



# Patient Focused Funding ALBERTA



**Price Book 2026 – 2027**



This report has been prepared by Corporate Services, Acute Care Alberta, for use by Alberta health service providers.

Acute Care Alberta acknowledges the contribution and collaboration of Alberta Health Services, Covenant Health, Health Shared Services, and Dr. Glen L. Sumner of the University of Calgary in supporting the development of the Alberta Patient-Focused Funding (PFF) model.

For more information, please visit [www.acutecarealberta.ca/pff](http://www.acutecarealberta.ca/pff)

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## Background

Alberta is placing greater emphasis on efficiency, value for money, and accountability within the healthcare system. At the same time, the province continues to look for ways to reduce wait-times and improve access to care. Alberta is examining whether these concerns can be at least partly addressed by changing how healthcare funding is allocated.

Patient Focused Funding (PFF) is one approach being applied. It is an activity-based funding (ABF) model used in several Canadian and international health systems. Under ABF, health services providers (HSPs), like Alberta Health Services (AHS) and Covenant Health (CH), are paid based on the volume, type, and complexity of the care they deliver, rather than receiving a fixed annual budget. Detailed information about how ABF works generally and in other Canadian jurisdictions is available through resources published by the Canadian Institute for Health Information.<sup>1</sup>

In Alberta, PFF is intended to improve transparency, accountability, access, and efficiency in acute care by aligning funding more closely with the services that are provided, while maintaining high quality and safe patient care. As part of this initiative, selected procedures will transition from the current global funding model, where HSPs receive a fixed amount of funding each year, to an activity-based funding model, where funding reflects the number and complexity of procedures performed.

To implement PFF, we must first describe the activity (sites, procedures, and volumes). Next, we must understand costs and assign a price to each group of activities. Finally, mechanisms must be put in place to monitor and evaluate program performance, supported by transparent reporting to communicate health system outcomes.

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<sup>1</sup> [The Why, the What and the How of Activity-Based Funding in Canada: A Resource for Health System Funders and Hospital Managers](https://www.cihi.ca/sites/default/files/document/activity-based-funding-manual-en.pdf) <https://www.cihi.ca/sites/default/files/document/activity-based-funding-manual-en.pdf>



## Objectives

Patient Focused Funding has four key objectives:

1. Enhance **transparency and accountability** in healthcare spending. Transparency means making it clear how healthcare funding decisions are made. By clearly explaining the rules, methods, and processes used to allocate funding, PFF helps ensure decisions are understandable, consistent, and predictable. This reduces uncertainty, promotes accountability, supports hospital planning, and builds public confidence and trust in the health system.
2. Incentivize **efficiency**, strengthen **performance**, and support **access**. PFF encourages hospitals to operate more efficiently by linking funding to the volume and type of care they provide. This creates incentives to improve processes, reduce unnecessary delays, and deliver care more effectively. Transparent information on activity, patient complexity, and costs also strengthens performance monitoring by allowing funders to compare hospitals and identify differences in service delivery. Finally, PFF supports better access to care by encouraging higher service volumes and shorter wait times, since health service providers receive funding for each additional patient they treat.
3. Ensure **value** for the province's significant public investment in acute care regardless of where care is delivered. By setting predefined prices for different types of patients and services, PFF aligns funding with the actual resource requirements of care. This ensures hospitals are funded appropriately based on patient complexity, regardless of location, and that public funding is distributed fairly and consistently. As a result, the province can clearly demonstrate measurable value for its investment across the acute care system.
4. Support **safe, high-quality, patient-centred care** by tracking results and difference in care. Using consistent clinical and financial data, such as patient complexity, resource intensity weights, and other measures, helps identify outliers and areas that need improvement. Regular monitoring creates conditions that support ongoing quality and safety oversight.

PFF represents a significant shift from current funding practices in Alberta. While transparency will remain a core objective of PFF, it is important to recognize that ABF models (including PFF) inherently involve greater complexity and administrative effort to achieve the intended benefits and will continue to require specialized analytical expertise to interpret and apply. International experience demonstrates this trade-off clearly.



## Glossary

**Activity-Based Funding (ABF):** An approach to funding healthcare in which providers are reimbursed at a set price for delivering specific patient care services (e.g., surgeries). ABF incentivizes efficiency and access by linking funding to the volume and type of care provided and by making service providers financially responsible for delivering care at or below the established price for typical cases. Patient Focused Funding is Alberta's version of ABF.

**Acute Care Alberta (ACA):** The Provincial Health Agency (PHA) responsible for overseeing acute care delivery in Alberta. ACA implements the Government of Alberta's priorities, allocates acute care funding, and sets operational standards for acute care providers. In the context of PFF, ACA is accountable to the Ministry of Hospital and Surgical Health Services for the performance of PFF as a component of Alberta's acute care system.

**Alberta Health Services (AHS):** A Provincial Health Corporation and the largest operator of acute care hospitals in Alberta. AHS operates nine of the 12 sites involved in PFF for the 2026/27 fiscal year. It is responsible for delivering PFF services and is accountable to ACA for performance, financial management, and reporting under the program.

**Atypical Cases:** Cases in which the patient is transferred between hospitals during their stay, has an unusually long stay (usually due to waiting for a continuing care bed when unable to be safely discharged home), died, or signed out against medical advice. These cases are excluded from PFF because they are likely to have meaningfully different costs than typical cases and are the result of factors outside of the provider's control.

**Canadian Institute for Health Information (CIHI):** A national organization that sets data standards and collects, analyzes and distributes health data across Canada to accelerate improvement in healthcare, health system performance, and population health.

**Chartered Surgical Facilities (CSFs):** Publicly funded, privately operated surgical facilities in Alberta. CSFs are not funded through the Patient-Focused Funding (PFF) program and are not paid PFF Prices. PFF prices will be used to inform procurement decisions and support consistency across publicly funded surgical services.

