critical component of the CJR-X design. However, we urge CMS to reevaluate the proposed threshold.** The purpose of a low-volume threshold is multifaceted. It should ensure that hospitals have enough cases to integrate changes in care delivery and determine if they had an impact based on statistical significance. Additionally, it should ensure that the costs associated with standing up infrastructure for model participation (for example, analytics and staffing) can be offset by potential gains in the model. Financially, it should provide protection against outliers and volatility inherent in small sample sizes. A set threshold of 31 cases across three baseline years would not accomplish these objectives.

Our analysis underscores this point. **In analyzing the average gains and losses per episode (that is, spending below or above the regional target price), we found that high losses and high variation were experienced in hospitals with up to 344 episodes over the three-year baseline period (see Table 5).** Indeed, hospitals with fewer than 344 cases had projected repayments more than twice as high as all hospitals as well as significant variation in their range of repayments.

**Table 5. Gain/Loss Values for Hospitals Before Application of Stop-loss and Stop-gain Limits**

| | | | | | Gain/Loss Per Episode | | | |
|---|---|---|---|---|---|---|---|---|
| Decile by Episode Volume | Number of Hospitals | Average Number of Episodes | Minimum Number of Episodes | Maximum Number of Episodes | Weighted Average | Minimum | Maximum | Range |
| 1 | 203 | | | 20 | -$2,351 | -$68,461 | $31,684 | $100,145 |
| 2 | 204 | 35 | 20 | 53 | -$2,682 | -$22,029 | $8,597 | $30,626 |
| 3 | 204 | 77 | 53 | 103 | -$1,604 | -$13,249 | $10,190 | $23,439 |
| 4 | 204 | 133 | 103 | 162 | -$1,469 | -$11,462 | $5,221 | $16,683 |
| 5 | 203 | 203 | 162 | 243 | -$1,088 | -$11,868 | $4,027 | $15,895 |
| 6 | 204 | 289 | 243 | 344 | -$1,059 | -$10,599 | $3,193 | $13,791 |
| 7 | 204 | 408 | 344 | 470 | -$686 | -$8,609 | $3,118 | $11,727 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 8 | 204 | 571 | 471 | 674 | -$623 | -$7,034 | $4,254 | $11,288 |
| 9 | 204 | 844 | 677 | 1,058 | -$137 | -$4,809 | $3,993 | $8,802 |
| 10 | 204 | 1,669 | 1,060 | 4,732 | -$116 | -$4,027 | $3,119 | $7,146 |
| **Total** | **2,038** | **424** | | **4,732** | **-$449** | **-$68,461** | **$31,684** | **$100,145** |

Source: AHA analysis of FY 2023-2025 Medicare claims data.

Even when adjusting for the application of proposed stop-gain and stop-loss limits, high average losses coupled with high variation were still experienced well beyond 31 cases (see Table 6).

**Table 6. Gain/Loss for Hospitals After Application of Stop-loss and Stop-gain Limits**

| | | | | | Gain/Loss per Episode | | | |
|---|---|---|---|---|---|---|---|---|
| **Decile by Episode Volume** | **Number of Hospitals** | **Average Number of Episodes** | **Minimum Number of Episodes** | **Maximum Number of Episodes** | **Weighted Average** | **Minimum** | **Maximum** | **Range** |
| 1 | 203 | | | 20 | $343 | -$10,767 | $11,878 | $22,645 |
| 2 | 204 | 35 | 20 | 53 | -$744 | -$9,570 | $8,597 | $18,167 |
| 3 | 204 | 77 | 53 | 103 | -$647 | -$9,701 | $10,190 | $19,891 |
| 4 | 204 | 133 | 103 | 162 | -$755 | -$6,991 | $5,188 | $12,178 |
| 5 | 203 | 203 | 162 | 243 | -$677 | -$5,730 | $4,027 | $9,757 |
| 6 | 204 | 289 | 243 | 344 | -$691 | -$7,862 | $3,193 | $11,054 |
| 7 | 204 | 408 | 344 | 470 | -$501 | -$5,136 | $3,118 | $8,254 |
| 8 | 204 | 571 | 471 | 674 | -$378 | -$6,824 | $4,254 | $11,078 |
| 9 | 204 | 844 | 677 | 1,058 | -$41 | -$4,809 | $3,993 | $8,802 |
| 10 | 204 | 1,669 | 1,060 | 4,732 | -$93 | -$4,027 | $3,119 | $7,146 |
| **Total** | **2,038** | **424** | | **4,732** | **-$264** | **-$10,767** | **$11,878** | **$22,645** |

Source: AHA analysis of FYs 2023-2025 Medicare claims data.

