118TH CONGRESS
2D SESSION

H. R. 7379

To amend title XXX of the Public Health Service Act to establish standards and protocols to improve patient matching.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 15, 2024

Mr. KELLY of Pennsylvania (for himself and Mr. FOSTER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XXX of the Public Health Service Act to establish standards and protocols to improve patient matching.

1 *Be it enacted by the Senate and House of Representa-*

2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Patient Matching And

5 Transparency in Certified Health IT Act of 2024" or the

6 "MATCH IT Act of 2024".

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1   (1) Ensuring accurate patient identification and
2 matching is key to achieving the interoperability
3 within the health care system called for by Congress
4 in the 21st Century Cures Act and the Health Infor-
5 mation Technology for Economic and Clinical
6 Health (HITECH) Act.

7   (2) There is currently no national strategy to
8 ensure patients are accurately matched with their
9 medical records.

10   (3) There is no standard definition across the
11 health care system of "patient match rate" to ensure
12 the ability to accurately measure patient matches
13 and patient misidentification.

14   (4) The patient match rates that are available
15 can vary widely, with an estimate from CHIME not-
16 ing that matching within facilities can be as low as
17 80 percent–meaning that one out of every five pa-
18 tients may not be matched to all his or her records.

19   (5) Patient misidentification within the United
20 States health care system is a threat to patient safe-
21 ty, patient privacy, and a driver of unnecessary costs
22 to patients and providers.

23   (6) The inability of clinicians to ensure patients
24 are accurately matched with their medical record has
25 caused medical errors, and even lives lost. Patient

1 misidentification has been named a recurrent patient
2 safety challenge in multiple years by ECRI.

3 (7) Patients must undergo unnecessary re-
4 peated medical tests because of the inability to en-
5 sure accurate matches to their medical record.

6 (8) The expense of repeated medical care due to
7 duplicate records costs an average of $1,950 per pa-
8 tient inpatient stay, and more than $1,700 per
9 emergency department visit. Thirty-five percent of
10 all denied claims result from inaccurate patient iden-
11 tification, costing the average hospital $2.5 million
12 and the United States health care system more than
13 $6.7 billion annually.

14 (9) Overlaid records, caused by merging mul-
15 tiple patients' data into one medical record, may re-
16 sult in unauthorized disclosures under the Health
17 Insurance Portability and Accountability Act
18 (HIPAA), as well as the risk of a patient receiving
19 treatment for another patient's condition.

20 (10) This Act would decrease the prevalence of
21 patient misidentification by further promoting inter-
22 operability, thereby protecting patients and address-
23 ing high costs driven by this issue.

1 **SEC. 3. STANDARDS AND PROTOCOLS TO IMPROVE PA-**

2   **TIENT MATCHING.**

3   (a) IN GENERAL.—Subtitle C of title XXX of the

4 Public Health Service Act (42 U.S.C. 300jj–51 et seq.)

5 is amended by adding at the end the following new section:

6 **"SEC. 3023. STANDARDS AND PROTOCOLS TO IMPROVE PA-**

7   **TIENT MATCHING.**

8   "(a) ESTABLISHING A UNIFORM DEFINITION FOR

9 PATIENT MATCH RATE.—

10   "(1) IN GENERAL.—Not later than 180 days

11   after the date of enactment of this section, the Sec-

12   retary shall, in consultation with health care pro-

13   viders, vendors of electronic health records and

14   health information technology, patient groups, and

15   other relevant stakeholders, develop a definition and

16   standards for accurate and precise patient matching

17   to track patient match rates and document improve-

18   ments of patient matching over time. The Secretary

19   shall ensure that such definition and standards for

20   patient match rate account for—

21   "(A) duplicate records;

22   "(B) overlaid records;

23   "(C) instances of multiple matches found;

24   and

25   "(D) mismatch rates within the same

26   healthcare organizations and provider systems.

1   "(2) REVIEW AND UPDATE.—In consultation
2   with health care providers, vendors of electronic
3   health records and health information technology,
4   patient groups, and other relevant stakeholders, the
5   Secretary shall review and update the definition and
6   standards developed under paragraph (1), as appro-
7   priate, not less frequently than once every 3 years
8   to ensure that such definition and standards are
9   consistent with updates and improvements in tech-
10   nologies and processes.

11   "(b) DEVELOPMENT OF A STANDARD DATA SET TO
12 IMPROVE PATIENT MATCHING.—

13   "(1) IN GENERAL.—Not later than 180 days
14   after the date of enactment of this section, subject
15   to paragraph (2), the National Coordinator shall re-
16   view the current data set in the United States Core
17   Data for Interoperability and identify, define, and
18   adopt the minimum data set needed to support the
19   adoption of patient matching by entities, including
20   health care providers, developers of health care in-
21   formation technology or certified health IT, or
22   health information networks of exchange, at a rate
23   of 99.9 percent. The National Coordinator shall in-
24   clude such minimum data set in the United States
25   Core Data for Interoperability.

1 ''(2) DEVELOPMENT OF DATA STANDARDS IN
2 UNITED STATES CORE DATA FOR INTEROPER-
3 ABILITY.—For purposes of improving interoperable
4 health exchange, not later than 1 year after defining
5 the minimum data set described in paragraph (1),
6 the National Coordinator shall create, update, or
7 adopt data standards for the data elements identi-
8 fied in the minimum data set and incorporate such
9 standards into the United States Core Data for
10 Interoperability.

