Division of Medicaid
Office of the Governor
State of Mississippi
Drug Utilization Review (DUR) Board Meeting

MISSISSIPPI DIVISION OF
MEDICAID

March 20, 2025 at 1:00pm

Walter Sillers Building, Cobb Conference Room

Jackson, MS

Prepared by:

MS | DUR Evidence-Based DUR Initiative
The University of Mississippi School of Pharmacy

Drug Utilization Review Board

Joseph Austin, MD
Vicksburg Women's Care
100 Maxwell Drive
Vicksburg, MS 39180
Term Expires: June 30, 2025

Amy Catherine Baggett, PharmD
Love's Pharmacy of Diamondhead
45000 E Aloha Dr., Suite B
Diamondhead, MS 39525
Term Expires: June 30, 2027

Terrence Brown, PharmD
BioScrip Infusion Services
187 Country Place Pkwy, Suite C
Pearl, MS 39208
Term Expires: June 20, 2026

Chrysanthia Davis, PharmD (Chair)
Omnicare Pharmacy
100 Business Park Dr, Ste D
Ridgeland, MS 39157
Term Expires: June 30, 2025

Dena Jackson, MD
King's Daughters Specialty Clinic
940 Brookway Blvd
Brookhaven, MS 39601
Term Expires: June 30, 2026

Jessica Lavender, MD
UMMC
2500 N. State Street
Jackson, MS 39216
Term Expires: June 30, 2025

Holly R. Moore, PharmD
Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301
Term Expires: June 30, 2026

Joshua Pierce, PharmD (Vice-Chair)
McGuffee Drugs
102 Main St.
Magee, MS 39111
Term Expires: June 30, 2027

Gaylen Sanders, MD
The Pediatric Clinic
415 South 28th Avenue
Hattiesburg, MS 39401
Term Expires: June 30, 2027

Joshua Trull, DO
UMMC Dept of Psychiatry
2500 N. State Street
Jackson, MS 39216
Term Expires: June 30, 2027

Bobbie West, MD
MEA Medical Clinic
342 Gilchrist Drive
Pearl, MS 39208
Term Expires: June 30, 2025

2025 DUR Board Meeting Dates

March 20, 2025
June 12, 2025
September 18, 2025
December 11, 2025

As with any analysis, great efforts are made to ensure that the information reported in this document is accurate. The most recent administrative claims data available are being used at the time the reports are generated, which includes the most recent adjudication history. As a result, values may vary between reporting periods and between DUR Board meetings, reflecting updated reversals and claims adjustments.

Unless otherwise indicated, all MS-DUR analyses are conducted for the entire Mississippi Medicaid program including beneficiaries receiving services through the Medicaid fee-for-service (FFS) and the Mississippi Medicaid Coordinated Care Organizations (CCOs). When dollar figures are reported, the reported dollar figures represent reimbursement amounts paid to providers and are not representative of final Medicaid costs after rebates. Any reported enrollment data presented are unofficial and are only for general information purposes for the DUR Board.

Please refer to the Mississippi Division of Medicaid website for the current official Universal Preferred Drug List (PDL).

http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

MISSISSIPPI DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
DRUG UTILIZATION REVIEW BOARD
AGENDA
March 20, 2025

Welcome

Old Business

Resource Utilization Review

Follow-up and Discussion from the Board

New Business

Pharmacy Program Update

Next Meeting Information
June 12, 2025

DUR Board Meeting Minutes

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE SEPTEMBER 12, 2024 MEETING

DUR Board Roster: State Fiscal Year 2024 (July 1, 2024 – June 30, 2025)	**Dec 2023**	**Mar 2024**	**Jun 2024**	**Sep 2024**
Joseph Austin, MD	✓		✓	
Amy Catherine Baggett, PharmD	✓	✓		
Terrence Brown, PharmD	✓	✓	✓	
Chrysanthia Davis, PharmD	✓	✓	✓	✓
Dena Jackson, MD	✓	✓		✓
Jessica Lavender, MD	NA	✓	✓	✓
Holly Moore, PharmD		✓		✓
Kristi Phelps, RPh		✓		
Joshua Pierce, PharmD			✓	✓
Gaylen Sanders, MD	NA	NA	NA	✓
Joshua Trull, DO	NA	✓	✓	✓
Bobbie West, MD	✓	✓	✓	
TOTAL PRESENT**	**8**	**10**	**8**	**7**

*** Total Present may not be reflected by individual members marked as present above due to members who either resigned or whose terms expired being removed from the list.*

Also Present:

Division of Medicaid (DOM) Staff:
Terri Kirby, RPH, CPM, Pharmacy Director; Dennis Smith, RPH, DUR Coordinator; Amy Ly-Ha, PharmD, Pharmacist II;

University of Mississippi School of Pharmacy - MS-DUR Staff:
Eric Pittman, PharmD, MS-DUR Project Director; Kaustuv Bhattacharya, PhD, MS-DUR Research Assistant Professor;

Coordinated Care Organization (CCO) Staff:
Jenni Grantham, PharmD, Director of Pharmacy, Magnolia Health; Trina Stewart, PharmD, Pharmacy Manager, Molina Healthcare;

Gainwell Staff:
Lew Ann Snow, RN, Advisor Business Analyst;

Telligen Staff:
Buddy Ogletree, PharmD, Pharmacist; Bruce Reed, Pharmacy Student;

Visitors: None.

Call to Order/Welcome:
The meeting was called to order at 1:08 pm.

OLD BUSINESS:
Dr. Pierce moved to approve the minutes from the June 2024 DUR Board Meeting, seconded by Dr. Lavender, and unanimously approved by the DUR Board.

Resource Utilization Review
Dr. Pittman presented the resource utilization report for June 2024. Data presented was across all pharmacy programs.

Follow-up and Discussion from the Board
Dr. Pittman presented the Board with a draft version of a provider educational letter addressing the treatment of asthma. This was a recommendation made by the Board at the June 2024 meeting. The letter will be sent to providers treating individuals covered by Medicaid with an asthma diagnosis who had a history of 3 or more short-acting beta agonist prescription claims in the previous six months and did not have a claim for a controller medication. The Board verbalized their support for the mailing.

NEW BUSINESS:

Appointment of Officers
Dr. Lavender made a motion to appoint Dr. Pierce as the new vice-chair. Dr. Jackson seconded the motion, and the motion was unanimously approved by the Board.

Update on MS-DUR Educational Interventions
Dr. Pittman provided an overview of all DUR mailings and educational notices that occurred between June 2024 through August 2024.

Influenza Annual Update
Dr. Pittman presented the Board with an overview of the utilization of influenza vaccinations and anti-influenza prescription agents between July 1, 2023 and June 30, 2024 (SFY 2024). Dr. Pittman noted that compared to the two previous years, the number of claims for influenza vaccinations administered to individuals covered by Medicaid was down this past year. This corresponds to national data indicating that fewer influenza vaccinations were administered in retail pharmacies and medical offices in the U.S. during the 2023-2024 season compared to the prior year. Dr. Pittman urged DOM to encourage providers to be diligent in their recommendations for influenza vaccination for this upcoming season.

RSV Annual Update:
Dr. Pittman presented an overview of the utilization of agents for the prevention of RSV among Medicaid covered individuals. With the approval of nirsevimab and two RSV vaccines, the landscape for RSV protection dramatically changed this past year. Supply issues prevented the

optimal uptake of nirsevimab last year, but those issues have been resolved. Analysis indicated that approximately 10% of newborn infants covered by Medicaid received RSV protection by receipt of nirsevimab or maternal RSV vaccination during the 2023/2024 RSV season.

Trikafta Initiation and Healthcare Utilization

Dr. Pittman presented an analysis project describing and comparing healthcare resource utilization and total cost of care associated with the initiation of Trikafta (elexacaftor/ tezacaftor/ ivacaftor) among the Mississippi Medicaid population. Trikafta, the first triple-therapy cystic fibrosis transmembrane conductance regulator (CFTR) modulator, expanded CFTR therapy options to over 90% of individuals diagnosed with cystic fibrosis. The study findings suggest that while Trikafta leads to increased pharmacy and total costs, it may have a pronounced effect on reducing acute care needs and improving respiratory outcomes regardless of prior CFTR modulator use.

Concomitant Prescribing of Opioids and Psychotropic Agents

The dangers of the concomitant prescribing of opioids and psychotropic medications is well documented. Individuals who take these medications concurrently are at greater risks of experiencing opioid-related adverse events. This study described trends in the concomitant prescribing of opioids and psychotropic medications among the Mississippi Medicaid population over a 5-year period. Follow up analyses will explore the occurrence of adverse events among those concomitantly prescribed opioids and psychotropic agents and will identify factors associated with these adverse events.

FDA Drug Safety Updates:

No new FDA drug safety communications were published between June 2024 and August 2024.

Pharmacy Program Update:

Ms. Kirby provided a pharmacy program update highlighting the following item:

- The use of a single pharmacy benefit administrator (PBA) began July 1, 2024. Since that time, all pharmacy claims have been processed through Gainwell. Ms. Kirby received positive feedback from Board members on their experiences with the single PBA system.

Next Meeting Information:

Remaining meeting dates for 2024:

- December 5, 2024

Dr. Jackson adjourned the meeting at 2:21 pm.

Submitted,

Eric Pittman, PharmD
Evidence-Based DUR Initiative, MS-DUR

DUR Board Meeting Resources

Members

The DUR Board is composed of twelve participating Medicaid providers who are in good standing with their representative organizations.