**Therefore, we urge CMS to substantially increase the low-volume threshold to ensure statistical significance and effectively mitigate potential impacts of outliers and volatility in cases.** Ultimately, APMs should provide a level playing field to ensure that participants have a fair chance of earning savings. This goal would not be met by forcing hospitals without sufficient volume to participate in CJR-X.

**Annual Reconciliation**

As it does with other bundled payment models, CMS proposes to reconcile PY spending on CJR-X episodes against target prices to determine if participants would receive a reconciliation payment or owe a repayment. Preliminary target prices would be adjusted for risk, trend, normalization and geographic wage factors to create reconciliation target

prices. Additionally, CMS proposes to adjust the 2% discount factor based on a CJR-X participant's composite quality score (CQS) using four categories. A participant must earn a CQS of at least 6.1 to be eligible for a reconciliation payment.

**Stop-loss and Stop-gain Limits**

CMS proposes to apply stop-loss and stop-gain limits of 20% to most CJR-X participants and stop-loss limits of 5% to special designation hospitals (rural, Medicare-dependent, sole community and safety-net hospitals). Although the agency did not specifically address stop-gain limits for special designation hospitals in the proposed rule, we support application of the same 20% stop-gain limit for these hospitals as well and recommend that CMS clarify this point in the final rule.

**We support limitations on the repayment responsibility for participant hospitals. However, we are concerned that CMS' proposed approach does not provide an adequate glide path for participants, particularly in an expanded nationwide mandatory model.** Although CMS would limit losses to 20% of the target price, in reality this is a much higher percentage limit when considering hospitals' actual payments. Specifically, as we noted previously, payments for the anchor hospitalization or procedure account for 53% of total episode payments. Therefore, if hospitals are at risk for repayments equal to 20% of the target price, they are actually at risk for repayments equal to 38% of their episode payments. For example, if the target price were $100 and hospital payments accounted for $53 (53%) of that amount, a stop-loss of $20 (20%) would represent 38% ($20/$53) of the hospital's payment.

Given the ratchet effect caused by CJR-X's design elements and the limited experience of hospitals that did not participate in CJR or BPCI-A, **we urge CMS to phase in the maximum stop-loss limit gradually over a period of at least five years** after the initial data sharing year that we have recommended above. **Additionally, we recommend that the maximum stop-loss limit be no more than 10% for most CJR-X participants and 2.5% for special designation hospitals (to the extent CMS chooses to subject them to downside risk at all).**

**Participant Responsibility for Increased Post-episode Payments**

To identify and address inappropriate shifting of care, CMS proposes to determine whether a CJR-X participant's average 30-day post-episode spending in a PY is greater than three standard deviations above the regional average. If the participant's spending exceeds this threshold, they would repay Medicare for that amount, which would not be subject to stop-loss limits. Although we agree with the intent of this proposal to ensure services are not withheld or delayed until after an episode ends, we are concerned that certain complex cases requiring substantial post-acute care may exceed the proposed threshold, resulting in penalties for care that is clinically appropriate. **To avoid holding participants responsible for necessary post-episode care, we recommend that the**

**stop-loss limits policy for participant repayment of episode spending also apply to post-episode spending amounts owed.**

## CONCURRENT PARTICIPATION IN OTHER CMS MODELS

CMS proposes that a beneficiary who is in a CJR-X episode also may be attributed to a provider participating in a total cost of care or shared savings model or program, such as the Medicare Shared Savings Program or CMMI ACO models. While CJR-X episode spending would be included in the other model's total cost of care calculation, CJR-X's reconciliation payments and repayments would not be included. Similarly, the other model's shared savings payments and losses would not be counted as episode spending in CJR-X.

CMS also proposes that hospitals participating in TEAM would be excluded from CJR-X. If an LEJR procedure occurs at a TEAM participant hospital, it would trigger a TEAM episode rather than a CJR-X episode. Further, if a beneficiary in a TEAM episode has an LEJR procedure performed at a CJR-X participant hospital during TEAM's 30-day post-discharge period, the LEJR procedure would not initiate a CJR-X episode, and the spending would be included in the TEAM episode.

