



The Harvest Report

Fall 2026 Insights on bringing in every dollar earned: biologic workflow, supplemental data, and the 2027 HCC changes.

SECTION 01 • BIOLOGIC WORKFLOW

Protect the margin on every biologic dose

Biologics are often a practice's highest-cost line item. One broken link (an expired authorization, a mismatched NDC, a missing waste modifier) turns a reimbursable dose into a write-off. Manage it as one chain:

01	Verify benefits	Medical vs. pharmacy benefit, site of care, and patient cost share.
02	Authorize	Match drug, NDC, units, dates, and site; track every expiration.
03	Acquire	Buy-and-bill or specialty pharmacy per payer; never before approval.
04	Administer	Document dose, lot, route, time, and any discarded amount.
05	Code & bill	HCPCS code, 11-digit NDC, billing units, and JW/JZ modifiers.
06	Reconcile	Paid vs. contracted rate vs. acquisition cost, per dose.

Before December 31

- › Re-verify 2027 coverage for every active biologic patient once open enrollment closes.
- › Start renewals now for authorizations that expire in Q1 2027.
- › Reconcile inventory purchased to doses administered, billed, and paid.

THE EXECUTIVE QUESTION

“Can we trace every dose purchased to a dose administered, billed, and paid at contract?”



SECTION 02 · VALUE-BASED CARE

Documented isn't closed

Supplemental data drives quality gap closure and risk-adjusted revenue in Medicare Advantage and ACO REACH. The clinical work is often done; what's missing is proof the payer received, matched, and accepted it.

1 DOCUMENTED

Service performed and recorded in the EHR

2 SUBMITTED

Sent by 837, electronic feed, or manual submission

3 PAYER ACCEPTED

Accepted, matched, and reflected as gap closure

Validate each outcome on its own: a gap isn't closed until the payer confirms it. The goal is performance above the 4-Star cut point.

Five questions for every payer

- 1 Which pathway carries each measure, and how often?
- 2 Who owns submission, and who owns corrections?
- 3 How are rejections reported, and how fast are they fixed?
- 4 Are submissions reconciled to payer acceptance?
- 5 Does closure appear in HEDIS and Stars reports?

Three pathways to confirm

837 claim. CPT II, HCPCS, and ICD-10 codes on the claim

Electronic feed. Standardized EHR data sent to the payer

Manual review. Abstracted records for gaps claims miss

CMS UPDATE · CY 2027 RATE ANNOUNCEMENT · APRIL 6, 2026

2027 HCC capture is tied to the encounter

+2.48%

Average MA payment increase for 2027, over \$13 billion.

2024 HCC

CMS kept the 2024 CMS-HCC model and dropped the proposed recalibration.

-1.53%

Average risk score impact of excluding unlinked chart review diagnoses.

Audio-only

Diagnoses from audio-only visits are excluded; audio-video telehealth still counts.

What it means now: Payment year 2027 runs on 2026 dates of service. Chart review diagnoses count only when linked to an encounter, with a narrow exception for members who switch plans, so every remaining 2026 visit is the moment to document chronic conditions and submit them on the encounter.