- DUR Board Member List

Meetings

Meetings will be held on the following dates at 1:00 pm at the location as noted:

- ~~March 7, 2024~~
- ~~June 13, 2024~~
- Sept. 12, 2024 – Walter Sillers Building, 550 High Street, Jackson, MS – Map
- Dec. 5, 2024

The September 12 meeting may be viewed virtually by clicking on the following link:
Click Here for MS Medicaid DUR Live Broadcast on September 12 2024 at 1:00 p.m.

Please note: This link will only be live during the meeting and will not be archived for future viewing.

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE DECEMBER 5, 2024 MEETING

DUR Board Roster: State Fiscal Year 2024 (July 1, 2024 – June 30, 2025)	Mar 2024	Jun 2024	Sep 2024	Dec 2024
Joseph Austin, MD		✓		✓
Amy Catherine Baggett, PharmD	✓			
Terrence Brown, PharmD	✓	✓		
Chrysanthia Davis, PharmD	✓	✓	✓	✓
Dena Jackson, MD	✓		✓	
Jessica Lavender, MD	✓	✓	✓	
Holly Moore, PharmD	✓		✓	✓
Joshua Pierce, PharmD		✓	✓	
Gaylen Sanders, MD	NA	NA	✓	✓
Joshua Trull, DO	✓	✓	✓	✓
Bobbie West, MD	✓	✓		
TOTAL PRESENT**	**10**	**8**	**7**	**5**

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Also Present:

Division of Medicaid (DOM) Staff:
Terri Kirby, RPH, CPM, Pharmacy Director; Dennis Smith, RPH, DUR Coordinator; Amy Ly-Ha, PharmD, Pharmacist II; Anish Patel, PharmD, Pharmacist II; Catherine Brett, MD, Clinical Medical Director, Health Informatics;

University of Mississippi School of Pharmacy - MS-DUR Staff:
Eric Pittman, PharmD, MS-DUR Project Director; Kaustuv Bhattacharya, PhD, MS-DUR Research Assistant Professor;

Coordinated Care Organization (CCO) Staff:
Jenni Grantham, PharmD, Director of Pharmacy, Magnolia Health; Heather Odem, PharmD, Director of Pharmacy - Mississippi, UnitedHealthcare Community & State;

Gainwell Staff:
Lew Ann Snow, RN, Advisor Business Analyst;

MedImpact Staff:
Lynn Boudreaux, PharmD;

Telligen Staff:
Buddy Ogletree, PharmD, Pharmacist;

Visitors: Ashley Zichelli, Johnson and Johnson; Paula Whatley, Novo Nordisk.

Call to Order/Welcome:
The meeting began at 1:10 pm.

OLD BUSINESS:
Due to the lack of a quorum being present, minutes from the September 12, 2024 meeting were not approved. This item will be added to the March 2025 meeting agenda.

Resource Utilization Review
Dr. Pittman presented the resource utilization report for September 2024. Data presented was across all pharmacy programs.

NEW BUSINESS:

Update on MS-DUR Educational Interventions
Dr. Pittman provided an overview of all DUR mailings and educational notices that occurred between September 2024 and November 2024.

Zolgensma® Utilization
Dr. Pittman presented the Board with an overview of the utilization of Zolgensma®, a gene therapy product for the treatment of spinal muscular atrophy. Among the members who received Zolgensma® therapy, 43.8% have received subsequent treatment with either Spinraza® or Evrysdi®. Limited data exists supporting the effectiveness and feasibility of combination therapy with Zolgensma® and these agents.

Anti-obesity GLP-1 Medication Use Among Medicaid Members
Mississippi Medicaid is one of a handful of state Medicaid programs to begin covering anti-obesity medications. Since coverage began in July 2023, 2,948 individuals initiated medications for obesity management. This study examined the demographic and clinical profiles of Mississippi Medicaid members initiating GLP-1 medications for obesity management. Among members included in this analysis, the majority were Black females between 21-40 years of age with an obesity diagnosis (BMI $\geq$ 30) and had chronic, comorbid conditions. Future work will examine adherence, outcomes, and changes in healthcare resource utilization among individuals initiating anti-obesity GLP-1 medications.

Adverse Events Associated with the Concomitant Use of Opioids and Psychotropic Medications
The concomitant prescribing of opioids and psychotropic medications is common practice despite evidence indicating that individuals concurrently prescribed these medications are more likely to experience opioid-related adverse events. This study examined the association between opioid-related adverse events among Medicaid members on long-term opioid therapy and the concurrent prescribing of opioids and psychotropic medications. Our results found that those individuals with concurrent opioid/psychotropic medication use had statistically greater

odds of experiencing both respiratory events and opioid overdose/mortality events compared with individuals not concurrently taking these medications. Next steps to consider may include examining the impact of concomitant prescribing on adverse events by specific psychotropic drug class or opioid dosing levels to inform a targeted education campaign focusing on the awareness of the increased risks and strategies to prevent their occurrence among Medicaid members.

FDA Drug Safety Updates:
Dr. Pittman reviewed the FDA drug safety communications published between September 2024 and November 2024.

Pharmacy Program Update:
Ms. Kirby provided a pharmacy program update highlighting recent State Plan Amendment (SPA) approvals:

- Diabetic supplies are now covered through pharmacy claims;
- DOM now has the approval to engage in value-based contracting agreements with manufacturers;
- Modifications to DOM's prescription coverage limit to allow for more than six prescriptions monthly for adults with a prior authorization;
- DOM will now cover imported drugs during drug shortages.

Next Meeting Information:
Proposed meeting dates for 2025:

- March 20, 2025
- June 12, 2025
- September 18, 2025
- December 11, 2025

Submitted,

Eric Pittman, PharmD
Evidence-Based DUR Initiative, MS-DUR

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Resource Utilizaton Review

TABLE 04A: ENROLLMENT STATISTICS FOR LAST 6 MONTHS
July 1, 2024 through December 31, 2024

			Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Total enrollment			728,933	729,080	727,594	725,971	722,760	717,361
Dual-eligibles			160,681	161,199	161,597	161,862	161,935	160,263
Pharmacy benefits			570,724	570,334	568,050	565,811	562,380	557,784
	LTC		15,780	15,762	15,712	15,721	15,623	15,376
	PLAN %	**FFS**	23.9%	23.5%	23.1%	22.2%	21.4%	20.7%
		MSCAN-UHC	28.6%	28.7%	28.8%	29.1%	29.3%	29.5%
		MSCAN-Magnolia	30.2%	30.3%	30.5%	30.8%	31.1%	31.4%
		MSCAN-Molina	17.3%	17.5%	17.6%	17.9%	18.2%	18.4%

TABLE 04B: PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS
July 1, 2024 through December 31, 2024

		Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
# Rx Fills	**FFS**	92,202	101,539	92,749	99,416	92,529	93,588
	MSCAN-UHC	126,195	144,631	131,013	142,902	135,311	137,743
	MSCAN-Mag	135,260	159,063	142,485	156,748	148,069	150,833
	MSCAN-Mol	58,466	69,459	62,499	69,657	66,258	67,465
# Rx Fills / Bene	**FFS**	0.7	0.8	0.7	0.8	0.8	0.8
	MSCAN-UHC	0.8	0.9	0.8	0.9	0.8	0.8
	MSCAN-Mag	0.8	0.9	0.8	0.9	0.8	0.9
	MSCAN-Mol	0.6	0.7	0.6	0.7	0.6	0.7
$ Paid Rx	**FFS**	$11,933,944	$12,761,685	$12,238,865	$13,364,392	$11,477,846	$12,253,184
	MSCAN-UHC	$19,615,537	$18,886,146	$17,500,362	$18,841,214	$17,833,782	$18,870,421
	MSCAN-Mag	$19,520,335	$20,660,634	$18,931,437	$20,806,239	$19,583,321	$19,610,543
	MSCAN-Mol	$7,371,093	$7,709,982	$7,117,392	$8,304,879	$7,328,442	$7,417,294
$ /Rx Fill	**FFS**	$129.43	$125.68	$131.96	$134.43	$124.05	$130.93
	MSCAN-UHC	$155.44	$130.58	$133.58	$131.85	$131.80	$137.00
	MSCAN-Mag	$144.32	$129.89	$132.87	$132.74	$132.26	$130.01
	MSCAN-Mol	$126.07	$111.00	$113.88	$119.23	$110.60	$109.94
$ /Bene	**FFS**	$87.49	$95.22	$93.27	$106.40	$95.37	$106.12
	MSCAN-UHC	$120.17	$115.38	$106.97	$114.43	$108.23	$114.68
	MSCAN-Mag	$113.25	$119.56	$109.27	$119.39	$111.97	$111.97
	MSCAN-Mol	$74.66	$77.25	$71.19	$82.00	$71.60	$72.27

NOTE: Paid amounts represent amount reported on claims as paid to the pharmacy. These amounts do not reflect final actual costs after rebates, etc.

