Journal of Life Care Planning, Vol. 15, No. 3, (19-29)
Printed in U.S.A. All rights reserved 2017 Int'l Assoc. of Rehab Professionals

2017 Life Care Planning Summit Proceedings

Tracy Albee, RN
Jamie N. Gamez, MA
Cloie B. Johnson, MEd

Life care planning is an advanced specialty practice performed by a diverse community of professionals in various health care fields. Due to the diversity of professional backgrounds in life care planning and because this specialized practice continues to grow and develop, it is vital that a coordinated effort with standardized approaches be promoted. Education of emerging and experienced practicing professionals is a key aspect of fostering the advancement of the field. While process and standards of practice for life care planning have been established and published, consensus and unity in this diverse field is an evolving process. Through life care planning Summits, life care planners have the opportunity to examine relevant issues, contribute to the resolution of these issues, and be involved in the evolution of the specialty practice, (Johnson, 2012; Johnson and Gamez, 2015; Johnson and Gamez, 2017).

Life care planning Summits are historically biennial events attended by life care planning practitioners with the goal of exploring the current state and future direction of life care planning. Since 2000, over 600 life care planners have participated in Summits, demonstrating a commitment to addressing cutting-edge issues affecting the life care planning community.

Published Summit results are generally accepted and relied upon by life care planning practitioners. The Best Practices and Consensus and Majority Statements derived from past Summits (Johnson 2015; Preston and Johnson, 2012) serve as reinforcement for the work of the life care planner. Summits are unique, in that their proceedings are developed by practicing life care planners, for life care planners and about life care planning. At the 2017 Summit, consensus was achieved in several key areas.

2017 Life Care Planning Summit

On May 19-20, 2017, the tenth life care planning Summit was held in Denver, Colorado. The summit was attended by 102 life care planners from diverse backgrounds and geographic locations. Past Summit locations and dates include:

- Dallas, TX – April 12, 2000
- Chicago, IL – May 18-19, 2002
- Atlanta, GA – April 24-25, 2004
- Chicago, IL – May 6-7, 2006
- Los Angeles, CA – May 15-16, 2008
- Atlanta, GA – April 17-18, 2010
- Toronto, ON – June 3-4, 2011
- Dallas, TX – May 5-6, 2012
- Scottsdale, AZ – September 18, 2015

This article includes 2017 Summit proceedings, including submissions by organizational representatives and panelists from IALCP, AANLCP, ICHCC and FLCPR. The content was reviewed by the Summit committee and presented to attendees for their review to ensure that the contents accurately reflect the events of the 2017 Summit proceedings.

The 2017 Summit was sponsored by the International Association of Rehabilitation Professionals (IARP) and the Life Care Planning Section/International Academy of Life Care Planners (IALCP) with support and representation from the International Commission on Health Care Certification (ICHCC), the American Association of Nurse Life Care Planners (AANLCP) and the Foundation for Life Care Planning Research (FLCPR). The IALCP took the leadership role in chairing the Summit, with collaboration and support from various associations and organizations within the life care planning community. The 2017 summit was chaired by Cloie B. Johnson and Susan Grisham. The planning committee included Tracy Albee, Debbie Berens, Jamie Gamez, Sherry Latham, Karen Preston, Patricia Rapson, Evelyn Roberts and Denise Wrenn. There were also numerous volunteers who contributed to the success of the Summit. Practicing life care planning professionals in attendance included nurses, rehabilitation counselors, physicians, social workers, physical therapists, occupational therapists and speech language therapists.

Pre-Summit Workshop: May 12, 2017

Prior to the Summit, twelve facilitators and recorders of the nominal group process were identified by the program chairpersons to assist in the coordination of Summit activities. Facilitators were Tracy Albee, Reg Gibbs, Karen Preston and Steve Yuhas and recorders were Debbie Berens, Brook Feerick, Carol Hyland, Jody Masterson, Linda Olzack, Dana Penilton, Patricia Rapson and Laura Woodard. These individuals were qualified practicing life care planning professionals. On May 12, 2017, a Pre-Summit workshop was held via video conference call with the facilitators and recorders to allow them the opportunity to participate in Summit sessions. During this Pre-Summit, Cloie Johnson served as facilitator and John Cary and Laura Stajduhar served as recorders. Participant responses collected during the workshop were incorporated into the second day of Summit proceedings During this workshop, these individuals also received training on their Summit duties from Cloie Johnson.

Summit Day One Proceedings: Friday May 19, 2017

On the first day of the Summit, all event attendees were assembled in a general session for presentations and panels explaining the purpose of the 2017 Summit. The goal of the 2017 summit, to further define "associated costs", was presented. Topics included how costs are derived and methods to determine and utilize collateral sources. A presentation covering a review of past Summits and a specific look at where "associated costs" were already referenced within the current Consensus and Majority Statements (Johnson, 2015; Preston & Johnson, 2012) and the Standards of Practice for Life Care Planners (IARP, 2015) was conducted.

Practicing life care planning professionals in attendance actively participated in this review, which set the stage for the remainder of the Summit. During the general session on May 19th, the focus was on providing a foundation of knowledge for the nominal group process, which would unfold during the second day of the Summit in the breakout sessions and the large group discussion.