**Covenant Health (CH):** A hospital operator responsible for several acute care hospitals and other facilities in Alberta. CH operates three of the 12 sites involved in PFF for the 2026/27 fiscal year. It is responsible for delivering PFF services and accountable to ACA for performance and reporting under the program.

**Health Services Provider (HSP):** Organizations responsible for delivering healthcare services in Alberta, including Provincial Health Corporations like AHS, hospital operators like CH, and other regulated facilities like CSFs.

**Health Shared Services (HSS):** An organization that provides shared corporate services across Alberta's health system, including finance, costing, data and analytics, information technology, human resources, privacy, and legal services. HSS is responsible for maintaining



costing systems and overseeing data used to support PFF pricing and CSF information systems.

**Patient Focused Funding (PFF):** Alberta's application of ABF, designed to allocate funding based on the volume, type, and complexity of patients treated, rather than global funding.

**PFF Price:** The predetermined price paid under PFF to a service provider for delivering a specific patient service or procedure, based on expected resource requirements for a typical case.

**Schedule of Medical Benefits (SOMB):** The agreement that defines fee-for-service payments from the Government of Alberta to physicians for publicly insured medical services.

**Surgical Care Alberta (SCA):** A provincial program within Acute Care Alberta (ACA) that serves as a provincial hub for surgical expertise, standardization, and planning. SCA Combines surgical responsibilities under one program to reduce surgical wait times and to ensure surgical quality.



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## How to Use This Document

This document provides information on the development and implementation of Alberta's PFF program. Its primary audience is hospital leadership, with the goal of informing operating decisions. It is also made publicly available to promote transparency in the administration of the program.

The first section defines the activity (i.e., procedures, sites, and volumes) in-scope for fiscal year 2026/27. PFF applies exclusively to eligible procedures performed at participating sites. All other procedures and sites are still funded under the existing global funding system.

The next section describes the price formula and what is included or excluded in the PFF price.

The last two sections describe the PFF Prices for 2026/27 and the planned reporting. The initial PFF phase needs to ensure a reasonable starting point to gather data to evaluate potential strategies for the mid-term to long-term.



## Activity

Describing hospital activity is the first step in establishing PFF. This section describes the procedures, and sites that will be included in the PFF Program in 2026/27. See Appendix D for Alberta's 2024/25 PFF procedure volume.

## Procedures

For 2026/27 the following four (4) surgical procedures will be funded via Patient Focused Funding. The descriptions below are based on diagnostic and procedure codes in AHS's patient care databases. See Appendix A for code details.

1. **Unilateral Hip Replacements** (Appendix A – Service Definitions)
  - a. The primary reason for the patient's admission is to receive a total or partial unilateral hip arthroplasty. Excludes bilateral procedures and revisions of previous arthroplasties
  - b. The procedure takes place in a hospital, either during acute admission or as a day procedure (excludes all cases performed at CSFs)
  - c. Includes only elective cases (excludes emergency and trauma cases)
  - d. Excludes pediatric cases
  - e. Excludes atypical cases and cases with infection
  
2. **Unilateral Knee Replacement** (Appendix A – Service Definitions)
  - a. The primary reason for the patient's admission is to receive a total or partial unilateral knee arthroplasty. Excludes bilateral procedures and revisions of previous arthroplasties
  - b. The procedure takes place in a hospital, either during acute admission or as a day procedure (excludes all cases performed at CSFs)
  - c. Includes only elective cases (excludes emergency and trauma cases)
  - d. Excludes pediatric cases
  - e. Excludes atypical cases and cases with infection
  
3. **Cataract Replacement** (Appendix A – Service Definitions)
  - a. The patient had a total lens excision performed, and diagnostic codes indicate that they had a cataract or cataracts
  - b. Takes place in a hospital (excludes CSFs)
  - c. Includes *only* day surgery (excludes any acute hospital stays)
  - d. Includes both unilateral and bilateral (If cases are not explicitly listed as bilateral, they will be treated as unilateral)
  - e. Excludes pediatric cases
  - f. Excludes emergency cases
  
4. **Shoulder - Rotator Cuff Replacement** (Appendix A – Service Definitions)
  - a. The primary procedure performed during the surgical episode was an endoscopic repair of the rotator cuff using an apposition technique or tenodesis



- b. It takes place in a hospital (excludes all cases performed at CSFs)
- c. Includes day surgery only (excludes any acute hospital stays). For this procedure, patients are typically only admitted for unusually complex cases or in trauma situations that are not appropriate for PFF funding
- d. Excludes pediatric cases
- e. Excludes emergency cases

## Sites

In the most recent complete fiscal year (2024/25), PFF procedures above were completed in 30 public hospitals and several CSFs. However, for initial implementation, only twelve sites are included.

### PFF Sites 2026/27

	Site	Service Delivery Organization
1.	Chinook Regional Hospital	Alberta Health Services
2.	Grande Prairie Regional Hospital	Alberta Health Services
3.	Innisfail Health Centre	Alberta Health Services
4.	Medicine Hat Regional Hospital	Alberta Health Services
5.	Red Deer Regional Hospital Centre	Alberta Health Services
6.	Rockyview General Hospital	Alberta Health Services
7.	Royal Alexandra Hospital	Alberta Health Services
8.	Westlock Healthcare Centre	Alberta Health Services
9.	Wetaskiwin Hospital and Care Centre	Alberta Health Services
10.	Grey Nuns Community Hospital	Covenant Health
11.	Misericordia Community Hospital	Covenant Health
12.	St. Mary's Hospital	Covenant Health

## Price Calculations

The price is the amount ACA pays to AHS, CH, or other health service providers for a particular activity or procedure. The payment covers the direct cost of performing the procedure, as well as a portion of related operating costs, like maintaining the facility.