TABLE C: TOP 10 DRUG CATEGORIES BY NUMBER OF CLAIMS IN DEC 2024 (FFS AND CCOs)

Category	Month Year	Rank Volume	# RXs	$ Paid	# Unique Benes
CNS stimulants	Dec 2024	1	21,281	$3,013,222	18,484
(*ex. methylphenidate, amphetamine-*	Nov 2024	1	21,787	$3,133,530	19,168
dextroamphetamine)	Oct 2024	1	24,012	$3,488,533	20,720
aminopenicillins	Dec 2024	2	16,097	$226,375	15,853
(*ex. amoxicillin)*	Nov 2024	2	16,957	$246,151	16,690
	Oct 2024	2	16,152	$234,184	15,846
adrenergic bronchodilators	Dec 2024	3	15,665	$595,958	13,844
(ex. albuterol)	Nov 2024	3	15,645	$638,835	13,816
	Oct 2024	3	15,847	$694,846	13,669
glucocorticoids	Dec 2024	4	14,970	$446,496	14,399
(ex. prednisolone)	Nov 2024	4	15,087	$444,809	14,505
	Oct 2024	5	14,003	$541,248	13,443
macrolides	Dec 2024	5	14,683	$263,423	14,418
(ex. azithromycin)	Nov 2024	5	14,014	$265,475	13,755
	Oct 2024	9	12,193	$238,279	11,969
atypical antipsychotics	Dec 2024	6	13,695	$5,089,968	11,342
(ex. risperidone, paliperidone)	Nov 2024	6	13,172	$4,787,225	11,173
	Oct 2024	4	14,390	$5,413,047	11,922
SSRI antidepressants	Dec 2024	7	12,545	$160,466	11,386
(ex. sertraline, paroxetine)	Nov 2024	8	12,244	$165,198	11,321
	Oct 2024	7	13,283	$174,434	12,027
nonsteroidal anti-inflammatory agents	Dec 2024	8	12,314	$162,559	11,763
(ex. ibuprofen)	Nov 2024	7	12,415	$170,504	11,886
	Oct 2024	6	13,440	$186,811	12,759
antiadrenergic agents, centrally acting	Dec 2024	9	11,086	$157,742	9,807
(ex. clonidine)	Nov 2024	10	10,690	$163,233	9,697
	Oct 2024	10	11,532	$185,589	10,222
antihistamines	Dec 2024	10	10,975	$165,753	10,611
(ex. cetirizine)	Nov 2024	9	11,353	$175,319	11,046
	Oct 2024	8	12,420	$203,852	11,941

TABLE D: TOP 10 DRUG CATEGORIES BY DOLLARS PAID IN DEC 2024 (FFS AND CCOs)

Category	Month Year	Rank Paid Amt	# RXs	$ Paid	# Unique Benes
interleukin inhibitors	Dec 2024	1	958	$5,652,894	862
(ex. Dupixent, Stelara, Taltz)	Nov 2024	1	907	$5,175,861	867
	Oct 2024	1	1,004	$5,879,640	902
atypical antipsychotics	Dec 2024	2	13,695	$5,089,968	11,342
(ex. Invega Sustenna, Vraylar)	Nov 2024	2	13,172	$4,787,225	11,173
	Oct 2024	2	14,390	$5,413,047	11,922
TNF alpha inhibitors	Dec 2024	3	378	$3,043,575	328
(Humira)	Nov 2024	4	343	$2,668,964	322
	Oct 2024	4	364	$2,900,872	321
CNS stimulants	Dec 2024	4	21,281	$3,013,222	18,484
(methylphenidate, lisdexamfetamine)	Nov 2024	3	21,787	$3,133,530	19,168
	Oct 2024	3	24,012	$3,488,533	20,720
antiviral combinations	Dec 2024	5	677	$2,515,181	624
(ex. Biktarvy)	Nov 2024	5	641	$2,367,715	607
	Oct 2024	5	706	$2,565,139	658
GLP-1 receptor agonists for obesity	Dec 2024	6	1,760	$2,259,044	1,641
(ex. Wegovy)	Nov 2024	8	1,631	$2,095,504	1,562
	Oct 2024	6	1,883	$2,422,889	1,709
factor for bleeding disorders	Dec 2024	7	124	$2,166,452	97
(ex. Hemlibra, antihemophilic factors)	Nov 2024	10	118	$1,619,274	95
	Oct 2024	11	141	$1,539,602	112
GLP-1 receptor agonists for non-obesity indications	Dec 2024	8	2,339	$2,132,295	2,179
(ex. Trulicity)	Nov 2024	6	2,396	$2,187,167	2,286
	Oct 2024	8	2,556	$2,303,576	2,377
CFTR combinations	Dec 2024	9	80	$1,966,138	72
(ex. Trikafta)	Nov 2024	7	86	$2,132,136	80
	Oct 2024	7	98	$2,321,728	82
SGLT-2 inhibitors	Dec 2024	10	2,099	$1,602,690	1,993
(ex. Jardiance, Farxiga)	Nov 2024	9	2,148	$1,635,991	2,056
	Oct 2024	9	2,271	$1,775,081	2,144

TABLE E: TOP 25 DRUG MOLECULES
BY NUMBER OF CLAIMS IN DEC 2024 (FFS and CCOs)

Drug Molecule Therapeutic Category	Nov 2024 # Claims	Dec 2024 # Claims	Dec 2024 $ Paid	Dec 2024 # Unique Benes
amoxicillin / aminopenicillins	16,932	16,072	$225,846	15,830
albuterol / adrenergic bronchodilators	15,047	15,134	$452,021	13,448
azithromycin / macrolides	13,691	14,348	$215,057	14,113
ondansetron / 5HT3 receptor antagonists	8,245	8,319	$125,812	8,030
prednisolone / glucocorticoids	8,528	8,209	$165,044	7,931
methylphenidate / CNS stimulants	7,755	7,584	$1,458,949	6,760
cetirizine / antihistamines	7,802	7,394	$108,586	7,269
oseltamivir / neuraminidase inhibitors	1,616	7,384	$175,678	7,364
amphetamine-dextroamphetamine / CNS stimulants	7,276	7,149	$224,827	6,211
cefdinir / third generation cephalosporins	7,159	6,981	$138,077	6,880
clonidine / antiadrenergic agents, centrally acting	6,489	6,780	$79,472	6,271
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	6,456	6,691	$134,549	6,603
ibuprofen / nonsteroidal anti-inflammatory agents	6,501	6,668	$83,170	6,535
fluticasone nasal / nasal steroids	6,899	6,654	$113,349	6,585
gabapentin / gamma-aminobutyric acid analogs	5,992	6,150	$91,896	5,699
montelukast / leukotriene modifiers	6,373	6,143	$86,618	5,969
sertraline / SSRI antidepressants	4,830	4,957	$62,043	4,463
acetaminophen-hydrocodone / narcotic analgesic combinations	5,101	4,947	$94,219	4,655
amlodipine / calcium channel blocking agents	4,397	4,592	$68,876	4,274
omeprazole / proton pump inhibitors	4,258	4,332	$54,273	4,138
guanfacine / antiadrenergic agents, centrally acting	4,201	4,306	$78,270	4,045
ergocalciferol / vitamins	3,950	4,071	$37,324	3,340
pantoprazole / proton pump inhibitors	3,904	4,002	$50,159	3,740
hydroxyzine / miscellaneous anxiolytics, sedatives and hypnotics	3,898	3,856	$61,999	3,640
prednisone / glucocorticoids	3,753	3,824	$40,060	3,706

TABLE F: TOP 25 DRUG MOLECULES
BY DOLLARS PAID IN DEC 2024 (FFS and CCOs)

Drug Molecule Therapeutic Category	Nov 2024 $ Paid	Dec 2024 $ Paid	Dec 2024 # Claims	Dec 2024 # Unique Benes
adalimumab / antirheumatics	$2,449,804	$2,678,683	293	253
dupilumab / interleukin inhibitors	$2,548,343	$2,671,662	705	630
semaglutide / GLP-1 receptor agonists for obesity	$2,068,460	$2,233,816	1,737	1,619
paliperidone / atypical antipsychotics	$1,982,042	$2,009,030	650	583
elexacaftor/ivacaftor/tezacaftor / CFTR combinations	$2,083,991	$1,917,993	78	70
dulaglutide / GLP-1 receptor agonists for non-obesity indications	$1,557,686	$1,577,447	1,689	1,568
aripiprazole / atypical antipsychotics	$1,245,939	$1,464,953	3,615	3,318
methylphenidate / CNS stimulants	$1,523,184	$1,458,949	7,584	6,760
bictegravir/emtricitabine/tenofovir / antiviral combinations	$1,251,865	$1,180,839	296	276
ustekinumab / interleukin inhibitors	$840,147	$1,045,361	41	37
emicizumab / factor for bleeding disorders	$684,041	$947,770	31	25
empagliflozin / SGLT-2 inhibitors	$785,648	$818,470	1,032	971
cariprazine / atypical antipsychotics	$820,698	$810,619	581	548
dapagliflozin / SGLT-2 inhibitors	$842,213	$776,832	1,054	1,015
etanercept / antirheumatics	$600,775	$763,456	113	97
ixekizumab / interleukin inhibitors	$618,809	$697,288	91	82
antihemophilic factor / factor for bleeding disorders	$501,889	$581,191	21	11
apixaban / factor Xa inhibitors	$560,484	$560,480	1,141	979
cannabidiol / miscellaneous anticonvulsants	$452,339	$552,322	169	150
somatropin / growth hormones	$465,079	$501,646	114	102
sacubitril-valsartan / angiotensin receptor blockers and neprilysin inhibitors	$438,103	$481,130	768	716
lisdexamfetamine / CNS stimulants	$487,846	$467,705	2,453	2,382
risperidone / atypical antipsychotics	$377,635	$454,619	3,791	3,350
albuterol / adrenergic bronchodilators	$473,083	$452,021	15,134	13,448
anti-inhibitor coagulant complex / factor for bleeding disorders	$146,447	$439,835	3	2

TABLE G: TOP 25 DRUG MOLECULES
BY CHANGE IN NUMBER OF CLAIMS FROM OCT 2024 TO DEC 2024 (FFS and CCOs)

