

Oversight Council Meeting

September 23, 2026



Agenda

1. Approval of Prior Meeting Minutes [Vote]
2. Executive Director's Report
3. Enhanced Enrollment Initiative: Proposal and Strategic Discussion
4. AI Proof of Concept: Opportunities, Risks, and Potential Applications



Approval of Prior Meeting Minutes

[Vote]



Executive Director's Report



Legislative Update

- Final day for passing major, high-profile legislation during formal session wrapped up July 31, 2026
 - Legislature remains technically in session through rest of calendar year
 - We continue to monitor legislation that may have policy, operational, or strategic significance for CHIA
- Work commenced September 1, 2026, on next series of Mandated Benefit Reviews, for publication December 2026
 - H.1249, 'An Act relative to PANDAS/PANS screening in medical/clinical settings'
 - H. 2202, 'An Act creating parity for mental and behavioral health services'



PBM Analysis and Reporting



PROJECT UPDATE

- Received data submissions from all PBMs required to submit
- Year 1 data QA focused on high-level checks, e.g.:
 - Aligning submitted fields with data specification manual for ease of aggregation and analysis
 - Ensuring field logic tied out
- Year 1 public report focus:
 - PBM landscape in MA—market share of covered members and dispensed prescriptions
 - Financial flow of fees among PBMs, health plans, and other entities
 - Flow of drug rebates, including percentage passed through
 - Impact of rebates—gross and net cost per prescription and days' supply



Dental Analysis and Reporting

PROJECT UPDATE

- Analytic data quality assessment and validation with data submitters uncovered concerns with 2 major dental insurance carriers
- CHIA expanding data profiling activities to identify any other anomalies and resolve those issues with payers as needed
- Next steps include:
 - Detailed data profiling
 - Review/implementation of versioning logic
 - Analytic data quality assessment for public reporting



Inside the MA APCD

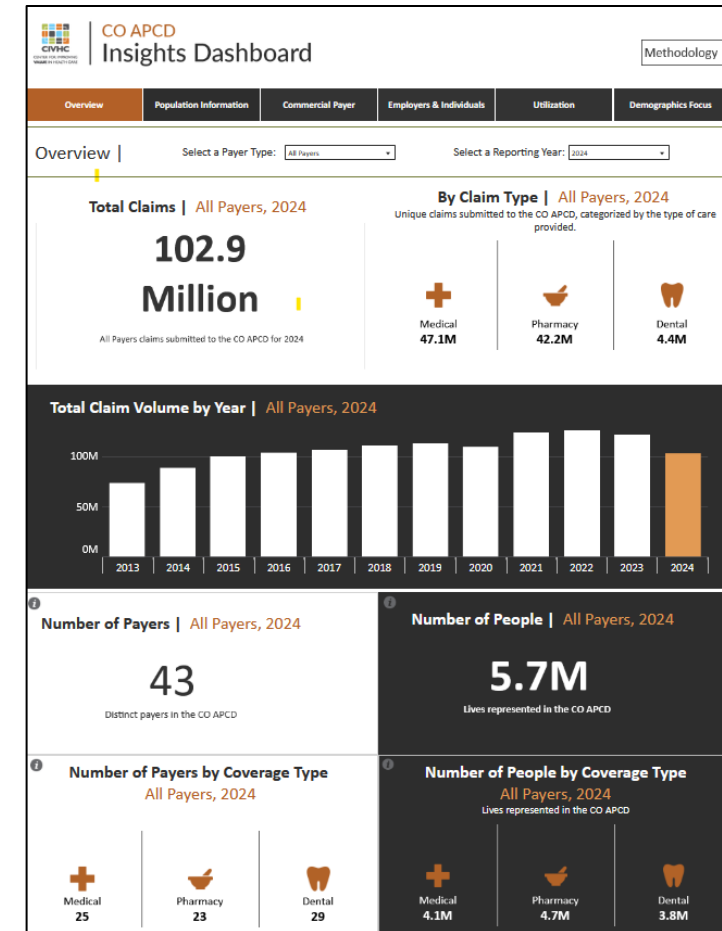
PROJECT PURPOSE

- Provide public-facing resource to respond to common questions that can be answered by aggregated claims and enrollment data
- Many recurring questions incorporated into new and existing publications:
 - Cost drivers → Prescription Drug Use and Spending
 - Insurance coverage → Enrollment Trends, MA Health Insurance Survey
 - Service-specific topics → Research and policy briefs, topical dashboards
- **Cross-topic, summary-level dashboard** will address additional information needs, such as:
 - How representative is the MA APCD of the Massachusetts population?
 - Which types of services are Massachusetts residents receiving, and how is that changing over time?
 - Who is receiving these services, and how is that changing over time?