The PFF Price does not include physician compensation. Physicians are paid separately through Alberta's fee-for-service system (SOMB). Corporate overhead costs that fall outside the PFF model are funded through a health service provider's regular operating budget.

Prices are not meant to represent the total cost for a hospital to provide care for an individual patient. Rather, they reflect an evidence-informed estimate of the typical costs to complete a procedure for an average patient in Alberta. The price is then adjusted to account for other factors like patient characteristics (complexity) that affect cost and are outside the hospital's control.

The Alberta PFF Price is calculated using a three-component formula:


$$A \times B + C = \text{PFF Price}$$

### A = Base Procedure Costs

Base procedure costs and associated adjusters were calculated using a combination of AHS and CH financial and clinical data from the Discharge Abstract Database (DAD) and the National Ambulatory Care Reporting System (NACRS) for inpatients and day surgery procedures, respectively. These databases provide data elements necessary to quantify the number of patients funded under PFF (see Appendix A – Service Definitions for data definitions) and their associated costs.

Cost data represent the most recent available complete fiscal year (Fiscal Year 2024/25, April 1, 2024, to March 31, 2025).

Component A is the sum of several different cost types (Appendix C – Detailed Historical Costs) including:

- Nursing Units
- Operating Rooms (including turnover time and capital equipment)
- Supply Costs (Implantable devices)
- Drugs
- Laboratory
- Diagnostic Imaging
- Emergency Department
- Other Incremental Costs (e.g., linen supply, food services)



Costs are estimated by Health Shared Services' Activity and Costing department. They combine health record data from the DAD and NACRS with financial data to estimate patient-level costs.

Some costs like implants or drugs are directly linked to patients that use them. Other costs are shared across patients proportionally based on their expected usage.

For example, to calculate the cost of using an operating room (OR), the total cost of operating the OR is divided by the total number of surgical minutes delivered in that room. This produces an average OR cost per minute. The OR cost per minute is then multiplied by the number of minutes required for a particular patient to determine that patient's share of OR costs.

The OR cost per minute reflects both the overall cost of operating the OR and how efficiently OR time is used. Sites that consistently deliver a high number of surgical minutes spread fixed costs over more activity, resulting in a lower cost per minute. Conversely, sites with higher levels of surgical downtime, such as longer turnover times, will have fewer surgical minutes, which increases the cost per minute compared with otherwise similar sites.

These 2024/25 costs are then inflated to 2026/27 dollars. The total inflation adjustment is 6.1% (weighted across cost components; approximately 3% per annum compounded over two years). See Appendix B – Inflation Calculation for details of the calculation.

Part of the goal of PFF is to encourage more efficient care while maintaining quality. One component of that is providing surgery as day procedures where appropriate rather than keeping patients overnight. To appropriately and effectively incentivize day surgery uptake, component A's price was increased by 2% for day surgery acuity categories and reduced by 2% for no comorbidity cases. Low and high comorbidity cases were also reduced by 2% to incentivize efficiencies. The impact of this approach will be monitored to ensure its effectiveness. A detailed table of prices can be found in the subsequent section.

## B = Complexity Adjustment

Some medical procedures cost more than others, and not all patients or hospital sites are the same. PFF includes complexity adjustments, so funding reflects differences in patient needs and the care required. These adjustments ensure that sites caring for patients who need more support receive appropriate funding.

### Why Costs Differ Between Patients

Not all patients require the same level of care. Some have additional health conditions that make their procedures more complex. These patients may:

- Need more time in the OR
- Require longer hospital stays
- Use more specialized equipment or monitoring

However, clinical complexity does not always translate into higher cost. Cost adjustments are applied only when a patient's conditions are expected to meaningfully affect resource use and



cost. While some patients may have multiple comorbidities, these conditions do not necessarily meaningfully affect how the procedure is delivered or its cost. The Canadian Institute for Health Information (CIHI) analyzes Canadian data to determine which comorbidities meaningfully affect expected resource use and cost for specific procedures and which do not.

As PFF continues to expand, additional data will help identify which patient factors consistently influence cost and which do not. This will support more accurate, evidence-based adjustments over time.

### How Complexity is Included in 2026/27

In 2026/27, PFF accounts for differences in complexity by grouping procedures into categories based on how resource-intensive they typically are:

- Hip and knee replacements: day procedures plus three inpatient complexity levels
- Cataract surgeries: unilateral (one eye) and bilateral (both eyes)
- Rotator cuff procedures: one combined category

For hip and knee inpatient cases, complexity levels are based on whether the patient has cost-relevant comorbidities. ACA relies on CIHI's data to identify combinations of conditions that meaningfully increase the cost of care. In Alberta in 2024/25 this group of patients had the following secondary diagnoses:

- Most hip and knee patients (about 99%) have no cost-relevant comorbidities
- About 1% have conditions that raise costs by ~25–100%
- A small number (about 0.2%) have conditions that more than double expected cost

Many common or expected conditions do not increase funding because they do not meaningfully affect how the procedure is performed, or they are already reflected in the base price. Only conditions that meaningfully increase the level of care or resource use are considered cost-relevant for funding. As PFF is implemented across more clinical areas, new adjustments may be added to reflect patient or site factors that impact cost.

### Comorbidities and Comorbidity Levels

All diagnoses recorded in a patient's chart are abstracted by health record professionals and grouped. For complexity purposes, the common groups are:

1. Pre-Admit Comorbidities
2. Post-Admit Comorbidities
3. Secondary Diagnosis (does not affect comorbidity levels)

A diagnosis is counted as a comorbidity (rather than a secondary diagnosis) only if at least one of the following criteria is met:

1. Requires treatment beyond routine maintenance of a pre-existing condition
2. Increases the length of stay by at least 24 hours
3. Meaningfully affects the treatment received (e.g., level of care, monitoring, interventions)



Whether a diagnosis meets criteria to be included as a pre-admit or post-admit comorbidity is determined by review of the DAD or NACRS at the time of discharge. Diagnoses that do not meet these criteria are coded as secondary diagnoses (not comorbidities) and are not included in comorbidity level calculations.

