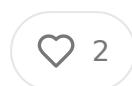


# CMS-0062-P Deep Dive: What the 202 Interoperability and Prior Authorization for Drugs Proposed Rule Actually Means for Health Tech Investors and Entrepreneurs

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## Abstract

CMS released CMS-0062-P on April 10, 2026, a proposed rule that extends prior authorization interoperability requirements to drugs for the first time, mandates FHIR-based API endpoint reporting, proposes FHIR as the HIPAA standard for related transactions, and tightens decision timeframes across MA, Medicaid, CHIP, and QHP programs. Key dates and numbers:

- Comment deadline: June 15, 2026
- Compliance target for most proposals: October 1, 2027
- Drug PA timeframes proposed: 24 hours (Medicaid/CHIP drugs), 72 hours standard (MA), 24 hours expedited (QHPs)
- Required IGs include CARIN Blue Button 2.2.0, Da Vinci PDex 2.1.0, CRD 2.2.0, DTR 2.2.0, PAS 2.2.1
- Old IG versions (STU 2 era) proposed to expire January 1, 2028
- Builds on 2020 interoperability final rule and 2024 PA final rule
- New coverage: small group market QHP issuers on FF-SHOPs added as impact payers

## **Background: The Regulatory Arc from 2020 to 2026**

To understand why CMS-0062-P matters, you have to understand where it sits in a multi-year regulatory campaign that started in earnest in 2020. The 2020 CMS Interoperability and Patient Access Final Rule (CMS-9115-F) was the opening salvo that told Medicare Advantage plans, Medicaid, CHIP, and qualified health plan issuers that they had to build and maintain FHIR-based APIs for patient access, provider directories, payer-to-payer data exchange, and eventually prior authorization. That mandate was a structural shock to an industry that had grown comfortable with EDI transactions, fax-based PA workflows, and the general opacity of payer administrative systems.

Then came the 2024 CMS Interoperability and Prior Authorization Final Rule, which went further and required actual electronic prior authorization support for non-drug items and services, with decision timeframe mandates and public reporting obligations for PA metrics. That rule gave the industry a taste of what FHIR-native workflows look like in practice, at least for the medical side of the house. Drugs conspicuously left out, which everyone in the industry noticed and fully expected would be addressed in subsequent rulemaking.

CMS-0062-P is that subsequent rulemaking. It closes the drug PA gap, extends the requirement stack, adds an entirely new mandatory FHIR endpoint registry, and layers HIPAA administrative simplification proposals on top of all of it. The cumulative effect is a regulatory architecture that, when fully implemented, would make FHIR-based interoperability the legal floor for how prior authorization works in America rather than just a best practice or a pilot.

For health tech founders and early-stage investors, this is not just regulatory background noise. This is the demand signal. Every compliance obligation in this space is a vendor opportunity somewhere in the stack. The question is where the real value is and who is positioned to capture it.

## What FHIR Endpoints Actually Are and Why They Matter Here



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