Life Care Plan Venues

A closer look into venues where life care plans are utilized was undertaken. As a group, attendees generated 29 venues or applications in which a life care plan may be developed by a qualified professional. These are outlined in Table 1 below.

Table 1
Life Care Planning Venues

Civil litigation to include personal injury, general liability and medical malpractice
Trust funds
Wealth management
Setting reserves
Vaccine cases
Worker's compensation cases
Structured settlements
Private hire
Medicare Set-Asides (MSA)
Marital dissolution proceedings
Discharge planning
Business dissolution
Specialized injury compensation funds
Veteran's disability
Veteran's independent living assessments
Estate planning
Pre-litigation settlement
Deceased/replacement costs
Conservatorships/guardianships
Victim's assistance programs
American Civil Liberty Union (ACLU) matters
Pre-nuptial agreements
Fundraising support
Case management
Elder advocacy
Adoption
Clinical trial adverse results
Special education planning
Embezzlement/fraudulent use of funds

Collateral Sources

Day one also provided a review of results from the 2017 Collateral Source Survey (Pomeranz, N.d.) which was sent to all known life care planners in March 2017, prior to the 2017 Summit. A total of 187 life care planners from 26 states responded to the survey. A total of 47% of the respondents reported being asked to include collateral sources in life care plans, while 53% had not. Of the respondents, 59% reported never having included collateral sources in the development of a life care plan, 39% sometimes include collateral sources and 2% reported always including collateral sources in life care plans. When asked who instructs them to include collateral sources in the development of a life care plan, respondents answered: The referral source (57%), federal rulings (4%), state rulings (6%) or done at my discretion (34%). When asked what specific collateral sources they had included in the development of life care plans, the following were reported: Medicaid (35%), Medicare (41%), Tricare (16%), VA Benefits (22%), Medicaid Waivers (13%), Federal/State mandated Vocational Rehabilitation Services (20%), Federal/State mandated Blind Services (14%), Federal/State mandated Deaf Services (8%), ACA or other private health insurance (35%) and Other (47%). Respondents included collateral sources in the following types of cases: Litigated Plaintiff Cases (38%), Litigated Defense Cases (59%), Trusts (17%), Vaccine Cases (16%), Dissolution Cases (8%), Direct Hire from Family (18%) and Other (25%).

The following survey question was posed: *When including collateral sources in the development of life care plans, do you verify and document the limitations? (Examples: Waiting lists for Medicaid Waivers or if Medicaid is a payer source, one can only go to physicians who accept Medicaid)*. The following answers were given: Always (49%), Sometimes (21%) and Never (29%). Regarding knowledge of collateral sources, respondents noted: I am aware of all of the them and everything they pay for (11%); I know some information about some of them and/or some of what they pay for (68%); I know little about them and what they pay for (14%); I know nothing about them and what they pay for (4%); and I don't care (3%).

Professional Organization Input

A working lunch was held during the first day of the Summit proceedings. During this lunch, updates were provided by organizations which offer support, certification, education and/or guidance to life care planners. Presentations were made by representatives of the ICHCC, IARP, IALCP, FLCPR and AANLCP. The American Academy of Physician

Life Care Planners (AAPLCP) was invited, however, declined attendance. Below is a summary of remarks made by representatives of each involved organization.

International Commission on Health Care Certification.

Ms. Sherry Latham provided an update for the International Commission on Health Care Certification. The International Commission on Health Care Certification assumed the responsibility to provide the first specialty certification for life care planners, the Certified Life Care Planner (CLCP) credential, in 1996. The CLCP was developed out of a growing need for professionals to demonstrate competency, qualifications, and professional expertise in the role as a life care planner.

Ms. Latham stressed that all representatives of the ICHCC are available to assist life care planners with questions about the certification itself, approved educational programs as preparation for the Certified Life Care Planner (CLCP) certification, the standards of the CLCP, ethical dilemmas, approved continuing educational programs or any other matters associated with the field of life care planning.

The ICHCC has been actively pursuing accreditation for the CLCP through the National Commission for Certifying Agencies (NCCA), and continues to strive to fulfill the stringent requirements. An important factor in obtaining accreditation is the need for statistical information demonstrating a comprehensive analysis of the certification practices providing valid and reliable information. The ICHCC currently has surveys available to life care planners to address those needs. There are two surveys, the role and function study and a report writing survey, which can be located on their website, www.//ichcc.org. It is vital that the Commission collect as much information for the best representation of statistical information. Four CLCP CEU's can be obtained for completing each survey. Another component of accreditation is the statistical information involving a Beta test, which will be posted soon on the ICHCC website. A post will be sent out on the list-serves when available and the ICHCC encourages everyone to participate in this vital component of the accreditation process.

Foundation for Life Care Planning Research.