**We support the proposal to allow concurrent attribution of CJR-X beneficiaries to participants in total cost of care and shared savings models and programs.** We agree that savings and losses under one model or program should not count against participants in another model or program. **Additionally, we support the proposal to exclude TEAM participants from CJR-X. However, as discussed above in the Participation section, we recommend that TEAM participants be given the choice to participate in CJR-X when TEAM ends or if they no longer meet the criteria for inclusion in TEAM.** Similarly, hospitals participating in other APMs also should be allowed to opt in voluntarily to CJR-X, including those participating in AHEAD, IOTA and ACO models and programs.

## FINANCIAL ARRANGEMENTS AND BENEFICIARY INCENTIVES

Prior to issuance of a final rule, the AHA urges the secretary to use the full scope of the authority granted by Congress under section 1115A(d)(1) of the Social Security Act to issue waivers of the potentially applicable fraud and abuse laws to enable participant hospitals to form the financial relationships necessary to succeed in CJR-X. Specifically, to the extent these arrangements are not already captured within the value-based care exceptions and CMS-sponsored model arrangements and patient incentives safe harbor, the secretary should waive the Physician Self-Referral Law, the Anti-Kickback Statute and the Beneficiary Inducements Civil Monetary Penalty (CMP) Law (the "fraud and abuse laws") with respect to financial arrangements formed by hospitals participating in CJR-X that comply with the requirements in the proposed rule. The secretary ultimately recognized the necessity of these waivers to the success of the CJR Model, issuing them in conjunction with the rule finalizing that model. We urge the

same to occur for this proposed CJR-X Model. These waivers are consistent with the Department of Health and Human Services' (HHS') efforts to broaden the use of value-based payment models and are essential to enable hospitals to form financial arrangements with other providers and suppliers collaborating in the model. Without these arrangements, hospitals cannot make sure the organizations — for whose outcomes the hospitals would be held accountable — have a real stake in achieving the model's goals.

As proposed, any financial arrangement or agreement under CJR-X that implicates the fraud and abuse laws would not be protected unless it falls under an existing exception or safe harbor. Although the AHA takes the position that the value-based care exceptions to the fraud and abuse laws and the CMS-sponsored model arrangements and patient incentives safe harbor to the Anti-Kickback Statute should cover many scenarios, it is critical that HHS fully mitigate the risk for hospitals, whose participation in CJR-X would be mandatory. They should not have to spend hundreds of hours or thousands of dollars in hopes of stringing together components from the existing exceptions and safe harbors or developing inefficient workarounds to meet the demands of this new model and avoid running afoul of the fraud and abuse laws. **Hospitals must have these necessary, explicit protections in place and adequate time to form financial arrangements. Such models cannot be successful for Medicare and its beneficiaries without these protections.**

Under CJR-X, hospitals would bear responsibility for the financial and quality outcomes of other providers and suppliers who provide care to Medicare beneficiaries during episodes. In the proposed rule, CMS states that participant hospitals may rely on financial arrangements with those providers and suppliers, which CMS refers to as "CJR-X collaborators," to share the model's potential risks and rewards. Indeed, our members report that such financial arrangements are not just desirable but rather essential to successful participation in CJR-X. CMS itself acknowledges in the proposed rule that the financial relationships between participant hospitals and CJR-X collaborators may implicate the fraud and abuse laws. Despite this recognition, the proposed rule does not include waivers of any of the potentially applicable fraud and abuse laws. CMS indicated that it expects to make a determination that the Anti-Kickback Statute safe harbor for CMS-sponsored model arrangements and patient incentives is available to protect remuneration exchanged pursuant to certain financial arrangements and patient incentives in CJR-X, but there is no parallel exception to the Physician Self-Referral Law.

**Sharing Arrangements**

CMS proposes a detailed regulatory structure that would govern any CJR-X financial arrangements and also serve as a built-in safeguard against fraud and abuse concerns. Hospital participants, for example, would be required to set forth a written agreement that includes the terms of any sharing arrangements, such as sharing of reconciliation payments or hospital internal cost savings, or of repayments to Medicare. The written

agreement detailing the sharing arrangements would be subject to extensive requirements, including descriptions of the methodologies used to calculate any payments to and from participant hospitals and CJR-X collaborators (known as gainsharing and alignment payments); plans regarding care redesign, changes in care coordination or delivery and a description of how success would be measured; and information on management and staffing personnel. Further, any gainsharing and alignment payments would be subject to specific requirements.