Drug Molecule	Oct 2024 # Claims	Nov 2024 # Claims	Dec 2024 # Claims	Dec 2024 $ Paid	Dec 2024 # Unique Benes
oseltamivir / neuraminidase inhibitors	906	1,616	7,384	$175,678	7,364
azithromycin / macrolides	11,883	13,691	14,348	$215,057	14,113
prednisolone / glucocorticoids	7,214	8,528	8,209	$165,044	7,931
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	5,960	6,456	6,691	$134,549	6,603
benzonatate / antitussives	1,129	1,243	1,506	$19,304	1,480
cefdinir / third generation cephalosporins	6,617	7,159	6,981	$138,077	6,880
codeine-guaifenesin / upper respiratory combinations	86	87	162	$2,680	161
doxycycline / tetracyclines	1,996	1,959	2,062	$27,907	2,021
albuterol-ipratropium / bronchodilator combinations	538	522	601	$53,149	555
levofloxacin / quinolones	437	469	497	$6,360	478
budesonide / inhaled corticosteroids	1,719	1,656	1,770	$161,034	1,711
acetaminophen-oxycodone / narcotic analgesic combinations	2,117	2,105	2,163	$42,715	2,043
prednisone / glucocorticoids	3,779	3,753	3,824	$40,060	3,706
valsartan / angiotensin II inhibitors	293	290	328	$6,123	315
clarithromycin / macrolides	223	246	255	$22,868	251
olmesartan / angiotensin II inhibitors	347	331	379	$5,297	368
sacubitril-valsartan / angiotensin receptor blockers and neprilysin inhibitors	737	705	768	$481,130	716
ipratropium / anticholinergic bronchodilators	101	111	124	$16,595	112
enalapril / angiotensin converting enzyme (ACE) inhibitors	244	227	266	$22,706	250
acyclovir / purine nucleosides	376	331	397	$6,268	383
progesterone / progestins	101	118	121	$2,576	118
oxycodone / narcotic analgesics	619	618	635	$21,158	597
glyburide / sulfonylureas	66	70	81	$1,329	76
ethinyl estradiol-levonorgestrel / contraceptives	491	527	506	$11,770	475
nirmatrelvir-ritonavir / antiviral combinations	56	51	70	$97,137	70

TABLE H: TOP 25 DRUG MOLECULES
BY CHANGE IN AMOUNT PAID FROM OCT 2024 TO DEC 2024 (FFS and CCOs)

Drug Molecule	Oct 2024 $ Paid	Nov 2024 $ Paid	Dec 2024 $ Paid	Dec 2024 # Claims	Dec 2024 # Unique Benes
anti-inhibitor coagulant complex / factor for bleeding disorders	$0	$146,447	$439,835	3	2
teduglutide / miscellaneous GI agents	$228,667	$367,091	$409,844	9	9
oseltamivir / neuraminidase inhibitors	$26,186	$42,346	$175,678	7,384	7,364
glecaprevir-pibrentasvir / antiviral combinations	$25,709	$78,046	$164,153	14	11
risankizumab / interleukin inhibitors	$302,242	$184,376	$417,130	23	23
trofinetide / miscellaneous central nervous system agents	$70,806	$83,127	$166,242	3	2
emicizumab / factor for bleeding disorders	$863,809	$684,041	$947,770	31	25
antihemophilic factor / factor for bleeding disorders	$506,727	$501,889	$581,191	21	11
ivosidenib / miscellaneous antineoplastics	$0	$33,166	$66,331	2	2
regorafenib / multikinase inhibitors	$15,143	$43,811	$72,480	4	3
c1 esterase inhibitor, human / hereditary angioedema agents	$55,880	$90,802	$111,748	3	2
cysteamine / miscellaneous uncategorized agents	$261,356	$371,414	$316,385	3	3
risdiplam / miscellaneous uncategorized agents	$271,949	$181,310	$323,768	16	11
lanadelumab / hereditary angioedema agents	$0	$0	$51,182	1	1
cannabidiol / miscellaneous anticonvulsants	$506,021	$452,339	$552,322	169	150
immune globulin intravenous and subcutaneous / immune globulins	$286,951	$292,782	$330,300	27	23
ublituximab / CD20 monoclonal antibodies	$0	$0	$41,913	2	1
setmelanotide / melanocortin receptor agonists	$236,910	$278,094	$278,094	9	8
nitisinone / miscellaneous metabolic agents	$0	$24,131	$40,214	3	2
tucatinib / HER2 inhibitors	$25,641	$25,641	$64,062	5	2
pemigatinib / multikinase inhibitors	$0	$37,533	$37,533	2	1
givinostat / histone deacetylase inhibitors	$37,011	$37,011	$74,023	2	1
eltrombopag / platelet-stimulating agents	$42,136	$48,693	$78,552	6	5
tovorafenib / multikinase inhibitors	$0	$0	$33,927	1	1
interferon beta-1a / interferons	$42,743	$58,832	$74,798	9	7

TABLE I: TOP 15 DRUG SOLID DOSAGE FORM HIGH VOLUME (100+ RX FILLS LAST MONTH) PRODUCTS WITH UNIT COST > $1
BY PERCENT CHANGE IN AMOUNT PAID PER UNIT OCT 2024 TO DEC 2024 (FFS and CCOs)

Drug Product Therapeutic Category	Dec 2024 # Claims	Dec 2024 $ Paid	Dec 2024 Avr. Paid Per Rx	Dec 2024 Avr. Units Per Rx	Oct 2024 Paid Per Unit	Nov 2024 Paid Per Unit	Dec 2024 Paid Per Unit	Percent Change
lisdexamfetamine 30 mg capsule / CNS stimulants (Y)	518	$90,218	$174.17	30	$4.26	$5.51	$5.47	28.4%
lisdexamfetamine 70 mg capsule / CNS stimulants (Y)	143	$26,072	$182.32	30	$4.67	$5.33	$5.70	21.9%
lisdexamfetamine 40 mg capsule / CNS stimulants (Y)	406	$62,768	$154.60	30	$4.20	$4.64	$4.79	14.1%
lisdexamfetamine 20 mg capsule / CNS stimulants (Y)	281	$45,646	$162.44	30	$4.50	$4.93	$5.07	12.5%
Brilinta (ticagrelor) (ticagrelor) 90 mg tablet / platelet aggregation inhibitors (Y)	121	$49,303	$407.47	56	$6.91	$6.97	$7.00	1.3%
Linzess (linaclotide) 290 mcg capsule / guanylate cyclase-C agonists (Y)	142	$73,842	$520.01	30	$16.76	$16.57	$16.96	1.2%
Xarelto (rivaroxaban) 20 mg tablet / factor Xa inhibitors (Y)	373	$189,273	$507.44	28	$17.47	$17.54	$17.66	1.1%
Entresto (sacubitril-valsartan) 49 mg-51 mg tablet / angiotensin receptor blockers and neprilysin inhibitors (Y)	190	$119,720	$630.10	58	$10.56	$10.58	$10.67	1.0%
dexmethylphenidate 20 mg capsule, extended release / CNS stimulants (Y)	400	$21,098	$52.74	30	$1.37	$1.34	$1.38	0.6%
Slynd (drospirenone) 4 mg tablet / progestins (Y)	290	$66,480	$229.24	33	$6.60	$6.64	$6.64	0.6%
Entresto (sacubitril-valsartan) 97 mg-103 mg tablet / angiotensin receptor blockers and neprilysin inhibitors (Y)	221	$143,303	$648.43	59	$10.69	$10.65	$10.74	0.5%
Vraylar (cariprazine) 1.5 mg capsule / atypical antipsychotics (Y)	269	$377,869	$1,404.72	30	$45.88	$45.90	$46.02	0.3%
QuilliChew ER (methylphenidate) 40 mg/24 hr tablet, chewable, extended release / CNS stimulants (Y)	617	$226,629	$367.31	30	$11.81	$11.84	$11.84	0.3%
Biktarvy (bictegravir/emtricitabine/tenofovir) 50 mg-200 mg-25 mg tablet / antiviral combinations (Y)	294	$1,173,084	$3,990.08	36	$118.00	$117.75	$118.17	0.1%
Eliquis (apixaban) 2.5 mg tablet / factor Xa inhibitors (Y)	143	$63,967	$447.32	47	$9.12	$9.10	$9.13	0.1%

Products are only included if 100 or more fills in last month and average cost per unit in reference month was >= $1.

New Business

Special Analysis Projects

MISSISSIPPI DIVISION OF MEDICAID

MS-DUR INTERVENTION / EDUCATIONAL INITIATIVE UPDATE

DECEMBER 2025 – FEBRUARY 2025

Ongoing Mailings:

PROVIDER SHOPPING FOR OPIOIDS (≥4 Prescribers AND ≥4 Pharmacies)				CONCOMITANT USE OF OPIOIDS AND ANTIPSYCHOTICS			SABA MONOTHERAPY		
Month	Prescribers Mailed	Pharms Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed
24-Mar	0	0	0	24-Mar	6	6	24-Mar	NA	NA
24-Apr	4	4	8	24-Apr	67	87	24-Apr	NA	NA
24-May	3	3	6	24-May	42	47	24-May	NA	NA
24-Jun	5	5	10	24-Jun	30	32	24-Jun	NA	NA
24-Jul	4	3	7	24-Jul	29	32	24-Jul	NA	NA
24-Aug	4	4	8	24-Aug	52	65	24-Aug	NA	NA
24-Sep	3	4	7	24-Sep	36	40	24-Sep	NA	NA
24-Oct	5	5	10	24-Oct	46	48	24-Oct	NA	NA
24-Nov	4	4	8	24-Nov	59	67	24-Nov	NA	NA
24-Dec	2	2	4	24-Dec	44	54	24-Dec	NA	NA
25-Jan	2	2	4	25-Jan	51	57	25-Jan	150	216
25-Feb	1	1	2	25-Feb	41	47	25-Feb	150	190

Note: Before April 2024, only FFS data was available for the period presented in this table.
Beginning in April 2024, all plans were included.