Dr. Debbie Berens provided an update for the Foundation for Life Care Planning Research. First, appreciation was extended for allowing the Foundation for Life Care Planning Research to provide an update on the organization. Dr. Paul Deutsch, who typically provides the update, was instrumental in forming the FLCPR in 2002 and continues to champion its mission. Unfortunately, Dr. Deutsch has had some medical issues that have resulted in his retirement from his practice and his primary Foundation leadership responsibilities. Dr. Deutsch sounds well and he wants everyone to know that even though he has retired from his active life care planning practice, he continues to follow what is going on in life care planning and remains very interested in the progress, leadership, and future direction of our specialty practice. Susan Riddick-Grisham who led the Foundation for many years as Chair of the Board, rolled off the Board over the summer and appreciation of her tremendous work for the Foundation was expressed. In 2016, Dr. Debbie Berens was named co-President with Dr. Deutsch and since his retirement, she has served as President of the Foundation.

The Foundation is a nonprofit research group with the primary mission of supporting research on the process of life care planning, including research on the reliability and validity of the life care planning process. Several years ago, the Foundation made the decision to shift away from sponsoring or co-sponsoring educational conferences (mainly the International Symposium on Life Care Planning/ISLCP) to focus on the Foundation's primary mission of supporting research related to life care planning. Over the past 15 years of funding research, the Board has broadened the scope of its mission to consider any well-developed research design in life care planning that advances the field and/or makes a significant contribution to the population of individuals with disabilities who life care planners seek to serve.

The Foundation reported that it is currently funding a research project designed to replicate and expand a study published in 2006 regarding replacement values of durable medical equipment (DME). Results of the current study are expected to enhance and advance the field in the area of recommended replacement schedules, frequency and maintenance costs of some of the most commonly recommended DME included in life care plans. While other studies relevant to life care planning also are currently being conducted, all are invited to consider submitting a proposal to the FLCPR for a research grant. One suggested project is to update the Bibliography of Life Care Planning and Related Publications, originally published in the inaugural issue of the *Journal of Life Care Planning* in 2002. The bibliography has not been updated since that time and it is believed there are life care planning and related publications over the past 15 years that could be added to it. For anyone interested in conducting research and how the FLCPR may be able to help, please go to the Foundation's website, www.flcpr.org.

International Association of Rehabilitation Professionals.

Mr. Steven A. Yuhas, IARP President-Elect, provided an updated on IARP activities. Appreciation was given of everyone's attendance at the IARP 2017 Summit and of the 2017 Summit conference committee, Cloie Johnson, Susan Riddick Grisham, and Tracy Albee. Appreciation was noted of IARP/ IALCP Section leadership, its members and ongoing contributions with recognition given the past and present IALCP Board members in attendance.

An overview of IARP was provided noting they were comprehensively striving to serve life care planners and the rehabilitation community. Kim Bailey was announced as IARP's new Executive Director. The ISLCP/ IARP Conference will be held in St. Louis in October 2017. Noted appreciation was also given to Susan Riddick Grisham for her more than 20 years contribution with ISLCP. The ISLCP 2017 RFP's received to date were also shared with Summit attendees.

International Academy of Life Care Planners (IALCP).

Debbe Marcinko, IALCP Immediate Past Chair provided an updated of IALCP. The IALCP (formerly the American Academy of Life Care Planners) became a section of the International Association of Rehabilitation Professionals (IARP) in 2006. The association with IARP has afforded greater networking and sharing of resources of the various professional disciplines and experts in rehabilitation. They have chaired and co-sponsored the Life Care Planning Summits since 2000, and the annual Symposium of Life Care Planning (since 1994) including the Symposium of Life Care Planning conference combined with the IARP annual conference in 2016. Their first Standards of Practice were published in 2000 and are now in the 3rd Edition (IARP, 2015). The *Journal of Life Care Planning* was introduced in April 2002. As a member of the IALCP Life Care Planning IARP Section, members receive a subscription to the *Journal of Life Care Planning* and the *Rehabilitation Professional*, access to live and pre-recorded webinars, the annual conference, access to networking and discussion groups of all IARP sections, and access to affinity programs such as FairHealth, American Hospital Agreement, AAACEUs, and liability insurance coverage.

The Fellow designation (FIALCP) was established in 1996 (through the IALCP) and continues under IARP. The purpose of the fellow program is to recognize expertise, experience and contribution to the field of life care planning. The program recognizes those life care planners who have achieved a high level of skill and who use their skills and knowledge to promote the advancement of life care planning. IALCP promotes relationships with other organizations for education, coalition, and collaboration in the promotion of life care planning.

American Association of Nurse Life Care Planners (AANLCP).

Denise Wrenn provided an update of activities in AANLCP. On January 2, 2017, Denise Wrenn assumed the role of president of AANLCP®. In 2017, the AANLCP® executive board held their annual strategic planning meeting in Reno, Nevada. The association selected Annie Wiest, KAMO Management Company as Executive Director and Mariann F. Cosby, accepted the position as the new journal editor. During the 2017 conference, Colleen Manzetti Research Committee Chair presented the findings from a research project completed in 2016.

The Association continues to offer tier memberships, which allow not only registered nurses interested in nurse life care planning, but an associate membership to individuals in other health care professions. The association is on schedule to complete an update to *A Core Curriculum for Nurse Life Care Planning*, an essential knowledge resource for the practice. The 2018 release date has yet to be determined.

