    - Quality and Cost: are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
    - Payment methodology: pays APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
    - Scope: aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited.
    - Ability to be evaluated: have evaluable goals for quality of care, cost, and any other goals of the Physician-focused Payment Model.
- Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.
    - Integration and Care Coordination: encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the Physician-Focused Payment Model.
    - Patient Choice: encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients
    - Patient Safety: aim to maintain or improve standards of patient safety.
- Information Enhancements: Improving the availability of information to guide decision-making.
    - Health Information Technology: encourage use of health information technology to inform care.

AAFP Response
In general, the proposed criteria are a reasonable place to start. However, we were disappointed that they did not include a criterion that, first and foremost, PFPMs should be primary care-centered. There is ample evidence that health systems that are more primary care-oriented are more effective, more efficient, and yield better outcomes than those that are not. We believe that the same is true for PFPMs. Thus, the first criterion should be "How primary care oriented or focused is the proposed PFPM?" That is, to what extent is the proposed PFPM based on first contact, comprehensive, continuous, coordinated, and connected primary care, and to what extent does it encourage treatment on an ambulatory basis rather than in a costly institutional setting? If it is physician-led and primary care-oriented, it should do both of these things. Equally important would be to assess and to what extent does the proposed PFPM use medical homes expanded under section 1115A(c) and to prioritize consideration of such proposals.

Other criteria that we believe the PFPM TAC should use in assessing PFPM proposals include:

- Is the entity to which payment will be directed physician-led? Is a majority of the governing board(s) comprised of independent physicians, members of a participating IPA, or physicians employed by physician organizations, and is a majority of those physicians comprised of family medicine and other primary care representation?