COMPLIANCE MEASUREMENTS FOR INITIATORS OF GLP-1 ANTI-OBESITY MEDICATIONS

BACKGROUND

With mounting evidence supporting the benefits of glucagon-like peptide 1 receptor agonists (GLP-1 RAs) in treating multiple chronic health conditions, their place in therapy for many of these conditions, such as their role in obesity management, is growing.[1–3] However, limited real-world evidence examining the use of GLP-1 RAs for obesity management exists.[4] Beginning July 1, 2023, the Mississippi Division of Medicaid added anti-obesity select agents to their Universal Preferred Drug List (UPDL) and become one of the first state Medicaid programs to cover GLP-1 RA anti-obesity medications (AOMs).[5] At the December 2024 DUR Board meeting, MS-DUR presented a report describing the demographic and clinical profiles of Medicaid members who initiated GLP-1 RA AOMs since coverage began in July 2023. Among members included in the analysis, the majority were Black females between 21-40 years of age with an obesity diagnosis along with other chronic, comorbid conditions.

This present study aims to expand on previous work by estimating compliance metrics for Mississippi Medicaid members who initiated GLP-1 RA AOMs.

METHODS

Study Design and Data Source

This observational analysis utilized Mississippi Medicaid administrative claims data from July 2023 to December 2024. The dataset included claims from both the Fee-for-Service (FFS) program and Coordinated Care Organizations (CCOs), which comprised Magnolia Health (MAG), Molina Healthcare (MOL), and UnitedHealthcare (UHC). Pharmacy claims were used to identify all initiations of GLP-1RA-AOMs during the study period.

Study Population

GLP-1RA-AOM initiators for the compliance measurements were identified between July 1, 2023, and December 31, 2023. The first prescription fill for a GLP-1RA-AOM was defined as the index date. Each member was required to have continuous enrollment in Mississippi Medicaid in the 6-month baseline period and the 12-month follow-up period.

For trajectory modeling, two cohorts were developed. For model 1 (adherence assessment during the 12-month follow-up period): GLP-1RA-AOM initiators between July 1, 2023, and December 31, 2023, were identified. The date of initiation was defined as the index date. Eligible members were required to have continuous enrollment in Mississippi Medicaid for 12 months following the index date. For model 2 (adherence assessment during the 6-month follow-up period), GLP-1RA-AOM initiators between July 1, 2023, and June 30, 2024, were identified, with the date of initiation set as the index date. Eligible members were required to have continuous enrollment in Mississippi Medicaid for 6 months before the index date (for clinical characteristics assessment) and 6 months after the index date.

Outcomes

Several compliance measures were assessed, including adherence, persistence, discontinuation, and reinitiation of these medications. Compliance measures were noted at 3-month, 6-month, and 12-month periods.

- ***Adherence rate*** was measured as proportion of individuals who had their prescriptions filled to cover at least 80% of the time.
- ***Persistence rate*** was defined as continuously taking medication without a consecutive 60-day gap.
- ***Discontinuation*** was defined as a gap of 60 or more consecutive days without a prescription refill following the last recorded fill date. The discontinuation date was determined as the last day of medication possession before the gap. Discontinuation rates were evaluated at 3-month, 6-month, and 12-month intervals.
- ***Reinitiation*** was defined as a prescription fill occurring after a discontinuation period of at least 60 days. The reinitiation date was recorded as the first day of medication possession following the discontinuation gap. The study also examined whether beneficiaries reinitiated the same GLP-1 medication or switched to a different formulation (e.g., Saxenda to Wegovy or vice versa).

Measurement of adherence for trajectory modeling

For trajectory modeling, GLP-1RA-AOM adherence was measured using the monthly proportion of days covered (PDC) during the 12-month follow-up period (model 1) and 6-month follow-up period (model 2) following the index date. PDC, a frequently used adherence metric, defined as the ratio of total days covered by a medication (based on days' supply) to the total days in the observation period. Group-based trajectory modeling (GBTM) was employed to categorize individuals based on distinct adherence trends. The model input was monthly PDC values during the 1-year follow-up period (model 1) and 6-months follow-up period (model 2) following the index date. For the estimation of model parameters, GBTM used maximum likelihood estimation (MLE). The final trajectory model was selected from 2 to 5 adherence groups based on Bayesian information criteria (BIC), clinical significance, and a sample size of 5% membership requirement.

Covariates

Several characteristics were measured in the study to better understand the medication utilization patterns. Demographic characteristics included age, sex, race, and health plan. Age and health plan were assessed as of the index date. Comorbidities were assessed during the six-month baseline period before the index date and included obesity, overweight, hypertension, hyperlipidemia, prediabetes, type 1 diabetes, type 2 diabetes, sleep apnea, atherosclerotic cardiovascular disease (ASCVD), non-alcoholic fatty liver disease (NAFLD), heart failure, atrial fibrillation and flutter, and myocardial infarction. Hypertension, hyperlipidemia, type 1 diabetes, and type 2 diabetes were defined by the presence of at least one clinical diagnosis and corresponding medication use during the baseline period. Use of comedications was also assessed, including the use of other GLP-1 RAs medications in the baseline period, and anti-

vomiting medication utilization (ondansetron, promethazine, and proton pump inhibitors [PPIs]) during the follow-up period.

Statistical Analysis

Descriptive statistics were performed to summarize member demographic and clinical characteristics. A multinomial logistic regression model was used to identify predictors of adherence trajectories to GLP-1RA-AOMs in a cohort with a 6-month follow-up period (model 2), with the consistently adherent group as the reference category.

RESULTS

A total of 768 individuals were identified as initiators of GLP-1 RA AOMs between July 2023 and December 2023. Of these, 264 individuals were excluded due to not meeting inclusion criteria. Table 1 summarizes the GLP-1 RA AOM adherence rate among the 504 initiators in the final sample.

Overall, the adherence rate to GLP-1 RA AOM initiators was 46.5% at the 3-month period and declined to 24.6% at the 12-month period. These numbers are in line with adherence reported in a recent study that examined real-world adherence and persistence to GLP-1 RAs among obese, commercially- insured adults without diabetes.[4] Among our sample, older individuals consistently had higher adherence than younger individuals. Blacks had lower adherence rates compared to other racial groups. Among health plans, those enrolled in CCOs tended to have higher adherence compared to those enrolled in FFS. Finally, Wegovy users generally had higher adherence rates as compared to Saxenda.

Table 1. GLP-1 Anti-obesity Medication Adherence Among Initiators in Mississippi Medicaid July 2023 - December 2024

	N	3 months	6 months	12 months
Total	**504**	46.5%	32.3%	24.6%
Gender				
Male	58	46.6%	36.2%	27.6%
Female	446	46.5%	31.8%	24.2%
Age				
<18	57	38.6%	22.8%	22.8%
18-20	10	40.0%	30.0%	10.0%
21-40	262	47.7%	32.4%	22.9%
41-64	175	47.7%	35.2%	28.4%
Race				
Whites	208	50.5%	33.7%	27.4%
Blacks	226	42.3%	29.5%	21.1%
Others	70	48.6%	37.1%	27.1%
Plan*				
FFS	70	34.3%	22.9%	14.3%
MAG	193	46.1%	30.6%	25.4%
MOL	83	48.2%	37.3%	24.1%
UHC	158	51.6%	35.8%	28.3%
Clinical Characteristics				
Obesity	472	47.1%	32.6%	24.7%
Overweight	21	47.6%	38.1%	14.3%
Presence of any of the following comorbid conditions	**331**	**44.9%**	**31.9%**	**25.9%**
Hypertension	218	43.8%	32.7%	26.5%
Hyperlipidemia	156	45.5%	32.3%	26.9%
Prediabetes	70	29.9%	20.8%	23.4%
Obstructive sleep apnea	87	37.2%	28.7%	24.5%
Type 2 DM	58	49.2%	26.2%	18.0%
ASCVD	47	28.0%	20.0%	24.0%
NAFLD	36	45.0%	37.5%	22.5%
Heart Failure	21	20.8%	12.5%	12.5%
Atrial Fibrillation and Flutter	15	18.8%	12.5%	12.5%
Type 1 DM	0	NA	NA	NA
Myocardial Infraction	3	33.3%	33.3%	33.3%
Weight Loss Medication				
Saxenda	137	24.1%	16.8%	14.6%
Wegovy	367	54.9%	38.0%	28.3%
GLP-1 medication use during baseline period**	63	52.4%	34.9%	20.6%
Anti-vomiting medication***				
Ondansetron	97	49.5%	32.0%	20.6%
Promethazine	31	38.7%	25.8%	25.8%
Proton pump inhibitors (PPI)	91	46.2%	26.4%	20.9%
Composite (ondansetron, promethazine, PPI)	183	48.1%	30.1%	22.4%

Notes: FFS - Fee for Service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare;
*Adherence rate defined as the proportion of individuals had a PDC (Proportion of Days Covered) ≥ than 80%
** Baseline period - 6-month period prior to the index date (date of initiation).
*** Anti-vomiting medication use assessed from index date through 12-months after index date.

Table 2 shows that 65.7% of patients remained persistent with anti-obesity medication at 3 months, dropping to 46.8% at 6 months and 33.5% at 12 months. Again, these numbers are similar to the persistence rates found by Gleason et al.[4] Persistence was generally higher among women, older adults, and those enrolled in CCOs. Whites and other racial groups also demonstrated higher persistence rates than Blacks. Wegovy users exhibited higher persistences rates compared to Saxenda users, most notably at 3-months.