The association mission in 2017 continues to focus on supporting the nursing community's efforts to achieve excellence in the practice of nurse life care planning. During the planning sessions, the board identified five drivers of organizational performance with goals designed as a strategic alignment to move the association closer to the vision, mission, and values of the association over the next three to five years. The five strategic domains are: Membership, finance, education, research and practice management and these domains are to become the pillars of the association in 2017 and beyond. The domains support the organization's mission and the focus on action and define the specific strategies to attain crucial goals.

In March 2017, the annual education conference was held in Scottsdale, Arizona. The association hosted keynote speaker JR Martinez, 'Dancing with the Stars' 2011 Season 12 winner, and a world-renowned motivational speaker, actor, best-selling author and U.S. Army veteran. The conference committee put together a rock-star line-up of speakers who motivated, informed, and inspired all who attended. The 2018 education conference, The Art of Life Care Planning will be held in St. Petersburg, Florida on March 16-19. They are expecting to repeat the excitement experienced in Scottsdale.

Ethics Workshop.

On day one of the life care planning Summit, an Ethics Workshop was held. During the workshop, a review of the various credentials for those who prepare life care plans was shared. It is well-known that life care planning is a specialty practice, in which a variety of professionals, holding various licensures and certifications, participate. A review of the various credentials for those who prepare life care plans was shared with historical background for each. The credentials explored include American Board of Vocational Experts (ABVE), Certified Case Manager (CCM), Certified Disability Management Specialist (CDMS), Certified Life Care Planner (CLCP), Certified Nurse life care planner (CNLCP), Certified Physician Life Care Planner (CPLCP) and Certified Rehabilitation Counselor (CRC). The analysis of each credential included identifying if there was independent accreditation, the year established, minimum education and experience requirements, code of ethics/standards of practice, requirement for examination and continuing education units (CEU) as well as non-profit status. This information is presented in Table 2 below and was originally published in Field, Choppa, Johnson,

Fountaine & Jayne (2007), which was updated in Johnson, Lacerte and Fountaine (2015) and most recently updated in 2017. It is illustrative of the historical nature, background and requirements of each credential.

Table 2

Credential Analysis

Credential	Independent Accreditation	Year Est.	Minimum Education Required	Minimum Experience Required	Code of Ethics/ Standards of Practice	Exam Required	CEUs Required	Non-Profit
ABVE	No	1980	Yes	Yes	Yes	Yes	Yes	Yes
CCM	Yes	1993	Yes	Yes	Yes	Yes	Yes	Yes
CDMS	Yes	1984	Yes	Yes	Yes	Yes	Yes	Yes
CLCP	No	1996	Yes	Yes	Yes	Yes	Yes	No
CNLCP	No	1999	Yes	Yes	Yes	Yes	Yes	Yes
CPLCP	No	2014	Yes	Yes	Yes	Yes	Yes	Yes
CRC	Yes	1975	Yes	Yes	Yes	Yes	Yes	Yes

The presentation included aspects of various credential codes of ethics, followed by small and large group discussion surrounding a variety of applicable ethical dilemmas. Participants were asked to contemplate and propose resolutions to various ethical dilemmas.

Panel Presentation – Charges.

After the working lunch, two panel presentations filled the remainder of Summit day one. The first panel was made up of four speakers: Lan Lievense of Healthcare Financial Consultants; Dr. Robert Meier of Amputee Services of America; Cassandra Smith of Yavapai Professional Medical Billing and Coding; and Ray Agostinelli of FairHealth. The following questions were posed to panel participants:

- How do providers set their charges?
- Is there a commonly accepted definition of "usual and customary"? What other terms are used? What do these terms really mean? Do providers ever expect to get paid their full billed amount?
- Do providers have a single charge for each CPT code or do they have a variety of charges for a variety of circumstances? For example, self or private pay v. insurance v. lien rates
- What can you tell us about providers that do not accept any insurance or have a concierge practice?
- What is the best terminology to use when we call to get cost information?
- Is there an accepted concept that charges/contracts for cash payers or large insurance companies must be higher in order to cover their losses that occur by accepting Medicaid/Medicare?
- Does a quoted charge fully reflect what a provider will receive and might there be other "incentives" within the contracts?

The following is a summary of the panel presentation. The statements are the product of each panelist and not an endorsement by the attendees of the Summit, planning committee or any organization involved in the Summit. The summary statements below were developed from the presentations given and were reviewed by each individual panel participant.

Lan Lievense of Healthcare Financial Consultants

Usual, Customary and Reasonable Fee (UCR) is the charge or range of charges evaluated against another provider for similar services in a geographical area. Usual, Customary and Reasonable Fees are not set for the healthcare industry, by Medicare, or any third-party payer, although payers may choose to define how much they will pay. Databases can show the range of charges for the same or similar services by the same or similar medical provider in a comparable geographic area. Usual, Customary and Reasonable Fee (UCR) calculations must include the geographical location. There is a difference between the amount charged and the amount that will be paid, with payments ranging from 0 to 140% of the gross charges. The amount providers are paid

change every day, therefore, trying to estimate what will be paid is completely speculative.