There are several other less common diagnoses categories that aren't relevant or common for this patient group.<sup>2</sup>

CIHI has identified a large set of potential secondary diagnoses for specific patient groups that may significantly affect the expected cost of a patient. For hip and knee replacement there are over 700 different secondary diagnoses that can be considered significant (and therefore a comorbidity) if they meet one of the three criteria listed above.

Including both cost-relevant comorbidities and secondary diagnoses:

- 22% have zero other diagnoses
- 23% have one other diagnoses
- 18% have two other diagnoses
- 13% have three other diagnoses
- 23% have more than three other diagnoses

Commonly documented secondary diagnoses that rarely meet comorbidity criteria include:

- Benign hypertension (29% of these cases)
- Type 2 diabetes mellitus without (mention of) complications (5% of these cases)
- Unspecified diabetes mellitus without (mention of) complication (2% of these cases)

Common pre-admit secondary diagnoses that usually are not cost-relevant include:

- Varus deformity, not elsewhere classified (1.5% of cases)
- Synovial cyst of popliteal space [Baker] (1.1% of cases)
- Contracture of joint, lower leg (0.5% of cases)

None of the secondary diagnoses above are considered cost-relevant unless they meet one of the three criteria listed above.

Common post-admit secondary diagnoses (generally not cost-relevant) include:

- Hypo-osmolality and hyponatremia (0.4% of cases)
- Acute Pain (0.2% of cases)
- Retention of Urine (0.2% of cases)

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<sup>2</sup> [Assigning Diagnosis Types to DAD Abstracts](http://www.cihi.ca/sites/default/files/document/assigning-diagnosis-types-to-dad-abstracts-job-aid-en.pdf) – www.cihi.ca/sites/default/files/document/assigning-diagnosis-types-to-dad-abstracts-job-aid-en.pdf



For all patients in the low comorbidity level, common cost-relevant pre-admit diagnoses include:

- Type 2 diabetes mellitus with established or advanced kidney disease (5.5% of these cases)
- Palliative Care (4.4% of these cases)

Common cost-relevant post-admit comorbidities include:

- Other Delirium (13% of these cases)
- Vascular complications following a procedure, not elsewhere classified (12% of these cases)

Patients in the high comorbidity level typically have multiple cost-relevant comorbidities (e.g., acute renal failure, unspecified plus staphylococcal infection, unspecified site).

Comorbidity level is driven by clinically significant conditions, not simply the number of diagnoses documented. Only diagnoses that meet the criteria and meaningfully affect resource use and cost are counted as comorbidities for funding.

## C= Other Adjusters

### Why Costs May Differ Between Sites

Some hospitals may naturally face higher costs because of how and where they operate. For example:

- Rural and remote sites may have higher operating costs because of travel distances, staffing challenges, or lower procedure volumes
- Teaching hospitals may need additional staff and resources to support training

These differences are expected and are reflected in how funding is allocated. For 2026/27, however, there was limited evidence of meaningful cost variation across the 12 sites for these four PFF procedures. As a result, no site-specific adjustments were applied, and funding for these items is based on historical averages and included in the base price. While these adjustments were not applied in 2026/27, this component of the pricing model will be monitored and updated as needed. Future potential adjusters may include increased payments for some rural sites with staffing challenges and for teaching hospitals. In the interim, the PFF reserve fund will be used during 2026/27 to compensate sites for significant, justifiable funding disparities.



## Comparing PFF prices to Chartered Surgical Facility Fees (CSF)

CSFs and hospitals are funded differently. CSFs are paid through contracts; their negotiated fees cover the costs defined in each agreement (e.g., facility overhead and nursing). As a result of these structural differences, PFF prices are not directly comparable to CSF fees. Over time, enhanced reporting will improve comparability by better quantifying these differences.

PFF pricing will be one input into future procurement discussions with CSFs where appropriate. This approach supports gradual alignment across funding models while recognizing current structural differences and ensuring value for Albertans.

Procedure Costs	Included in PFF Price	Included in CSF fees <sup>3</sup>
Nursing Units Operating Room <sup>4</sup> Drugs	Yes	Yes
Physician payments (SOMB)	No	No
Building costs (capital) Return to Operator (operator margin)	No	Yes
Implants / Devices	Yes	No <sup>5</sup>
Laboratory Diagnostic Imaging Allied Health	Yes	No <sup>6</sup>
Anesthesia Care team <sup>7</sup>	Yes	No
Emergency department	Yes	No
Chartered Surgical Facilities Information System (CSFIS) Contracting Invoicing Health Information Management Quality monitoring and improvement Activity monitoring	No	No

<sup>3</sup> CSF fee inclusions vary by agreement. CSFs are not funded under PFF and are not paid PFF Prices; PFF pricing may be used to help inform procurement

<sup>4</sup> Includes turnover time, Post Anesthesia Care Unit (PACU) and OR Capital Equipment (e.g., depreciation embedded)

<sup>5</sup> CSF implants/devices are commonly billed as pass-through/cost-recovery items unless explicitly included in the facility fee

<sup>6</sup> CSFs do not provide full Lab/DI/Allied Health. These services are mainly provided by hospitals or clinics prior to the CSF admission or after discharge

<sup>7</sup> Anesthesia care team refers to provider-side supports (techs, supplies, monitoring). Physician anesthesia services are paid separately through SOMB in both settings



## PFF Prices 2026/27

Using the inflated and adjusted costs and the pricing principles described below, the following prices have been developed for the 2026/27 fiscal year.<sup>8</sup> For full procedure definitions, see Appendix A – Service Definitions. For context on which costs are reflected in these prices, see Appendix C – Detailed Historical Costs. For 2024/25 volume data, see Appendix D – Detailed Volume.

