Rainfall Health

June 8, 2026

The Honorable Mehmet Oz, MD

Administrator, Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services

Attention: CJR-X Proposed Rule

Re: Comments on the Proposed Comprehensive Joint Replacement Model (CJR-X)

Dear Administrator Oz:

Rainfall Health is an AI-powered clinical operations and compliance company focused on helping hospitals deliver high-quality, cost-effective surgical care for Medicare beneficiaries, particularly in safety net, rural, Medicare Dependent, and Sole Community Hospitals. Our platform reduces the administrative burden of CMS value-based care participation by integrating episode cost analytics, quality performance monitoring, post-acute network optimization, and electronic care coordination across hospitals, skilled nursing facilities, home health agencies, and primary care providers. Purpose-built for mandatory models such as the Transforming Episode Accountability Model (TEAM), our platform enables hospitals to manage the full 30-day surgical episode as a coordinated continuum of care rather than a series of disconnected encounters. By leveraging existing CMS data sources and workflows, we help organizations improve care transitions, reduce avoidable post-acute spending, and identify actionable opportunities to improve quality and outcomes during the episode itself.

Our mission aligns closely with CMS's transition from fee-for-service reimbursement to episode-based accountability by: (1) reducing participation barriers for smaller and resource-constrained hospitals; (2) improving cost-efficient care delivery across the entire 30-day episode, including post-acute care; and (3) strengthening patient outcomes through timely information exchange and proactive care coordination.

Rainfall Health works directly with TEAM participants across diverse hospital settings, providing firsthand insight into the operational and financial impacts of the model for all five TEAM procedures: lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion, coronary artery bypass grafting, and major bowel procedures. The recommendations that follow are informed by our experience supporting these hospitals in real-world implementation.

Support for the CJR-X Model

We support CMS's proposal to expand the Comprehensive Care for Joint Replacement model nationwide. Lower-extremity joint replacement remains one of the highest-volume surgical episodes in Medicare and one of the clearest opportunities to improve care coordination

while reducing avoidable spending. The independent CJR evaluation found that participating hospitals reduced average episode payments by approximately $1,000 per episode, with reductions driven primarily by more appropriate post-acute care utilization rather than by reductions in clinical quality (Lewin Group / CMS Second Annual Evaluation Report; Health Care Transformation Task Force CJR Assessment). Quality of care, as measured by unplanned readmissions, emergency department visits, and mortality was maintained (Skilled Nursing News summary of Lewin findings).

CJR-X builds appropriately on this foundation and, as the first nationally mandatory Innovation Center expansion, will significantly broaden the evidence base for episode-based payment (CMS Press Release, April 10, 2026; McDermott+ Regs & Eggs analysis).

Executive Summary

1. We support CJR-X, including its mandatory, nationwide scope and its alignment with the broader episode-based reform trajectory anchored by the Transforming Episode Accountability Model (TEAM).
2. We strongly support maintaining the 90-day episode window. Evaluation evidence and clinical experience confirm that the majority of avoidable post-acute spending and complications occur after the index discharge, not during the inpatient stay.
3. We recommend strengthening risk adjustment for medically complex, dual-eligible, and frail beneficiaries to prevent selection bias and protect access for the patients most likely to benefit from coordinated care.
4. We support the proposed differentiated stop-loss/stop-gain limits (5% for safety-net, rural, Medicare-Dependent, and Sole Community Hospitals; 20% for all others) and recommend CMS also adopt peer grouping by dual-eligible share for benchmarking, consistent with the Hospital Readmissions Reduction Program.
5. We recommend CMS heavily weigh the THA/TKA PRO-PM in the Composite Quality Score and require transparent, timely PROM data feedback to participants.
6. We recommend CMS shorten the reconciliation and data-feedback cycle and publish target-price methodology with sufficient detail for participants to model performance prospectively.
7. We recommend CMS extend the in-home telehealth G-codes to include geriatric assessment and 4Ms-aligned services, given the median age of the CJR-X population.

The Importance of the 90-Day Episode Window

We particularly support CMS's decision to maintain a 90-day episode duration. The 90-day window aligns payment accountability with the clinical reality of joint replacement recovery: complications, readmissions, functional setbacks, and post-acute care needs frequently emerge well after the index discharge.

An independent CJR evaluation confirmed that nearly all of the program's per-episode savings were attributable to changes that occur *after* hospital discharge, specifically, a 2.3-day average reduction in SNF length of stay (≈$508 per episode), a $357 reduction in IRF spending per episode, and increased direct-to-home discharges, all without measurable harm to functional status or readmission rates (Lewin Group via Skilled Nursing News). These are the precise behaviors a 90-day window incentivizes;and they would be largely lost under a shorter episode definition.

A shorter window (30 or 60 days) would:

- Create incentives for premature discharge without adequate post-acute support;
- Truncate accountability before most complications and readmissions are identified;
- Undermine investment in patient education, rehabilitation engagement, and post-acute network design — the same activities the CJR evaluation found to drive 89% of participating hospitals to implement same-day post-surgery ambulation and structured discharge planning (HCTTF CJR Assessment).

The 90-day window is the structural feature most responsible for CJR's measured behavior change. We strongly urge CMS to preserve it.