Charges are determined by the provider identifying the cost to provide a service and dividing it by the number of those services they are expected to deliver. There are direct costs and indirect costs. This process is simply a budget. The goal of the insurance company is to set premiums high and buy services low. There are patients who would rather pay 100% of a medical bill than to run it through their insurance, which happens frequently in affluent areas of the country (e.g. famous people who do not want their insurance charged, as it opens them up to lack of confidentiality).

An explanation of capitation contracts was undertaken. A provider may get more than 100% of their billed charges if the insurance pays a flat amount monthly, regardless of the charges incurred. If the patient is not seen at all in the hospital in any given month, the provider is still paid the contracted amount.

Databases are absolutely needed to look at historical charges within a geographical area. These databases prove whether charges are falling within the UCR range. When doing a past cost analysis, Mr. Lievense typically uses two or three (or more) databases. Mr. Lievense does not change the databases but does ask the database vendors how each program handles charge outliers. He agrees that a provider can charge anything that they want and the provider can accept any payment that they want; however, there is legislation coming soon that may change that. A properly managed medical office/provider will have only one fee schedule and the amount of payment they accept may vary depending on business situations, contracts and social considerations (i.e. many medical offices write off copay amounts for clergy.) Payments from insurance companies include more than what is on a bill. For example, a provider may receive 80% of the bill on paper, but then receive a balloon payment at the end of the contract. This will not show up on a patient invoice or explanation of benefits. Providers with a concierge practice may charge a flat fee or they may have a charge structure. For example, the provider may charge an application fee, an enrollment fee, an annual charge for being a member of their practice, and a published fee schedule for the services provided. Concierge practices do not accept insurance or do third party billing. Concierge practices are not required to release their financial information, unless to a potential client who needs to know this before deciding to join the practice. There is a current trend for providers to move towards a concierge practice and these charges are not included in the standard databases. It is unknown how the industry will handle these new practice concepts.

Mr. Lievense recommends looking up "cost shifting" to find a remarkable amount of information on how providers make money. Cost shifting is a methodology used in all businesses, including healthcare. When Medicare or Medicaid decreases their payments, the provider generally needs to increase their charges. In order to stay in business, a provider must get 100% of their operating costs through billed charges. This does not happen by the entire patient population, but rather by the case-mix. If a provider only considers one payer source as a valuation of their medical services, then they are only considering a small portion of what their cost of service really is.

Dr. Robert Meier of Amputee Services of America.

Usual, Customary and Reasonable Fee (UCR) is most consistently defined by the "Medicare allowable" and represents the profit beyond the cost to provide the service. A physician group can charge whatever they please, but that does not mean that is what they will be paid. Payments are very much regionally based. Life care planners need to go to an authoritative source to get the charges for certain services. For example, if you have a patient with a spinal cord injury, should you go to a local provider or should you go to a place like Craig Hospital? Life care planners need to get their costs from the experts in any particular field. This is a reason not to use databases in some circumstances.

Cassandra Smith of Yavapai Professional Medical Billing and Coding

Ms. Smith shared that she agrees with Mr. Lievense regarding the definition of UCR; however, in reality the UCR varies based upon zip codes, formularies of the insurance companies, and the payments based on any given contract. Every insurance plan pays a different amount with hundreds of factors involved in each contract. The UCR really means nothing and it is often just a way for insurance companies to get out of paying a bill. Providers know that when they accept a particular insurance contract, they will get what they get and it is a "take it or leave it" system. She noted prices are typically set around any given provider's current contracts and the provider may also determine a non-insurance pricing model. Insurance, whether a provider takes it or not, typically guides the billing practices. Retail pricing is, more likely than not, a multiplication of the Medicare allowable fee schedule. For example, the industry standard is to set the charges at 300 to 400% of the Medicare fee schedule. Providers do not expect to be paid their retail price, but this is the base pricing. Providers are lucky if they receive 50% of their billed amount, with average payment being 30% to 50% of the charge, when the patient is out-of-network. However, they may receive 0 payments for out-of-network patients as well. If the patient is in-network, the provider may get 90% to 100% of the billed amount, as defined by the contract. A provider could bill for the same services for 20 patients, all with the same contract, and could receive 20 different reimbursements.

Physicians who work for corporations have no control over their charges, so if a life care planner is trying to obtain the charge for a service, they must get to the practice manager. Most physicians do not have any understanding of

how their own charges are determined. Often it is the biller who decides what to bill, not the providers themselves. There are different rates for different payers, such as self-pay, liens and insurance

A provider must be careful how they disclose their different rates for different payers due to antitrust laws that may apply. If a provider is caught giving out different rates to different payers, they risk losing their insurance company contracts. Ms. Smith's company advises providers to have one charged rate for everybody, but that it is okay to accept the insurance payment and then to bill the balance to the patient, if this is allowed by the contract. When asked about the concept of providers charging some patients more to make up for those payers who pay too little, this is not allowed. There are three types of payers: In-network, out-of-network, and private pay. A provider must take a balanced approach and look at what percentage of their patients are Medicare, Medicaid, insurance and private pay. That is the only way to offset losses.

Ray Agostinelli of FairHealth.

