

new financial models. These options are described below.

- The Medicare Advantage Program could encourage improved beneficiary access to their personal health information by incorporating new measures in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Medicare CAHPS® surveys are a set of surveys sponsored by CMS that collect consumer evaluations of health care experiences that are not currently assessed by other means. Questions could be expanded to include topics such as the extent to which patients believe they are able to participate collaboratively in decisions about their health, and the extent to which information technology supports their ability to share and communicate with providers and other members of their health care team, and manage their care between various providers.

- CMS could promote the use of Blue Button. The Blue Button provides easy electronic access to personal health information for consumers. To strengthen its success, ONC released guidelines for data holders and application developers that support the growth of an ecosystem of tools to help consumers manage their health. The Blue Button Plus guidelines include specifications for a structured data format (consistent with Meaningful Use Stage 2), and enable updates of the information contained in individual consumer's health records to be sent automatically to the applications of their choice. Tools built on Blue Button Plus specifications could be made available to all CMS beneficiaries, and widely promoted by healthcare providers and via avenues such as the Medicare Handbook, Medicare.gov, and Medicare Advantage plans.

- As stated previously, under the Affordable Care Act, CMS has the authority to test innovative payment and service delivery models that have the potential to reduce program expenditures while maintaining or improving the quality of care for beneficiaries. In future and new models, CMS could encourage applicants to experiment with providing incentives for consumers to more actively participate in their health and health care—including through shared-decision making—supported by the collection, use, and sharing of electronic health information.

- Modifications to Clinical Laboratory Improvement Amendments of 1988 regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule could enable patients' direct access to their lab

results from laboratories. CMS and the HHS Office for Civil Rights (OCR) received public comments on this potential modification through a notice for proposed rulemaking (76 FR 56712).

III. Questions for Public Comment

CMS and ONC are soliciting public comments on the following questions:

1. What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?

2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

3. To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in "data lock-in" or restricting consumer and provider choice in services and providers? Are there specific ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?

4. What CMS and ONC policies and programs would most impact post acute, long term care providers (institutional and HCBS) and behavioral health providers' (for example, mental health and substance use disorders) exchange of health information, including electronic HIE, with other treating providers? How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?

5. How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post acute, long-term care, and behavioral health providers?

6. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

7. How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

8. How can the new authorities under the Affordable Care Act for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards-based electronic HIE across treating providers?

9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care?

What specific HHS policy changes would significantly increase standards based electronic exchange of laboratory results?

Dated: February 22, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: February 27, 2013.

Farzad Mostashari,

National Coordinator.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Findings of Research Misconduct

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: Notice is hereby given that the Office of Research Integrity (ORI)

has taken final action in the following case:

Adam C. Savine, Washington University in St. Louis: Based on the report from Washington University in St. Louis (WUSTL) and Respondent's admission, ORI found that Mr. Adam C. Savine, former doctoral student, Department of Psychology, WUSTL, engaged in research misconduct in research supported by National Institute of Mental Health (NIMH), National Institutes of Health (NIH), grant R56 MH066078, National Institute on Drug Abuse (NIDA), NIH, grants F31 DA032152 and R21 DA027821, and National Institute on Aging (NIA), NIH, grant T32 AG00030.

ORI found that the Respondent engaged in research misconduct by falsifying data that were included in the following three publications and six conference abstracts:

Publications

1. Savine, A.C., & Braver, T.S. "Local and global effects of motivation on cognitive control." *Cogn Affect Behav Neurosci.* 12(4):692–718, 2012 Dec. (hereafter referred to as *Cogn Affect Behav Neurosci.* 2012).

2. Savine, A.C., McDaniel, M.A., Shelton, J.T., Scullin, M.K. "A characterization of individual differences in prospective memory monitoring using the Complex Ongoing Serial Task." *J Exp Psychol Gen.* 141(2):337–62, 2012 May (hereafter referred to as *J Exp Psychol Gen.* 2012).

3. Savine, A.C., & Braver, T.S. "Motivated cognitive control: Reward incentives modulate preparatory neural activity during task-switching." *J Neurosci.* 30(31):10294–305, 2010 Aug 4 (hereafter referred to as *J Neurosci.* 2010).

Conference Abstracts

1. Savine, A.C., & Braver, T.S. (November 2010) "The contextual and local effects of motivation on cognitive control." Psychonomics Society, St. Louis, MO.

2. Savine, A.C., & Braver, T.S. (November 2010) "A model-based characterization of the individual differences in prospective memory monitoring." Psychonomics Society, St. Louis, MO.

