119TH CONGRESS
2D SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Mr. WARNER introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patient Matching And Transparency in Certified Health IT Act of 2026'' or the ''MATCH IT Act of 2026''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Ensuring accurate patient identification and matching is key to achieving the interoperability

within the health care system called for by Congress in the 21st Century Cures Act (Public Law 114–255) and the Health Information Technology for Economic and Clinical Health (HITECH) Act (title XIII of division A and title IV of division B of Public Law 111–5).

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

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

(4) The patient match rates that are available can vary widely, with an estimate from CHIME noting that matching within facilities can be as low as 80 percent—meaning that 1 out of every 5 patients may not be matched to all his or her records.

(5) Patient misidentification within the United States health care system is a threat to patient safety, patient privacy, and a driver of unnecessary costs to patients and providers.

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

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

(7) Patients must undergo unnecessary repeated medical tests because of the inability to ensure accurate matches to their medical record.

(8) The expense of repeated medical care due to duplicate records costs an average of $1,950 per patient inpatient stay, and more than $1,700 per emergency department visit. Thirty-five percent of all denied claims result from inaccurate patient identification, costing the average hospital $2,500,000 and the United States health care system more than $6,700,000,000 annually.

(9) Overlaid records, caused by merging multiple patients' data into one medical record, may result in unauthorized disclosures under the Health Insurance Portability and Accountability Act (HIPAA), as well as the risk of a patient receiving treatment for another patient's condition.

(10) This Act would decrease the prevalence of patient misidentification by further promoting interoperability, thereby protecting patients and addressing high costs driven by this issue.

SEC. 3. STANDARDS AND PROTOCOLS TO IMPROVE PATIENT MATCHING.

(a) IN GENERAL.—Subtitle C of title XXX of the Public Health Service Act (42 U.S.C. 300jj–51 et seq.) is amended by adding at the end the following:

"SEC. 3023. STANDARDS AND PROTOCOLS TO IMPROVE PATIENT MATCHING.

"(a) ESTABLISHING A UNIFORM DEFINITION FOR PATIENT MATCH RATE.—

"(1) IN GENERAL.—Not later than 180 days after the date of enactment of this section, the Secretary, in consultation with health care providers, vendors of electronic health records and health information technology, patient groups, and other relevant stakeholders, shall develop a definition and standards for accurate and precise patient matching to track patient match rates and document improvements of patient matching over time. The Secretary shall ensure that such definition and standards for patient match rate account for—

"(A) duplicate records;

"(B) overlaid records;

"(C) instances of multiple matches found; and

"(D) mismatch rates within the same healthcare organizations and provider systems.

''(2) REVIEW AND UPDATE.—The Secretary, in consultation with health care providers, vendors of electronic health records and health information technology, patient groups, and other relevant stakeholders, shall review and update the definition and standards developed under paragraph (1), as appropriate, not less frequently than once every 3 years to ensure that such definition and standards are consistent with updates and improvements in technologies and processes.

''(b) DEVELOPMENT OF A STANDARD DATA SET TO IMPROVE PATIENT MATCHING.—

''(1) IN GENERAL.—Not later than 180 days after the date of enactment of this section, subject to paragraph (2), the National Coordinator shall review the current data set in the United States Core Data for Interoperability and identify, define, and adopt the minimum data set needed to support the adoption of patient matching by entities, including health care providers, developers of health care information technology or certified health IT, and health information networks of exchange, at a rate of 99.9 percent. The National Coordinator shall include such minimum data set in the United States Core Data for Interoperability.

''(2) DEVELOPMENT OF DATA STANDARDS IN UNITED STATES CORE DATA FOR INTEROPERABILITY.—For purposes of improving interoperable health exchange, not later than 1 year after defining the minimum data set described in paragraph (1), the National Coordinator shall create, update, or adopt data standards for the data elements identified in the minimum data set and incorporate such standards into the United States Core Data for Interoperability.