Procedure	Complexity Category	Inflation Adjusted Costs 2026/27 or *2024/25 <sup>9</sup>	Initial Pricing Incentives @	PFF Prices
Hip	Day Surgery	\$ 8,722	102%	\$ 8,900
	No Co-Morbidity	\$ 9,613	98%	\$ 9,420
	Low Co-Morbidity	\$ 16,016*	98%	\$ 15,700
	High Co-Morbidity	\$ 34,120*	98%	\$ 33,440
Knee	Day Surgery	\$ 8,365	102%	\$ 8,530
	No Co-Morbidity	\$ 9,210	98%	\$ 9,030
	Low Co-Morbidity	\$ 16,169*	98%	\$ 15,850
	High Co-Morbidity	\$ 25,294*	98%	\$ 24,790
Cataract	Unilateral	\$ 899	98%	\$ 880
	Bilateral <sup>10</sup>	\$ 1,629*	98%	\$ 1,600
Shoulder	NA	\$ 6,940	98%	\$ 6,800

<sup>8</sup> Historical (2024/25) costs are available upon request

<sup>9</sup> For categories with lower volumes, (\*) 2024/25 volume data were used; and for categories with high volumes, 2026/27 volume data were used to calculate average costs

<sup>10</sup> Counted as 2 Unilateral cataracts



## Pricing Principles

A series of general principles were used to develop PFF pricing for 2026/27 as follows:

### 2026/27 is a learning year

2026/27 is a deliberate learning year. The program will prioritize continuity of services and avoid material disruption to providers and patients.

PFF funding will follow activity-based funding principles with standard prices for standard units of service. Funding adjustments will occur if funded volumes are not achieved.

Initially, physical payments will align with existing funding processes and occur at the same time as global funding payments. Adjustments may be necessary throughout the year as PFF continues to be implemented, and processes are enhanced.

### Pricing is linked to actual costs and volumes

Historical cost data were used to inform price calculations. Adjusted 2024/25 costs, including updates for factors such as inflation, served as a key starting point for setting 2026/27 prices. See appendices B, C, and D for more details.

### Initial incentives will be tested

For some procedures, prices have been set above or below estimated costs to encourage alignment with evidence-based practice and system priorities. For 2026/27, PFF prices were set within a range of 98% to 102% of the adjusted average cost, supporting a gradual alignment of pricing while encouraging appropriate changes in system practice.

For 2026/27 hip and knee day-surgery cases will be funded at 102% of expected cost while inpatient volumes will be funded at 98% of expected cost.

Cataract and shoulder surgery will also be funded at 98% of expected cost. Funding slightly below expected costs will encourage efficiency without affecting quality.

### Shared success is critical in year one

Applying a single standardized price to a specific surgery does not fully account for differences in underlying costs across hospital sites. For 2026/27, Acute Care Alberta, AHS, and CH will focus on managing these differences so that no site experiences significant financial impacts as the program is introduced. This approach supports a smooth transition to PFF and helps ensure the program is stable, sustainable, and delivers value for Albertans.

Acute Care Alberta will retain a small portion of funding as a reserve to help manage unforeseen pressures during 2026/27 and to support system stability. This reserve is intended to help avoid unintended impacts on access or quality as the PFF model is implemented.

### PFF prices are rounded to the nearest 10

Prices were rounded to the nearest ten (10) dollar amount to simplify calculations.



### PFF adjustments will be updated over time

The 2024/25 supply costs for cataracts have been adjusted to \$75 for unilateral cataract replacement and \$150 for bilateral cataract replacement and does not include optional premium lenses.

An Inflation rate of 6.1% (details in Appendix B – Inflation Calculation) has been used to increase the 2024/25 costs, averaging approximately 3% per annum.



## Funding

Surgical Care Alberta (SCA) collaborates with HSPs to establish planned and anticipated surgical volumes by procedure for upcoming fiscal years. For 2026/27 SCA has projected the expected volumes for hip replacement, knee replacement and cataract replacement surgeries as reported by the HSPs. These figures represent an initial allocation derived from forecasting models and remain subject to adjustments throughout the fiscal year.

### PFF Volumes 2026/27

Funded Volumes	Hip	Knee	Cataract	Shoulder
AHS Total	4,340	6,590	13,190	340
Covenant Health Total	370	650	-	280
<b>Total</b>	<b>4,710</b>	<b>7,240</b>	<b>13,190</b>	<b>620</b>

### Funding Envelopes 2026/27

ACA will establish procedure-specific PFF funding envelopes for AHS and CH, separate from their global operating funding. These envelopes will reflect planned volumes and associated funding for each of the four surgery types. ACA will communicate envelopes to AHS and CH and will monitor activity and funding throughout the year. Funding levels may be adjusted, where appropriate, in alignment with the principles outlined above.

Within the approved envelopes, AHS and CH will determine site-level allocations, consistent with intended outcomes related to access, transparency, and efficiency. The envelope approach and related processes will be refined during the learning year to reflect experience gained through Phase 1 implementation.

Funding Envelopes	Hip	Knee	Cataract	Shoulder
AHS Total	\$ 40,560,000	\$ 59,350,000	\$ 11,560,000	\$ 2,310,000
Covenant Health Total	\$ 3,560,000	\$ 5,920,000	\$ -	\$ 1,900,000
<b>Total</b>	<b>\$ 44,120,000</b>	<b>\$ 65,270,000</b>	<b>\$ 11,560,000</b>	<b>\$ 4,220,000</b>

## Reporting

### Volume Reporting

PFF prices are set for each procedure. Because funding is tied directly to activity, accurate and timely volume information is essential. Reliable volume data ensures funding flows to the right places and supports performance monitoring over time.

