Federation of American Hospitals

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President and CEO

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Via electronic submission at *http://www.regulations.gov*

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1849–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Quality Programs Requirements; and Other Policy Changes (CMS–1849–P) — Comments on the Proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

Dear Dr. Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model, published in the Federal Register on April 14, 2026 as part of the above-referenced Proposed Rule. FAH's comments in this letter are limited to the proposed CJR-X Model; comments on the remaining provisions of the Proposed Rule were submitted separately.

FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C. and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health and long-term care hospitals, and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's and cancer services.

FAH appreciates the Administration's continued interest in testing innovative approaches to improve care coordination, accountability, and patient outcomes across the Medicare program. FAH and its member hospitals support appropriately designed episode-based payment models that encourage high-quality, efficient care delivery while preserving patient access and maintaining operational stability for providers serving diverse communities and patient populations.

FAH members have substantial experience participating in episode-based payment initiatives developed through the Center for Medicare and Medicaid Innovation (Innovation Center), including the original Comprehensive Care for Joint Replacement (CJR) Model and other alternative payment models. That experience has provided hospitals with significant practical insight into both the opportunities and challenges associated with episode accountability, care redesign, quality measurement, financial benchmarking, and operational implementation.

FAH's concerns with the proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model are therefore not rooted in opposition to innovation or value-based care concepts generally. Rather, our concerns reflect the significant policy, operational, legal, and financial implications associated with the proposed structure of CJR-X, particularly its mandatory design, compressed implementation timeline, expanding financial accountability framework, and the cumulative burden created by overlapping Medicare payment and quality initiatives.

As CMS continues to advance Innovation Center models, it is critical that payment reforms remain transparent, operationally feasible, appropriately tested, and supported by reliable methodologies that accurately reflect provider

performance and patient complexity. Hospitals continue to operate under sustained financial pressures, prolonged negative Medicare margins, workforce shortages, and rapidly evolving regulatory requirements. In this environment, large-scale mandatory payment changes should be implemented cautiously and with sufficient opportunity for stakeholder engagement, operational readiness, and meaningful evaluation.

Against this backdrop, FAH offers the following recommendations and concerns regarding the proposed CJR-X Model.

EXECUTIVE SUMMARY

FAH members participated in and operated under episode-based payment models tested through the Center for Medicare and Medicaid Innovation, including the original Comprehensive Care for Joint Replacement (CJR) Model. As noted above, the Federation's concerns with CJR-X are not with the concept of testing episode-based payment approaches. Rather, they are concerns with the establishment of a mandatory payment structure that materially changes how hospitals are reimbursed for lower extremity joint replacement care.

The Federation strongly opposes the implementation of CJR-X as proposed and urges CMS to:

- **Ensure Innovation Center models remain voluntary and appropriately limited demonstrations.** CJR-X is a nationwide mandatory framework that limits provider flexibility and imposes a one-size-fits-all approach to care redesign. Innovation Center models are most successful when providers have the opportunity to opt in, demonstrate results, and compete on performance rather than operate under a federal mandate. This approach also raises important questions about whether the proposed model remains consistent with the Innovation Center's demonstration authority and the limits Congress established for model expansion. As proposed, CJR-X exceeds the scope of a permissible section 1115A(c) expansion and would establish a mandatory payment framework without clear congressional authorization.

- **Address structural design features that create automatic and compounding payment reductions unrelated to care improvement.** CMS's own analysis projects Medicare savings even if hospitals make no changes to care delivery, reflecting structural model mechanics rather than demonstrated efficiency gains. FAH urges CMS to establish a defined end date, meaningful evaluation milestones, and reforms to the model's payment methodology.

- **Remove the Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome Performance Measure (THA/TKA PRO-PM) and revisit the proposed quality measurement framework before tying it to mandatory financial accountability.** The THA/TKA PRO-PM measure, in its current form, imposes substantial and unfeasible data-collection burdens on hospitals and patients, and its design flaws disproportionately affect rural, safety-net, and low-volume facilities, undermining quality goals. A redesigned THA/TKA PRO-PM must incorporate a defensible case minimum, feasible data-collection and evidence-based response-rate standards suitable for low-volume settings, explicit exclusion criteria for patients who decline, and clinically realistic data-collection timelines that align with everyday workflows. Approximately half of the proposed Composite Quality Score depends on measures that hospitals cannot reliably control under current specifications. Quality measures should support accurate assessment and improvement of care, not impose financial penalties based on unstable, untested, or incomplete methodologies.

- **Revise key operational and financial design elements that unnecessarily increase provider burden and financial exposure.** Several aspects of the proposed model depart from CMS's own recent approach to episode-based payment policy and would impose avoidable operational complexity and overlapping accountability obligations on participating hospitals. CMS should align CJR-X more closely with the design principles reflected in the Transforming Episode Accountability Model (TEAM) and other recent Innovation Center models, particularly with respect to risk calibration, safety-net protections, quality incentives, and operational transparency.

- **Delay implementation until at least October 1, 2028, and provide a non-risk-bearing first performance year.** The breadth of structural, operational, and quality measurement concerns warrants a delayed implementation timeline and a glide path to financial risk. CMS should first resolve key methodological and operational issues and provide clear, stable program expectations before requiring mandatory participation. Hospitals likewise require adequate time to operationalize care redesign, financial, and compliance changes against finalized model requirements while continuing to manage sustained financial pressures, including prolonged negative Medicare margins.

While these recommendations would not resolve the Federation's broader concerns with CJR-X as a mandatory model, they would materially improve the operational stability, methodological integrity, and policy alignment of the proposed model and better align CJR-X with CMS's own recent episode-based payment policies, design choices, and evaluation findings.

CONCLUSION

CJR-X, as proposed, presents a complex set of structural, methodological, and operational concerns that warrant substantial reconsideration before the model is finalized. The Federation respectfully urges CMS to revisit the proposed model design in light of the substantive concerns set forth in this letter, the cumulative financial pressures hospitals continue to face and the evolving environment in which mandatory payment changes are being imposed across the Medicare program. The Federation continues to support thoughtful, voluntary testing of episode-based payment models and welcomes the opportunity to work with CMS to advance care delivery in a manner that is reliable, evidence-based, and fair to the hospitals and improves the quality of care for patients.

If you have any questions about our comments or need further information, please contact Alyssa Keefe, Senior Vice President, Head of Policy, at akeefe@fah.org or (202) 624-1500.

Sincerely,

/s/
Charlene MacDonald
President and CEO

APPENDIX A
FAH Detailed Comments on CJR-X Model (CMS-1849-P)

I. STRUCTURAL DESIGN FLAWS OF THE PROPOSED MODEL (Part X.C.1 and X.C.2.a)

The proposed CJR-X Model is not a time-limited demonstration. CMS states in the Proposed Rule that CJR-X is "not being proposed as a finite model test that will occur over a relatively short period of time". Yet CMS establishes no defined end date or formal evaluation milestones for determining whether the model is achieving its stated objectives. At the same time, CMS retains unilateral authority under section 1115A(b)(3)(B) of the Social Security Act to terminate the model at any time, with that determination insulated from administrative and judicial review. In effect, the proposal creates an open-ended mandatory payment framework for hospitals while preserving complete discretion for CMS to end the model on its own terms.