11 ''(3) CONSULTATION REQUIRED.—In identifying
12 and defining the minimum data set described in
13 paragraph (1) and creating, updating, or adopting
14 data standards described in paragraph (2), the Na-
15 tional Coordinator shall consult with—

16 ''(A) health care providers;

17 ''(B) vendors of electronic health records;

18 ''(C) vendors of health information tech-
19 nology;

20 ''(D) patient groups;

21 ''(E) Federal agencies, including the Na-
22 tional Institute of Standards and Technology,
23 the Centers for Disease Control and Prevention,
24 the Department of Defense, the National Insti-
25 tutes of Health, the Department of Veterans

1 Affairs, the Social Security Administration, the

2 Indian Health Service, and the Office for Civil

3 Rights;

4 "(F) public health authorities within State,

5 local, territorial, and Tribal; and

6 "(G) any other stakeholders the Secretary

7 determines appropriate.

8 "(4) RULE OF CONSTRUCTION.—Nothing in

9 this subsection shall be construed to require an enti-

10 ty to meet a minimum patient match rate of 99.9

11 percent.".

12 (b) INCORPORATING THE MINIMUM DATA SET FOR

13 PATIENT MATCHING INTO CERTIFICATION REQUIRE-

14 MENTS.—Section 3004(b) of subtitle B of title XXX of

15 the Public Health Service Act (42 U.S.C. 300jj–14(b)) is

16 amended by adding at the end the following new subpara-

17 graph:

18 "(4) SPECIAL RULE.—

19 "(A) INCORPORATION OF MINIMUM DATA

20 SET INTO HEALTH IT CERTIFICATION REQUIRE-

21 MENTS.—Notwithstanding paragraph (3), the

22 Secretary shall incorporate and adopt the min-

23 imum data set for patient matching established

24 under section 3023 into the certification criteria

1   adopted under this section not later than 180

2   days after such data set is finalized.

3   "(B) INCORPORATION OF MINIMUM DATA

4   SET INTO MEDICARE INTEROPERABILITY PRO-

5   GRAM REQUIREMENTS.—Not later than 24

6   months after the incorporation of the minimum

7   data set for patient matching into the certifi-

8   cation criteria as required in subparagraph (A),

9   the Secretary shall incorporate and adopt such

10   minimum data set for patient matching estab-

11   lished under section 3023 into program require-

12   ments to promote the interoperability of cer-

13   tified EHR technology for entities participating

14   in the Medicare program under title XVIII of

15   the Social Security Act.".

16   (c) ADDITIONAL INCENTIVES TO PROMOTE INTER-

17   OPERABILITY.—

18   (1) IN GENERAL.—Not later than 24 months

19   after the incorporation and adoption of the min-

20   imum data set for patient matching into the pro-

21   gram requirements to promote the interoperability of

22   certified EHR technology for entities participating

23   under the Medicare program under title XVIII of

24   the Social Security Act as required in subparagraph

25   (B) of section 3004(b)(4) of title XXX of the Public

1 Health Service Act (42 U.S.C. 300jj–14(b)), the Ad-
2 ministrator of the Centers for Medicare and Med-
3 icaid Services shall, through rulemaking, establish a
4 voluntary bonus measure within the Medicare Pro-
5 moting Interoperability Program for eligible pro-
6 viders who meet an accurate patient match rate (as
7 defined under section 3023 of subtitle C of title
8 XXX of the Public Health Service Act) of at least
9 90 percent or the rate determined under paragraph
10 (4) to voluntary attest to and receive a payment ad-
11 justment for meeting such measure.

12 (2) SPECIAL RULE.—In establishing the vol-
13 untary bonus measure described in paragraph (1),
14 the Administrator shall—

15 (A) ensure that the total score for incen-
16 tive payments or status as an eligible provider
17 will not be negatively impacted if the eligible
18 provider does not attest to an accurate patient
19 match rate; and

20 (B) ensure that the voluntary attestations
21 regarding patient matching rates shall not be
22 publicly disclosed.

23 (3) VOLUNTARY REPORTING PROGRAM.—The
24 National Coordinator, along with the Centers for
25 Medicare and Medicaid Services and other Federal

1 agencies determined appropriate by the Secretary,

2 shall develop a voluntary reporting program for eligi-

3 ble providers to anonymously submit patient match-

4 ing accuracy data to the Department of Health and

5 Human Services.

6 (4) ANNUAL REVIEW OF PATIENT MATCH

7 RATE.—

8 (A) IN GENERAL.—Utilizing the patient

9 matching accuracy data described in paragraph

10 (2) and any additional data sources available,

11 the Administrator of the Centers of Medicare

12 and Medicaid Services shall review and evaluate

13 the patient match attestation rates annually to

14 determine if such rate should be adjusted.

15 (B) ADJUSTMENT.—The Administrator

16 may adjust the patient match rate described in

17 paragraph (1) if the Administrator determines

18 that the patient match attestation rate should

19 be adjusted to further incentivize the voluntary

20 reporting of accurate patient match rates.

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