Recommendations to Strengthen CJR-X

1. Strengthen Risk Adjustment for Medically and Socially Complex Beneficiaries

A well-documented weakness of original CJR was that safety-net hospitals — defined as those in the top quartile of dual-eligible LEJR volume — faced systematically higher episode spending due to medical and social complexity, requiring substantially larger cost reductions than non-safety-net hospitals to achieve reconciliation payments (OHSU CJR Safety-Net Analysis). We appreciate that CJR-X proposes expanded risk adjustment incorporating dual-eligibility and hospital bed count alongside episode-level acuity adjusters (Force Therapeutics analysis). We recommend CMS go further by:

- **Adopting peer-group benchmarking** by dual-eligible share, consistent with the methodology CMS uses in the Hospital Readmissions Reduction Program;
- **Incorporating frailty indicators** (e.g., Hospital Frailty Risk Score or CMS Hierarchical Condition Categories frailty proxies) into episode-level risk adjustment;
- **Publishing risk-adjustment model performance** (C-statistic, calibration by decile) annually so participants and stakeholders can evaluate whether adjustment is keeping pace with population complexity.

2. Protect Safety-Net, Rural, and Low-Volume Participants

We support the proposed 5% stop-loss/stop-gain limit for safety-net, rural, Medicare-Dependent, and Sole Community Hospitals, and the exemption from reconciliation for hospitals with fewer than 31 baseline LEJR procedures (McDermott+ analysis). We further recommend CMS:

- Provide a **glide path** (e.g., 0% downside in Performance Year 1, scaling to 5% by PY3) for first-time mandatory participants that did not participate in original CJR or TEAM;
- Offer **targeted technical assistance funding** for safety-net and rural participants, including support for episode analytics, post-acute network development, and quality reporting infrastructure.

3. Heavily Weigh Patient-Reported Outcomes in the Composite Quality Score

We support inclusion of the THA/TKA PRO-PM and the proposed heavier weighting of patient-reported outcomes in the Composite Quality Score relative to TEAM or the Hospital Quality Reporting program (Force Therapeutics analysis). The CJR evaluation noted that institutional post-acute care reductions were achieved without measurable loss of functional status — but also that PROM collection infrastructure remained uneven across participants (Lewin findings; AAOS PROMs Registry guidance). To make PROMs a credible quality lever under CJR-X, we recommend CMS:

- **Publish minimum data completeness thresholds** (e.g., ≥50% pre- and post-operative PROM capture) clearly in advance of PY1;
- **Provide hospital-level PROM benchmarking dashboards** with national and peer-group comparisons no less than quarterly;
- **Standardize the PROM instruments** (e.g., HOOS, JR / KOOS, JR) and EHR-extractable specifications to reduce administrative burden, particularly for low-volume participants.

4. Improve Data Timeliness and Target-Price Transparency

Participants in original CJR consistently identified delayed claims data and opaque target-price methodology as barriers to managing episode performance prospectively. We recommend CMS:

- Deliver **monthly claims and episode-level feedback** with a target lag of ≤60 days;
- Publish the **target-price calculation methodology in full**, including trend factor derivation, regional blending, and risk-adjustment coefficients, before each performance year;
- Provide hospitals with **prospective target prices and modeled reconciliation scenarios** at least 60 days before the start of each performance year.

5. Align CJR-X with Age-Friendly and Geriatric Surgery Priorities

The CJR-X population is overwhelmingly older adults, and CMS has separately advanced the Age-Friendly Hospital Measure under the IPPS FY2025 Inpatient Quality Reporting program. CJR-X is a natural place to operationalize age-friendly care within an accountable episode. We recommend CMS:

- **Make the proposed in-home telehealth G-codes broadly applicable** to 4Ms-aligned services (Mentation, Mobility, Medications, What Matters), including geriatric assessment, delirium screening follow-up, and medication reconciliation post-discharge;
- **Recognize frailty screening and prehabilitation** as qualifying care-redesign activities under any forthcoming CJR-X learning system or beneficiary engagement guidance;
- **Coordinate CJR-X measure specifications with the Age-Friendly Hospital Measure** to avoid duplicative reporting burden for participants.

6. Coordinate with TEAM and Avoid Duplicative or Conflicting Incentives

Because CJR-X excludes hospitals currently participating in TEAM and will absorb those hospitals upon TEAM's conclusion (Force Therapeutics analysis), we recommend CMS publish, in advance of PY1, a clear transition framework specifying how hospital baseline data, prior reconciliation history, quality reporting infrastructure, and care-redesign investments under TEAM will carry over into CJR-X.

Conclusion

Rainfall Health supports the proposed CJR-X model. The 90-day episode window, the differentiated stop-loss limits for vulnerable participants, the inclusion of outpatient LEJR procedures, and the expanded risk-adjustment methodology together represent meaningful refinements over original CJR.

With the additional refinements outlined above, particularly stronger risk adjustment for socially and medically complex beneficiaries, faster and more transparent data feedback, heavier and better-supported PROM accountability, and explicit alignment with CMS's age-friendly priorities ,CJR-X can deliver durable improvements in both patient outcomes and Medicare program performance.

We appreciate the opportunity to comment and welcome the opportunity to share additional operational data and platform-level observations with CMS staff as the agency finalizes the model.

Respectfully Submitted,

Christina Keny, PhD, MHA, RN, CPHQ, CMBBLSS

Vice President of Clinical AI, Rainfall Health

Associate Faculty, The University of California, San Francisco

Email: ckeny@rainfallhealth.com christina.keny@ucsf.edu

Jessica Ohlssen

Senior Vice President of Revenue

Rainfall Health

Email: johlssen@rainfallhealth.com