The absence of a defined end date is not a technical drafting issue. It is the foundation on which three design elements operate concurrently to produce cumulative payment reductions independent of hospital performance. CMS proposes a 2 percent discount factor applied annually to regional benchmark prices. The discount factor operates on a regional benchmark that is itself a moving target, because each performance year incorporates the most recent baseline data and spending reductions generated by participating hospitals lower the regional benchmark used in subsequent performance years. CMS then applies a retrospective trend factor at reconciliation, capped at plus or minus 3 percent, to capture nationwide spending pattern changes during the performance year. The final reconciliation target price is therefore not knowable to participating hospitals during the performance year.

CMS's own preamble acknowledges the cumulative effect of these design elements. In discussing the choice of a 2 percent discount factor rather than 3 percent, CMS states that a higher discount factor would not be sustainable for an expanded model and could result in more price ratcheting over a longer time horizon. This statement acknowledges an inherent flaw in the model design as a whole, and a lower discount factor is insufficient to remedy the issue. Under a permanent expansion with no defined end date and a moving regional baseline, any nonzero discount factor produces cumulative downward pressure on payment that compounds over time. The Lewin Group identified the moving baseline as a driver of hospital financial performance in the Performance Year 6 evaluation of the CJR Model.[1]

The consequence is quantified in CMS's own sensitivity analysis. Table K-CL.-02 of the Proposed Rule projects that even at zero intervention effect, meaning even if participating hospitals make no changes whatsoever to care delivery, CJR-X will generate Medicare savings of 1.0 percent in fiscal year 2028, 1.0 percent in fiscal year 2029, 1.0 percent in fiscal year 2030, 0.8 percent in fiscal year 2031 and 0.7 percent in fiscal year 2032. These projected savings represent blunt payment cuts—direct transfers from hospitals to Medicare absent any change in clinical practice. They are the mathematical product of the discount factor, the moving regional baseline and the retrospective trend factor operating in combination over time under a model design that incorporates no defined endpoint.

Section 1115A(c) of the Social Security Act provides Phase II expansion authority for models that have been tested under subsection (b). The statutory framework assumes that models are tested, evaluated, terminated or modified based on results, either completed or expanded and then completed if not adopted as a permanent program change by Congress. CJR-X departs from this framework by proposing a permanent expansion with no defined evaluation horizon at which the Innovation Center would reassess the model's continuation.

FAH urges CMS to define an end date for CJR-X consistent with the Phase II expansion authority CMS invokes, and to establish defined evaluation milestones at which the Innovation Center will reassess the model consistent with section 1115A(b) and (c). Such milestones would provide both CMS and participating hospitals with a defined framework for measuring whether the model is achieving its stated objectives over time. These changes would also eliminate one unlawful element of the proposed model by defining the duration of the model. The Federation further urges CMS to address the three structural mechanisms by which the model generates payment reductions independent of care delivery improvement, beginning with the discount factor and continuing through the elements of pricing methodology developed in Section VIII.

II. SCOPE, DURATION AND START DATE (Part X.C.2.a)

CMS proposes to begin CJR-X on October 1, 2027, with the first performance year running from October 1, 2027 through September 30, 2028. This timeline is not workable for several reasons.

CMS proposes to expand CJR-X to approximately 2,000 hospitals nationwide that have no prior experience with mandatory episode-based payment for lower extremity joint replacement. The original CJR Model included approximately 800 hospitals selected from 67 metropolitan statistical areas. CJR-X would require nearly three times that number of hospitals to build the clinical, financial and data infrastructure necessary for episode-based payment, and to do so within twelve months of any final rule. Hospital experience with comparable models, including the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model and the original CJR Model, consistently shows that at least twelve months are necessary to build the operational capacity for successful participation. For hospitals operating in regions where TEAM is also being implemented, the operational complexity is compounded.

The quality measure set proposed for CJR-X is also not ready for use as an accountability measure tied to payment. As detailed in Section VII, the Hospital-Level Total Hip Arthroplasty (THA) / Total Knee Arthroplasty (TKA) Patient-Reported Outcome-Based Performance Measure has not functioned as intended in voluntary reporting. The Hospital Consumer Assessment of Healthcare Providers and Systems Survey has not been reviewed by a Consensus-Based Entity since recent significant changes. The Outpatient and Ambulatory Surgery CAHPS Survey has never been submitted for Consensus-Based Entity review. The Risk-Standardized Complication Rate measure case minimum of 25 cases is insufficient to achieve the reliability threshold appropriate for accountability measures. CMS needs time to address these structural problems before tying these measures to financial consequences.

CJR-X also imposes downside risk from Performance Year 1. The original CJR Model waived downside risk during Performance Year 1 to allow participating hospitals time to enact practice changes that would help them succeed in the model. FAH urges CMS to restore this protection. Nearly all of the hospitals proposed to participate in CJR-X are new to mandatory episode-based payment under CJR-X and require a non-risk-bearing performance year to build operational capacity, conduct claims data analysis and redesign care pathways. Imposing downside risk from Performance Year 1 increases the likelihood that hospitals will be financially penalized for circumstances unrelated to care quality, and for that reason, CMMI has routinely included a glide path in downside risk models involving participants without experience bearing such risks.

Finally, hospitals are currently operating under unprecedented financial strain. Approximately 40 percent of hospitals are operating at negative margins.[2] Medicare margins are projected to reach negative 10 percent in 2026, the twenty-third consecutive year of negative Medicare margins.[3] The Center for Healthcare Quality and Payment Reform reports that 734 rural hospitals are at risk of closing, with 309 at immediate risk.[4] Recent statutory changes to Medicaid coverage and provider tax revenue under the Working Families and Tax Relief Act compound this pressure. Hospitals do not currently have the operational or financial capacity to absorb a poorly timed payment model launch. Many hospitals will need to engage outside expertise to analyze claims data, identify operational opportunities, redesign care pathways, and implement the necessary changes to support success under the model. At present, there is limited consultant capacity with the specialized experience required to support hospitals through this type of large-scale transformation, creating additional implementation risk and operational strain.

FAH urges CMS to delay the start date of CJR-X to October 1, 2028, and to waive downside risk for the first performance year. A delay of one year, with a non-risk-bearing first performance year consistent with the original CJR Model, would provide hospitals adequate preparation time, allow CMS time to address measure set deficiencies, maintain the design feature of an upside-only Performance Year 1 that worked in the original CJR Model and account for the cumulative financial pressure on hospitals.

III. PARTICIPANT DEFINITION AND PROPOSED EXCEPTIONS (Part X.C.2.b)

A. Full Exclusion of Rural and Protected Categories

CMS proposes to apply a 5 percent stop-loss to rural hospitals as defined at proposed § 512.605, Medicare-Dependent Hospitals (MDH), Sole Community Hospitals (SCH) and safety net hospitals. CMS does not propose to exclude these hospitals from mandatory participation.

The 5 percent stop-loss is inadequate protection for these hospital categories given the cumulative financial pressure on the hospital sector and the operational realities documented by CMS's own contractor. The Lewin Group's Performance Year 7 Safety-Net Hospital Experiences report, released in December 2025, documents that safety net hospitals were overrepresented among hospitals with the highest per-episode repayments to Medicare during the CJR Extension.[5] Safety net hospitals performed an average of 32 lower extremity joint replacement episodes per hospital compared to 140 episodes at non-safety net hospitals; served 18 percent fracture episodes compared to 10 percent at non-safety net hospitals; and performed 69 percent of elective lower extremity joint replacements in the outpatient setting compared to 77 percent at non-safety net hospitals.[5] CMS's own contractor concluded that the additional risk

adjustments introduced in Performance Year 6 "had no clear impact on their performance in the model and were not enough to offset internal increases in costs."[5]

The challenges documented for safety net hospitals apply with equal or greater force to rural hospitals, MDH, and SCH. These hospitals share the operational characteristics, including lower episode volume, fewer capital resources and less ability to shift care to outpatient settings, that drive financial underperformance in episode-based payment models. A 5 percent stop-loss does not address these structural disadvantages. It limits the per-episode magnitude of loss but does not address the cumulative annual exposure of hospitals already operating at negative Medicare margins.