The official sources for PFF volumes are the Discharge Abstract Database (DAD) and the National Ambulatory Care Reporting System (NACRS). These are the gold standard for surgical and ambulatory activity, with an approximate 45-day lag after month-end.

To support near-real-time monitoring, the Connect Care Operating Room system will also be used. It provides timely counts of surgeries and closely aligns with DAD/NACRS, making it a strong early indicator before official data are released.

The HSS Financial Planning team will implement PFF dashboards that combine these sources and track volumes as they occur. These dashboards (and the underlying data) are key tools for PFF volume monitoring and reporting.

### Quality Monitoring and Reporting

PFF, and ABF more broadly, creates strong incentives for efficiency and increased activity. While these incentives can support improvements in cost management and throughput, they can also raise concerns that quality of care could be compromised if providers focus too heavily on volume or cost containment.

Evidence from health-care research suggests that poor-quality care typically increases costs over time due to higher rates of complications, longer lengths of stay, and avoidable readmissions. For this reason, quality will be actively monitored to ensure that efficiency incentives remain aligned with strong patient outcomes. Over time, linking prices or financial adjustments to quality performance will also be important to reinforce accountability and support consistently high-quality care.

Integrating quality indicators directly into PFF will require agreement on which measures are appropriate for funding purposes, along with confirmation of reliable and timely data sources, consistent with ACA's oversight responsibilities. Once measures are defined and data availability is confirmed, they can be incorporated into future phases of PFF.

Until quality measures are fully defined and implemented, mitigating mechanisms, such as reserve funding and ongoing monitoring, will remain in place to help ensure that quality of care is maintained during the learning and transition period.

### Cost Reporting

PFF establishes a price for the resources used to provide care. Because of this, accurate cost data is essential. It allows us to understand how much it truly costs to deliver each type of procedure, compare costs across sites, identify efficiencies, and ensure funding reflects real



activity. Reliable cost information also supports monitoring of cost trends, identifying unexpected variances, and improving financial accountability.

HSS Costing (part of HSS's Financial Planning department) is responsible for generating all cost data used for PFF. Costing combines health records information from DAD and NACRS with financial data. These datasets are used together to estimate costs at a patient specific level. Because this process involves detailed data validation and financial reconciliation, the cost data is typically available three months after month-end, with longer timelines at year end.

## Coding Accuracy Monitoring

PFF is designed to ensure that patients with higher acuity and more complex needs receive the resources required for high quality care. As funding becomes more closely tied to the patient and patient complexity, it becomes critical that clinical documentation and coding more accurately reflect the patient's condition. Enhanced documentation ensures that funding is aligned with the level of care provided and that sites are appropriately compensated for treating more complex patients.

Achieving high quality complexity data requires close collaboration with HSS to build a shared understanding of how comorbidities and future acuity adjusters work in the funding model and ensure that coding practices are accurate, consistent across sites, and stable over time.

Ongoing monitoring of coding trends and variations will help identify opportunities for improvement, such as areas where additional education or clarification may be needed. Over time, incorporating medical professional audits may also strengthen documentation quality and support the overall integrity and reliability of the PFF model.



## Beyond 2026/27

### Scope Expansion

PFF implementation in 2026/27 is intended as a learning year with a limited scope and with financial guardrails in place to allow ACA, AHS, and CH to identify and minimize operational risks, validate underlying assumptions, and refine processes prior to expansion.

The scope of PFF is expected to expand in future years in several different directions:

- Broader adoption: Extend the current PFF procedures to all public hospitals.
- Wider coverage: Increase the number of procedures and/or clinical areas participating in PFF
- Methodology evolution: Evolve the PFF methodology to better reflect full episode-of-care costs where appropriate
- Procurement alignment: Use PFF prices as an input to inform future contracting and procurement decisions for services delivered through Chartered Surgical Facilities



## Appendix A – Service Definitions

### Hip Replacement

HIP ARTHROPLASTY	CCI Intervention Codes <sup>11</sup>	Data Inclusion	CMG/CACS	Subsequent Criteria Applied by PSDA <sup>12</sup> (exclusions)	Result
<b>Definitions for PFF Costing - Hip Inpatient</b>	NA	DAD for Inpatient	320 Unilateral Hip Replacement *only this CMG group	Time period: April 1, 2024 - Present  Acute Care sites only (excluding Lloyminster hospital)  Adult cases only (age_admit>=18)  Typical cases only (typ_seps = 1)  Planned cases only (visit_admit_cat = 'L')	Total number of IP cases: 4,719 all from DAD with CMG of 320 for period April 2024 through Sep 2025
<b>Definitions for PFF Costing - Hip Outpatient</b>	<p><b>Hip Arthroplasty - Primary Total Unilateral:</b> 1VA53LAPN^: Implantation of internal device, hip joint, open approach dual component prosthetic device [femoral with acetabular]</p> <p>1VA53LLPN^: Implantation of internal device, hip joint, open anterior approach dual component prosthetic device [femoral with acetabular]</p> <p><b>Hip Arthroplasty - Primary Partial Unilateral:</b> 1VA53LAPM^: Implantation of internal device, hip joint, open approach single component prosthetic device [femoral]</p> <p>1VA53LLPM^: Implantation of internal device, hip joint, open anterior approach single component prosthetic device [femoral]</p> <p>1SQ53LA^: Implantation of internal device, pelvis (dual and single components)</p> <p>Status Attribute = 'P' (Primary, mandatory coding) Out of Hospital Indicator is null Unilateral - Location Attribute = 'L' or 'R' or 'U' (Mandatory coding)</p>	NACRS for Ambulatory	C325: Joint Replacement *only this CACS group  Unilateral only	Time period: April 1, 2024 - Present  Acute Care sites only  Adult cases only (age_admit>=18)  Those with an inpatient record with matching case number from NACRS are deleted	Total number of OP cases: 1,122 all from NACRS with CACS of C325 for period April 2024 through Sep 2025

