Hospital Complex Continuing Care (CCC) Co-Payment

Questions and Answers

Resource to:
LHINs & Hospitals

Ministry of Health and Long-Term Care
Acute Services Division
Hospitals Branch

Updated June, 2008
HOSPITAL COMPLEX CONTINUING CARE CO-PAYMENT

Questions and Answers

Index

SECTION I

HOSPITAL COMPLEX CONTINUING CARE CO-PAYMENT CHARGES...........Page 3 - 5

- Statutory provisions for the administration of co-payment in Ontario
- Criteria/rationale to charge co-payment for Complex Continuing Care & ALC patients
- Information required from physician to facilitate the administration of co-payment

SECTION II

CO-PAYMENT APPLICATION ..................................................Page 6 - 10

- Rates and calculations
- Applicability to rehabilitation, convalescence, palliative and respite care patients
- Payment by third parties

SECTION III

CO-PAYMENT REDUCTION......................................................Page 1 - 15

- “Spouse in the community” reduction
- Definitions of spouse, dependants and estimated income
- Exemptions from co-payment
- Co-payment for persons 65+
- Ordering new forms

SECTION IV

GENERAL .................................................................Page 16

- Rationale for co-payment rate
- Involuntary separation
SECTION 1

HOSPITAL COMPLEX CONTINUING CARE CO-PAYMENT CHARGES

Please note: In Ontario, the terms “chronic care” and “complex continuing care” (CCC) are used interchangeably. Complex Continuing Care was applied to hospital-based continuing care by the Health Services Restructuring Commission (HSRC) in their July 1997 report entitled, Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies. There is no change to the type of care provided; it is merely an administrative clarification in the terminology consistently used in hospitals and complex continuing care facilities.

1. What is complex continuing care?

Complex Continuing Care (CCC) provides continuing, medically complex and specialized services to patients in hospitals with long-term illnesses or disabilities that typically require skilled, technology-based care not available in the community or in long-term care facilities. CCC provides patients with room, board and other basic necessities in addition to medical care.

2. What is a CCC Co-payment?

This is the CCC patient’s contribution toward accommodation and meals. In some cases the patients may pay a lesser amount; in other cases the co-payment does not apply. Chronic care/CCC co-payments have been in effect since 1979 for patients in chronic care hospitals/units.

3. What Statutory provisions are available for the administration of the CCC co-payment in Ontario?

The Canada Health Act provides the authority for a province to charge a co-payment to a patient who has been designated by the attending physician as requiring chronic care and is more or less a permanent resident in the hospital. Changes, consistent with the Canada Health Act, have been made to Regulation 552 of the Health Insurance Act to permit the co-payment in Ontario. Ontario Regulation 288/04 made under the Commitment to the Future of Medicare Act states, in part, that “a hospital may charge or accept co-payments as permitted under Regulation 552 of the Revised Regulations of Ontario, 1990 (General) made under the Health Insurance Act”, see subsection 4(b).

4. When can a patient be charged a co-payment?

The patient can be charged the co-payment on the day when, in the opinion of the attending physician the patient requires CCC and is more or less a permanent resident in a hospital or other institution. See Regulation 552, section 10(1).

Designated CCC patients in chronic units of acute care hospitals, or in a chronic care hospital will pay the assessed co-payment. See Regulation 552, section 10(2).
Alternative level of care (ALC) patients who have been designated as requiring CCC and are more or less a permanent resident of the hospital or ALC patients waiting for long term care (LTC) placement will also pay the co-payment (see Section I Questions 6-9).

5. What is meant by "the patient must be more or less a permanent resident in the hospital or other institution"?

This means that in the opinion of the attending physician, the patient requires chronic/complex continuing care and is, and will continue to be more or less permanently resident in the hospital or is waiting for long term care home placement.

In some cases, the patient could be designated as requiring CCC or long term care placement on the first day of admission; the co-payment would then commence.

6. Currently, some physicians only write an "Alternative Level of Care (ALC) order" but do not specify the type of care required for the patient. Does the physician need to provide more information?

Yes. It is important that the physician identify the level of care required and the date when this becomes applicable. This means that the patient may require a CCC bed where s/he would be more or less permanent resident of or is waiting for long term care home placement.

It should be noted that patients who are designated to return to the "community" or waiting for "community placement" do not pay the CCC co-payment. The "community" includes home with or without home care, residential homes and retirement homes.