The Federation has consistently advocated for the exclusion of small, rural and low-volume hospitals from mandatory bundled payment models since the original CJR Model. The intervening nine years of evaluation evidence, including findings of CMS's own contractor, confirm that this position remains correct.

FAH urges CMS to exclude from mandatory CJR-X participation: geographically rural hospitals as defined under § 412.64; hospitals in rural census tracts as defined under § 412.103(a)(1); hospitals reclassified as rural under Section 401 of the Benefits Improvement and Protection Act of 2000; Medicare-Dependent Hospitals; Sole Community Hospitals; and Rural Referral Centers, including reclassified Rural Referral Centers. These exclusions are consistent with the original CJR hospital exclusion lists.

B. Low-Volume Threshold

CMS proposes a low-volume threshold of fewer than 31 episodes during the baseline period, with low-volume hospitals receiving target prices based on 100 percent regional data but remaining in the model. CMS borrows this threshold from TEAM, which CMS finalized in August 2024 (89 Fed. Reg. 69748).

The 31-episode threshold is inadequate. FAH continues to maintain its longstanding position that the threshold for meaningful participation in episode-based payment should be 100 lower extremity joint replacement episodes per performance year, counting inpatient and outpatient episodes combined.

This threshold reflects operational realities. Hospitals with fewer than 100 lower extremity joint replacement episodes lack the volume to support reliable target pricing because regional benchmarks are derived from population means that smaller hospitals' patient mix does not approximate. They lack the volume to amortize the infrastructure investment necessary for successful participation. These hospitals lack the volume to construct workable gainsharing arrangements with collaborators, because the per-episode reconciliation amounts are too small to support meaningful collaborator engagement.

The Lewin Group's Performance Year 7 report documents the operational consequence of low volume. Citing one interviewed safety net hospital, the hospital's leadership team "did not invest in a dedicated program to manage CJR patients, or attempt to pursue better reconciliation payments to potentially offset the costs of investing in the program, due to their low volume of eligible patients."[5] **FAH recommends that CMS raise the low-volume threshold to 100 lower extremity joint replacement episodes per performance year, counting inpatient and outpatient episodes combined.** Hospitals below this threshold should not be subject to mandatory CJR-X participation.

IV. BENEFICIARY POPULATION AND EPISODE INITIATION (Part X.C.2.c and X.C.2.d)

CMS proposes a 90-day post-discharge episode length, consistent with the original CJR Model. The Federation supports this proposal. The 90-day episode is the design that was tested under the CJR Model, the design supported by nine years of evaluation evidence and the appropriate basis for any Phase II expansion under section 1115A(c).

The Federation notes that TEAM, which CMS implemented in August 2024 with a January 1, 2026 start date, tests a 30-day episode for the same lower extremity joint replacement procedures. CMS cannot simultaneously claim that CJR-X advances CJR Model evidence nationally while testing a fundamentally different episode design for the same procedures in a contemporaneous mandatory model. The methodological inconsistency undermines the integrity of both evaluations.

FAH recommends that CMS resolve this inconsistency by removing lower extremity joint replacement episodes from TEAM and consolidating all such episodes under CJR-X with a 90-day episode length. This approach maintains methodological consistency, preserves the integrity of both model evaluations and provides hospitals operating in TEAM regions with operational coherence on lower extremity joint replacement episode management.

CMS proposes that beneficiaries attributed to an Accountable Care Organization (ACO) remain within CJR-X episodes initiated at a CJR-X participant hospital. **FAH urges CMS to reverse this precedence so that beneficiaries attributed to a Medicare ACO are excluded from CJR-X reconciliation when they receive a lower extremity joint replacement at a CJR-X participant hospital.** To enable CJR-X participants to identify excluded episodes at the point of care and manage gainsharing and collaborator arrangements accordingly, CMS should determine ACO attribution status as of the date of the anchor hospitalization or anchor procedure and provide CJR-X participants with timely access to attribution data on at least a quarterly basis. The same approach should apply for TEAM.

The current ACO precedence rule creates two problems. The ACO already holds total cost of care accountability for the beneficiary. Adding a separate episode-based accountability layer at the hospital level creates conflicting incentives between the ACO's interest in coordinated care and the hospital's interest in episode-specific cost reduction. The Lewin Group's Performance Year 6 evaluation documented that hospitals participating in both an ACO and CJR built substantial system-level infrastructure to reconcile the two programs.[3] National health systems operating across multiple markets cannot reasonably be expected to maintain that reconciliation infrastructure indefinitely as CJR-X expands nationally alongside the Medicare Shared Savings Program and other ACO initiatives. Reversing ACO precedence would also align with the direction CMS has signaled in recent Innovation Center strategy regarding alignment across value-based payment programs.

V. EPISODE DEFINITION (Part X.C.2.d)

A. Exclusion of Hip Fracture Episodes

CMS proposes to include hip fracture episodes (MS-DRGs 521 and 522) in CJR-X. **FAH urges CMS to exclude hip fracture episodes from CJR-X entirely.**

The Federation has advocated for the exclusion of hip fractures from comprehensive joint replacement models since the 2015 proposed rule on the original Comprehensive Care for Joint Replacement (CCJR) Model. The intervening nine years of CMS evaluation evidence support this position with substantial documentary record.

The Lewin Group's Performance Year 7 Safety-Net Hospital Experiences report documents that safety net hospitals served 18 percent fracture episodes compared to 10 percent at non-safety net hospitals.[5] One interviewed safety net hospital reported that hip fractures comprised 80 percent of its CJR cases, and the hospital owed a repayment of approximately $250,000 in Performance Year 6.[5] The Lewin Group concluded that fracture episodes drive "exceptionally high-cost ('bundle busting') episodes" because patients with fractures cannot be optimized prior to surgery and are more likely to have complications or readmissions.[5]

The structural reasons are clinical. Hip fracture episodes are emergent. Hospitals cannot conduct presurgical patient optimization for fracture patients. The care pathway redesign strategies that drive cost reduction in elective lower extremity joint replacement episodes, including presurgical patient optimization, scheduled rehabilitation pathways and predictable discharge planning, are not available for fracture patients. Hospitals with higher concentrations of fracture episodes therefore have fewer easily managed elective episodes in their case mix.

CMS's risk adjustment methodology does not address this problem. The proposed methodology at § 512.645 provides separate target prices for elective versus fracture episodes, which addresses average cost differences. It does not address case-mix concentration. A hospital with 30 percent fracture episodes faces a different financial exposure than a hospital with 10 percent fracture episodes, even with risk adjustment, because fracture episodes have higher variance and more bundle-busters.

Excluding MS-DRGs 521 and 522 and the corresponding outpatient codes from the CJR-X episode definition would resolve a structural source of unfair financial outcomes documented by CMS's own contractor and would allow CJR-X to focus on the elective lower extremity joint replacement episodes for which episode-based payment is more predictable.

B. Unrelated Readmission Exclusion List

CMS proposes to exclude certain readmissions from CJR-X episode spending as "clinically unrelated," with the list of excluded MS-DRGs to be posted on the CMS CJR-X webpage. CMS does not publish the full criteria for inclusion or exclusion from this list.

