DOCTUSTECH

GUIDE

Step-by-step revenue defense plan for PACE Leaders entering V28

Most leaders know something is changing under V28. Very few can answer the question that matters:

"Exactly how many dollars are at risk, and which diagnoses are responsible?"

This plan exists to close that gap.

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Step 1: Turn V28 from a policy update into a dollar exposure report

Why PACE leaders get this step wrong

The most common V28 mistake isn't poor coding or late documentation. It's **talking about impact in percentages instead of dollars.**

A 3–5% RAF shift sounds manageable.
A **$2.4M annualized revenue gap tied to five diagnoses** does not.

If your organization can't quantify exposure early, every downstream decision (staffing, documentation strategy, vendor spend) is being made blindly.

How to do this in practice

PACE leaders who get ahead of V28 do one thing immediately: They force translation.

Not "Which HCCs were removed?" but:

- Which diagnoses lost value or were eliminated under V28?
- How frequently do those diagnoses appear in our PACE population?
- What does that translate to in per-member, per-year revenue loss?
- Which service lines and regions are now structurally overestimated?

This is no longer a coding exercise. It's a revenue accountability exercise.

How high-performing teams do this fast

Rather than waiting on retrospective reports or abstract RAF modeling, leading PACE organizations operationalize V28 immediately by:

1. Mapping removed and de-weighted HCCs to their active population
2. Quantifying historical diagnosis frequency
3. Translating RAF movement into real, forecast-level dollars
4. Flagging diagnoses that can no longer "carry" revenue expectations

To support this step, DoctusTech RAF Revenue Calculator converts V28 changes into clear financial exposure (not abstract risk scores), giving CMOs an early warning system before revenue erosion shows up in board decks.

Translate ICD-10 Changes into Revenue Impact

Why this step matters

- It anchors leadership around reality instead of estimates
- It prevents over-reacting in the wrong areas
- It sets priorities for clinical, compliance, and operational teams

You cannot manage what you haven't priced. And remember:

> **"Revenue loss** can be **mitigated,** not **prevented"**

Step 2: Shift From Volume-Based Coding to Prevalence-Driven Gap Identification

What changes in day-to-day operations

Under V28, revenue preservation no longer comes from documenting a broader set of diagnoses. Many conditions that previously contributed to RAF have been **removed or materially de-weighted**, and that revenue is not recoverable.

What is recoverable lies in identifying **clinically appropriate diagnoses that remain recognized under V28 but are underrepresented in your population data.**

How teams operationalize this shift

- Establish expected prevalence ranges for high-impact chronic conditions that remain in the model
- Compare the expected prevalence to your internal PACE population
- Prioritize gaps that are:
  - Clinically plausible
  - Operationally addressable
  - Defensible from a documentation and audit standpoint

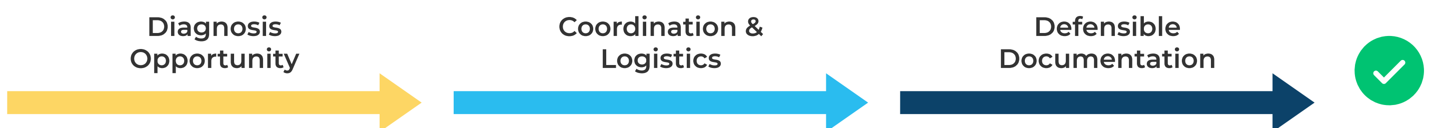
This reframes work across the organization:

- **Population health** focuses on statistically meaningful gaps
- **Medical leadership** validates clinical relevance
- **Operations** determines whether workflows can realistically support identification and confirmation

This is not about increasing coding intensity.
It is about **aligning documented disease burden with the true clinical complexity of the PACE population.**

Step 3: Redesign Workflows Around High-Value Diagnoses

In PACE programs



Many high-impact diagnoses under V28:

- Require imaging or testing
- Require coordination outside the home
- Require follow-up across settings

For PACE programs, this creates a **logistical challenge**, not a documentation one.

Operational questions leadership must now answer

- Which diagnoses justify additional screening efforts?
- Who owns coordination, clinician, care team, or ops?
- How do we standardize access (transport, mobile services, partners)?

If workflows don't change, documentation improvement will plateau.

