Bundles Are Back, Now Mandatory and Nationwide: A Builder's Field Guide to the New Companies, Tools, and Channels That Should Get Built Around CMS's CJR-X Lower-Extremity Joint Replacement Model

APR 19, 2026 • PAID

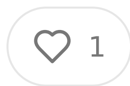

Table of Contents

What just happened on April 10

The size of the prize, in actual dollars and procedures

Why the old CJR playbook is only partially useful here

Builder opportunity one: the post-acute steerage and PT layer

Builder opportunity two: PROMs as a revenue cycle problem

Builder opportunity three: the outpatient migration toolkit

Builder opportunity four: risk-adjusted target price intelligence

Builder opportunity five: the convener and gainsharing back office

Builder opportunity six: device, implant, and supply rationalization

Builder opportunity seven: rural and safety net co-pilot

Builder opportunity eight: the patient navigation and demand-side play

Channel and GTM notes for anyone selling into this

Closing thoughts on timing, exits, and what could break the thesis

Abstract

Quick framing for anyone skimming:

- CMS dropped the FY27 IPPS proposed rule on April 10, 2026, and tucked insi CJR-X, the first ever mandatory, nationwide, episode-based payment model in U history.

- Start date: October 1, 2027. Five performance years through Sept 30, 2032. Rou 3,000+ IPPS hospitals in scope, minus the ~700 already in TEAM and minus Maryland.

- Episode = 90 days post-discharge from inpatient or outpatient hospital LEJR. Triggers: MS-DRG 469, 470, 521, 522, plus HCPCS 27447 (TKA) and 27130 (TH plus total ankle.

- Risk adjustment jumps from 3 levers in CJR to 29 in CJR-X (same engine as TE 5% stop-loss for safety net, dual-eligible heavy, geographically rural, MDH, and hospitals.

- Quality first: 5 measures including the THA/TKA PRO-PM (CMIT 1618), whic CMS plans to weight heavier than TEAM does. PROMs are now a P&L input.

- TAM context: ~1M+ Medicare TKAs and ~600K Medicare THAs annually as of growing at 5.9% and 7.6% CAGR respectively, with surgeon reimbursement dow ~55% inflation-adjusted since 2000. Hospitals are squeezed on the front end and risk-bearing on the back end.

- Net savings from the original CJR's PY6 and PY7 (2021 to 2023): $112.7M, witl quality flat. CMS has a green light to scale.

- Eight buildable categories laid out in the body, plus channel notes for selling i
hospitals, ortho groups, ASCs, SNFs, and home health.

What just happened on April 10

The April 10 release of the FY 2027 IPPS proposed rule, all 1,500-ish pages of it contained the regulatory equivalent of a starter pistol for healthcare services bu Buried inside that doorstop is CJR-X, which CMS would like to begin on Octob 2027 as the first nationwide test of a mandatory episode-based payment model. I comments are open through June 9, 2026. CMS Administrator Mehmet Oz fram in the press release as aligning incentives with outcomes and protecting taxpaye dollars, which is the standard phrasing for "we are putting hospitals on the hool 90 days of post-op spend whether they like it or not."

The mechanics are familiar to anyone who lived through the original CJR (2016 through 2024) or who has been reading the TEAM tea leaves. Acute care hospita a target price covering all Part A and Part B services in a 90 day episode beginni with the procedure. They keep getting paid FFS during the year. After year-end, reconciles actual spend against the target price, applies a quality adjustment ba the composite quality score, and either cuts a check or sends an invoice. Stop-lo set at 20% for most participants, 5% for the protected categories. The quality fir principle still applies, meaning if a hospital fails to clear the minimum composi quality score, no reconciliation payment, full stop.

What is meaningfully different from CJR is the scope. The original ran in 67 me peak, then settled into 34 MSAs. CJR-X is every IPPS hospital in the country exc Maryland (carved out by the Total Cost of Care waiver) and the roughly 700 hos already locked into TEAM, who flip into CJR-X when TEAM expires on Decemb 2030. Total ankle replacement is now in scope. Outpatient hospital procedures a now in scope. The episode definition follows the patient through the HOPD. Cri access hospitals and rural emergency hospitals stay exempt because they sit outs the IPPS/OPPS plumbing.

The other meaningful change is the risk adjustment engine. The old CJR ran wit three risk adjusters and got criticized, fairly, for clobbering hospitals that drew sicker, more complex populations. CJR-X imports the TEAM methodology: 29 adjusters at the episode level (age, HCC count, dual-eligibility, procedure type, disability as the original reason for Medicare enrollment, prior PAC use, plus 21 specific HCCs) and two at the participant level (bed count and dual-eligible shar For builders, this matters more than it sounds. A more sophisticated risk model means hospitals can no longer just "select better patients" to game the model. T acuity is priced in. The only way to win is to actually run a better episode.

The size of the prize, in actual dollars and procedures

Continue reading this post for free, courtesy of Special Interest Media.

Claim my free post

Or purchase a paid subscription.

© 2026 Thoughts on Healthcare · Privacy • Terms • Collection notice
Substack is the home for great culture