7. Why is the co-payment applicable only to those ALC patients who are awaiting placement in a CCC or long-term care home, and not all ALC patients?

The Canada Health Act permits a co-payment for accommodation and meals for those in-patients who, in the opinion of the attending physician, require CCC and are more or less permanent resident in a hospital or other institution. ALC patients waiting to return to the home/community cannot be charged, as they do not satisfy these criteria.

8. Why are hospitals now charging ALC patients who are waiting for placement in a CCC facility or long-term care home?

In the past, ALC patients who were awaiting CCC or long-term care placement had a financial incentive to remain in an acute care bed at no cost, while patients requiring the same or similar services and occupying a CCC bed had to pay the co-payment.

For the sake of fairness, patients requiring equal services (i.e., CCC, long-term care, or awaiting CCC long-term care placement) are now treated equally with regard to co-payment.
9. Are the co-payment policies for ALC designated patients waiting for LTC placement the same as those policies for CCC patients?

Yes, the co-payment policies and rates for these two groups of patients are the same. There is no exemption period, and the applications for co-payment reductions for ALC patients waiting for CCC placement or long-term care placement are the same as those for CCC patients.

10. Once an ALC patient is designated by the attending physician as requiring CCC and is more or less a permanent resident in the hospital, how often can the physician bill for CCC services?

If the patient requires CCC services, the physician can bill CHIP for eight visits each month. This applies to monitoring visits only; visits for illness are permitted without restrictions.
SECTION II

CO-PAYMENT CALCULATION

1. What is the maximum co-payment rate under the Health Insurance Act?

For 2008-2009, the maximum co-payment rate is $1,578.02 per month or $51.88 per day for CCC patients, and for alternative level of care patients awaiting complex continuing or long-term care placement.

2. Is there a minimum co-payment?

No. There is no minimum co-payment.

However, depending on the number of dependants and level of total family incomes, some patients may be fully or partially exempted from making a co-payment.

3. When will the CCC co-payment be changed again?

To synchronize with the Ontario Consumer Price Index, the CCC co-payment is generally adjusted annually. This change usually occurs around July of each year and, this year, the change will occur July 1, 2008.

It should be noted that, under paragraph 2 of Regulation 552 subsection 10(4), hospitals are required to provide patients with at least 30 days written notice of any increase. Therefore, when the CCC rates are next increased, patients will receive at least 30 days notice of any such increase.

4. What date should be used as a start date for co-payment charges? Does the co-payment commence once the physician completes the designation or after Placement Coordination Services has reviewed the file and indicated that the patient would be an appropriate long-term care placement?

The co-payment commences when the physician has completed the alternative level of care designation and notes the effective date. This is usually in the form of a discharge order, specifying the discharge date and level of care/type of facility required by the patient.

5. Why were the 60-day and two 180-day exemption periods eliminated?

The CCC, ALC (for patients waiting for long-term care home placement only) and long-term care co-payment systems have been harmonized where possible to eliminate incentives for patients to stay in settings where the levels of care are inappropriate. There is no exemption period for patients in long-term care.

6. Can we charge rehabilitation and convalescence patients the CCC co-payment?

No. Convalescence and rehabilitation patients should not be charged for the CCC co-payment because it is not permitted under the Canada Health Act. Only patients receiving CCC or designated as requiring CCC and are more or less a permanent
resident in the hospital may be charged the co-payment. Also, patients who are waiting for long-term care home placement and are not returning to the community may be charged the co-payment.

7. **Is the co-payment applicable to palliative care patients?**

Palliative care is defined as a program of active compassionate care primarily directed towards improving the quality of life of the dying.

Subsection 10(1) of Regulation 552 under the *Health Insurance Act* provides that a co-payment for accommodation and meals shall be made by or on behalf of an insured person who, in the opinion of the attending physician, requires CCC and is more or less permanently resident in a hospital or other institution.

For patients who are admitted to a hospital for palliative care, the co-payment would not be applicable. The patient is not "more or less permanently resident in the hospital" and therefore does not meet all the criteria to be charged the co-payment.

The condition of a patient who has already been designated by the attending physician as requiring CCC and more or less permanently resident in the hospital (and paying the co-payment) may change so that palliative care is required. The designation and co-payment would continue on the basis that the patient's residence status has not changed, i.e., the patient has been more or less permanently resident but now will require palliative care.