Table 2. GLP-1 Anti-obesity Medication Persistence Among Initiators in Mississippi Medicaid
July 2023 - December 2024

	N	3 months	6 months	12 months
Total	**504**	65.7%	46.8%	33.5%
Gender				
Male	58	62.1%	43.1%	32.8%
Female	446	66.1%	47.1%	33.6%
Age				
<18	57	61.4%	38.6%	33.3%
18-20	10	50.0%	40.0%	20.0%
21-40	262	65.6%	46.6%	32.1%
41-64	175	68.0%	50.3%	36.6%
Race				
Whites	208	67.8%	47.6%	35.6%
Blacks	226	60.6%	45.6%	31.0%
Others	70	75.7%	48.6%	35.7%
Plan*				
FFS	70	57.1%	35.7%	25.7%
MAG	193	60.6%	43.0%	32.1%
MOL	83	65.1%	50.6%	31.3%
UHC	158	75.9%	54.4%	39.9%
Clinical Characteristics				
Obesity	472	66.3%	47.7%	33.9%
Overweight	21	66.7%	38.1%	28.6%
Presence of any of the following comorbid conditions	**331**	**65.0%**	**48.0%**	**34.4%**
Hypertension	218	67.0%	51.8%	35.8%
Hyperlipidemia	156	68.6%	49.4%	36.5%
Prediabetes	70	52.9%	40.0%	34.3%
Obstructive sleep apnea	87	51.7%	37.9%	24.1%
Type 2 DM	58	70.7%	43.1%	29.3%
ASCVD	47	61.7%	42.6%	34.0%
NAFLD	36	58.3%	47.2%	33.3%
Heart Failure	21	38.1%	19.0%	14.3%
Atrial Fibrillation and Flutter	15	40.0%	26.7%	13.3%
Type 1 DM	0	NA	NA	NA
Myocardial Infraction	3	66.7%	33.3%	33.3%
Weight Loss Medication				
Saxenda	137	45.3%	31.4%	24.8%
Wegovy	367	73.3%	52.6%	36.8%
GLP-1 medication use during baseline period**	63	65.1%	44.4%	28.6%
Anti-vomiting medication***				
Ondansetron	97	67.0%	46.4%	29.9%
Promethazine	31	67.7%	45.2%	32.3%
Proton pump inhibitors (PPI)	91	62.6%	42.9%	28.6%
Composite (ondansetron, promethazine, PPI)	183	65.0%	45.4%	31.1%

Notes: FFS - Fee for Service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare;
*Persistence defined as not having a 60-day consecutive gap of medication use
** Baseline period - 6-month period prior to the index date (date of initiation).
*** Anti-vomiting medication use assessed from index date through 12-months after index date.

Table 3 summarizes the patterns of discontinuation and reinitiation among Mississippi Medicaid members prescribed GLP-1 RA AOMs. Among those individuals who discontinued therapy, 24.4% discontinued within the first three months, 17.9% between three to six months, and 24.8% between six to twelve months. Reinitiation rates were highest within the first three months (56.9%) and gradually decreased to 43.3% between three to six months and 39.2% between six to twelve months. Across the entire period, younger (18-20yrs), Black members in FFS had higher discontinuation rates compared to other groups. Reinitiation was observed more often among beneficiaries enrolled in MCO plans compared to those in FFS. The most observed comorbidities among discontinuers were obesity, hypertension, and type 2 diabetes. Reinitiation was reported more frequently among individuals with prediabetes and sleep apnea, suggesting these conditions may be associated with continued treatment. A higher proportion of Saxenda users discontinued treatment within the first three months compared to Wegovy users.

Table 3. GLP-1 Anti-obesity Medication Discontinuation & Reinitiation Among Mississippi Medicaid Members July 2023 - December 2024

Characteristics of Medicaid Members	Total Initiators	Less than 3 months				Between 3 to 6 months				Greater than 6 months to 12 months			
		Discontinuers		Reinitiators among Discontinuers		Discontinuers		Reinitiators among Discontinuers		Discontinuers		Reinitiators among Discontinuers	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Total	**504**	**123**	**24.4%**	**70**	**56.9%**	**90**	**17.9%**	**39**	**43.3%**	**125**	**24.8%**	**49**	**39.2%**
Gender													
Male	58	16	27.6%	9	56.3%	11	19.0%	5	45.5%	12	20.7%	5	41.7%
Female	446	107	24.0%	61	57.0%	79	17.7%	34	43.0%	113	25.3%	44	38.9%
Age													
Less than 18	57	15	26.3%	10	66.7%	14	24.6%	5	35.7%	10	17.5%	4	40.0%
18-20	10	5	50.0%	3	60.0%	1	10.0%	0	0.0%	2	20.0%	0	0.0%
21-40	262	59	22.5%	34	57.6%	53	20.2%	20	37.7%	67	25.6%	26	38.8%
41-64	175	44	25.1%	23	52.3%	22	12.6%	14	63.6%	46	26.3%	19	41.3%
Race													
Whites	208	50	24.0%	28	56.0%	37	17.8%	15	40.5%	50	24.0%	17	34.0%
Blacks	226	62	27.4%	35	56.5%	40	17.7%	18	45.0%	54	23.9%	25	46.3%
Others	70	11	15.7%	7	63.6%	13	18.6%	6	46.2%	21	30.0%	7	33.3%
Plan													
FFS	70	23	32.9%	10	43.5%	13	18.6%	7	53.8%	16	22.9%	6	37.5%
MAG	193	52	26.9%	32	61.5%	40	20.7%	19	47.5%	40	20.7%	18	45.0%
MOL	83	18	21.7%	10	55.6%	16	19.3%	3	18.8%	24	28.9%	9	37.5%
UHC	158	30	19.0%	18	60.0%	21	13.3%	10	47.6%	45	28.5%	16	35.6%
Clinical Characteristics													
Obesity	472	112	23.7%	63	56.3%	84	17.8%	39	46.4%	122	25.8%	48	39.3%
Overweight	21	4	19.0%	2	50.0%	6	28.6%	2	33.3%	5	23.8%	2	40.0%
Hypertension	218	64	29.4%	36	56.3%	41	18.8%	23	56.1%	71	32.6%	24	33.8%
Hyperlipidemia	156	36	23.1%	17	47.2%	27	17.3%	10	37.0%	37	23.7%	11	29.7%
Prediabetes	70	29	41.4%	15	51.7%	10	14.3%	6	60.0%	12	17.1%	7	58.3%
Type 1 DM	0	0		0		0		0		0		0	
Type 2 DM	58	20	34.5%	7	35.0%	19	32.8%	9	47.4%	23	39.7%	11	47.8%
Sleep apnea	87	25	28.7%	16	64.0%	15	17.2%	7	46.7%	19	21.8%	9	47.4%
NAFLD	36	9	25.0%	3	33.3%	9	25.0%	5	55.6%	9	25.0%	3	33.3%
Atrial Fibrillation and Flutter	15	3	20.0%	0	0.0%	7	46.7%	5	71.4%	4	26.7%	1	25.0%
Heart Failure	21	7	33.3%	4	57.1%	10	47.6%	6	60.0%	3	14.3%	1	33.3%
Myocardial Infraction	3	0		0		2	66.7%	1	50.0%	0		0	
ASCVD	47	11	23.4%	5	45.5%	12	25.5%	7	58.3%	11	23.4%	5	45.5%
Discontinued GLP-1 RA Medication													
Saxenda	137	58	42.3%	38	65.5%	24	17.5%	15	62.5%	10	7.3%	8	80.0%
Wegovy	367	65	17.7%	32	49.2%	66	18.0%	24	36.4%	115	31.3%	41	35.7%
Reinitiated GLP-1 RA Medication													
Saxenda		N/A		7		N/A		3		N/A		3	
Wegovy		N/A		63		N/A		36		N/A		46	
Anti-Vomiting Medications*													
Ondansetron		13		7	53.8%	19		8	42.1%	26		7	26.9%
Promethazine		4		3	75.0%	4		2	50.0%	10		4	40.0%
Proton Pump Inhibitors (PPI)		16		6	37.5%	15		5	33.3%	24		9	37.5%
Composite (ondansetron, promethazine, PPI)		30		15	50.0%	34		12	35.3%	45		15	33.3%

Notes: FFS - Fee for Service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare;

**Anti-vomiting medication use was measured from the index date to 7-days post discontinuation of the GLP-1 RA.*

For the group-based trajectory modeling, two models were created. The study cohort for model 1 (12-month adherence) included 512 Mississippi Medicaid members who initiated GLP-1RA AOMs between July 1, 2023 and December 31, 2023. Figure 1 presents four distinct adherence trajectory groups that were identified for model 1 in the 12-month follow-up period: consistent adherent (43.6%), early and rapid discontinuers (22.5%), gradual discontinuers (17.8%), and fluctuating adherent (16.2%).

