FHO Plus Model

Physician Transition Briefing — Effective April 1, 2026

Prepared by: Arsalan Afzal, PhD
Founder, LeafMD | Primary Care & Management Consultant
www.leafmd.ca

1. Why This Matters

The FHO Plus model fundamentally reshapes how family physicians are compensated in Ontario, effective April 1, 2026. The shift moves incentives away from flat-rate stability and delegation efficiency toward volume, time, and direct physician contact. This is not a minor update — it requires deliberate practice adjustments.

KEY SHIFT FHO rewarded efficiency and delegation. FHO Plus rewards volume of visits and physician time. These are opposite incentive structures.

2. The Hourly Billing Model

FHO Plus introduces an hourly billing rate replacing the previous access bonus and CCM fee structure. Understanding the categories and caps is critical.

Category	What It Includes
Direct Patient Care	In-person and telephone visits with rostered patients. This is the primary billing category — maximize this.
Indirect Patient Care	Chart reviews, care coordination, pre/post visit documentation. Capped at 25% of total daily billable hours.
Clinical Administration	Practice management activities. Also falls within the 25% indirect cap.
Daily Cap	Maximum 14 billable hours per day.
Rolling Cap	Maximum 240 billable hours per 28-day cycle.

ACTION ITEM Monitor your indirect/admin hours in real time — do not wait until end of day or end of billing cycle. Exceeding 25% indirect means working unpaid.

Documentation Requirements:

- Record total daily duration per category — specific start/stop times are NOT required
- Indirect care entries need a brief daily description (e.g., 'April 1 — Indirect Care 1hr: chart reviews')
- Create a test patient in PS Suite (no date of birth or health card) to attach documentation and submit billable codes

- Travel time for home visits is NOT billable; only time providing care and related documentation

3. Shadow Billing & In-Basket Services

Shadow billing for in-basket services provided to rostered patients increases from 19.4% to 30% — approximately a 50% increase in compensation for this category. Combined with permanent fee code increases (e.g., A007 now ~$44–45), the compounding effect is significant.

- Billing accuracy becomes MORE critical: small errors now have a greater financial impact
- Rejected or incorrect claims must be identified and corrected promptly
- After-hours premium (Q012) increases from 30% to 50% of eligible services billed after hours
- Ensure Q012 is consistently captured — it is commonly missed

OPPORTUNITY	At 30% shadow billing, high visit volume now materially moves revenue. Short, single-issue visits generate shadow billing revenue each time — whereas multi-issue visits did not.

4. Visit Strategy Under FHO Plus

This is the most significant operational shift. Under the original FHO, multi-issue visits were efficient and rewarded. Under FHO Plus, shorter single-issue visits are now more financially optimal for multiple compounding reasons:

- Each visit generates shadow billing revenue ($13+ per visit under hourly rate)
- More visits = more direct care hours = a larger 25% indirect care allowance
- More in-practice visits improve your Continuity of Care score (see Section 5)
- In-person visits are now preferred over delegation, phone messages, and portal messages

Practical changes to consider:

- Shift multi-issue appointments toward single or double-issue visits
- Convert patient portal messages and secure emails into phone call or visit encounters
- Limit prescription refills to 1–2 at a time instead of 3 to increase visit frequency
- Open online booking more broadly — prioritize a full daily schedule
- Call patients with results rather than sending portal messages
- Reduce reliance on self-management resources that reduce visit frequency

UNINSURED SERVICES NOTE	Prescription renewals and online medical advice without a visit are not covered under the hourly rate. These are separate uninsured revenue opportunities — review your block fee and uninsured service workflows accordingly.

5. Continuity of Care Measure

Effective April 1, 2026, each FHO physician will be measured individually on a Continuity of Care (CoC) rate, calculated quarterly. This replaces the previous access bonus negation structure.

CoC Metric	Detail
Threshold	75% of in-basket services must be provided by you or acceptable FHO providers
Calculation	# in-basket visits by you or your FHO group ÷ total in-basket visits by any family physician
Frequency	Calculated quarterly per individual physician
First Breach	Notification only — no financial penalty
Second Consecutive Breach	15% deduction to capitation for the related quarter
Example Impact	1,500 patient roster = ~$11,000 capitation deduction if threshold missed twice

What is NOT included in the CoC calculation:

- Out-of-basket services (prenatal care, diabetes management, STI management)
- Non-billable clinical tasks (secure patient emails)
- Care provided by nurse practitioners or allied health providers

ACTION ITEM Most FHO physicians currently meet the 75% threshold. The strategy to maintain it: keep patients coming to your practice, break multi-issue visits into smaller ones (each visit counts separately in numerator and denominator), and monitor your outside-use reports monthly.