As CMS itself states in the proposed rule, "[w]e propose several requirements for sharing arrangements to help ensure that *their sole purpose is to create financial alignment between CJR-X participants and CJR-X collaborators toward the goals of the model while maintaining adequate program integrity safeguards* (emphasis added)." **We agree and believe that satisfaction of these requirements and responsibilities should provide participant hospitals protection under the fraud and abuse laws.**

**Collaborators**

CMS proposes that several types of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative, may be CJR-X collaborators. **We urge CMS to also include rural emergency hospitals, federally qualified health centers and rural health clinics as additional types of organizations that may be CJR-X collaborators.** This would enable rural providers to better align their care delivery with model participants.

**Beneficiary Incentives**

**In addition, we urge the secretary to either waive the CMP Law for beneficiary incentives that comply with the requirements in the proposed rule or state explicitly that any incentives established under CJR-X that comply with the proposed requirements meet a statutory exception to the CMP Law.** CMS proposes to allow CJR-X participants to provide in-kind patient engagement incentives to beneficiaries in an episode, including items of technology, subject to certain conditions. However, the agency has not proposed to waive the CMP that prohibits beneficiary inducement, nor to declare that compliance with the terms and conditions satisfies a statutory carve-out to the prohibition. Therefore, CMS' proposal, as drafted, risks giving hospitals a false sense of security that the beneficiary incentives that may be offered as a programmatic element of CJR-X do not run afoul of the law.

**WAIVERS OF MEDICARE PROGRAM REQUIREMENTS**

The waiver of certain Medicare program requirements is essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time. **We urge CMS to provide CJR-X hospital participants with additional and maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals.** Specifically, we have

concerns over certain proposed waivers, namely those related to the SNF three-day rule. In addition, we recommend that the agency make additional waivers, outlined below, that would provide our members with valuable tools to increase quality and reduce unnecessary costs. These waivers are commensurate with the level of risk and accountability that CMS is asking hospitals to assume as it shifts the burden of risk further away from the Medicare program and onto providers.

**Post-discharge Home Visits and Homebound Requirement**

CMS proposes to waive the ‘‘incident to’’ rule to allow a CJR–X beneficiary who does not qualify for home health services to receive post-discharge visits in their home or place of residence any time during the episode. **We support this proposed waiver and agree that this flexibility would enable clinically appropriate home-based follow-up care to be provided to CJR-X beneficiaries.**

However, CMS did not expressly propose to waive the requirement that a beneficiary must be homebound to receive home health (HH) services. Rather, the agency proposed that the post-discharge visit would be billed under a HCPCS G-code specific to CJR-X to allow for a home visit for patient assessment performed by clinical staff for an individual not considered homebound. **To provide certainty for hospitals that would bill this G-code and mitigate the risk of noncompliance, we urge CMS to clarify in the final rule that it is also waiving the homebound requirement.** Hospitals may find good clinical rationale for utilizing HH services for non-homebound patients. Waiving the homebound requirement could result in lower episode spending in some instances, such as helping a non-homebound beneficiary avoid a hospital readmission. CMS should allow physicians, working together with participating hospitals, to determine the most clinically appropriate plan for a patient’s post-acute care, unimpeded by regulatory barriers.

**Telehealth**

**The AHA supports CMS’ proposed telehealth waivers.** Specifically, the agency would waive the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project approved as of Dec. 31, 2000. In addition, CMS would waive the originating site requirements that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system, but only when telehealth services are being furnished in the beneficiary's home or place of residence during the episode.

The agency also proposes to create a specific set of four HCPCS G-codes to describe the evaluation and management (E/M) services furnished to CJR-X beneficiaries in their homes via telehealth, like those in the BPCI-A and CJR models. In general, we recommend that CMS leverage existing coding practices to delineate telehealth visits as opposed to creating new codes. The G-codes proposed do not appear to differ clinically

from existing E/M codes and are the same E/M codes in the list of current telehealth codes covered by Medicare. As such, it is unclear why separate codes would be necessary, especially considering there is already guidance on using place of service codes for professional telehealth services to be provided to the patient's home.

