

CMS Comprehensive Care for Joint Replacement Model: Performance Years 6–8 Evaluation Report

Final Evaluation Report – Executive Summary



September 2026

Prepared for: **Centers for Medicare & Medicaid Services**

Submitted by: **The Lewin Group, with GDIT and Telligen**



Executive Summary

Final Evaluation Report

The Centers for Medicare & Medicaid Services (CMS) launched the Comprehensive Care for Joint Replacement (CJR) Model in April 2016 as part of a broader effort to test episode-based payment models that emphasize value over volume.

Under the CJR Model, hospitals in selected metropolitan areas were held accountable for the cost and quality of care delivered during a 90-day episode following a lower extremity joint replacement (LEJR). Hospitals could earn a reconciliation payment or owe a repayment to CMS based on whether episode spending fell below or above a target price. Over time, CMS refined the model to concentrate on higher-spending markets, where the potential for care redesign and cost containment was greatest.

This report presents findings from the final independent evaluation of the CJR Model, focusing on Performance Years (PYs) 6 through 8, after CMS extended and substantially modified the model. The evaluation assessed the model's impact by comparing changes in key spending and quality outcomes between baseline and PYs 6–8 for CJR hospitals relative to a randomized control group, and by estimating the resulting net savings to Medicare.

Model Background

- **Timeline:** April 2016–Dec. 2024
- **Participants:** Mandatory participation for hospitals in randomly selected Metropolitan Statistical Areas
- **Procedures:** LEJRs include elective hip and knee replacements and hip replacements after a fracture
- **Patients:** Original Medicare patients with an inpatient stay or outpatient procedure for an LEJR at a hospital
- **LEJR Episode Definition:** Procedure plus 90-days after discharge
- **Target Price:** Based on risk-adjusted average spending within a hospital's region for each included procedure
- **Risk Adjustment:** Age, dual eligibility status, and count of chronic conditions

Key model research questions:

1. Was the CJR Model associated with reductions in expenditures and care transformation that resulted in savings to Medicare?
2. Did the model improve or maintain quality of care?

Impact of the CJR Model during the extension period



Saved the Medicare Program \$180 million



Reduced spending by \$1,226 per elective episode relative to the randomized control group



Reduced inpatient rehabilitation facility payments by \$443 per episode relative to the control group by shifting post-discharge care patterns



Maintained quality of care despite reducing expenditures

Mandatory participation engaged a broad set of hospitals.

During the extension period, 321 participating hospitals performed approximately 143,000 LEJRs that initiated model episodes, representing nearly 9% of all hospital-based LEJRs performed nationwide. The vast majority (89%) of CJR LEJRs were elective procedures. The model was intentionally modified to focus on metropolitan areas with higher historical spending. As a result, CJR episodes, on average, involved slightly older and more medically complex patients than LEJR episodes nationally, with a higher burden of chronic conditions. CMS also updated target pricing and included outpatient LEJRs as episodes during the extension period to better align the model with changes in Medicare payment policies and evolving practice patterns. Through mandatory participation, the CJR Model engaged a diverse set of hospitals, including safety-net hospitals and others that may not have voluntarily participated in a bundled payment model.



9% of LEJRs nationally

321

Hospitals

34

Metropolitan
Statistical
Areas

143,000 +

Lower Extremity
Joint Replacement
Procedures

48,000+

Inpatient procedures

94,000+

Outpatient procedures



66% of CJR LEJRs were in outpatient settings, slightly lower than **71%** of LEJRs nationally

The CJR Model generated \$180 million in net Medicare savings.

Across PYs 6–8, the CJR Model consistently generated net savings to Medicare. The majority of these savings resulted from reductions in episode payments, with the remaining share reflecting repayments to CMS from hospitals whose total episode spending exceeded their target prices.

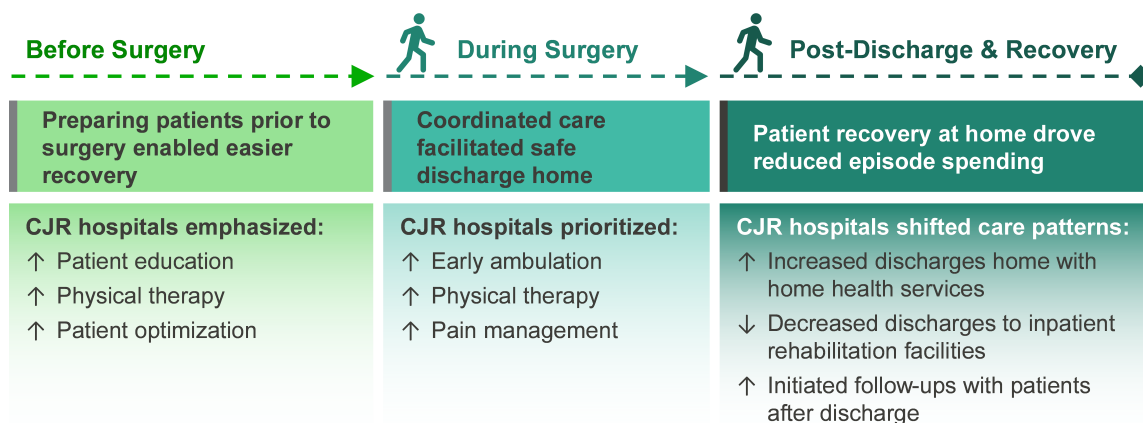


Episode payment reductions were concentrated among elective LEJR episodes, which made up the majority of CJR episodes during the extension period. Relative to control hospitals, CJR hospitals reduced total episode payments for elective LEJRs by \$1,226 per episode during PYs 6-8. Because elective episodes accounted for such a large portion of all episodes, evaluation findings for all LEJR episodes generally mirrored those for elective episodes. We did not observe a reduction in total episode payments for hip fracture LEJRs during PYs 6–8.