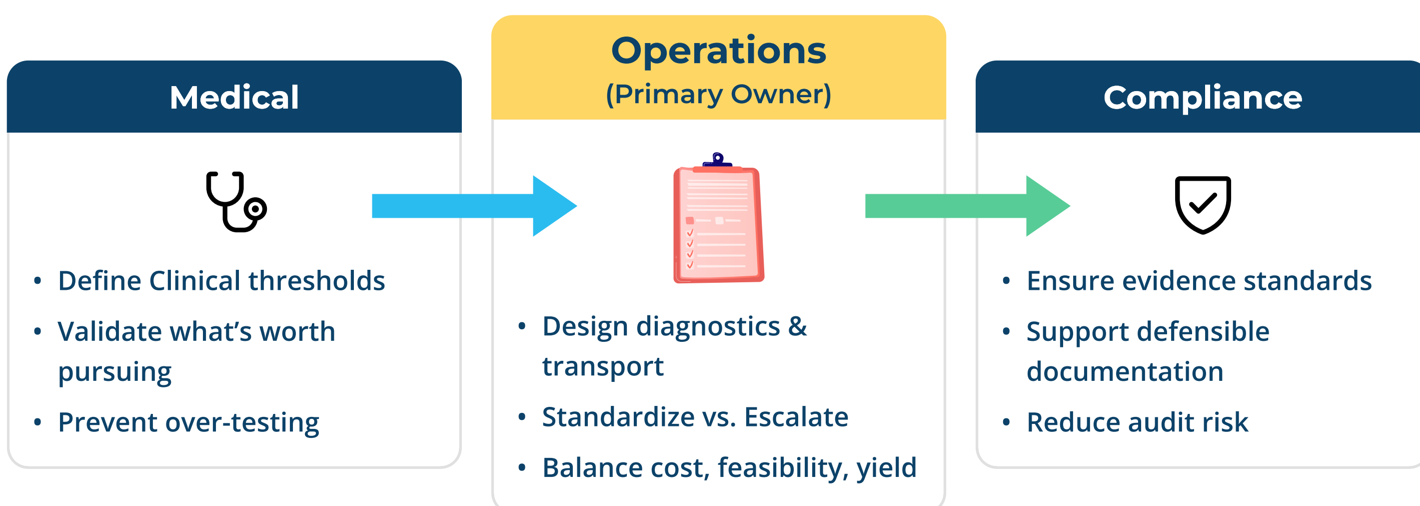
V28 rewards **operational maturity**, not effort.

Role Alignment at This Step

Primary Owner: Operations Leadership
Operations owns how this works in real life. This includes determining how diagnostics are obtained, how transport and follow-up are coordinated, what gets standardized versus handled on a case-by-case basis, and how cost, feasibility, and clinical yield are balanced.

Supporting role: Medical Leadership
Medical leaders define the clinical thresholds that justify screening and escalation of care. Their role is to ensure the program focuses on clinically appropriate diagnoses under V28, while preventing over-testing or inappropriate pursuit of marginal conditions.

Supporting role: Compliance Leadership
Compliance ensures that redesigned workflows reliably produce defensible documentation. This includes confirming that evidence standards will be met consistently and that operational shortcuts do not introduce audit risk.
When these roles are aligned, missed diagnoses are addressed at the system level. When they are not, gaps persist; not because clinicians don't know what to document, but because the organization has not made it possible to find and support those diagnoses consistently.



Under V28, missed diagnoses are usually a workflow failure-**not a clinical one.**

Bottom line: under V28, missed diagnoses are most often a workflow failure, not clinical.

Step 4: Treat Documentation Risk as a Revenue Protection Function

Under V28, documentation is no longer a back-end compliance activity; it is a revenue protection function.

What changes in oversight

As margins compress:

- Audit recoupments become more damaging
- Documentation errors carry outsized financial risk
- “We’ll catch it later” becomes untenable

High-risk behaviors often emerge from normal PACE operations:

- Copy-forward notes for frequently seen participants
- Over-templated physical exams
- Mismatches between assessment and exam findings

Operational shift

- Risk detection must happen before submission
- Oversight must be continuous, not episodic
- Medical and compliance leadership need visibility without manual burden