FairHealth was founded in 2009. They have 60+ contributors, including private payers, TPAs and self-insured employer plans. There are now 23 billion claims included in their data, reflecting over 150 million covered lives. It is geographically specific with over 500 geographical zip codes. FairHealth's benchmark products array billed charges across a range of percentiles (50th to 95th) reflecting the distribution of market rates for healthcare services in specific geographic areas. Many payers use the benchmark products in developing fee schedules, including plans that reimburse out-of-network providers based on a percent of usual and customary rates. When asked about whether a life care planner should ask for charges or expected payments, he agreed with other panelists that the actual paid amount can vary greatly based on a variety of factors and opined that a database based on billed charges will provide less variability in those numbers. Providers who do not accept insurance must set their fee schedule, which they do by using a database or they may set their charges on a percentage of the Medicare fee schedule. If providers will not disclose their fees, this is a practice management issue.

Panel Presentation – Collateral Sources

The second panel of the day included Tony Choppa, Joan Schofield, Amy Sutton, Ray Agostinelli and Lan Lievense. The theme of this panel was "Associated Costs and Collateral Sources – Understanding the various payer sources which impact life care plans combined with court rulings that also direct the inclusion or exclusion of payer sources or billed versus paid amounts in various jurisdictions." A summary of the panel presentation is found below. The statements are the product of each panelist and not an endorsement by the attendees of the Summit, planning committee or any organization involved in the Summit.

Panelist 1: Tony Choppa.

Mr. Choppa provided a brief review of the presentation by himself, Dr. Timothy Field, and Cloie Johnson who authored *The Collateral Source Rule and the ACA: Implications for life Care Planning*, originally presented at the 2015 International Symposium on Life Care Planning (ISLCP). There is an increasing friction among life care planners and attorneys about how to handle collateral sources. This is a state-by-state issue, but life care planning standards are not based on case law.

Mr. Choppa referred to the Matlock Chart, used in a prior presentation, which was based on 2013 data. The Matlock Chart has not been updated, despite the case law that has evolved, since its publication. There are three categories of statutes: Those that reduce the verdict solely on the collateral sources; those that eliminate collateral sources altogether; and those that require consideration of collateral sources. Case law is the driving force.

Prior Life Care Planning Consensus Statements (Johnson, 2015; Preston & Johnson, 2012) require the life care plan to be objective and consistent (#51); life-long and flexible (#52); transparent and reproducible (#82) and use non-discounted and market rates (#98). Standards and Consensus Statements must allow the flexibility for life care planner to meet the legal precedents of a specific jurisdiction. There is nothing that prohibits the providing of a variety of information, but how this is done while staying within standards and ethics is the challenge. Footnotes to the life care plan can be added to the life care plan for accuracy and ensuring compliance with standards of practice.

Motions-in-limine are usually about the methodology of how a life care planner arrives at the opinion they hold, not the opinion itself. The trier of fact, not life care planners, decides what the right cost is or who should pay.

Panelist 2: Joan Schofield.

Ms. Schofield uses Medicaid Waiver collateral sources within her practice when pricing support services are not generally available. In her area (New Mexico), up to 50% of the population qualifies for government benefits / healthcare. She uses the Waiver programs within her state and can find fee schedules on the government websites. The providers who accept government funding may provide care to a person who does not have government funding and ask for same amount in reimbursement that they would have collected from the government (i.e. they do not mark up the care for cash payers). This provides value of these services based upon the public agency fee schedule.

Panelist 3: Amy Sutton.

Ms. Sutton provides a choice of prices. Her goal is to assure that the individual will have funds to purchase the services, but if asked to consider a different scenario (such as what the Medicare or Medicaid reimbursement would be), she will do so. She takes case law into consideration. The definition of "non-discounted rates" does not imply that cash rates are "discounted". Discounted rates are ones that have been negotiated for an entity and are not available to the general public.

Panelist 4: Ray Agostinelli.

Mr. Agostinelli expressed his opinion that it is important for life care planners to understand the rules and statutes of the states where they work. FairHealth's data includes worker's compensation fee schedules. Because FairHealth is used for dispute resolution (in New York), they often must defend their methodology. The level of their consistency makes their database defensible. FairHealth updates their benchmarks two to four times per year and they are released within one to two months of the data becoming available. FairHealth database was not developed for life care planners; however, the repository of the data is an asset to life care planners. FairHealth is a window into the market.

Panelist 5: Lan Lievense.

Mr. Lievense emphasizes that he is not attorney and no statement may be regarded as legal advice. The only valid test to predict the future costs of care is today's charges. Collateral sources are speculative because: There is no guarantee that the plaintiff will be eligible for an insurance; that the insurance will cover the services; or that there will be medical providers in the plaintiff's geographic area accepting a specific insurance. There are two pending litigated cases where the plaintiff received an award based on collateral sources and now that collateral source is not available and the plaintiff does not have enough money to purchase the care.