The Lewin Group's Performance Year 7 evaluation surfaced bundle-buster readmissions as a key driver of hospital financial underperformance.[5] The current exclusion list does not capture readmissions for conditions such as sepsis,

pneumonia or acute myocardial infarction that are clinically unrelated to the lower extremity joint replacement but occur during the 90-day window. Post-acute care services following a readmission are also included in episode spending even when the readmission itself is excluded, leaving hospitals accountable for downstream care costs they did not initiate.

FAH recommends that CMS expand the unrelated readmission exclusion list, publish a transparent methodology for inclusion, exclude post-acute care services following an excluded readmission and establish a participant petition process by which CJR-X participants can request additional exclusions based on clinical evidence.

C. Subsequent Qualifying Procedures During an Active Episode

CMS proposes to cancel a CJR-X episode under four specific circumstances: the beneficiary no longer meets inclusion criteria; the beneficiary dies during the episode; the CJR-X participant is subject to the extreme and uncontrollable circumstances policy; and the beneficiary is in a TEAM episode and has a lower extremity joint replacement procedure at a CJR-X participant during the 30-day post-discharge period after a TEAM anchor. CMS also proposes to cancel an episode if an anchor hospitalization occurs within three days of an anchor procedure.

The Proposed Rule does not address what occurs when a beneficiary undergoes a subsequent qualifying lower extremity joint replacement procedure during an active CJR-X episode, such as staged bilateral knee replacement where the second procedure typically occurs six to twelve weeks after the first. Staged bilateral procedures are common clinical practice and are not addressed by the existing cancellation provisions.

FAH recommends that CMS adopt the approach used in the original CJR Model, under which a subsequent qualifying procedure during an active episode triggers a new episode with the prior episode ending on the date of the new anchor. This approach was clinically and operationally workable under CJR and should be preserved in CJR-X to provide hospitals with operational certainty for common clinical scenarios.

FAH further recommends that CMS adopt a 30-day post-episode clearance period during which a new CJR-X episode would not be triggered for the same beneficiary. A 30-day post-episode clearance would mirror the 30-day post-discharge structure CMS already applies in TEAM and would reduce hospital exposure to compounding episode liability for the same beneficiary in a short clinical window.

VI. QUALITY MEASURES AND COMPOSITE QUALITY SCORE (Part X.C.2.e)

FAH urges CMS to pause mandatory Patient-Reported Outcome-Based Performance Measure (PRO-PM) reporting in all programs until structural deficiencies are addressed, and to defer launch of CJR-X until the broader measure set is capable of providing patients, hospitals and CMS itself with a reliable picture of the quality of care delivered. Quality measures exist to inform and improve patient care, not to penalize hospitals for circumstances beyond their control. A measurement regime tied to payment must be reliable enough that patients can trust what it tells them, that hospitals can act on what it reveals and that CMS can defend the consequences it imposes. The proposed measure set does not yet meet that standard.

CMS proposes two modifications to the measure set relative to the CJR Model. First, CMS proposes to weight the Total Hip Arthroplasty / Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome Measure more heavily. Second, CJR-X would adopt two additional measures to account for the high percentage of hospital outpatient lower extremity joint replacement procedures. CMS specifically proposes to use in CJR-X the following measures:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) following elective primary THA and TKA; Hospital Visits Within 7 Days of Hospital Outpatient Department (HOPD) Surgery; the
- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS); the
- Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS); and the
- Hospital-Level THA/TKA Patient Reported Outcome-Based Performance Measure (PRO-PM).

The Federation has substantial concerns with the proposed measure set and our detailed comments are noted below. Taken together, these measures cannot provide the reliable picture of quality that patients, hospitals and CMS need before payment consequences are imposed.

A. Hospital-Level RSCR Following Elective Primary THA and TKA

The current case minimum of 25 procedures is insufficient to ensure the measure achieves the 0.7 minimum reliability threshold that should be the standard for any measure used for accountability purposes. Using an unreliable measure to evaluate hospital performance and impose financial consequences is contrary to sound measurement practice and to fair payment policy.

The risk adjustment methodology also fails to account for factors that materially affect a patient's ability to recover successfully at home, including caregiver availability, access to outpatient follow-up care and patient health status at the time of admission. The Federation appreciates CMS's adoption of a TEAM-equivalent risk adjustment methodology that includes individual Hierarchical Condition Category (HCC) flags for clinical conditions such as morbid obesity and diabetes with severe complications. The RSCR measure as currently specified does not benefit from those refinements. CMS should align the measure's risk adjustment with the broader CJR-X risk adjustment methodology before this measure is used for any accountability purpose.

The measure has additional shortcomings. The "clinically unrelated" exclusions are undefined. Because the measure is inpatient-only, most hospitals no longer qualify for the measure as procedures have shifted to the outpatient setting. The measure as currently constituted will not provide meaningful information about the quality of joint replacement care under CJR-X.

CMS should substantially increase the case minimum, align the measure's risk adjustment with the TEAM-equivalent methodology adopted for CJR-X pricing clarify or revise the exclusion criteria before this measure is used for accountability purposes.

B. Hospital Visits within 7 Days of HOPD Surgery

The Federation does not believe the Hospital Visits within 7 Days of HOPD Surgery measure is appropriate for inclusion in CJR-X and urges CMS to remove it. The fact that the measure may capture some lower extremity joint replacement surgeries does not make it sufficiently comparable to the inpatient complications measure for accountability purposes. A measure must do more than tangentially relate to the procedures and outcomes under evaluation. It must be one on which hospitals can make targeted, actionable improvements, and one that provides patients with meaningful, procedure-specific information to support informed decision-making.

An overly broad denominator encompassing a wide range of surgical procedures makes neither of these goals achievable. Observed differences between hospitals will reflect variation across the full spectrum of outpatient surgeries, not the quality of joint replacement care specifically. Including this measure in CJR-X will mislead patients seeking information about hospital joint replacement quality and will impose accountability on hospitals for outcomes they cannot specifically address through improvements in joint replacement care.

C. HCAHPS and OAS CAHPS Surveys

Three of the five proposed measures depend on patient-reported survey data. This is a substantial overreliance on a measurement modality with documented and worsening reliability concerns.

The HCAHPS Survey has undergone significant changes in recent years, including new sub-measures and expanded modes of administration. None of these changes have undergone review by a Consensus-Based Entity (CBE) to confirm that the measure remains reliable and valid in its updated form. Using measures that have not been independently validated for reliability and validity in any accountability program, particularly one with financial consequences for hospitals, is contrary to the principles CMS itself has articulated for the appropriate use of quality measures.

The OAS CAHPS Survey has never been submitted for CBE review. Hospitals, patients and policymakers therefore have no independent assurance of its appropriateness, either generally or for use in this model specifically.

Response rates for both surveys are critically low. Recent analyses show HCAHPS response rates hovering just above 30 percent. For OAS CAHPS, fewer than 1 percent of facilities administering the survey by mail with phone follow-up achieve response rates above 36 percent; the substantial majority of facilities across other modes of administration achieve rates between 17 and 26 percent. These figures are not a technical concern. They represent a fundamental challenge to the representativeness and validity of the underlying data. Survey fatigue is real, persistent and worsening.