3. Savine, A.C., & Braver, T.S. (November 2010) "Motivated cognitive control: Reward incentives modulate preparatory neural activity during task-switching." Society for Neuroscience, San Diego, CA.

4. Savine, A.C., & Braver, T.S. (June 2010) "Motivated cognitive control: Reward incentives modulate preparatory neural activity during task-switching." Motivation and Cognitive Control Conference, Oxford, England.

5. Savine, A.C., & Braver, T.S. (January 2010) "Neural correlates of the motivation/cognitive control interaction: Activation dynamics and Performance prediction during task-switching." Genetic and Experiential Influences on Executive Function, Boulder, CO.

6. Savine, A.C., & Braver, T.S. (June 2009) "Incentive Induced Changes in Neural

Patterns During Task-Switching." Organization for Human Brain Mapping, San Francisco, CA.

As a result of the Respondent's admission, the senior authors will request that the published papers be retracted or corrected.

ORI finds that Respondent falsified data and related text in *Cogn Affect Behav Neurosci.* 2012, *J Exp Psychol Gen.* 2012, *J Neurosci.* 2010, and in six (6) meeting abstracts, by altering the experimental data to improve the statistical results. Specifically, Respondent:

1. Falsified data in *Cogn Affect Behav Neurosci.* 2012 to show an unambiguous dissociation between local and global motivational effects. Specifically, Respondent exaggerated (1) the effect of incentive context on response times and error rates in Table 1 and Figures 1 and 3 for experiment 1 and (2) the effect of incentive cue timing on response times and error rates in Table 2 and in Figures 6, 9, and S2 for experiment 2.

2. Falsified data in *J Exp Psychol Gen.* 2012 to show that prospective memory is influenced by three dissociable underlying monitoring patterns (attentional focus, secondary memory retrieval, information thresholding), which are stable within individuals over time and are influenced by personality and cognitive differences. Specifically, Respondent modified the data to support the three category model and to show (1) that individuals fitting into each of the three categories exhibited differential patterns of prospective memory performance and ongoing task performance in Tables 1–3; Figures 5–8, and (2) that certain cognitive and personality differences were predictive of distinct monitoring approaches within the three categories in Figure 9.

3. Falsified data in *J Neurosci.* 2010 and mislabeled brain images to show that motivational incentives enhance task-switching performance and are associated with activation of reward-related brain regions, behavioral performance, and trial outcomes. Specifically, Respondent modified the data so that he could show a stronger relationship between brain activity and behavior in Table 2 and Figure 4 and used brain images that fit the data rather than the images that corresponded to the actual Talairach coordinates in Figure 3.

Mr. Savine has entered into a Voluntary Settlement Agreement and has voluntarily agreed for a period of three (3) years, beginning on February 22, 2013:

(1) To have his research supervised; Respondent agreed that prior to the submission of an application for U.S.

Public Health Service (PHS) support for a research project on which his participation is proposed and prior to his participation in any capacity on PHS-supported research, Respondent shall ensure that a plan for supervision of his duties is submitted to ORI for approval; the supervision plan must be designed to ensure the scientific integrity of his research contribution; he agreed that he shall not participate in any PHS-supported research until such a supervision plan is submitted to and approved by ORI; Respondent agreed to maintain responsibility for compliance with the agreed upon supervision plan;

(2) That any institution employing him shall submit, in conjunction with each application for PHS funds, or report, manuscript, or abstract involving PHS-supported research in which Respondent is involved, a certification to ORI that the data provided by Respondent are based on actual experiments or are otherwise legitimately derived and that the data, procedures, and methodology are accurately reported in the application, report, manuscript, or abstract;

(3) To exclude himself voluntarily from serving in any advisory capacity to PHS including, but not limited to, service on any PHS advisory committee, board, and/or peer review committee, or as a consultant; and

(4) That the senior authors will request that the following papers be retracted or corrected: *Cogn Affect Behav Neurosci.* 2012, *J Exp Psychol Gen.* 2012, and *J Neurosci.* 2010.

FOR FURTHER INFORMATION CONTACT: Director, Office of Research Integrity, 1101 Wootton Parkway, Suite 750, Rockville, MD 20852, (240) 453–8200.

David E. Wright,

Director, Office of Research Integrity.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of the Assistant Secretary for Health, Office of the Surgeon General of the United States Public Health Service.

ACTION: Notice.

SUMMARY: In accordance with Section 10(a) of the Federal Advisory Committee Act, Public Law 92–463, as amended (5 U.S.C. App.), notice is hereby given that a meeting is scheduled to be held for the