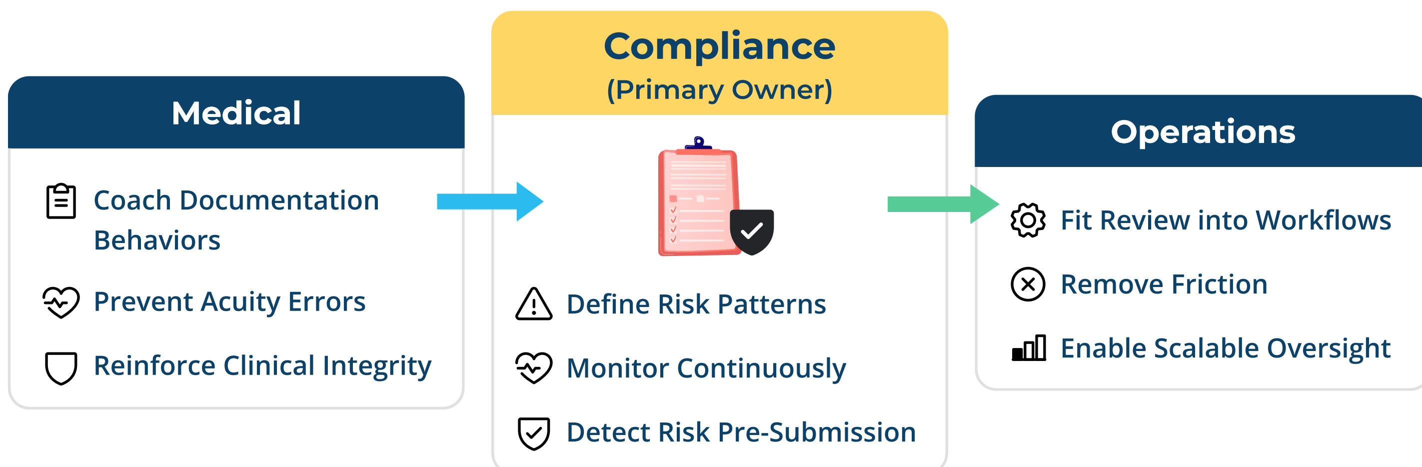
This step is about defending what remains, not just growing what’s possible.

Role Alignment at This Step

Primary Owner: Compliance Leadership
Compliance defines what documentation risk looks like under V28. This includes identifying patterns to monitor, setting internal review standards, and shifting focus from sample-based audits to systemic risk detection across the organization.

Supporting role: Medical Leadership
Medical directors reinforce documentation integrity as a component of clinical professionalism.

Supporting role: Operations
Operations ensures that review processes fit real clinical workflows.



When these roles are aligned, documentation risk is managed proactively. When they are not, errors compound silently until they surface as financial loss.

Bottom line: under V28, documentation discipline is no longer optional, it is a core operational safeguard.

Step 5: Use Automation to Absorb What Humans Can't Scale

Under V28, the operating reality changes: **the margin for manual error disappears, but the workload does not.**

PACE organizations are now expected to defend documentation at scale, with fewer dollars and the same audit exposure.

This creates an unavoidable constraint.

Why This Step Is Unavoidable

PACE organizations cannot sustainably:

- Manually review 100% of progress notes
- Reliably catch MEAT, acuity, and evidence inconsistencies across clinicians
- Add compliance headcount fast enough to keep pace with volume

Even well-run teams hit a ceiling. At the V28 scale, human review becomes selective by necessity, and selective review creates blind spots.

Automation is not about replacing clinical judgment.
It is about absorbing the volume humans physically cannot.

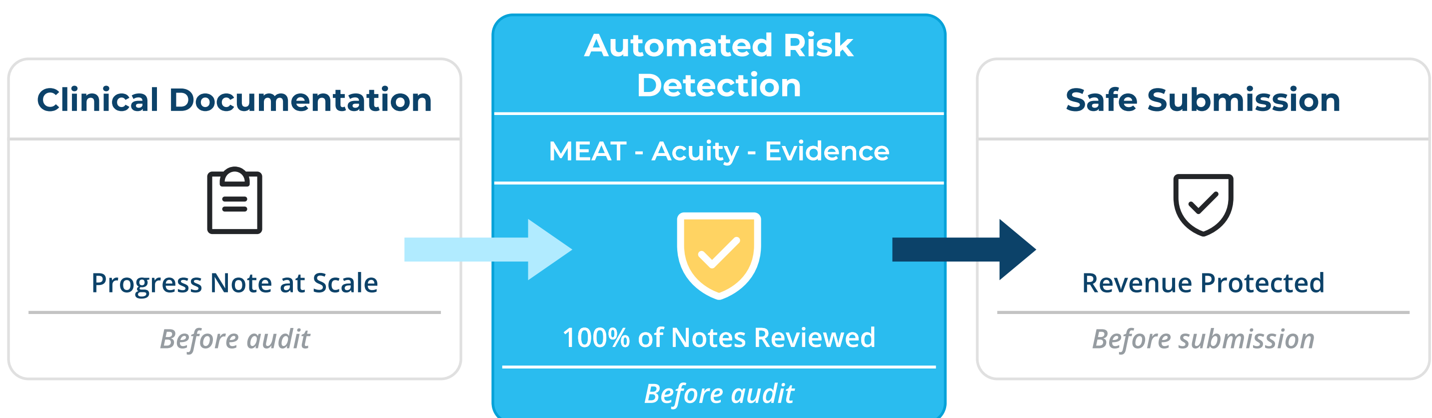
What Automation Actually Does in Practice