The concentration of three survey-based measures in a single composite quality score compounds these reliability concerns. The Federation respectfully submits that data collected under these conditions cannot reliably represent the quality of care delivered in either inpatient or outpatient settings. **CMS should not hold hospitals accountable through financial penalties based on data with these characteristics.**

D. Hospital-Level THA/TKA Patient-Reported Outcomes Performance Measure (PRO-PM)

[5]FAH reiterates its position that the Hospital-Level Total Hip Arthroplasty / Total Knee Arthroplasty Patient-Reported Outcome Performance Measure (THA/TKA PRO-PM) should not carry negative payment adjustments in the Hospital IQR program, should be removed from TEAM mandatory model, as well as from consideration for the proposed mandatory CJR-X model or any other CMS program until a fundamental redesign is completed and validated. The measure, in its current form, imposes an extraordinary data-collection burden on hospitals and patients, lacks foundational design safeguards, and has demonstrated systemic implementation failures that undermine the objectives of quality measurement and value-based care.

Evidence from CMS and independent analyses demonstrates the core flaws of the THA/TKA PRO-PM as currently configured. CMS data released February 25, 2026, show that roughly 60 percent of the 111 hospitals that voluntarily reported the measure failed to meet the 50 percent sample-size requirement and achieve a score. Reporting success was disproportionately concentrated among larger urban teaching hospitals with more than 200 beds, while smaller, rural, and medically underserved facilities were systematically unable to achieve a score, not because of care quality, but because of the measure's design characteristics.

The Lewin Group's Performance Year 7 Safety-Net Hospital Experiences report corroborates that safety-net hospitals operate with lower volumes, higher fracture concentrations, and substantially different patient populations than non-safety-net institutions. These realities are precisely the operational factors that determine whether a hospital can meet the THA/TKA PRO-PM's thresholds. If the measure is mandated across programs, these disparities would likely be entrenched and amplified, rather than addressed, undermining the programs' goals that CMS seeks to advance.

The measure's structural deficiencies are numerous and substantial. It contains no case minimum, and the 50 percent response-rate requirement imposes an unrealistic and disproportionate burden, particularly on low-volume and rural hospitals from the outset. Such a threshold even exceeds the current HCAHPS national response rates for the 90th percentile of hospitals across any mode.[6] In addition, the timing and volume of data collection have never been adequately tested from the patient's perspective, leading to misalignment with real-world workflows and administrative capabilities. Hospitals cannot exclude patients who actively decline to participate or those who transition from outpatient to inpatient status unexpectedly, yet penalties are levied on patient choices rather than on care quality.

The denominator cannot be limited to patients for whom Medicare is the primary payer, and the pre-operative data collection requirement compounds burden in ways that undermine any realistic possibility of attaining a 50 percent threshold over the lengthy post-operative period. Post-discharge follow-up often occurs through the surgeon's practice rather than the hospital, further eroding hospital-based engagement and survey response rates. In short, the measure as designed does not reflect the operational realities faced by many hospitals, particularly those serving vulnerable populations in rural and safety-net contexts, and it creates a disproportionate risk of penalties without corresponding accountability for care quality.

Operational realities further undercut feasibility. Rural settings frequently lack reliable bandwidth and integrated data systems, complicating data capture and timely reporting. The involvement of non-employed providers and multiple, non-integrated EMR systems increases data-validation burdens and delays. Hospitals must absorb the costs and workload of pre-operative data collection, patient outreach, and post-operative follow-up across diverse provider environments, which often operate independently from hospital-based processes. The result is a misalignment between the measure's requirements and the practical workflows that govern patient care and data gathering in many settings, particularly those serving high proportions of uninsured or underinsured patients.

Given these findings, continuing to impose negative payment adjustments for this THA/TKA PRO-PM within Hospital IQR, TEAM, or any mandatory CMS framework would be inappropriate and counterproductive. CMS should promptly remove any Hospital IQR penalties tied to the Hospital-Level THA/TKA PRO-PM, revise the measure, ensure the measure has been tested across diverse hospital settings, and produces a measure that is scientifically sound and operationally feasible. Any revised THA/TKA PRO-PM should incorporate an appropriate case minimum, e.g. 10 for small and/or rural hospitals and 25 for larger, urban hospitals, a feasible data-collection framework with an evidence-based response rate less than 50% that is realistic for low-volume and rural settings, meaningful patient-exclusion criteria (including explicit opt-out provisions when patients decline to participate or are in hospice), and clinically realistic data-collection timelines that align with everyday clinical workflows. Until such

refinements are completed and validated, the measure should not be used for mandatory purposes, including CJR-X, and should be removed from TEAM for mandatory participation.

The Federation urges CMS to remove the current penalties associated with the measure in the Hospital IQR program, proceed with a comprehensive redesign of the measure, and exclude it from mandatory uses in the TEAM model and in the proposed CJR-X model. The Federation looks forward to working with CMS to redesign a measure that accurately reflects care quality, supports hospitals across the full spectrum of settings, and avoids punitive consequences driven by fundamental design flaws rather than true performance.

E. Composite Quality Score

Given the deficiencies described above, particularly in the Patient Experience and Patient-Reported Outcome domains, the proposed Composite Quality Score is structurally compromised. Approximately 50 percent of the composite score depends on measures that hospitals cannot reliably control under current specifications. The Patient Experience domain accounts for 40 percent of the score. The Patient-Reported Outcome domain accounts for 10 percent. As detailed above, the measures in these domains rely on survey response rates and reporting capacity that are not within the hospital's control to remediate.

A model design in which half of the quality determination depends on measures the hospital cannot influence does not measure quality. It introduces a payment penalty that operates independently of care delivery. FAH respectfully submits that this is not the design CMS intends and is inconsistent with the Innovation Center's stated commitment to advancing care quality.

For all of these reasons, taken together, the measures proposed for CJR-X cannot provide CMS, patients or the public with a reliable, valid or equitable picture of hospital quality for joint replacement surgery. Because the measure set does not specifically assess the dimensions of joint replacement quality that matter to patient outcomes, it cannot assure patients, hospitals or CMS that financial accountability tied to these measures reflects the quality of care being delivered.

FAH urges CMS to pause mandatory PRO-PM reporting in all programs until the structural deficiencies are addressed and to defer launch of CJR-X until the broader measure set is capable of providing patients, hospitals and CMS itself with a reliable picture of the quality of care delivered. If CMS proceeds with the proposed measure set notwithstanding these concerns, the Federation urges CMS to restore and expand quality improvement points as harm mitigation, as set forth in Section VIII.B.

VII. PRICING AND PAYMENT METHODOLOGY (Part X.C.2.f)

A. Discount Factor

CMS proposes a 2 percent discount factor applied to benchmark prices to represent Medicare's portion of reduced expenditures from the episode. In the same preamble, CMS states that the agency considered but [is] not proposing lower discount factors including 1.5 percent, 1 percent, or no discount factor. CMS further acknowledges that an even higher discount rate would not be sustainable for an expanded model and could result in more price ratcheting over a longer time horizon.

This last statement applies the same logical principle that warrants reducing the discount factor below 2 percent. If 3 percent generates unsustainable ratcheting under a permanent national model, 2 percent generates ratcheting at a slower but still cumulative rate. The principle scales. Under a permanent expansion with no defined end date and a moving regional baseline, any nonzero discount factor produces cumulative downward pressure on payment that compounds over time.

FAH urges CMS to eliminate the discount factor entirely, consistent with the "no discount factor" alternative CMS itself considered. If CMS rejects elimination, the Federation urges CMS to reduce the discount factor to 1 percent, which is the lowest of the three alternative nonzero discount rates CMS itself considered and the alternative that most directly addresses the ratcheting concern CMS articulated in its own preamble.

B. Quality Improvement Points

CMS proposes to eliminate quality improvement points from CJR-X. In the CJR Extension, hospitals that demonstrated quality improvement of two deciles or more in measure performance score could be awarded 10 percent of the maximum measure performance score, with a cap for the overall composite quality score at 20 points.