The attending physician is responsible for determining if the patient requires CCC or palliative care.

8. **Is the co-payment applicable to respite care patients?**

No. A patient receiving respite care is expected to return to the community, and is not more or less a permanent resident in the hospital. Therefore, the co-payment is not applicable.

9. **Is the CCC co-payment applicable to those patients who have been designated as requiring complex continuing care and more or less permanently resident in the hospital or other institution, but at some time require acute care services?**

If the physician changes the patient's designation whereby he/she no longer requires CCC and/or is not more or less permanently resident in the hospital, the co-payment cannot be charged.

It is anticipated that CCC patients may be hospitalized for many years. During this period of hospitalization unanticipated acute episodes may occur such as pneumonia, heart attack, etc.

If the patient requires acute care or some other type of care but still requires CCC and will continue to be more or less permanently resident in the hospital, the co-payment remains applicable.
10. Does a hospital patient who is awaiting placement in a retirement/rest home or group home pay the co-payment?

The co-payment is not applicable, as the patient is not more or less permanently resident in the hospital and is not waiting for CCC or long term care placement. In this case, the patient is deemed waiting to return to the community or placement in the community (see Section I Question 4).

11. If a patient from a long term care home becomes designated as requiring complex continuing care and is more or less permanently resident in the hospital, is s/he exempt from the co-payment for the first 60 days?

No. Under the January 1, 1997 revised regulations, the 60-day exemption has been eliminated and this patient would be charged from the date the designation is made by the attending physician.

12. Does the co-payment arrangement apply to residents of other provinces who have been admitted to an Ontario hospital?

If an insured resident from another province is designated by the attending physician as requiring CCC and is more or less permanently resident in the hospital, s/he would not be required to pay the co-payment if the province is paying the interprovincial rate. The co-payment is partial payment of the per diem and would not apply since the entire hospital cost is being paid by another province’s health insurance program.

If the full interprovincial rate is not being paid on behalf of the patient, s/he would be charged the co-payment by the hospital.

13. Does the CCC co-payment apply in the case of a patient whose full hospital service is being paid by himself or an agency other than OHIP? (Agencies such as: any other insurance agency, Workers’ Compensation Board, the Federal Government of Canada, i.e. Veteran Affairs Canada/Department of Veterans Affairs, Health Canada.)

The co-payment is partial payment of the per diem (accommodation and meals) and would not apply, since the entire hospital cost is being paid by an agency other than OHIP. If the third party payer claim is rejected/denied, the patient is fully liable for the co-payment from the first day.

14. Does the Veteran Affairs Canada/Department of Veteran Affairs (VAC/DVA) pay the full interprovincial rate for all VAC/DVA related patients?

No. VAC/DVA pays the full interprovincial rate only for those patients who are disability pensioners that are in hospital because of their pension condition. The VAC/DVA tops up the co-payment from the VAC/DVA national rate for those who require CCC and:

i) are War Veterans Allowance recipients;
ii) are Civilian War Allowance recipients, or
iii) would qualify for War Veterans Allowance or Civilian War Allowance were it not for payments made to them under the Old Age Security Act.
15. How is the CCC co-payment determined for the VAC/DVA patients who are not listed above?

Please visit www.vac-acc.gc.ca or contact your closest Veteran Affairs District Office for information.

16. If a patient who is expected to be discharged after a stay of, i.e. approximately two months (not more or less a permanent resident) but the designation changes whereby the stay continues on a more or less permanent basis, can the hospital charge the co-payment retroactively?

No. A retroactive charge cannot be made. The hospital can only commence the co-payment when the attending physician designates that the patient requires CCC and is more or less permanently resident in the hospital or other institution or if the patient is awaiting long term care placement.

17. When calculating the co-payment does the hospital use net income or gross income?

The gross income of the patient and his/her dependants is used. Please see form (3264-54) entitled Co-Payment Calculation for further details.

18. Is the co-payment a deductible medical expense for income tax purposes?

To our knowledge there is no specific provision in the Income Tax Act (Canada) that addresses the tax treatment of co-payment charges. However, the Income Tax Interpretation Bulletin, No: IT-519R2 (Consolidated), Para. 19 (a Canada Revenue Agency publication) suggests that such a payment may be deductible by a taxpayer. The patient or his/her representative is advised to obtain confirmation from the Canada Revenue Agency prior to deducting co-payment charges on his/her tax return.

