June 16, 2025

Honorable Robert F. Kennedy, Jr.
Secretary
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Information; Health Technology Ecosystem (CMS-0042-NC)

Submitted electronically to https://www.regulations.gov

Dear Secretary Kennedy:

On behalf of the Patient ID Now coalition, we write in response to the Centers for Medicare and Medicaid Services (CMS) and Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) request for information on the health technology ecosystem.

Patient ID Now is a coalition of more than 50 healthcare organizations representing a wide range of healthcare stakeholders, including patients, physicians, health information professionals, health IT companies, and public health, committed to advancing a nationwide strategy to address patient identification and matching. The coalition is pleased to have the opportunity to contribute to improving interoperability and health information technology within the healthcare ecosystem. The Patient ID Now coalition offers the following feedback in response to the request for information.

C. Providers

PR-9. *How might CMS encourage providers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins that need to be tracked for each provider relationship?*

For over 25 years, innovation and industry progress on patient matching have been stifled due to an appropriations language included in Section 510 of the Departments of Labor, Health and Human Services, Education and Related Agencies (Labor-HHS) Appropriations bills that prohibits the US Department of Health and Human Services (HHS) from spending federal dollars to promulgate or adopt a unique patient identifier (UPI) for individuals. Interpretation of this language has led to the failure to institute a nationwide patient identification strategy, preventing patients from having longitudinal access to their complete and accurate health information as they seek treatment across the care continuum.

The repeal of Section 510 would remove the barriers currently in place preventing CMS from exploring all potential solutions that could improve patient identification and matching, including but not limited to a UPI, and foster the implementation of a nationwide patient identification strategy. The Patient ID Now coalition urges the Administration to support the repeal of Section 510 from the Labor-HHS appropriations bill within the fiscal year (FY) 2026 federal budget.

E. Technology Vendors, Data Providers, and Networks

TD-3. *Regarding digital identity implementation: What are the challenges and benefits?*

Patient misidentification happens in the healthcare ecosystem in two main ways: duplicate records and overlaid records. Duplicate records occur when a patient visits multiple healthcare settings, and each of those settings has a separate medical record for the patient that are not combined into one record, resulting in clinicians working from incomplete patient information. Overlaid records occur when two or more patients' information is combined into one health record because of similar demographic information, potentially leading to privacy violations if a patient can access another patient's health information, or leading to safety risks, where one patient may be treated based on another patient's information.

Without the ability of clinicians to correctly connect a patient with their medical record, lives have been lost and medical errors have needlessly occurred. These are situations that could have been avoided had patients been accurately identified and matched with their records. This problem is so dire that one of the nation's leading patient safety organizations, the ECRI Institute, has named patient misidentification as a recurring top ten threats to patient safety.

The lack of a national strategy on patient identification and matching also creates financial burdens for patients, clinicians, and institutions. The expense of repeated medical care due to duplicate records costs an average of $1,950 per patient inpatient stay, and over $1,700 per emergency department visit. Thirty five percent of all denied claims result from inaccurate patient identification, costing the average hospital $2.5 million and the US healthcare system over $6.7 billion annually.[1] In a survey conducted by the Patient ID Now coalition, 72 percent of respondents agreed that there are delays in billing and reimbursement due to inaccurate patient information, and 70 percent indicated that patients undergo or receive duplicative or unnecessary testing or services due to difficulties in managing patient identities.[2]

The lack of a national strategy on patient identification and matching also contributes to patient privacy concerns. Specifically, the risk of overlaid records can result in a patient having access to another patient's health information, which could result in an unauthorized disclosure under the Health Insurance Portability and Accountability Act (HIPAA), or even worse, a patient receiving treatment based on another patient's diagnosis.

[1] Available at: https://www.blackbookmarketresearch.com/blog/improving-the-patient-identification-process-and-interoperability-to-decrease-patient-record-error-rates.
[2] Available at: https://patientidnow.org/wp-content/uploads/2022/11/PIDN-Research-Findings-Final.pdf.

These are all challenges that, if addressed through a comprehensive national strategy on patient identification and matching, could bring real benefits to patient safety and privacy, while lowering healthcare costs.