The Federation's concerns with the proposed CJR-X quality measure set are developed in Section VII. Those concerns are not addressed by eliminating one of the few mechanisms in the model that allows hospitals to mitigate financial exposure under a measurement regime that, as documented in Section VII, remains deficient for accountability purposes.

CMS justifies the elimination by stating that "CJR-X is structured to emphasize absolute quality performance on clinically meaningful outcomes, rather than short-term year-over-year changes that may reflect random variation or changes in case mix". This rationale does not engage the substantive problem. If the measure set is unreliable for accountability purposes, the appropriate response is not to eliminate the mitigation mechanism that gave hospitals a path to relief. The appropriate response is to fix the measures, restore the mitigation mechanism, or both.

FAH urges CMS to first address the measure set as described above and then restore quality improvement points and to expand them to provide partial credit for one-decile improvement. The original CJR Extension methodology awarded points only for two-decile improvement, a threshold that proved difficult to achieve. Partial credit for one-decile improvement extends the benefit to a broader range of hospitals demonstrating measurable progress under a measure set that remains in development.

C. Pricing Methodology Alignment with TEAM

CMS proposes to use 100 percent regional target pricing in CJR-X, consistent with the methodology used in TEAM and in the later years of the CJR Extension. The Federation does not separately challenge this methodological choice but identifies three specific design elements in CJR-X that diverge from contemporaneous design choices in TEAM without articulated justification.

CMS proposes to incorporate Ambulatory Payment Classification (APC) and Medicare Severity Diagnosis-Related Group (MS-DRG) payment rule changes at reconciliation, without providing participants visibility into these adjustments during the performance year. TEAM, by contrast, proposes to provide participants with named APC and MS-DRG update factor multipliers as part of the prospective trend factor, allowing TEAM participants to manage to a known target during the performance year. **FAH recommends that CMS align CJR-X with TEAM by providing named update factor multipliers visible during the performance year.**

CMS proposes to define a safety net hospital for purposes of the 5 percent stop-loss eligibility as a hospital in the top 25th percentile in their region for percentage of fee-for-service (FFS) Lower Extremity Joint Replacement (LEJR) inpatient episodes provided to dually eligible beneficiaries. This is a regional, single-criterion, inpatient-only definition. TEAM, by contrast, defines a safety net hospital as a hospital that exceeds 75th percentile nationally for proportion of dual-eligible OR Part D Low-Income Subsidy (LIS)-eligible beneficiaries, using a national, either-criterion definition. The Federation's members include hospitals serving substantial dual-eligible and low-income subsidy populations across urban and rural markets. Many of these hospitals would qualify for safety net protections under TEAM's definition but not under the narrower CJR-X definition. CMS provides no articulated justification for adopting a different and narrower safety net definition in CJR-X than the agency adopted in TEAM in the same calendar year. **FAH urges CMS to align the CJR-X safety net hospital definition with the TEAM definition.**

D. Risk Adjustment

CMS proposes to use the same risk adjustment methodology in CJR-X as in TEAM, including hospital bed size adjustment, safety net adjustment, age bracket adjustment, beneficiary economic risk adjustment using a three-criterion definition incorporating area deprivation index, Part D low-income subsidy eligibility and full Medicaid eligibility, and 21 episode-specific Hierarchical Condition Category flags including morbid obesity and diabetes with severe acute or chronic complications. **FAH appreciates this substantial improvement over the CJR Extension risk adjustment methodology**, which the Federation and other stakeholders have urged CMS to strengthen since the 2015 CCJR proposed rule.

The risk adjustment methodology as proposed addresses many concerns the Federation has historically raised regarding patient health status at admission, including modifiable chronic disease burden that hospitals inherit rather than create. Patients arriving for lower extremity joint replacement with uncontrolled diabetes, morbid obesity and other chronic conditions drive higher episode costs that are not within the hospital's control to remediate within the 90-day episode. CMS's adoption of the TEAM risk adjustment methodology reflects recognition of these clinical realities.

In addition, FAH recommends that CMS consider options to risk adjust both for beneficiary choice and for the availability of high-performing post-acute providers in the community. As discussed further in Section IX, below, post-episode spending recoupment exposure as proposed would leave hospitals at risk for circumstances that are beyond the

hospital's ability to control or substantially influence. In particular, beneficiaries may exercise their freedom of choice to select or decline preferred options for post-acute care, and the local market of post-acute care providers may not provide adequate options for high-quality post-acute care. To the extent that these factors drive post-episode spending recoupments, the savings are operating as a mere payment cut and would not promote the aims of CJR-X.

E. Trend Factor Methodology Transparency

CMS proposes to apply a retrospective trend factor at reconciliation, capped at plus or minus 3 percent, to capture nationwide spending pattern changes during the performance year. Hospitals do not have visibility into the trend factor during the performance year. The trend factor is applied retrospectively, so the final target price against which a hospital's episode spending is measured is not knowable until after the performance year concludes.

The Federation recognizes that retrospective trend factor application captures spending pattern information that prospective application cannot fully anticipate. The concern is not the retrospective application itself but the lack of intra-year visibility. Hospitals cannot make care delivery management decisions during the performance year based on a target they do not know.

FAH urges CMS to publish the trend factor calculation methodology in operational detail, provide CJR-X participants with quarterly updates during the performance year showing the trend factor's current trajectory based on year-to-date data and commit to a defined methodology for the trend factor that participants can model independently. These measures preserve CMS's flexibility in retrospective trend factor calculation while providing hospitals with the visibility needed to manage to a known target during the performance year.

VIII. RECONCILIATION, STOP-LOSS AND POST-EPISODE SPENDING (Part X.C.2.f.(5))

CMS proposes a 20 percent symmetric stop-loss and stop-gain limit for most CJR-X participants and a 5 percent stop-loss for rural hospitals, MDH, SCH and safety net hospitals. The Federation supports the continuation of the 20 percent stop-loss / stop-gain methodology from the CJR Extension as the appropriate baseline for participants not excluded from CJR-X under Section IV of this letter.

The Federation reiterates its position from Section IV that rural hospitals, MDH, SCH and Section 401 reclassified hospitals should be excluded from mandatory CJR-X participation entirely rather than protected through a 5 percent stop-loss. If CMS rejects the Federation's exclusion recommendation, the proposed 5 percent stop-loss is the appropriate floor of protection. **FAH further urges CMS to expand the categories eligible for the 5 percent stop-loss to include the broader safety net definition aligned with TEAM, as set forth in Section VIII.C.**

CMS proposes to recoup spending that exceeds defined thresholds in the 30-day window following the end of the 90-day episode. The Lewin Group's Performance Year 7 Safety-Net Hospital Experiences report documents that safety net hospitals faced these recoupments at twice the rate of non-safety net hospitals during the CJR Extension.[5] As Lewin further documented, recoupments for high post-episode spending accounted for a small portion of total hospital repayments, but the disparate impact on safety net hospitals reflects the underlying difficulty hospitals have controlling spending that occurs after the 90-day episode window.

FAH urges CMS to limit post-episode spending recoupment exposure by applying the same stop-loss limits that apply to in-episode spending to post-episode recoupment for any single hospital in any single performance year, and by providing hospitals with operational guidance on how to identify and manage post-episode spending risks before recoupment occurs.