<sup>11</sup> Intervention cannot be abandoned or performed out of hospital

<sup>12</sup> Provincial Surgery Data and Analytics



## Knee Replacement

KNEE ARTHROPLASTY	CCI Intervention Codes <sup>13</sup>	Data Inclusion	CMG/CACS	Subsequent Criteria Applied by PSDA <sup>14</sup> (exclusions)	Result
<p><b>Definitions for PFF Costing - Knee Inpatient</b></p>	<p>NA</p>	<p>DAD for Inpatient</p>	<p>321 Unilateral Knee Replacement *only this CMG group</p>	<p>Time period: April 1, 2024 - Present</p> <p>Acute Care sites only (excluding Lloyminster hospital)</p> <p>Adult cases only (age_admit&gt;=18)</p> <p>Typical cases only (typ_seps = 1)</p> <p>Planned cases only (visit_admit_cat = 'L')</p>	<p>Total number of IP cases: 8,869 all from DAD with CMG of 320 for period April 2024 through Sep 2025</p>
<p><b>Definitions for PFF Costing - Knee Outpatient</b></p>	<p><b>Knee Arthroplasty - Primary Total and Partial Unilateral:</b></p> <p>1VG53LAPM^ - Implantation of internal device, knee joint, single component prosthetic device</p> <p>1VG53LAPN^ - Implantation of internal device, knee joint, dual component prosthetic device</p> <p>1VG53LAPP^ - Implantation of internal device, knee joint, tri component prosthetic device</p> <p>1VG53LAPR: - Implantation of internal device, knee joint, partial component [e.g. tibial liner (insert) alone]</p> <p>OR:</p> <p>1VP53^: - Implantation of internal device, patella</p> <p>Extent Attribute = any value Status Attribute = 'P' Out of Hospital Indicator is null Unilateral - Location Attribute = 'L' or 'R' or 'U'</p>	<p>NACRS for Ambulatory</p>	<p>C325: Joint Replacement *only this CACS group</p> <p>Unilateral only</p>	<p>Time period: April 1, 2024 - Present</p> <p>Acute Care sites only</p> <p>Adult cases only (age_admit&gt;=18)</p> <p>Those with an inpatient record with matching case number from NACRS are deleted</p>	<p>Total number of OP cases: 916 all from NACRS with CACS of C325 for period April 2024 through Sep 2025</p>

<sup>13</sup> Intervention cannot be abandoned or performed out of hospital

<sup>14</sup> Provincial Surgery Data and Analytics



## Cataract

CATARACT SURGERY	ICD10CA Diagnosis Codes	CCI Intervention Codes <sup>15</sup>	Data Notes	CMG/CACS	Subsequent Criteria Applied by PSDA <sup>16</sup> (exclusions)	Result
<b>Definition Refined for PFF Costing</b>	One of the following ICD10CA Diagnosis codes in any diagnosis field (25 inpatient, 10 amb):	<b>1CL89<sup>A</sup></b> - Excision total, lens	Combination of one of the diagnosis codes is required in conjunction with the intervention code.	NACRS only, for Ambulatory	Time period: April 1, 2024 - Present <b>Acute Care sites only</b> Adult cases only (age_admit>=18)	Total number of cases: 30,996 all from NACRS for period from April 2024 through Sep 2025  Additional months will be incorporated as NACRS data is updated
	<b>H25<sup>A</sup></b> - Senile cataract <b>H26<sup>A</sup></b> - Other cataract	Status Attribute <> 'A' or is null				
	<b>H280 - Diabetic cataract (E10-E14† with common fourth character .3)</b> <b>H281</b> - Cataract in other endocrine, nutritional and metabolic diseases <b>H282</b> - Cataract in other diseases classified elsewhere	Out of Hospital Indicator is null	H280, H281 and H282 are known as asterisk codes and will always have a dagger code preceding them. †/* Dagger and asterisk used to designate the etiology code and the manifestation code respectively, for terms subject to dual classification.	C060: Cataract Removal/Lens Insertion *only this CACS group	Relationship between definition criteria are 'AND'	
	<b>Q120</b> - Congenital cataract	Abstract_type in ('O') for OP (NACRS)	Those with an inpatient record with matching case number from NACRS are deleted		All laterality (unilateral, bilateral, unspecified, and unknown) are included	

<sup>15</sup> Intervention cannot be abandoned or performed out of hospital

<sup>16</sup> Provincial Surgery Data and Analytics



## Shoulder (Rotator Cuff)

ROTATOR CUFF SURGERY	CCI Intervention Codes <sup>17</sup>	CMG/CACS	Subsequent Criteria Applied by PSDA <sup>18</sup> (exclusions)	Result
Definition Refined for PFF Costing - Outpatient arthroscopic procedure only	<b>1.TC.80.DA^</b> - Repair, rotator cuff, endoscopic [arthroscopic] approach, using apposition technique <b>1.TC.80.GC^</b> - Repair, rotator cuff, endoscopic [arthroscopic] approach, using tenodesis	NACRS only, for Ambulatory  <b>CACS: C305 -</b> Shoulder Intervention *only this CACS group	Time period: April 1, 2024 - Present <b>Acute Care sites only</b> Adult cases only (age_admit>=18)	Total number of cases: 1,892 all from NACRS for period from April 2024 through Sep 2025  Additional months will be incorporated as NACRS data is updated
	Status Attribute <> 'A' or is null		Relationship between definition criteria are 'AND'	
	Out of Hospital Indicator is null		Those with an inpatient record with matching case number from NACRS are deleted	
	Abstract_type in ('O') for OP (NACRS)		All laterality (unilateral, bilateral, unspecified, and unknown) are included	

