Unpacking the FY 2027 IPPS Final Rul CMS-1849-F: How Mandatory Electror Prior Auth, FHIR APIs, Sepsis Readmission Penalties, and Expandec eCQMs Are Reshaping Hospital Tech Investment Priorities

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Podcast

Thoughts on Healthcare Markets & Technology

Unpacking the FY 2027 IPPS Final Rule CMS-1849-F: How Mandatory Electronic Prior Auth, FHIR APIs, Sepsis Readmission Penalties, and Expanded eCQMs Are Reshaping Hospital Tech Investment Priorities

Nearly 70% of U.S. hospitals got hit with readmission penalties in FY 2026. Around $290M redistributed out of their budgets. CMS-1849-F just made that program harder to escape. Thread on what changed...

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Abstract

- CMS dropped CMS-1849-F on July 31, 2026, bumping hospital pay by rough $2.1B but tightening the screws on readmissions, HACs, and interop laggard
- Electronic prior auth flips from optional bonus in CY 2027 to mandatory in 2028, with Da Vinci FHIR IGs as the technical spine
- New sepsis 30-day readmission measure enters confidential reporting, hits payment in FY 2030, adding real teeth to the HRRP which already dinged n 70% of hospitals last cycle
- Medicare Advantage patients now folded into mortality and readmission ma which matters a lot when MA is over half of Medicare enrollment
- eCQM slate expands (Advance Care Planning, Postop VTE, Malnutrition Ca Score) mandatory for FY 2030 payment determinations
- UDI capture for implantables added to the Public Health and Clinical Data Exchange objective
- Interop solutions market projected to grow from $3.4B (2023) to $8.57B (203 quality mgmt software from $1.8B (2026) to $3.1B (2030)
- Prior auth burden runs ~13 hrs/wk/physician at $20-50/hr, a captive TAM th second the mandate flips on
- Startup lanes: ePA automation on FHIR, sepsis readmission prediction, eCQ abstraction, UDI/RTLS tracking

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One. The Rule in Plain English and Why the Money Actually Moves

The FY 2027 IPPS and LTCH PPS Final Rule, officially CMS-1849-F, landed on 31, 2026, and while the headline number is a $2.1B pay bump for hospitals, that line figure is almost a decoy. The real story is buried in the penalty structure and tech mandates, which together represent one of the more aggressive digital-transformation nudges CMS has issued since Meaningful Use Stage 2. Hospitals more money on paper, sure, but the rule simultaneously tightens the noose on readmissions, hospital-acquired conditions, and any hospital that has been drag its feet on interop. The net effect for a lot of systems is going to feel less like a ra and more like being handed a bigger paycheck with a longer list of things they c fined for.

The mechanics matter here because CMS is not just tweaking dials. The agency using its favorite lever, which is Medicare reimbursement, to force capital alloca decisions inside hospital IT departments. When a CFO sees that failure to hit th Hospital IQR reporting bar knocks a quarter of their annual payment update, or the VBP program is skimming 2% off base operating payments to redistribute ba

on performance, the calculus around buying quality software or hiring a Chief D Officer changes fast. This is the CMS playbook in a nutshell: create a penalty sca enough that the market has to build tools to help hospitals avoid it, and let the p sector figure out the rest.

What is different about CMS-1849-F is the layering. Prior rules focused on one areas at a time. This one hits interop, quality measurement, prior auth, and devi tracking all at once, and it does so with FHIR standards baked directly into the compliance path. That is not accidental. CMS and ONC have clearly coordinated this, and the finalized adoption of the Da Vinci Coverage Requirements Discove Documentation Templates and Rules, and Prior Authorization Support Implementation Guides is the tell. Once those IGs are inside the rule, they beco facto federal building codes for health IT.

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