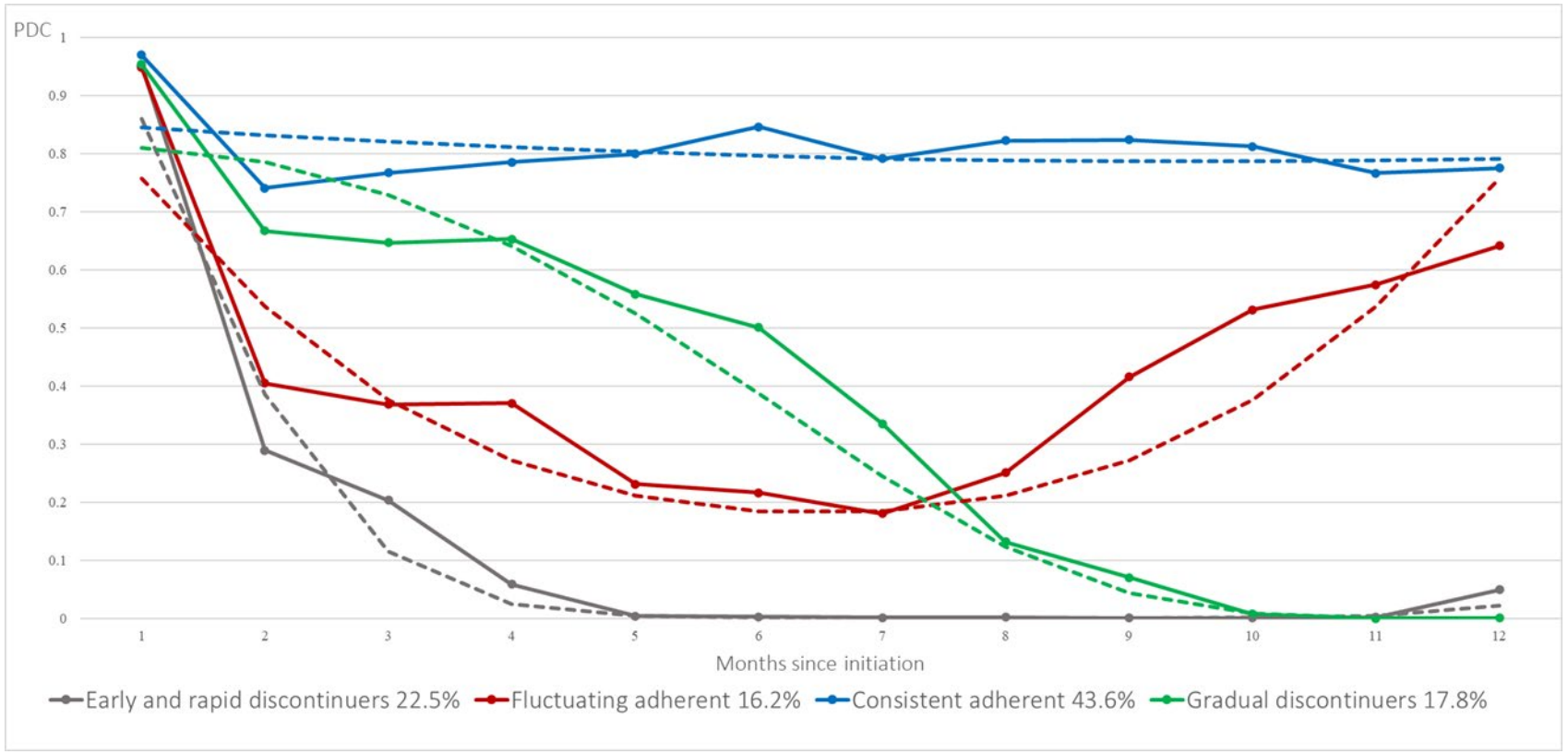

Figure 1. GLP-1 RA AOM Adherence Trajectories in 12-month (model 1)

Model 2 examined adherence trajectories for initiators of GLP RA AOMs between July 1, 2023 and June 30, 2024 with a 6-month followed. This model included 1,601 members. Again, four distinct adherence trajectories were identified for model 2 in the 6-month follow-up period: consistent adherent (59.2%), gradual decliners (16.1%), rapid discontinuers (15.7%), and fluctuating adherers (8.6%). (Figure 2)

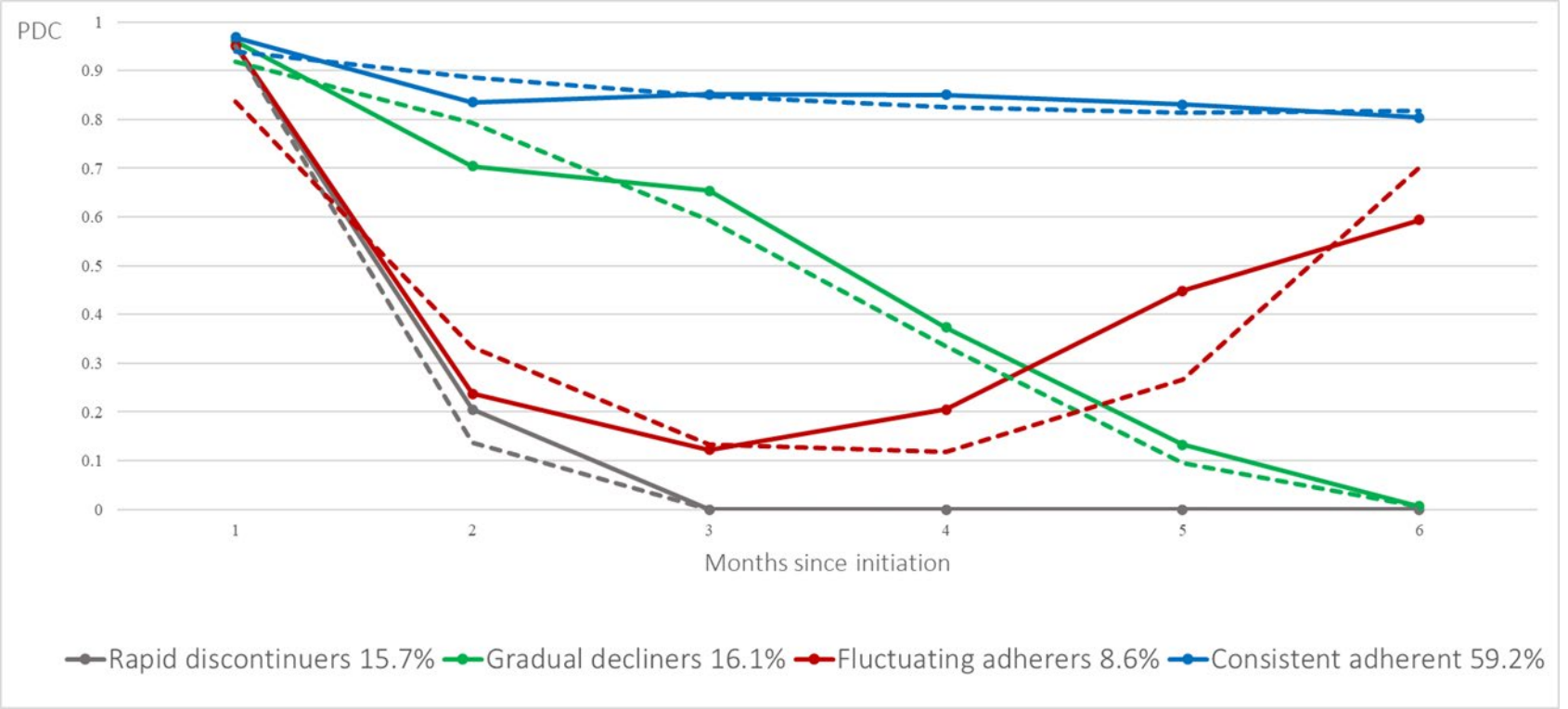

Figure 2. GLP-1 RA AOM Adherence Trajectories in 6-month modeling (model 2)

Table 4 presents the descriptive statistics of the four trajectories identified from Model 2. Among age groups, 54.9% of individuals aged <18 years were in the consistent adherent group, while 65.1% of those aged 46–64 years were consistent adherents. Regarding health plans, 67.1% of UHC enrollees were consistent adherents, compared to only 44.6% of FFS enrollees.

Table 4. Demographic and Clinical Characteristics of Members Included in Model 2

Beneficiary Characteristics		Total	Consistent adherent		Rapid discontinuers		Gradual decliners		Fluctuating adherent	
			Number	%	Number	%	Number	%	Number	%
TOTAL		1,601	953	59.5%	252	15.7%	258	16.1%	138	8.6%
Age	<18 years	182	100	54.9%	30	16.5%	33	18.1%	19	10.4%
	18 - 44 years	1,069	625	58.5%	169	15.8%	182	17.0%	93	8.7%
	46 - 64 years	350	228	65.1%	53	15.1%	43	12.3%	26	7.4%
Gender	Male	176	110	62.5%	30	17.0%	25	14.2%	11	6.3%
	Female	1,425	843	59.2%	222	15.6%	233	16.4%	127	8.9%
Race	White	609	359	58.9%	95	15.6%	104	17.1%	51	8.4%
	Black	757	435	57.5%	127	16.8%	123	16.2%	72	9.5%
	Other	235	159	67.7%	30	12.8%	31	13.2%	15	6.4%
Pharmacy Program	FFS	193	86	44.6%	43	22.3%	40	20.7%	24	12.4%
	UHC	511	343	67.1%	62	12.1%	66	12.9%	40	7.8%
	MAG	592	347	58.6%	94	15.9%	99	16.7%	52	8.8%
	MOL	305	177	58.0%	53	17.4%	53	17.4%	22	7.2%
Clinical Characteristics	Obesity	1394	837	60.0%	215	15.4%	224	16.1%	118	8.5%
	Overweight	63	37	58.7%	10	15.9%	10	15.9%	6	9.5%
	Hypertension	648	404	62.3%	98	15.1%	96	14.8%	50	7.7%
	Hyperlipidemia	172	112	65.1%	20	11.6%	26	15.1%	14	8.1%
	Glucose dysregulation	473	280	59.2%	72	15.2%	75	15.9%	46	9.7%
	Prediabetes	108	67	62.0%	19	17.6%	12	11.1%	10	9.3%
	Type 1 DM	14	8	57.1%	3	21.4%	2	14.3%	1	7.1%
	Type 2 DM	163	105	64.4%	23	14.1%	27	16.6%	8	4.9%
	Sleep apnea	261	174	66.7%	33	12.6%	29	11.1%	25	9.6%
	NAFLD	105	59	56.2%	15	14.3%	19	18.1%	12	11.4%
	Atrial Fibrillation and Flutter	29	14	48.3%	4	13.8%	6	20.7%	5	17.2%
	Heart Failure	78	40	51.3%	14	17.9%	13	16.7%	11	14.1%
	Myocardial Infraction	9	4	44.4%	0	0.0%	4	44.4%	1	11.1%
	ASCVD	133	83	62.4%	15	11.3%	20	15.0%	15	11.3%