<sup>17</sup> Intervention cannot be abandoned or performed out of hospital

<sup>18</sup> Provincial Surgery Data and Analytics



## Appendix B – Inflation Calculation

Cost Component		Hip	Knee	Shoulder	Cataract
Implant	Weight	39%	40%	38%	36%
	Inflation	4.6%	4.6%	4.6%	4.6%
Nursing Compensation	Weight	29%	29%	28%	28%
	Inflation	8.6%	8.6%	8.6%	8.6%
Other Direct Non-compensation	Weight	9%	9%	9%	8%
	Inflation	4.6%	4.6%	4.6%	4.6%
Indirect	Weight	23%	22%	25%	28%
	Inflation	6.1%	6.1%	6.1%	6.1%
<b>Weighted Average 2-year Inflation</b>		<b>6.1%</b>	<b>6.1%</b>	<b>6.1%</b>	<b>6.1%</b>

- **Implant** costs are dependent on procurement contracts. General inflation for healthcare in Alberta from September 2023 to September 2025 (the most recent complete two-year interval) was used as an interim value. Actual prices will be used for in-year and post-2026/27 audits and reconciliation.
- **Nursing compensation** includes Registered Nurses (RNs, 69%), Licenced Practical Nurses (LPNs, 19%), and Healthcare Aides (HCAs, 12%). Based on recent collective bargaining agreements inflation is estimated to be above the Alberta rate of healthcare inflation at 8.6%.
- All **other direct non-compensation** costs are assumed to increase at the rate of Alberta healthcare inflation.
- **Indirect** costs refer to facility maintenance and other support services as well as hospital overhead. These costs are also largely comprised of union staff wages. Based on recent collective bargaining agreements, inflation is estimated to be above the Alberta rate of healthcare inflation at 6.1%.



## Appendix C – Detailed Historical Costs

Procedure	Complexity Category	Costed Volume	Nursing Unit	Operating Room / PACU <sup>19</sup>	Implant Costs, Supplies	Drug, Diagnostic Imaging, Labs, Allied Health <sup>20</sup>	Incremental <sup>21</sup> / Other	Total Cost (Excluding Corporate Costs)
Hip	Day Surgery	591	\$ 261	\$ 2,441	\$ 3,964	\$ 373	\$ 1,202	\$ 8,241
Hip	No Comorbidity	2,198	\$ 1,229	\$ 2,001	\$ 3,796	\$ 545	\$ 1,356	\$ 8,927
Hip	Low Comorbidity	23	\$ 5,057	\$ 2,270	\$ 3,936	\$ 1,532	\$ 2,301	\$ 15,096
Hip	High Comorbidity	5	\$ 14,053	\$ 1,796	\$ 3,829	\$ 6,290	\$ 6,190	\$ 32,158
Knee	Day Surgery	448	\$ 370	\$ 2,247	\$ 3,809	\$ 294	\$ 1,170	\$ 7,890
Knee	No Comorbidity	3,544	\$ 1,167	\$ 1,894	\$ 3,738	\$ 418	\$ 1,258	\$ 8,476
Knee	Low Comorbidity	27	\$ 5,491	\$ 2,016	\$ 3,791	\$ 1,534	\$ 2,407	\$ 15,240
Knee	High Comorbidity	2	\$ 10,549	\$ 2,258	\$ 4,044	\$ 3,701	\$ 3,288	\$ 23,840
Cataract	Unilateral	14,930	\$ -	\$ 432	\$ 510	\$ 87	\$ 228	\$ 1,256
Cataract	Bilateral	251	\$ -	\$ 853	\$ 889	\$ 120	\$ 413	\$ 2,274
Shoulder	NA	608	\$ 1	\$ 2,623	\$ 2,537	\$ 129	\$ 1,187	\$ 6,478

<sup>19</sup> Post Anesthesia Care Unit

<sup>20</sup> Including anesthesia teams

<sup>21</sup> Laundry, Food Services, Health Records, other direct costs not otherwise captured



## Appendix D – Detailed Volume 2024/25 PFF Volume

Site Name	Hip	Knee	Cataract	Shoulder
Chinook Regional Hospital	214	480	2,482	10
Grande Prairie Regional Hospital	226	418	1,486	129
Innisfail Health Centre	-	-	2,099	-
Medicine Hat Regional Hospital	389	444	1,761	85
Red Deer Regional Hospital Centre	381	445	62	56
Rockyview General Hospital	621	866	25	5
Royal Alexandra Hospital	754	892	5,087	1
Westlock Healthcare Centre	162	269	1,219	55
Wetaskiwin Hospital and Care Centre	-	-	1,259	-
Grey Nuns Community Hospital	-	-	-	279
Misericordia Community Hospital	193	264	-	1
St. Mary's Hospital	110	205	-	-
<b>TOTAL - Under PFF Funding</b>	<b>3,050</b>	<b>4,283</b>	<b>15,480</b>	<b>621</b>

## 2024/25 Other Public Sites PFF Volume

Volume 2024/25	Hip	Knee	Cataract	Shoulder
AHS Other Sites	906	2,023	4,363	578
Covenant Health Other Sites	36	47	-	23
Lamont Other Sites	-	-	1,462	-
<b>Total Other Sites</b>	<b>942</b>	<b>2,070</b>	<b>5,825</b>	<b>601</b>



## 2024/25 Chartered Surgical Facility PFF Volume

Volume 2024/25	Hip	Knee	Cataract	Shoulder
Chartered Surgical Facilities	1,221	1,554	29,524	84

## 2024/25 Total PFF Volume

Volume 2024/25	Hip	Knee	Cataract	Shoulder
PFF Sites	3,050	4,283	15,480	621
Other Hospitals	942	2,070	5,825	601
Chartered Surgical Facilities	1,221	1,554	29,524	84
<b>Alberta Total</b>	<b>5,213</b>	<b>7,907</b>	<b>50,829</b>	<b>1,306</b>