19. Will patients in public psychiatric hospitals pay the co-payment?

No. The co-payment is not applicable to patients in psychiatric hospitals.

20. Do patients in psychiatric beds in acute care hospitals pay co-payment? If, for example, a patient is in an acute care psychiatric bed and waiting for a long-term care placement, will the co-payment apply?

No. Psychiatric patients in acute care hospitals cannot be charged the co-payment even if they have been designated as requiring CCC or if they are waiting long term care placement.

Section 46 of the Health Insurance Act (HIA) applies to both voluntary and involuntary patients admitted to psychiatric facilities under the Mental Health Act. Services provided to psychiatric patients under this section of the HIA are to be provided without charge other than a co-payment prescribed in the regulation under a clause in Section 46. No regulations have yet been enacted under this clause.
The general CCC co-payment provisions contained in the HIA do not apply to the specific patient group identified in Section 48.

21. Will patients in private CCC hospitals pay the co-payment?

Yes. The co-payment requirements and processes are the same for patients in private CCC hospitals as those patients in public hospitals.

22. If a patient were transferred to another facility would the patient be charged the co-payment twice on the day of transfer?

In cases where the co-payment is applicable for the patient in both the sending and receiving facilities, the facilities should communicate to ensure that the co-payment is only charged once on the day of transfer.

23. Is it the patient's priority to pay the CCC co-payment for his/her preferred accommodation?

The patient may have a third party insurer (i.e. insurance company, employee benefits) that covers both preferred accommodation and the co-payment for which the insurer can be billed.

If the patient has a third party insurer that covers only preferred accommodation, the insurer can be billed. The patient would be responsible for the assessed CCC co-payment fee.

If the patient does not have a third party insurer that covers preferred accommodation, then the patient's first responsibility is to pay the co-payment, and then the full cost of the preferred accommodation if funds are available. However, for patients who are now in preferred accommodation and are unable to afford both the CCC co-payment rate and the preferred accommodation rate, the hospital has discretion to charge a lower co-payment. This discretionary decision is made where there are extenuating circumstances and/or financial difficulties or to provide a reduction in the preferred accommodation rate.
SECTION III

CO-PAYMENT REDUCTION

1. Which patients are fully exempt from the CCC co-payment?
   - A person who was receiving benefits under the General Welfare Assistance Act or the Family Benefits Act, income support under the Ontario Disability Support Program Act, 1997, or income assistance under the Ontario Works Act, 1997 on the day before the person was admitted to the hospital,
   - Children under the age of eighteen years,
   - Those below a minimum monthly income that is established annually for insured persons with dependants (see Table 1).

2. What are the other opportunities for rate reductions?

A partial rate reduction may be available depending on the monthly income of the patient and the number of his or her dependents and their income.

Patients without dependants keep $122 of their monthly income as a comfort allowance. (Note: The comfort allowance increases to $125 on November 1, 2008). Any income above this level will be used up to the maximum co-payment.

For patients with dependants, a formula is used to calculate the co-payment rate. Depending on the number of dependants, a patient may be eligible for a lower co-payment if his/her family (see Table 1).

Please see Table 1 and Questions 4 - 7 for more information.

Table 1:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Full Reduction</th>
<th>Partial Reduction</th>
<th>No Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>One dependent</td>
<td>$3,487 or less</td>
<td>$3,488 - $8,221</td>
<td>$8,222 or more</td>
</tr>
<tr>
<td>Two dependants</td>
<td>$3,986 or less</td>
<td>$3,987 - $8,720</td>
<td>$8,721 or more</td>
</tr>
<tr>
<td>Three dependants</td>
<td>$4,441 or less</td>
<td>$4,442 - $9,175</td>
<td>$9,176 or more</td>
</tr>
<tr>
<td>Four or more</td>
<td>$4,847 or less</td>
<td>$4,848 - $9,581</td>
<td>$9,582 or more</td>
</tr>
</tbody>
</table>

3. What is the reduction for "spouse in the community"?

The reduction for "spouse in the community", (see Form 3268-54) was introduced on January 1, 1997. It replaced the reduction process, which entailed an assessment using "Form 7" under the Family Benefits Act. To be eligible, the spouse has to be receiving Old Age Security (OAS) or Guaranteed Annual Income System (GAINS) and living outside a government-funded facility.
In accordance with subsection 10(9) of Regulation 552, co-payment rate reductions expire on June 30th of each year or the last day of the month immediately preceding the month in which the next application for reduction is made - whichever is earlier.