TD-7. *To what degree has USCDI improved interoperability and exchange and what are its limitations?*

The United States Core Data for Interoperability (USCDI) has been integral to the standardization of available data elements within certified health IT products, leading to improved interoperability and exchange. However, many elements within the current version of USCDI (e.g., first name, last name, and date of birth) do not have standards that dictate how these data should be entered, causing variation across systems and challenges in data usability and care coordination. Additionally, while the number of data elements included in the Draft USCDI V6 has more than doubled the number of data elements from what was included in USCDI V1, it is not known if the current number of data elements is enough to allow each patient to be uniquely identified, which in turn could avoid circumstances where two patients have the exact same demographic information within their health records leading to an overlaid record.

As a result, additional standards and research are needed to improve and evaluate USCDI. These challenges led to the introduction of HR 2002: the Patient Matching and Transparency in Certified Health IT Act of 2025 or the MATCH IT Act of 2025. The MATCH IT Act has four tenets, aimed at improving patient identification and matching through improved standardization of demographic elements within health records. This legislation would:

1. **DEFINE A PATIENT MATCH RATE**: Today, there is no consistent industry definition that allows for comparisons to measure patient misidentification. Under this legislation, HHS will work with providers, health IT vendors, and other relevant industry stakeholders to define and standardize the term “patient match rate” to include accounting for duplicate records, overlaid records, instances of multiple matches found, and mismatch rates within a healthcare organization. It will also allow the tracking of patient match rates across organizations and foster process improvement across the industry over time.

2. **ESTABLISH AN INDUSTRY STANDARD DATA SET TO IMPROVE PATIENT MATCHING**: This instructs ASTP/ONC to work with stakeholders to define and adopt a minimum data set needed to reach a 99.9% patient match rate. This does not require any entity to reach a 99.9% match rate. Rather, it instructs ASTP/ONC to consider which demographic elements should be available to reach a 99.9% match rate if possible.

   Once ASTP/ONC has defined the minimum demographic data set, ASTP/ONC is instructed to create, update, or adopt data standards, (including an established industry standard, if available) to ensure demographic elements are entered in a standardized format. These additional elements and standards would be incorporated into the next version of USCDI.

3. **UPDATE HEALTH IT CERTIFICATION REQUIREMENTS**: This provision updates the ASTP/ONC Health IT Certification Program requirements to include the minimum data set that was incorporated into the newest version of USCDI, referenced above, within certified health IT products.

4. **PROMOTE INTEROPERABILITY REQUIREMENTS**: Finally, the bill requires CMS to include a voluntary attestation within the CMS Promoting Interoperability Program for eligible providers who meet an accurate match rate of 90%. The attestation is a bonus measure and a "no" attestation will not affect the total score or status of the eligible hospital, critical access hospital (CAH), or eligible professional. CMS would evaluate patient matching attestation rates yearly to determine whether the accurate match rate level should be adjusted.

   ASTP/ONC would also be directed to coordinate with other federal partners to set up an anonymous voluntary reporting program for providers to submit matching accuracy data to HHS.

The Patient ID Now coalition encourages the Administration to consider the MATCH IT Act of 2025 to address patient identification and matching through improving definitions and standardization, including standardization within USCDI.

F. Value-Based Care Organizations

VB-3. *What are essential health IT capabilities for value-based care arrangements?*

a. *Examples (not comprehensive) may include: care planning, patient event notification, data extraction/normalization, quality performance measurement, access to claims data, attribution and patient ID matching, remote device interoperability, or other patient empowerment tools.*

Value-based care and other care arrangements depend on ensuring patient health information is complete, accurate, and timely. Under the current system, care is impeded because of patient misidentification. Patient safety, privacy, and the cost of care are challenging because of the lack of a national strategy around patient identification and matching. A national strategy may incorporate multiple solutions, including increased standardization of data elements and input standards, improved ability to measure the current scope of patient misidentification nationwide, or a UPI.

Thank you for the opportunity to comment on this request for information. The Patient ID Now coalition applauds your commitment to improving health technology for the benefit of patients and we look forward to working with you to achieve these goals. Should you or your staff have any additional questions or comments, please contact Kate McFadyen, senior director of government affairs, AHIMA at kate.mcfadyen@ahima.org.

Sincerely,

Patient ID Now