Discussion of *Howell v. Hamilton* (2011) and *Corenbaum v. Lampkin* (2013) was undertaken. In *Howell*, the California Supreme Court ruled that an individual was entitled only to the economic damages in the amount that they or their insurers paid/will pay for medical services, not the difference in what is billed and what is paid. The *Howell* case did not affect the reality of the healthcare financial industry because the underlying direct and indirect costs of healthcare services remained unchanged but resulted in an increase in attorneys encouraging plaintiffs to get their healthcare on a lien instead of using their insurance or applying for insurance(s) for which the plaintiff may be eligible. The healthcare industry cannot force a patient to use existing insurance if the patient wishes to pay in other ways including cash or lien arrangements.

This is part of what generated *Corenbaum v. Lampkin* (2013) where the court held that billed amounts were irrelevant and inadmissible if treatment was covered by insurance and that non-economic damages and expert testimony could use unadjusted bills when determining damages. These rulings resulted in defense attorneys arguing that a plaintiff has the responsibility to mitigate their own damages.

Summit Day Two Proceedings

The second day of the Summit began with a review of the group nominal process. Each participant was assigned to one of four groups comprised of life care planners with a mix of experience, training and knowledge. Each attendee rotated through all focus groups and participated in discussions of all topics. The modified nominal group technique was used within each group, gathering information in an organized format, aimed to reduce the influence of any overly verbal or assertive participants, on the outcome. The nominal group technique is described below.

First, group members write down their top three to five suggestions in order of priority and facilitators use flip charts to go around the group and write down suggestions, combining suggestions when possible. After the issues are recorded, the attendees are asked to "vote" on their top five of the suggestions listed. After the vote, the group facilitator assigns five points to the responses with the highest count, four points to the second highest, three points to the third choice, two points to the fourth choice and one point to the fifth choice. The facilitator adds up the score for each and the top scoring three to five recommendations represent the decisions for the group. When the large group reconvened, each small group contributed three to five recommendations for consideration by all participants. Theoretically, several overlapping recommendations should be made. The 2017 Summit, like previous Summits, utilized two recorders per facilitator, to allow one to record responses on the easel for all to review and one on a laptop computer to record the data in a formatted spreadsheet for verification and transport of data. Following the rotating group nominal process, results were collated and participants were reconvened into a general session where the results were discussed to determine consensus. On topics or recommendations where everyone agreed, consensus is achieved. If a majority agreed, the statement is considered "support by the majority" but not consensus. If fewer than one-half of attendees agreed, the decision reflects "minority viewpoint" or is removed from the list. Consensus is the goal. After lively discussion, the following results were obtained:

Consensus: A comprehensive and systematic review of the existing 102 statements from the life care planning Summits since 2000 through a multi-association process to determine if they are still appropriate and relevant is needed.

Consensus: Life care planners shall develop a position statement (white paper) regarding the presentation of charges and/or costs presented in the life care plan that provides guidance to life care planners for the variety of uses and jurisdictional requirements encountered by life care planners.

The paper:

a. Must take into consideration that "associated costs" are referenced in the definition of a life care plan and

b. Ensure the current geographically relevant monetary charges for a good and service are in the life care plan.

Consensus: There was a consensus to reaffirm prior Consensus and Majority Statements including #98, #86, #82 and #79, which were reaffirmed during the 2017 Summit proceedings. For reference, these items are outlined in Table 3 below.

Table 3
2017 Consensus Statements

#98, Best practices for identifying costs in Life Care Plans include:

- Verifiable data from appropriately referenced sources
- Costs identified are geographically specific when appropriate and available.
- Non-discounted/market rate prices.
- More than one cost estimate, when appropriate.

#86, Life Care Planners shall assess the reliability, validity and accuracy of data and methods.

#82 Life Care Planning products and processes shall be transparent and consistent.

#79 Life Care Planners shall follow generally accepted methodology

Consensus: In the future review of the statements, it will be necessary to look closely at #56 (applicability, relevance and the obligation of life care planner to know the integrity of our data versus only the sources of data) to consider the definition of "integrity". It is noted that there was a consensus that the group did not want any statements specifically focused on the litigation aspect of the life care planning work.

Conclusion

In May 2017, the tenth biennial life care planning Summit was conducted as a cooperative effort with major life care planning organizations including the International Association of Rehabilitation Professionals, the American Association of Nurse Life Care Planners, the International Academy of Life Care Planners, the Foundation for Life Care Planning Research and the International Commission on Health Care Certification. This year's topic focused primarily on the subject of pricing items contained in a life care plan. With over 100 Summit attendees from diverse healthcare backgrounds, a rich dialogue was held among seasoned life care planning professionals. As a result of the process, four consensus statements were issued. These statements, along with topics discussed during the 2017 Summit are designed to enhance the practice of all life care planners and serve as a guide for best practices in the field.

References

Corenbaum v. Lampkin, 215 Cal. App. 4th 1308 - 2013 (California Supreme Court, 2013).

Field, T., Choppa A., Johnson, C., and Fountaine, J. (2015). The collateral source rule and the affordable care act: Implications for life care planning and economic damages. *Journal of Life Care Planning, 13* (3), 3-16.

Field, T., Choppa, A., Johnson, C., Fountaine, J. and Jayne, K. (2007). Rule of evidence vs. professional certifications: The real basis for establishing admissible testimony by rehabilitation counselors and case managers, *Rehabilitation Professional, 15*(3), 7 – 16.