CJR hospitals reduced spending by reshaping post-acute care (PAC) expectations.

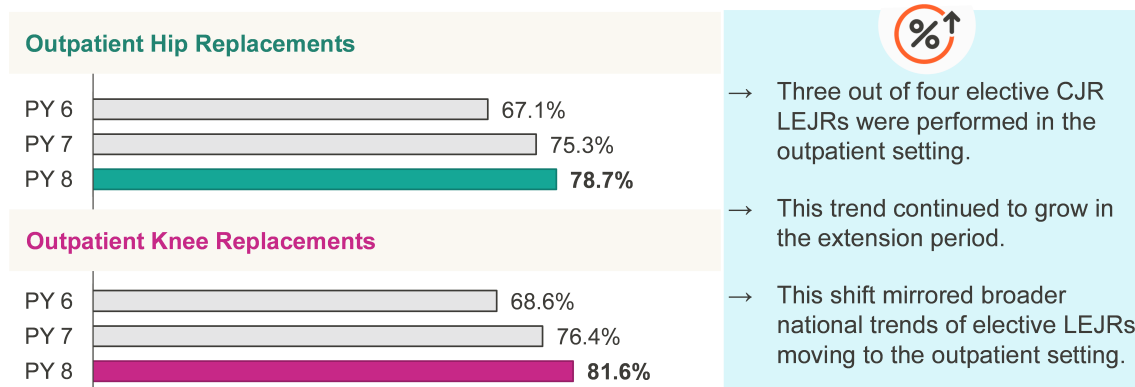
Shifts in PAC use were a key contributor to lower elective episode spending. During the extension period, CJR hospitals reduced use of inpatient rehabilitation facilities (IRFs) relative to the control group, reducing IRF spending by an estimated \$443 per episode. CJR hospitals shifted more patients away from institutional care and toward recovery at home with home health services, which substantially reduced Medicare expenditures in the post-discharge period.

The [CJR Drivers of Care Transformation Report](#) describes how CJR hospitals responded to the model and provides insight into the observed shifts in PAC use. Information gathered from physicians and hospital representatives through interviews and surveys conducted in earlier PYs documented changes in care delivery that emphasized preparing patients for recovery before surgery, setting patient expectations for discharge home, planning for patient discharge earlier in the hospital stay, and better coordinating care across settings. Hospitals also partnered with PAC providers on recommended care protocols for CJR patients. Together, these changes supported a sustained shift toward recovery at home when clinically appropriate.



During the extension period, outpatient LEJR use increased, aligning with national trends.

Throughout the extension period, the proportion of LEJRs performed in hospital outpatient settings increased for both CJR and control hospitals. Despite this growth, CJR hospitals had a slightly lower share of outpatient LEJRs than control hospitals. By the end of the model in December 2024, outpatient care had become the predominant setting for both hip and knee replacement procedures across both groups.



The CJR Model maintained quality of care while reducing costs.

We found no relative differences in key quality outcomes between CJR hospitals and control hospitals. Both CJR and control hospitals reduced the rate of unplanned hospital readmissions, complications, and mortality from baseline to the extension period, mirroring national trends in quality. Emergency department visits slightly increased across the same time period for both groups, but there was no notable relative difference between CJR and control episodes.

The CJR Model informed ongoing and future episode-based payment models.

The CJR Model demonstrated that episode-based payments can be implemented across a wide range of hospital settings and markets, helping to inform the design of subsequent mandatory initiatives such as the Transforming Episode Accountability Model (TEAM). Through broad participation, the model provided valuable insights into how aligned incentives and episode-level accountability can influence care delivery and generate savings across diverse markets while maintaining the quality of care for patients. The experience gained from CJR contributed to CMS' understanding of how episode-based approaches can drive measurable changes when applied consistently across providers. Building on these lessons, CMS has finalized an expansion of the CJR Model as the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model, extending episode-based accountability for LEJRs to a broader set of hospitals and geographic areas.

About this document

The Lewin Group, an independent contractor, analyzed claims, survey, interview, and site visit data for this evaluation to determine whether the model achieved its primary goals.

Submitted by:

The Lewin Group, Amanda Markovitz, Project Director

In partnership with GDIT and Telligen

Authors:

Amanda Markovitz, Soumita Lahiri, Elvedin Bijelic, Ian Morrall, Cassandra Fate, Cody Hopewell, Maxwell Mindock, Niklaus Julius, Colin Doyle, Mary Beth Schaefer

Prepared for:

Lauren Vanderwerker, Research and Rapid-Cycle Evaluation Group (RREG), Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS)

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The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The Lewin Group assumes responsibility for the accuracy and completeness of the information contained in this report.

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Interested in learning more?

In addition to this report, the following resources are available under the *Evaluation Reports* section of the [CJR Model website](#) to get a quick snapshot of key findings or to dive deep into the final evaluation report:

- **Findings at a Glance | 2 pages**
Concise visual summary of key findings
- **CJR Final Evaluation Report | 40 pages**
Comprehensive evaluation findings and methodology