Inside the MA APCD

PROJECT STATUS

- Foundational metrics for inclusion:
 - Count of medical claim lines by service category
 - Count of members by insurance type
 - Number of payers
- Developed data model to aggregate data and facilitate fast filtering
- Launch on CHIA's website in Q1 2027
- Future updates for additional measures and stratifications, such as:
 - Pharmacy and dental claims
 - Utilization trends
 - Member demographic information





How the Council Described CHIA's Strategic Opportunity

equity long-term care
modeling/support for health planning
affordability waste
cost primary care actionable
AI access hospital
monitoring



Enhanced Enrollment Initiative

Proposal and Strategic Discussion



Enhanced Enrollment Initiative

PROJECT SUMMARY

- Anticipated major changes in health insurance coverage in 2026 and beyond require more timely and detailed monitoring of enrollment shifts across coverage options
- Using APCD, CHIA reports enrollment trends 2x annually by **coverage type**
 - E.g.: MassHealth enrollment totaled X million on September 15, 2026, and Y million on December 15, 2026.
- New project will track **individuals across coverage types**
 - E.g.: 100 individuals had MassHealth coverage in September 2026; as of December 2026, 80 of these individuals continued to have MassHealth coverage, 10 were covered by the Connector, 5 by private insurance (fully insured), and 5 do not appear in the data.



Enhanced Enrollment Initiative

PROJECT UPDATE

- Developed analytic code and successfully produced results tracking individuals across quarters from March 2023 through March 2026
- Identified combinations of variables to reliably subset commercial coverage for plans purchased on Health Connector
- Reviewing results for reasonability using both resumption of MassHealth redeterminations (April 2023 onward) and Connector members who lost coverage (January 2026)
- Next steps:
 - Confirm identification of Health Connector members
 - Rerun analysis through June 2026
 - Review results with state agency partners
 - Develop plan for public release and ongoing monitoring



Enhanced Enrollment Initiative

ADDITIONAL ANALYSIS

- Project could also expand to profile individuals' prior health care utilization and anticipated disruptions
- Additional analytic options:
 - Member demographics (gender, geography)
 - Chronic condition status
 - Behavioral health condition status
 - Prior service utilization
 - Subsequent ED use or hospitalizations (Case Mix databases)
- *Discussion: Which other topics would be important for CHIA to consider, and how might we prioritize these additional analyses?*



AI Proof of Concept

Opportunities, Risks, and Potential Applications



Retrieval-Augmented Generation (RAG) Solution

Background

- Inquiries to CHIA require accurate, timely, transparent responses grounded in official state government sources
- Governed RAG approach would make CHIA information easier to find, verify, and use

Prototype Test for RAG Tool

- CHIA-approved sources
- Source-cited answers
- Secure Azure architecture
- Internal use only

How RAG Works

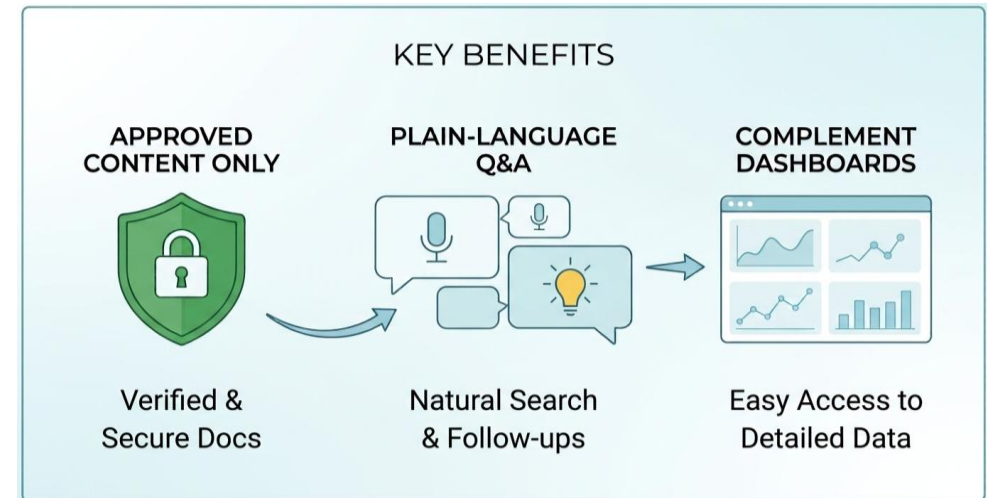
- General-purpose AI tools cannot reliably access, search, or answer questions
- RAG retrieves relevant agency content for grounded, source-cited responses