Howell vs. Hamilton Meats & Provisions, Inc. 52 Cal App. 4th 541 (California Supreme Court, 2011).

International Association of Rehabilitation Professionals (2015). *Standards of Practice for Life Care Planners, 3rd Edition*. Glenview, IL: IARP.

Johnson, C., (2012). The 2012 life care planning summit: Third time is a charm. *Journal of Life Care Planning, Vol. 11*(2), 3-8.

Johnson, C. (2015). 2015 life care planning summit: Moving forward and looking ahead, *Journal of Life Care Planning, 13*(4), 27-33.

Johnson, C. (2015). Consensus and majority statements derived from life care planning summits held in 2000, 2002, 2004, 2006, 2008, 2010, 2012 and 2015. *Journal of Life Care Planning, 13*(4), 35-38.

Johnson, C. and Gamez, J. (2015). What is the life care planning summit and why should you attend the 2015 Summit? *Journal of Life Care Planning, 13*(1), 19-22.

Johnson, C. and Gamez, J. (2017). Why should you attend the 2017 life care planning summit? *Journal of Life Care Planning, 15*(1), 41-43.

Johnson, C., Lacerte, M., and Fountaine, J. (2015). Certification standards for professionals coordinating life care plans for individuals who have acquired brain injury. *NeuroRehabilitation Journal, 36*(3), 235-241.

Preston, K. and Johnson, C. (2012). Consensus and majority statements derived from life care planning summits held in 2000, 2002, 2004, 2006, 2008, 2010 and 2012. *Journal of Life Care Planning, 11*(2), 9-14.

Attendees of the 2017 life care planning Summit:

Tracy Albee
Michele Albers
David Altman
Dorajane Apuna-Grummer
Jennifer Axelson
Dan Bagwell
Danny Beeman
Rebecca Bellerive

Debbie Berens
Harold Bialsky
Stephanie Birely
Nancy Bond
Jack Bopp
Kathy Bottroff
Kathlene Bracken
Susan Brooks
Diana Bubanja
Margot Burns
John Cary
Robynanne Cash-Howard
Tony Choppa
Dawn Cook
Alisa Cornetto
Aubrey Corwin
Mariann Cosby
Valerie Cummings
Shirley Daugherty
Elizabeth Davis
Ted Deshotels
Heidi Fawber
Brook Feerick
Ellen Fernandez
Carol Fricks
Jamie Gamez
Mary Geheb
Reg Gibbs
Bob Gisclair
David Goudelock
Cathy Gragg-Smith
Kerry Hanson
Walter Harrell
Cynthia Haseley
Stacey Helvin
Carol Hyland
Cloie Johnson
Elizabeth Kattman
Jacqueline Kelly
Valerie Knafelc
Mary Kay Kolar
Sarah Larsen
Sherry Latham
Joanne Latham
Veronica Leavitt
Leigh Anne Levy
Tracy Litzenberger
Lenora Maatouk
Ann Maniha
Debbe Marcinko
Michael Martinez
Jody Masterson
Franny Mazone
Mike McCord
Ruth McLeod
Andrew Melcher
Dorothy Miller
Teresa Millsap
Erin O'Connell
Linda Olzack
Dana Penilton
Gerri Pennachio
Karen Preston
Anne Rappaport
Patricia Rapson
Rhonda Renteria
Susan Riddick-Grisham
John Roberts
Mary Ann Rohrig
Jan Roughan
Mary Salerno
Joan Schofield
Ronald Smolarski
Stella Spencer
Gil Spruance
Laura Stajduhar
Diane Steffy
David Stewart
Molly Struble
Amy Sutton
Nadene Taniguchi
Robert Taylor
Kirsten Thomas
Daniel Turner
Miranda Van Horn
Hope Wade
Lora White
Heidee White
Susan Wirt
Laura Woodard
Denise Wrenn
Steven Yuhas
David Zak
Steven Zimmerman

Author Note

Tracy Albee, RN is a Registered Nurse practicing in Tracy, CA. She is a past Chair of the IALCP. Tracy is a Legal Nurse Consultant Certified, Certified life care planner and holds Fellow Status with the IALCP. She served as a volunteer at the 2017 life care planning Summit. Jamie N. Gamez, MA, and Cloie B. Johnson, MEd are all Rehabilitation Counselors and Case managers providing vocational assessments and life care planning services at OSC Vocational Systems, Inc. in Bothell, WA. Jamie is a Certified Rehabilitation Counselor, Certified Case Manager and Certified Disability Management Specialist and has been in practice since 2010. She served on the 2015 Summit Committee and is back for the 2017 Summit Committee.

Cloie is a Certified Case Manager, Diplomat with the American Board of Vocational Experts and co-owner of OSC. She is a past Chair of the IALCP and has chaired or co-chaired the Summits in 2010, 2011, 2012, 2015 and 2017. Cloie received the 2016 Lifetime Achievement Award in the specialty practice of life care planning.

Author Acknowledgement

A special thank you to all the attendees; specifically those who assisted with coordinating, facilitating, recording and note taking.