**SNF Three-day Rule**

CMS proposes to waive the SNF three-day rule for discharges to SNFs with at least a three-star rating in the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. The waiver also would apply if a CJR-X beneficiary receives SNF services through swing bed arrangements in a hospital or critical access hospital, although the minimum three-star rating requirement would not apply in those instances. We are concerned about CMS' proposal to limit the waiver to SNFs with at least a three-star rating given their limited availability in certain markets. **Specifically, we are concerned that the structure of CMS' proposed waiver would lead to two separate and unequal tiers of care: a more flexible, patient-centered level for patients in markets with an adequate supply of three-star SNFs and a more restrictive, regulation-driven level for patients in markets with an inadequate supply of three-star SNFs.**

We also have concerns about the star rating methodology itself. For example, the biggest part of a SNF's star rating is the facility inspections conducted by CMS or, most likely, state surveyors. While surveys are an important activity for ensuring compliance with regulations, there is significant state-to-state and surveyor-to-surveyor variation in how survey standards and guidance are applied. As a result, the findings from surveys can be highly subjective. Although CMS has attempted to account for the variation in survey practices by creating a distribution of star ratings on inspection data based on the relative performance of facilities within a state, we have concerns about the extent to which this adequately addresses the problem. As CMS proposes to hold participant hospitals financially accountable for the quality and costs of the entire episode of care, the decision to admit a patient to a setting of care should be at the discretion of the patient's physician, working together with them and the participant hospital.

**Hospital Discharge Planning Requirements**

**The AHA strongly urges CMS to waive hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services.** Such regulations inhibit the efficient coordination of care. When a patient elects to receive a bundle of services from a provider, that patient also elects to receive a carefully prescribed course of treatment that can span multiple provider settings. CMS would hold participant hospitals financially accountable for quality and costs for the entire episode of care. The agency also must provide them with the flexibility to direct patients to the most clinically appropriate, high-quality next setting of care.

**Inpatient Rehabilitation Facility "60% Rule"**

**We urge CMS to waive the inpatient rehabilitation facility (IRF) 60% Rule that requires that at least 60% of an IRF's patients have one of 13 clinical conditions.** Hospital participants have no incentive to over-utilize or inappropriately direct patients to IRFs. In contrast, they may find good clinical rationale for IRF stays for many patients, such as allowing beneficiaries to return to their communities more quickly. Further, as CMS would hold participant hospitals financially accountable for the quality and costs of the entire episode of care, the agency should provide them with the flexibility to direct patients to the most clinically appropriate next setting of care.

**IRF "Three-hour Rule"**

Medicare has a long-standing requirement that IRF patients require and receive at least three hours of therapy a day, the "preponderance" of which must be provided one-on-one. **We urge CMS to waive the "preponderance" requirement under CJR-X.** Medicare has stated that, for IRFs, the "standard of care is individualized (i.e., one-on-one) therapy." However, each mode of therapy is carefully selected by the therapist based on the individual needs of the patient, and hospital participants have every incentive to work with IRFs to obtain the best possible treatment for their patients. And for many patients, such as those for whom medical improvement, restoration of functional independence and the achievement of patient education goals are advanced through the social interaction and motivation gained through the group dynamic, concurrent or group therapy is often the preferred treatment method. Allowing more flexibility on the type of therapy an IRF provides would serve as a valuable tool for participants to increase quality and reduce unnecessary costs.

**DATA SHARING**

Model participants will need timely access to data about their patient populations. Historically, the lack of transparent, real-time data has created confusion on trigger events, eligibility for episodes and model participation. CMS proposes to make certain beneficiary-identifiable claims data and regional aggregate data available to CJR-X participants for the three-year baseline period and performance year. **We support the provision of these data points. However, providing them only one month prior to the start of the performance year will not allow enough time to perform necessary analyses and meaningfully use the data. We urge the agency to convey this information at least 60 days prior to the start of the relevant performance year.**

Moreover, a number of hospitals participating in historical models have indicated that their target prices often changed during the performance period, sometimes significantly and inexplicably. **To further stabilize the target prices for model participants, we urge CMS to update its underlying assumptions related to the target price annually and to do so through notice-and-comment rulemaking.**

**ALTERNATIVE PAYMENT MODEL OPTIONS**

CMS proposes to establish two APM options under CJR-X. Specifically, an Advanced APM option under which a participant's eligible clinicians may be assessed for Qualifying APM Participant (QP) determinations, and a non-Advanced APM option under which a participant's Merit-based Incentive Payment System (MIPS) eligible clinicians may be assessed for reporting and scoring through the APM Performance Pathway. **We support CMS creating options under CJR-X for participants' eligible clinicians to achieve QP status or participate in MIPS.**