Effective automation functions as a **protective layer between documentation and submission.**

Tools like DoctusTech's AI Coder operationalize this by:

- Reviewing **every progress note**, not samples
- Identifying documentation gaps *before* audits or submission
- Flagging risk patterns without interrupting care delivery

This shifts compliance from retrospective cleanup to **real-time risk prevention.**



Why This Matters Under V28

When revenue declines, efficiency becomes one of the few remaining levers available. Automation does not recover lost HCCs, but it **prevents preventable losses.**

Under V28, the organizations that remain stable are not the ones working harder. They are the ones **working with systems that scale discipline.**

Think about this:

"Even if your team is excellent, you cannot manually defend documentation at this scale. Automation isn't optional, it's structural."

Step 6: Retrain Clinicians on What Still Matters, Continuously!

What changes in clinician education

V28 narrows the field:

- Fewer diagnoses matter
- Documentation rules matter more
- Precision matters consistently

Clinicians need:

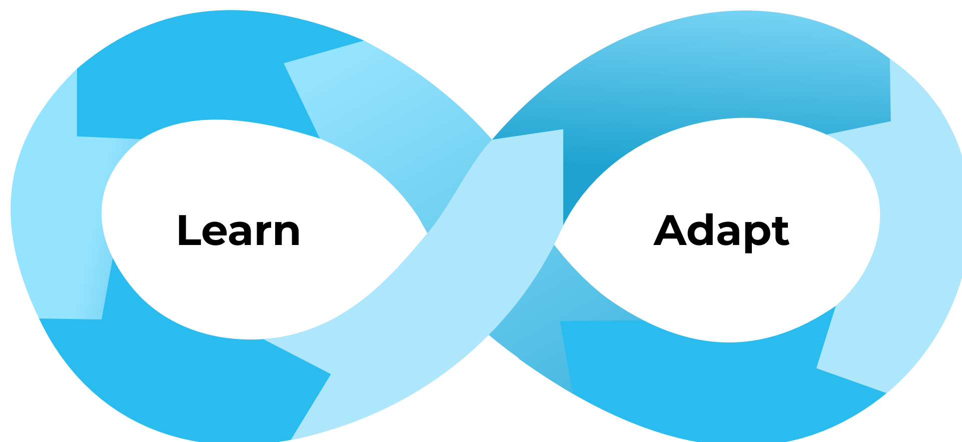
- Ongoing reinforcement, not one-time training
- Focus on high-impact conditions that remain
- Clear guidance aligned to evolving workflows

This is why short, continuous education performs better than annual sessions.

DoctusTech's **Mobile Learning App** supports this model by delivering:

- Weekly, targeted HCC education
- Practical documentation reinforcement
- Low-friction learning that fits clinical reality

Education becomes an **operational tool**, not an event.



Step 7: Re-Evaluate, Re-Prioritize, Repeat

V28 readiness is not a one-time transition.

PACE leaders should expect to:

- Reassess prevalence gaps regularly
- Monitor documentation risk trends
- Adjust workflows as guidance, audits, and payer behavior evolve

Organisations that treat V28 as a static change will fall behind those that institutionalize continuous control.

Organizations that treat V28 as a one-time adjustment will consistently underperform those that treat it as an **ongoing operating discipline.**

Bottom Line: V28 doesn't just change reimbursement. It reveals (in dollars) how resilient, repeatable, and defensible a PACE program's operations really are.

DoctusTech helps PACE organizations navigate V28 by continuously reviewing **100% of clinical notes**, flagging missing **MEAT elements**, and standardizing documentation **without adding burden to clinical teams.**

This is what prevention looks like, before gaps show up in the forecast, audits, or board conversations. **Book a Demo.**