4. What is a spouse?

In Regulation 552 under the *Health Insurance Act*,

A “spouse” is defined as a person

(a) to whom the person is married, or

(b) with whom the person was living, in a conjugal relationship outside marriage, if the two persons:

(i) have cohabited for at least one year,

(ii) are together the parents of a child, or

(iii) have together entered into a cohabitation agreement under section 53 of the 
*Family Law Act*.

5. What is a dependant?

In Regulation 552 of the *Health Insurance Act* a dependant is defined as:

“a spouse who is not receiving benefits under the *Old Age Security Act* (Canada) or the *Ontario Guaranteed Annual Income Act* and who was cohabiting with the insured person immediately before the insured person was admitted to the hospital where they are receiving insured inpatient services or, if the insured person has been in more than one hospital or institution continuously, immediately before they were first admitted to such a hospital or institution, or a child who is under 18 years of age.”

6. When is a child considered a dependant?

A child is considered a dependant if the child is under the age of 18 years and deemed to be living in the parental home, and thus forming part of the family unit, and who is wholly or partly dependent for food, shelter and general family support.

7. In the case of separation or divorce can a parent claim a child as a dependant when the child is living with the other parent?

Where the patient is separated/divorced from other parent with whom the child is living and forming a family unit, the patient cannot claim the child as a dependant.

In this case, the patient is considered single. However, any alimony and/or support payments would reduce his/her income used to determine the co-payment to be charged, consistent with the *Family Benefits Act* treatment of alimony and support payments.

8. How can a hospital determine the CCC co-payment reduction for a patient?

The co-payment forms “Co-payment Calculation Form” and the “Application for Reduction of Assessed Co-payment Fees Form” should be used to calculate the assessed co-payment.
Forms can be obtained from:

http://www.forms.ssb.gov.on.ca

For "Co-payment Calculation" form search for form number 014-3264-54.
For "Application for Reduction of Assessed Co-payment Fees" form search for form number 014-3266-54

Inventory Control Clerk
Warehouse Distribution Centre
Ministry of Health and Long-Term Care
99 Adesso Drive,
Concord, Ontario, L4K 3C7

Telephone: (416) 327-8222
Fax: (416) 327-0329

If you have any difficulties please call Kathryn DeGuire, at the Ministry of Health and Long-Term Care, Investment and Portfolio Management Branch at 416-314-1160.

9. These forms require that the estimated income of the insured person and his/her dependants (see Section III Question 4 for definition of dependant) be declared. Is a "statutory declaration of income" required for completing the forms for an exemption from co-payment?

No statutory declaration of income will be required.

10. Does the patient have to declare his/her assets in order to apply for a reduction?

Asset testing is not being used and, therefore, a person does not have to declare his/her assets.

11. Is only the income of the insured person (patient) used to calculate the co-payment?

No. The income used to calculate the amount of the co-payment is the patient's "estimated income" as that term is defined in Regulation 552 of the HIA.

Subsection 10(11) of Regulation 552 defines "estimated income" as "the average monthly income of any nature or kind whatsoever, as long as it is taxable under the Income Tax Act (Canada), of an insured person or of a dependant of an insured person, as estimated by the insured person or the insured person's representative and including:

a) payments made under any Act of the Parliament or Canada, except for payments made under the Universal Child Care Benefit Act (Canada);
b) income from salaries, wages and pensions;
c) income from an interest in or operation of a business less expenses incurred in earning the gross income; and
d) income from investments, less expenses incurred in earning such income.

Average monthly income is the total annual income of the patient and his/her dependants divided by 12 (see Section III Question 3 for the definition of a dependant)
12. What sources of income must be included when determining the exemptions or ability to pay?

All income of any nature so long as it is taxable under the Income Tax Act (Canada) of the insured person or a dependant of the insured person.

13. Are disability payments reported as income under the Income Tax Act (Canada)?

Some disability payments are reported as income. The Canada Revenue Agency has suggested that they be contacted if a hospital wishes to verify that the income for a disability payment or any other type of payment/income has to be reported under the Income Tax Act (Canada).