Why This Matters

KEY BENEFITS FOR CHIA

- Restrict knowledge base to approved content
- Support plain-language follow-up questions
- Complement dashboards by making technical appendices and supporting documents conversationally searchable



Known limitations

- RAG does not make AI large-language models (LLMs) more secure or accurate
- Prompts must be phrased properly for meaningful results
- Source documents must be monitored for recency



RAG Prototype Reinforces Guardrails for CHIA-Only Questions

- While strong prompting can make Copilot highly effective, RAG adds technical controls to reinforce boundaries
- Microsoft Copilot acknowledged using third-party sources despite CHIA-only instruction; RAG provides technical controls to prevent source leakage

Public AI/Broad Web Search

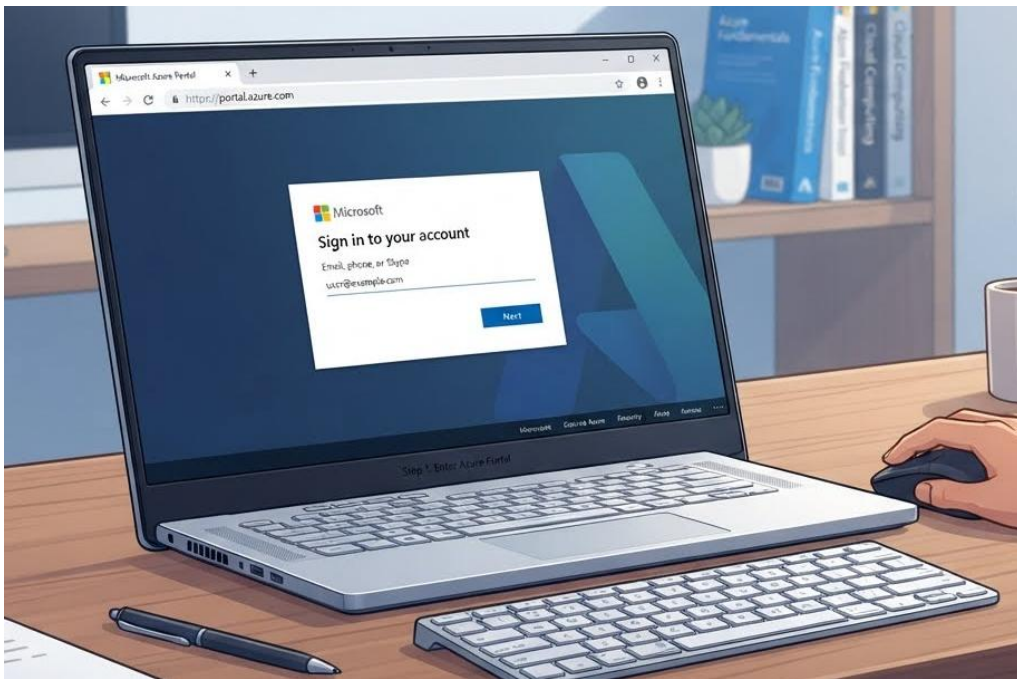
- ✗ May retrieve third-party summaries
- ✗ Can violate “CHIA only” source instruction
- ✗ Broad knowledge can obscure provenance