6. Fee Code Increases — Revenue Opportunities

Several fee codes are seeing material increases. These are not yet fully active as of April 1 but will be applied retroactively once implemented.

- In-office procedures: up to 50% fee increase — includes pap smears (G365), IUD insertions (G378), immunizations (G441–G848), skin biopsies (Z101, Z116, Z117)
- In-office procedures are now closer to cost-neutral or better — worth bringing back in-house, especially if you are near the annual in-office procedure bonus threshold
- Hospital services: move to 100% fee-for-service rate (previously in-basket at shadow billing rate)
- Hospital services NO LONGER count toward your group's fee-for-service hard cap
- After-hours Q012: increases from 30% to 50% of eligible after-hours services

7. New Patient Attachment Bonus

A new per-patient bonus is being introduced for newly attached unattached patients. Specific codes are not yet released but will be retroactive to July 1, 2025 once finalized.

Physician Type	Bonus Range (per eligible patient)
Established Physician	$100–$180 per newly attached unattached patient
New Graduate (within 3 yrs of residency)	$150–$270 per newly attached unattached patient

Eligibility requirements:

- Patient must be new to your entire FHO group — never previously enrolled with any group physician
- Patient must be genuinely unattached (no current family physician)
- Enrolled on or after July 1, 2025 using Q200 or appropriate rostering code
- New patient declaration + enrollment and consent forms signed on the day of enrollment

What does NOT qualify:

- Batch roster transfers from retiring physicians
- Patients switching from another family physician in the community
- Previously rostered patients who moved away and returned
- Newborns whose mother already has a family physician

ACTION NOW Continue billing Q200 for all new patient enrollments — this ensures the Ministry can retroactively apply the attachment bonus once codes are released. Ensure all consent forms are completed on the day of enrollment.

8. Group Management & Leadership Payment (GMLP)

The GMLP is being significantly enhanced under FHO Plus to better recognize the administrative and leadership responsibilities of running a group practice.

- Existing GMLP: $1 per enrolled patient per year, up to $25,000 annually
- New Enhanced GMLP: additional $4 per enrolled patient, up to $100,000 annually
- Combined maximum: $125,000 per group annually
- Minimum guaranteed combined payment: $25,000
- First-year payments will be paid quarterly (manually); automated solution to follow

How the enhanced GMLP is allocated is not prescribed — each group decides. Consider formalizing leadership roles (e.g., lead physician, IT/EMR lead, HR/staffing lead) and distributing accordingly.

9. Key Metrics to Monitor Going Forward

FHO Plus requires a shift from reactive billing to structured performance tracking. The following metrics should be reviewed monthly:

- **Indirect care % relative to total billable hours — stay at or below 25%**
- **Total billable hours vs. rolling 240-hour cap and 14-hour daily cap**
- **Visit volume and average visits per patient per year — under FHO Plus, higher is better**
- **Shadow billing capture rate — ensure all in-basket and after-hours codes are submitted correctly**
- **Continuity of Care rate quarterly — flag any trend below 80% as early warning**
- **New patient attachment codes — track eligible patients and total bonus revenue**
- **Revenue per hour — most meaningful efficiency metric under this model**
- **Hospital service revenue — now at 100% FFS and excluded from group cap**

10. Immediate Action Checklist

PRIORITY These actions should be completed before or immediately after April 1, 2026.

- Review and adjust daily scheduling to maximize in-person visit volume
- Set up a test patient in PS Suite for hourly billing documentation submission
- Review all active patient enrollment forms — ensure Q200 is being billed and consent forms are complete
- Confirm Q012 after-hours code is being captured consistently for eligible visits
- Review prescription refill and portal message workflows — convert where appropriate to billable encounters
- Review any pending in-office procedure referrals — consider whether to bring back in-house
- Discuss GMLP leadership role allocation within your physician group
- Review outside-use reports from the Ministry monthly to protect CoC rate
- Ensure locum physicians are properly registered through FHO channels before any coverage

This briefing was prepared by Arsalan Afzal, PhD (Founder, LeafMD | Primary Care Consultant) based on the DoctorCare FHO Plus webinar (March 2026). It is intended as an operational summary only and does not constitute formal billing or legal advice. Physicians should verify specifics with their billing service and the OMA as implementation details are finalized by the Ministry. For clinic management support, visit www.leafmd.ca