''(3) CONSULTATION REQUIRED.—In identifying and defining the minimum data set described in paragraph (1) and creating, updating, or adopting data standards described in paragraph (2), the National Coordinator shall consult with—

''(A) health care providers;

''(B) vendors of electronic health records;

''(C) vendors of health information technology;

''(D) patient groups;

''(E) the heads of Federal agencies, including the Director of the National Institute of Standards and Technology, the Director of the Centers for Disease Control and Prevention, the Secretary of Defense, the Director of the Na-

tional Institutes of Health, the Secretary of Veterans Affairs, the Commissioner of Social Security, the Director of the Indian Health Service, and the Director of the Office for Civil Rights of the Department of Health and Human Services;

''(F) public health authorities within State, local, territorial, and Tribal jurisdictions; and

''(G) any other stakeholders the Secretary determines appropriate.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require an entity to meet a minimum patient match rate of 99.9 percent.''.

(b) INCORPORATING THE MINIMUM DATA SET FOR PATIENT MATCHING INTO CERTIFICATION REQUIREMENTS.—Section 3004(b) of subtitle B of title XXX of the Public Health Service Act (42 U.S.C. 300jj–14(b)) is amended by adding at the end the following:

''(4) SPECIAL RULE.—

''(A) INCORPORATION OF MINIMUM DATA SET INTO HEALTH IT CERTIFICATION REQUIREMENTS.—Notwithstanding paragraph (3), the Secretary shall incorporate and adopt the minimum data set for patient matching established

under section 3023 into the certification criteria adopted under this section not later than 180 days after such data set is finalized.

"(B) INCORPORATION OF MINIMUM DATA SET INTO MEDICARE INTEROPERABILITY PROGRAM REQUIREMENTS.—Not later than 2 years after the incorporation of the minimum data set for patient matching into the certification criteria as required in subparagraph (A), the Secretary shall incorporate and adopt such minimum data set for patient matching established under section 3023 into program requirements to promote the interoperability of certified EHR technology for entities participating in the Medicare program under title XVIII of the Social Security Act.".

(c) ADDITIONAL INCENTIVES TO PROMOTE INTEROPERABILITY.—

(1) IN GENERAL.—Not later than 2 years after the incorporation and adoption of the minimum data set for patient matching into the program requirements to promote the interoperability of certified EHR technology for entities participating under the Medicare program under title XVIII of the Social Security Act as required by paragraph (4)(B) of sec-

tion 3004(b) of the Public Health Service Act (42 U.S.C. 300jj–14(b)), the Administrator of the Centers for Medicare & Medicaid Services shall, through rulemaking, establish a voluntary bonus measure within the Medicare Promoting Interoperability Program under which eligible providers may voluntarily attest to, and receive a payment adjustment for meeting, an accurate patient match rate (as defined under section 3023 of the Public Health Service Act (as added by subsection (a))) of, as applicable—

(A) not less than 90 percent; or

(B) the rate determined under paragraph (4).

(2) SPECIAL RULE.—In establishing the voluntary bonus measure described in paragraph (1), the Administrator shall—

(A) ensure that the total score for incentive payments or status as an eligible provider will not be negatively impacted if the eligible provider does not attest to an accurate patient match rate; and

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

(3) VOLUNTARY REPORTING PROGRAM.—The National Coordinator, in consultation with the Administrator of the Centers for Medicare & Medicaid Services and the heads of other Federal agencies determined appropriate by the Secretary of Health and Human Services, shall develop a voluntary reporting program for eligible providers to anonymously submit patient matching accuracy data to the Department of Health and Human Services.

(4) ANNUAL REVIEW OF PATIENT MATCH RATE.—

(A) IN GENERAL.—Utilizing the patient matching accuracy data described in paragraph (3) and any additional data sources available, the Administrator of the Centers for Medicare & Medicaid Services shall review and evaluate the patient match attestation rates annually to determine if such rate should be adjusted.

(B) ADJUSTMENT.—The Administrator may adjust the patient match rate described in paragraph (1) if the Administrator determines that the patient match attestation rate should be adjusted to further incentivize the voluntary reporting of accurate patient match rates.