CHIA RAG

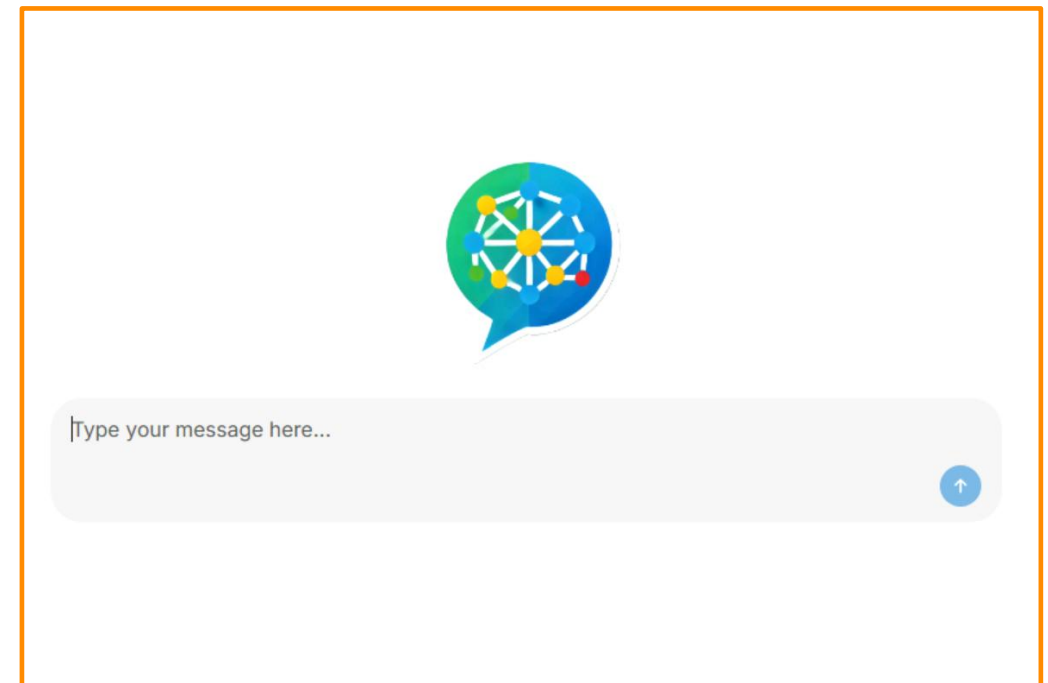
- ✓ Vector store contains only approved sources
- ✓ Metadata filters can reject non-compliant content
- ✓ Prompt can require evidence or explicit “not found” fallback

How To Use CHIA's RAG Tool

1. Enter Azure portal at <https://portal.azure.com>



2. Enter prompt in RAG user interface





RAG Demo #1



According to CHIA, what are five contributors to increases in total medical expenses in Massachusetts?

According to CHIA, the five largest contributors to increases in total medical expenses (THCE) in Massachusetts are:

- Pharmacy spending – largest driver (23.2% of net THCE growth; ~\$1,131.8M net) ([2026 Annual Report](#))
- Hospital outpatient services – second (21.8% of net THCE growth; ~\$1,066.6M) ([2026 Annual Report](#))
- Other professional services – third (16.0% of net THCE growth; ~\$781.1M) ([2026 Annual Report](#))
- Hospital inpatient services – fourth (14.0% of net THCE growth; ~\$686.0M) ([2026 Annual Report](#))
- Other medical services – fifth (13.1% of net THCE growth; ~\$640.1M) ([2026 Annual Report](#))

Source: CHIA, 2026 Annual Report ([2026 Annual Report](#)).



RAG Demo #2



What types of data does CHIA collect to advance health care transparency?

CHIA collects a wide range of payer- and provider-based data to support transparency. Key types include:

- Claims data (medical, pharmacy, and dental claims) submitted by commercial and public payers [MA APCD Overview](#).
- Member/enrollment and demographic data (eligibility files, member records, and—beginning in 2026—a Member Simplified file with race, ethnicity, language, disability status, sex assigned at birth, and sexual orientation/gender identity elements) [MA APCD Overview](#).
- Provider data (provider file records, National Provider Identifiers and related provider attributes) and product/plan files (product file, benefits plan control) used to describe networks and insurance products [MA APCD Overview](#).
- Derived and enhanced linkages such as a Master Patient Index (surrogate keys for tracking individuals across plans) and highest-version claim indicators to support accurate utilization and cost measures [MA APCD Overview](#).
- System-level measures used in public reporting and analysis: total health care expenditures, utilization (inpatient discharges, ED visits, ALOS), payer and hospital financial performance, behavioral health trends, quality metrics, and affordability/access measures—reported in CHIA’s Annual Report and analytic products [2025 Annual Report Press Release](#).