The Federation also notes the structural tension between hospital accountability for post-episode spending and the limitations on hospital ability to direct beneficiaries to high-performing post-acute care providers. CMS acknowledges in the Proposed Rule that CJR-X participants may recommend preferred providers based on quality and cost, but only within the constraints of current law, and "may not limit CJR-X beneficiaries to a preferred or recommended providers list that is not compliant with restrictions existing under current statutes and regulations". Hospitals are therefore held accountable for post-discharge and post-episode spending patterns they have limited ability to influence through provider selection. **FAH recommends that CMS, in coordination with the Office of Inspector General, examine the scope of existing patient choice and discharge planning requirements as applied to CJR-X participants and provide clear regulatory guidance on the extent to which CJR-X participants may direct beneficiaries to higher-performing post-acute care providers consistent with quality goals and clinical appropriateness.** Without such guidance or appropriately scoped flexibility, hospital accountability for post-discharge and post-episode spending will be significantly mismatched with hospital authority to shape the care pathway.

CMS proposes annual reconciliation with no interim reconciliation during the performance year. The Federation has consistently advocated for more frequent reconciliation since the original CCJR proposed rule. **FAH recommends that CMS provide quarterly preliminary reconciliation estimates during the performance year.** Quarterly visibility would provide hospitals with the cash flow predictability necessary to manage downstream provider relationships, distribute gainsharing payments to collaborators in a manner that maintains care coordination incentives throughout the performance year and identify and address performance issues before year-end reconciliation. The Federation does not propose changing the formal annual reconciliation; the recommendation is for preliminary estimates to support intra-year management.

IX. WAIVERS (Part X.C.2.j)

The Federation generally supports the waivers CMS proposes for CJR-X. CMS proposes to retain the principal waivers from the CJR Extension, including the three-day Skilled Nursing Facility rule waiver, up to 13 post-discharge home visits by non-physician practitioners under the incident to waiver, expanded telehealth flexibilities, gainsharing waivers under the Anti-Kickback Statute and physician self-referral law, and beneficiary engagement incentives of up to $1,000 of in-kind items or services. The Federation supports the continuation of these waivers, which provide CJR-X participants with the operational flexibility necessary to manage episodes effectively across the care continuum.

The Federation urges CMS to waive, for the duration of any CJR-X episode, the "3-hour rule" at 42 C.F.R. § 412.622(a)(3)(ii) and the "60 percent rule" compliance threshold at 42 C.F.R. § 412.29(b). Lower extremity joint replacement is not among the 13 conditions counted toward the 60 percent compliance threshold, and post-surgical LEJR patients who would clinically benefit from inpatient rehabilitation facility (IRF) care therefore consume IRF capacity without supporting the IRF's ability to maintain its classification. The 3-hour rule, in turn, requires intensive therapy participation that not every appropriately placed post-LEJR patient can tolerate in the immediate post-operative period, even where IRF-level care is clinically warranted. Together, these requirements operate as a categorical barrier to using IRFs as a post-acute setting under CJR-X, channeling beneficiaries to skilled nursing facilities and home health regardless of clinical appropriateness. **FAH recommends that CMS waive both requirements with respect to CJR-X beneficiaries**, allowing IRFs to provide a clinically appropriate intensity of therapy to CJR-X beneficiaries and allowing CJR-X beneficiaries treated in an IRF to count toward neither the 60 percent compliance threshold nor against it. This approach would align CJR-X with the principle CMS has applied to other Innovation Center waivers, under which model-specific flexibilities support care redesign without altering the underlying program requirements for non-model beneficiaries.

X. CONCURRENT PARTICIPATION AND FINANCIAL ARRANGEMENTS (Part X.C.2.h and X.C.2.i)

CMS proposes to expand the list of permissible CJR-X collaborators to include Medicare ACOs. The Federation supports the inclusion of Medicare ACOs in the CJR-X collaborator list and requests clarification on several operational questions raised by the interaction between CJR-X and Medicare ACO programs.

For hospitals participating in both CJR-X and a Medicare ACO, the interaction between CJR-X sharing arrangements and ACO shared savings distributions raises operational and compliance questions that CMS should address in any final rule. **Specifically, CMS should provide guidance on (1) whether and how the same physician group can be both a CJR-X collaborator and an ACO participating provider, (2) how gainsharing payments under CJR-X interact with ACO shared savings distributions for the same beneficiary, and (3) whether the existence of an ACO arrangement affects the calculation of internal cost savings available for distribution under CJR-X sharing arrangements.**

The Federation also reiterates the recommendation set forth in Section V that beneficiaries attributed to a Medicare ACO be excluded from CJR-X reconciliation when they receive a lower extremity joint replacement at a CJR-X participant hospital. Resolving the precedence question between CJR-X and Medicare ACO programs is essential to avoid the conflicting incentives and duplicative accountability layers described in Section V.

XI. BENEFICIARY NOTIFICATION (Part X.C.2.c.(1))

CMS proposes that every CJR-X participant provide written notification to each CJR-X beneficiary of inclusion in the model prior to discharge from the anchor hospitalization or anchor procedure. CMS also proposes that each CJR-X collaborator provide a separate written notice describing the sharing arrangement and quality and payment incentives no later than the time at which the beneficiary first receives an item or service from the collaborator.

CMS explicitly seeks comment on the alternative of not requiring CJR-X beneficiary notifications. The Proposed Rule states that other CMS initiatives, such as the Hospital Value-Based Purchasing Program or the Expanded Home Health Value-Based Purchasing Model, do not require entities participating in those initiatives to provide beneficiary notifications and acknowledges that a model that is expanded nationally, such as the proposed CJR-X, would become standard practice for hospitals to manage beneficiaries in a LEJR episode of care such that the beneficiaries' experience or treatment options should not materially change between participating hospitals. The Proposed Rule further recognizes that beneficiaries already receive a significant amount of information on discharge from the hospital or hospital outpatient department and a beneficiary notification may go unnoticed or be redundant and concludes that the administrative burden of notification may outweigh its value.

The Federation agrees with each of these points. The Federation has urged CMS since the 2015 CCJR proposed rule and the 2017 Episode Payment Models (EPM) proposed rule to reconsider beneficiary notification requirements as unnecessary and duplicative, particularly when beneficiaries may be subject to multiple overlapping CMS payment models simultaneously. CMS's reasoning in the Proposed Rule for considering elimination of the notification requirement applies fully and persuasively to CJR-X.

FAH urges CMS to adopt the alternative CMS itself articulated and eliminate the CJR-X beneficiary notification requirement.

If CMS nonetheless retains the notification requirement, the Federation urges CMS to permit electronic delivery with proof of receipt rather than paper-based written notice; to provide timing flexibility, particularly for outpatient anchor procedures and circumstances where the beneficiary's CJR-X status is not confirmed until after the procedure, by permitting notification "as soon as is reasonably practicable"; and to develop a single streamlined notice across CMS bundled payment and value-based programs, or to assume responsibility for the notice itself. With CJR-X expanding nationally to approximately 2,000 hospitals while TEAM runs concurrently for the same procedure category, beneficiaries will increasingly receive multiple model notices for the same care episode. Streamlining is more important now than when the Federation first proposed it in 2017. The Federation makes the same recommendation for collaborator notification.

XII. CJR-X IS NOT A LAWFUL EXPANSION AND CMS LACKS THE AUTHORITY TO MANDATE PROVIDER PARTICIPATION

CMS proposes to continue to test and evaluate the CJR Model as CJR-X as a national, mandatory Phase II model under section 1115A(c) of the Act. As detailed in prior comments regarding mandatory models, the Federation continues to strongly oppose mandatory provider participation in any Center for Medicare and Medicaid Innovation (CMMI) testing, including the expansion of previously terminated models, and urges the Department of Health and Human Services (HHS) to ensure that CMMI acts only within its designated authority to test voluntary alternative payment models. These legal and policy objections to mandatory demonstrations are particularly acute with respect to the CJR-X, which is framed as a Phase II model under section 1115A(c) of the Act.

