The Comprehensive Care for Joint Replacement (CJR) model launched on April 1, 2016 to test whether an episode-based payment model for lower extremity joint replacements (LEJR) can lower payments while maintaining or improving quality.

**Model Design Innovations**
- Hospitals are financially accountable for the cost of the surgery and health care services for the following 90 days.
- A target pricing approach that considers performance relative to a hospital’s regional peers and links payment to quality.
- A risk adjustment methodology that establishes higher quality-adjusted target prices for more complex episodes.

**Hospitals invested in care coordination to achieve the goals of the CJR model.**

Care coordination efforts typically required significant resources. As a result, 41% of hospitals hired additional staff or reassigned roles and 23% of hospitals dedicated additional staff or resources to care coordination due to the CJR model.

70% of care coordinators reported that the CJR model influenced…

**Survey data based on responses from care coordinators at 199 CJR hospitals.**
The CJR model continues to be a promising approach for reducing episode payments. Through the first five years, participating mandatory hospitals responded to the model’s financial incentives by reducing institutional post-acute care use, resulting in relative reductions in episode payments without compromising quality of care. This was observed for elective and fracture LEJR episodes, as well as all historically underserved populations. The CJR model did not impact the existing disparities between historically underserved populations and their reference populations in payments, utilization, and quality observed prior to the model. However, there was evidence suggesting that disparities in elective LEJR rates widened for some populations. CJR hospitals consistently generated savings until 2020 when smaller payment reductions and larger payments from CMS due to the pandemic offset cumulative savings and resulted in losses.

**FINDINGS**

- Mandatory CJR hospitals generated Medicare savings until 2020, when savings were offset due to the COVID-19 public health emergency policy to remove downside risk.

**KEY TAKEAWAYS**

- Quality of care was improved or maintained.
- We evaluated disparities under the CJR model for historically underserved populations.

Before the CJR model, there were large disparities in elective LEJR rates, payments, institutional post-acute care use, and quality. The elective LEJR rate was 40% to 60% lower for historically underserved populations than reference populations.

The CJR model reduced payments for all underserved populations, by reducing institutional post-acute care use. We observed larger payment reductions and a lower mortality rate for Black or African American patients than White patients.

Under the CJR model, the disparity in elective LEJR rates widened for Black or African American and Black or African American dually eligible patients. No other changes to the pre-existing disparities were observed.