CHIA also produces de-identified and limited datasets and applies strong de-identification, validation, and governance processes before releasing data to users [MA APCD Overview](#).



RAG Demo #3.1



What are the main reasons for emergency department utilization in Massachusetts?

Here are the main reasons and patterns for emergency department (ED) use in Massachusetts, based on the 2025 Massachusetts Health Insurance Survey detailed tables:

- Most ED visits are for physical health problems – about 96.6% of respondents reported their most recent ED visit was for a physical-health condition C.4-1.
- Mental-health-related visits are uncommon ($\approx 3.0\%$) and visits for alcohol/substance use disorder are rare ($\approx 0.8\%$) C.4-1.
- A substantial share of visits are for non-emergency conditions: $\sim 31.8\%$ reported their most recent ED visit was for a non-emergency problem C.4-1.
- Among those non-emergency visits, the most common reasons given were inability to get a timely appointment ($\sim 54.8\%$), needing care after normal office hours ($\sim 61.9\%$), and convenience of the ED ($\sim 49.5\%$); owing money to a clinic was cited much less often ($\sim 5.1\%$) C.4-1.
- Utilization varies by group: rates are higher among lower income residents (any ED visit: 35.1% for $<139\%$ FPL vs 16.4% for $\geq 500\%$ FPL) and are higher among older adults (65+ had $\sim 27.1\%$ with an ED visit) C.4-5 C.4-1. Females report slightly higher ED use than males (24.0% vs 21.1%) C.4-2.
- Bottom line: the large majority of ED visits are for physical-health needs, but access issues (unable to get a timely appointment, need for after-hours care) and convenience drive a sizable fraction of non-emergency ED use C.4-1.





RAG Demo #3.2



Would you like the exact table rows or a short chart summarizing these percentages?

Yes.

Great – below are the key table rows (percentages) from the 2025 Massachusetts Health Insurance Survey tables, plus short notes. Each item cites the table where the value appears.

Main ED-use measures (statewide)

- Any ED visit in past 12 months (total): 22.60% C.4-1.
- More than one ED visit in past 12 months (total): 8.12% C.4-1.
- Most recent ED visit was for a non-emergency condition (total): 31.84% C.4-1.
- Most recent ED visit was for a condition related to physical health (total): 96.57% C.4-1.
- Most recent ED visit related to mental health (total): 2.99% C.4-1.
- Most recent ED visit related to alcohol/substance use disorder (total): 0.82% C.4-1.
- Most recent ED visit related to mental health OR alcohol/substance use (total): 3.54% C.4-1.

Reasons for non-emergency ED visits (among those whose most recent visit was non-emergency)

- Unable to get a doctor/clinic appointment as soon as needed: 54.76% C.4-1.
- Needed care after normal office/clinic hours: 61.86% C.4-1.
- It was more convenient to go to the hospital ED: 49.53% C.4-1.
- Owed money to doctor's office/clinic (reason): 5.09% C.4-1.





RAG Demo #3.3



Selected subgroup differences

- By age (any ED visit in past 12 months): Children (0-18) 21.26%; Adults 19-64 21.63%; Elderly 65+ 27.10% C.4-1.
- By family income (any ED visit): <139% FPL 35.14%; 139-299% FPL 26.96%; 300-399% FPL 20.19%; 400-499% FPL 21.97%; 500%+ FPL 16.36% C.4-5.
- By sex (any ED visit): Male 21.10%; Female 24.01% C.4-2.

If you want:

The full raw rows (CSV or pasted table) from any specific table (C.4-1, C.4-2, C.4-3, C.4-4, or C.4-5), I can paste them or export them.

Or a simple visual (text bar chart) of the key percentages above.

Which would you prefer?

You are working very good today.

Thanks – I’m glad it’s been helpful! Would you like the full table rows (CSV/pasted), a text bar chart, or a visual chart of the key percentages next? [2026 Annual Report](#)



Next Steps

- Continue evaluation of RAG tool capabilities
- Validate responses to internal business unit prompts
- Test upload of additional file types

Questions?

Questions?