As a preliminary matter, CJR-X is not authorized under section 1115A(c) of the Act, which permits an expansion to the duration and the scope of a *model that is being tested* under subsection (b). CJR-X, however, is not an expansion of a model that is being tested. The Proposed Rule frames CJR-X as an expansion of the Comprehensive Care for Joint Replacement Model (CJR), which was implemented from April 1, 2016 to December 31, 2024. Because CJR is no longer a model that is being tested under subsection (b), it does not satisfy the baseline requirements for the Phase II expansion of a model under subsection (c). In fact, after the completion of CJR testing, CMMI began the TEAM model, which it characterized as being an extension and application of information learned from testing CJR and other models. Moreover, CJR-X incorporates untested modifications to CJR, which is likewise not authorized. For example, the discount factor tested by the CJR model was 3 percent, but CJR-X would use an untested 2 percent discount factor and would wholly abandon the quality improvement points that were part of the CJR model. Subsection (c) only permits an expansion of the duration and the scope of a model, rather than the substantive modification of the model itself to incorporate untested elements or eliminate tested elements. Thus, as a threshold matter, CJR-X is ineligible for expansion under subsection (c) because CJR is not a model that is being tested and CJR-X includes untested elements and changes beyond a mere expansion in duration and scope. Instead of proceeding to a Phase II expansion, any version of CJR-X must first be tested and evaluated as a Phase I model under subsection (b).

Even if CMS were to use its subsection (b) authority for a more limited test of CJR-X, mandatory provider participation in CJR-X would nonetheless be unlawful. **Mandatory provider and supplier participation in CMMI models constitutes an impermissible mandatory change to the Medicare program and runs counter to both the letter and spirit of the law that established the CMMI. CMMI's demonstration authority is limited to the testing of models under section 1115A and the making of recommendations to Congress; Congress reserved for itself**

the authority to make permanent or mandatory changes to the Medicare program and the Inpatient Prospective Payment System (IPPS) through legislation.

Case law confirms that CMS's assertion of authority under section 1115A to mandate a demonstration model is misplaced. In recent years, courts have continued to make clear that constitutional limits inform the scope of agency authority. In particular, grants of authority to agencies must be narrowly construed, and delegations of broad authority should not be presumed to exist. The Supreme Court has been explicit that agencies must have clear Congressional authorization to exercise extraordinary regulatory authority. "Agencies have only those powers given to them by Congress, and enabling legislation is generally not an 'open book to which the agency may add pages and change the plot line."[7] Congress does not typically use modest words, vague terms, subtle devices, or oblique or elliptical language to empower an agency to make a fundamental change to a statutory scheme.[7, 8]

Mandating provider participation in CJR-X (and other CMMI models) transforms the methodology through which providers receive Medicare payments from the statutorily mandated, predictable prospective payment system to a two-sided risk model with the uncertainty of repayment risks. No such authorization exists or should be presumed to exist here. Congress has not included in the authorizing statute any statements indicating that it intended to and actually did delegate its lawmaking role to CMS to require providers to accept this different, unpredictable payment scheme in lieu of full IPPS payments for these services. Rather, section 1115A(g) indicates Congress reserved for itself the authority to adopt such fundamental alterations to the statutory inpatient and outpatient payment systems.

Congress precluded administrative or judicial review of a substantial number of matters of CMMI demonstration authority under section 1115A(d)(2) to permit the testing or expansion of models. Under CMS's interpretation of section 1115A, CMMI would have unbounded authority to substitute alternative payment systems in lieu of the statutory inpatient and outpatient payment systems adopted by Congress, with no meaningful judicial check on that authority. Were Congress to have clearly articulated such a broad delegation of authority to CMS to alter the Medicare reimbursement scheme (again, it has not), Congress would need to provide intelligible principles defining the scope of the delegated authority to ensure such a delegation was constitutionally sound. The current statutory framework does not provide those principles.

CMMI authority is also limited to models of defined duration, and the proposal to implement CJR-X without any end date and with only the prospect of unilateral termination is unlawful. All models under section 1115A(b) and (c) must have a defined duration (*i.e.*, a completion date). The statute makes no reference to any regulatory process for making any model a permanent feature of the Medicare program. Rather, the statutory evaluation and recommendation requirements for models ensures that Congress has the information available to evaluate whether a model has enduring value and then can use its legislative authority to adopt payment and service delivery changes on a permanent basis where appropriate.

In sum, the mandatory CJR-X demonstration is an overreach of agency authority that contradicts the statutory mandate of section 1115A and raises concerns about impermissible delegation of lawmaking authority to the executive branch and unjust compensation for services provided to Medicare beneficiaries. These concerns are particularly acute in light of the extraordinary proposal to mandate CJR-X participation by nearly all acute care hospitals in the United States. Because section 1115A does not authorize mandatory payment demonstrations, the Federation strongly opposes the implementation of the CJR-X demonstration as proposed. **FAH strongly recommends that CMS ensure that all CMMI models are voluntary and designed to test, at an appropriate scale, alternative payment models.**

The Federation submits the substantive comments noted above in Sections I through XII without prejudice to the threshold legal objections set forth above. The submission of substantive comments does not constitute agreement that CJR-X is lawfully authorized under section 1115A of the Social Security Act, nor does it constitute concession that any specific design element is appropriate as a matter of policy. The Federation submits these comments to ensure that, if CMS proceeds with CJR-X in some form notwithstanding the Federation's threshold objections, the most harmful design choices are addressed in the final rule.

Endnotes

[1] The Lewin Group, *CMS Comprehensive Care for Joint Replacement Model: Performance Year 6 Evaluation* (Dec. 2024). Prepared for the Centers for Medicare & Medicaid Services. Available at https://www.cms.gov/priorities/innovation/data-and-reports/2024/cjr-py6-ar-execsumm.
[2] Kaufman Hall & Associates, *National Hospital Flash Report* (cited in Advisory Board, "Hospital margins, explained," Feb. 13, 2025). Available at https://www.advisory.com/daily-briefing/2025/02/13/hospital-margins-ec.
[3] American Hospital Association, *2025 Cost of Caring Report* (Apr. 2025).

[4] Center for Healthcare Quality and Payment Reform, *Rural Hospitals at Risk of Closing* (Dec. 2025). Available at https://ruralhospitals.chqpr.org/.
[5] The Lewin Group, *Safety-Net Hospital Experiences in a Bundled Payment Model: Lessons Learned for Providers and Payers* (Dec. 2025). Prepared for the Centers for Medicare & Medicaid Services.
[6] Centers for Medicare & Medicaid Services (CMS), HCAHPS Response Rate by Survey Mode Table, available at: HCAHPS Response Rate by Survey Mode (accessed June 2026). https://hcahpsonline.org/globalassets/hcahps/summary-analyses/rr-by-survey-mode/april-2024_response-rate-by-survey-mode.pdf
[7] *W. Virginia v. Env't Prot. Agency*, 597 U.S. 697, 723 (2022) (cleaned up).
[8] *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468 (2001); *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218, 229 (1994)); *see also Biden v. Nebraska*, 143 S. Ct. 2355, 2372–75 (2023) (Congress did not provide "clear congressional authorization" for the Secretary to act in ways that would in effect fundamentally revise the statutory scheme).