14. Is a hospital required to verify the estimated income?

Hospitals are not required to validate the income. However, hospitals can request a validation of declared estimated income such as a copy of prior years’ income tax statements or audit statements for a business. The “Co-payment Calculation Form” and the “Application for Reduction of Assessed Co-payment Fees Form” have a section requiring the signature of the patient/spouse to provide requested information. The patient/spouse signs a statement to provide requested information on the two co-payment forms.

15. What alternatives are available to the hospital if the patient and his/her dependants will not provide the financial information requested by the hospital or if they attempt to not fully disclose their income?

In order to receive a co-payment exemption/reduction, the patient/spouse signs the statement on the two co-payment forms indicating that they undertake to provide any required information. If the information is not provided by the patient after a hospital staff member explains to the patient or his/her representative the need for such information, the hospital may charge the full co-payment.

16. What can be done if the patient, because of legitimate financial difficulties, is unable to afford the assessed co-payment?

Hospitals should deal with cases where extenuating circumstances or financial problems make it difficult to pay the co-payment, and they can use discretion in how the patient’s assessed co-payment is resolved. The Chief Executive Officer or his/her designate should make this decision.

17. How are married persons over 65 to be treated under the CCC co-payment policy?

In general, persons over 65, both of whom are receiving OAS or GAINS, are to be treated as single individuals. In cases of hardship for a spouse living in the community, an additional exemption can be granted. An application for Reduction of Assessed Co-Payment Fees can be completed by (i) the patient with a spouse in the community when the spouse does not qualify as a dependant (ii) by the spouse or in the community when the spouse does not qualify as a dependant.
18. What happens in the case of a pensioner whose spouse is receiving Spouse's Allowance?

'Spouse's Allowance' is an allowance paid to spouses between the ages of 60 and 65 in lieu of OAS. Therefore, persons in this category would be treated the same way as pensioners. Should the payment of the full chronic care co-payment be a hardship for a spouse living in the community, an additional exemption may be granted by the hospital.

19. Many patients in hospitals receive Old Age Security but do not presently receive (Guaranteed Income Supplement) GIS or GAINS Supplements. They would be eligible for these benefits if they were living in the community. To meet the per diem cost of co-payment, may such patients or the hospital on behalf of such patients apply for the GIS and GAINS supplement benefits?

Patients will not be required to seek welfare, but can be encouraged to obtain any other supplementary benefits to meet the co-payment. Where existing income does not fully meet the charge, partial exemption would be applied.

Hospitals cannot apply for other supplementary benefits without the patients' knowledge and consent.

20. How do I know the amounts of OAS, GIS and GAINS benefits to be used for the calculation of the patient's co-payment charge?

The amount of OAS, GIS and GAINS have to be provided by the patient and/or the spouse directly. She can call the Income Security Office at 1-800-277-9914 or write to the local Human Resource Development Canada (HRDC) Income Security Office to obtain the information required.
Section IV

GENERAL

1. Is the co-payment charged in hospitals for accommodation and meals in acute and CCC facilities high?

No. It is significantly lower than the actual costs incurred.

2. Can patients designated as requiring CCC and more or less permanently resident in the hospital or other institution waiting for long term care placement apply for "marital involuntary separation"?

There are situations where couples find themselves "involuntarily separated" and living in separate dwellings for reasons beyond their control. This includes situations where:

- one person is in a nursing home or in a chronic care hospital;
- one person is hospitalized in a regular active treatment hospital waiting for a room in a nursing home or chronic care facility.

For married Old Age Security pensioners to be considered as being involuntarily separated, they must first apply for the Guaranteed Income Supplement (assuming that they are not already in receipt of this benefit) and provide evidence of the involuntary separation. A Statutory Declaration, outlining the circumstances that led to the separation, is considered acceptable evidence.

3. Why are designated complex continuing care patients in acute care hospitals charged a co-payment?

In the past, patients occupying a regular hospital bed while awaiting a chronic care or long-term care bed were not charged. Also, patients in chronic care hospitals or units were charged a lower co-payment rate than those receiving similar care in long-term care facilities. To ensure fairness, and to prevent inappropriate use of acute care resources, everyone is now charged the same rate. This policy allows better use of limited hospital resources, allowing hospitals to direct more resources to patient care, rather than accommodation.