Table 5 presents multinomial logistic regression analysis results examining factors associated with being in the consistent adherent trajectory group. Relative to the consistent adherent group, enrollment in CCO programs was significantly associated with lower odds of belonging to any of the other adherence groups (rapid discontinuers: odds ratio [OR] = 0.475, 95% confidence interval [CI] = 0.320–0.707; gradual decliners: OR = 0.533, 95% CI = 0.356–0.799; and fluctuating adherers: OR = 0.438, 95% CI = 0.269–0.713). Additionally, older age (>45 years; OR = 0.622, 95% CI = 0.443–0.874) and those with sleep apnea (OR = 0.567, 95% CI = 0.373–0.863) were associated with a decreased likelihood of belonging to the gradual decliner group, relative to the consistent adherent group. Members with type 2 diabetes mellitus (OR = 0.431, 95% CI = 0.196–0.946) were associated with a decreased likelihood of belonging to the fluctuating adherent group, relative to the consistent adherent group.

Table 5: Multinomial Logistic Regression Analysis of Factors Associated With GLP-1 RA AOM Adherence Trajectory Group

Beneficiary Characteristics		Rapid discontinuers vs. consistent adherent		Gradual decliners vs. consistent adherent		Fluctuating adherent vs. consistent adherent	
		Odds ratio (95%CI)	P-value	Odds ratio (95%CI)	P-value	Odds ratio (95%CI)	P-value
Age	<18 years	1.004(0.605 - 1.667)	0.9872	1.157(0.782 - 1.710)	0.4658	1.194(0.691 - 2.063)	0.5253
	18 - 44 years	Reference		Reference		Reference	
	46 - 64 years	0.953(0.657 - 1.382)	0.8005	**0.622(0.443 - 0.874)**	**0.0062**	0.764(0.482 - 1.211)	0.2517
Gender	Male	Reference		Reference		Reference	
	Female	0.966(0.628 - 1.484)	0.8733	1.216(0.769 - 1.922)	0.4022	1.505(0.788 - 2.875)	0.2154
Race	White	Reference		Reference		Reference	
	Black	1.106(0.819 - 1.493)	0.5116	0.978(0.728 - 1.316)	0.8846	1.184(0.806 - 1.738)	0.3886
	Other	0.709(0.451 - 1.112)	0.1341	0.669(0.430 - 1.041)	0.0746	0.617(0.332 1.146)	0.1262
Pharmacy Program	Fee-for-service	Reference		Reference		Reference	
	Coordinated Care Organizations	**0.475(0.320 - 0.707)**	**0.0002**	**0.533(0.356 - 0.799)**	**0.0023**	**0.438(0.269 - 0.713)**	**0.0009**
Clinical Characteristics	Obesity	0.804(0.540 - 1.199)	0.2851	0.912(0.605 - 1.374)	0.6593	0.810(0.485 - 1.352)	0.4197
	Overweight	1.023(0.502 - 2.087)	0.9501	0.998(0.490 - 2.036)	0.9962	1.125(0.466 - 2.718)	0.793
	Hypertension	0.896(0.652 - 1.233)	0.501	0.779(0.600 - 1.013)	0.0622	0.752(0.518 - 1.091)	0.1332
	Hyperlipidemia	0.648(0.394 - 1.065)	0.087	0.842(0.536 - 1.321)	0.4531	0.848(0.471 - 1.524)	0.5812
	Prediabetes	1.078(0.635 - 1.831)	0.7801	0.645(0.343 - 1.212)	0.1729	1.033(0.518 - 2.059)	0.9262
	Type 1 DM	1.424(0.375 - 5.406)	0.6034	0.923(0.195 - 4.373)	0.9194	0.862(0.107 - 6.948)	0.8892
	Type 2 DM	0.803(0.500 - 1.291)	0.3655	0.935(0.598 - 1.462)	0.7684	**0.431(0.196 - 0.946)**	**0.0359**
	Sleep apnea	0.675(0.452 - 1.008)	0.0545	**0.567(0.373 - 0.863)**	**0.0081**	0.990(0.623 - 1.574)	0.9678
	NAFLD	0.977(0.544 - 1.754)	0.937	1.227(0.717 - 2.100)	0.4561	1.605(0.855 - 3.013)	0.1411
	Atrial Fibrillation and Flutter	1.083(0.353 - 3.319)	0.8891	1.599(0.608 - 4.202)	0.3414	2.544(0.902 - 7.177)	0.0777
	Heart Failure	1.344(0.719 - 2.511)	0.3538	1.212(0.638 - 2.303)	0.5561	1.995(0.998 - 3.988)	0.0507
	Myocardial Infraction	N/A	N/A	3.736(0.928 - 15.042)	0.0636	1.732(0.192 - 15.607)	0.6245
	ASCVD	0.672(0.380 - 1.187)	0.1706	0.892(0.536 - 1.484)	0.6588	1.381(0.783 - 2.437)	0.2647

CONCLUSIONS

GLP-1 RAs have been shown to be effective agents for obesity management, however limited real-world evidence exists, particularly in a Medicaid population. This study estimated compliance metrics among a sample of Mississippi Medicaid members who were prescribed GLP-RA AOMs. Our study found the overall adherence rate for GLP-1 RA AOM initiators was 46.5% at 3 months and declined to 24.6% at 12 months, while persistence was 65.7% at 3 months and 33.5% at 12 months. These figures allign with another recent study examining individuals in a commercial health plan. Across all of the metrics examined, Medicaid members enrolled in CCO programs were found to have better compliance compared to those enrolled in FFS. It should be noted that the impacts on medication compliance resulting from recent drug shortages of GLP-1 RAs was not factored into this analysis. Future work will reexamine compliance to GLP-1 RA AOMs post-supply chain issues and will explore outcomes and healthcare resource utilization among individuals initiating GLP-1 RA AOMs.

RECOMMENDATIONS

This analysis aims to describe the compliance metrics associated with Medicaid members who initiated GLP-1 medications for obesity management. This report is part of a series of reports exploring the utilization and impact of GLP-1 RA AOMs among Mississippi Medicaid members.

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PERFORMANCE ON COB-AB QUALITY MEASURE INCORPORATING PMP DATA

BACKGROUND

The Mississippi Prescription Monitoring Program (MS PMP) is an electronic tracking program managed by the Mississippi Board of Pharmacy (MBOP) to aid practitioners and dispensers in providing proper pharmaceutical care relating to controlled substances.[1] It also serves as a tool for regulatory agencies and authorized law enforcement to identify potential inappropriate use of controlled substance prescription medication. The Mississippi Division of Medicaid (DOM) has a Memorandum of Understanding with the MBOP that allows MS-DUR to obtain MS PMP data for all beneficiaries enrolled in Medicaid.

Monthly, MS-DUR submits a request file of all members enrolled in Medicaid to Bamboo Health, the current data warehouse contractor for the MS PMP, and later receives an extract file containing all prescriptions filled for persons listed in the request file. These data go through an extensive validation process for matching MS PMP claims to Medicaid members.

In a report shared at the September 2023 DUR Board meeting, analysis of MS PMP data indicated that approximately 42% of opioid claims for individuals enrolled in Medicaid were paid for by a source other than Medicaid. It is unknown what potential impact incorporating MS PMP data into prescription claims data for Medicaid members will have on member monitoring parameters and routine reporting metrics related to controlled substance prescribing.

The goal of this study is to: a) determine the potential impact of incorporating MS PMP data, matched to Mississippi Medicaid members, on DOM's performance on a Medicaid Adult Core Set quality measure; b) identify factors associated with members who were additionally identified in the quality measure by incorporating MS-PMP data.

METHODS

Study Design and Data Source

The cohort study was conducted using Mississippi Medicaid fee-for-service (FFS) and coordinated care organization claims (CCOs), along with data from the Mississippi Prescription Monitoring Program for calendar year 2021.

Study Cohort

The "Concurrent Use of Opioids and Benzodiazepines" (COB-AD) measure for measurement year 2021, developed by the Pharmacy Quality Alliance, was utilized for the cohort development. The measure assesses the percentage of members who are taking opioids that have concurrent use of

benzodiazepines for 30 or more days. According to the measure, the denominator included Medicaid enrollees 18 years and older who had at least two opioid prescription claims with unique dates of service, for which the sum of the days' supply is at least 15 days. Eligible members were required to be continuously enrolled for the entire measurement year, allowing for no more than one enrollment gap of up to 45 days. Members were excluded if they had a diagnosis of cancer or sickle cell disease, or had received hospice and palliative care services during the observation year. Additionally, the initial opioid prescription fill date (IPSD) had to have occurred before December 2 of the measurement year. The numerator included members from the denominator who had concurrent use of opioids and benzodiazepines for 30 or more cumulative days. (Table 1) The resultant numerator of the measure obtained using both MS Medicaid and MS-PMP data was considered as the study cohort.

TABLE 1. COB-AD Measurement Specifications

Measurement Year	January 1, 2021 - December 31, 2021
Denominator	Medicaid enrollees 18 years and older with two or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is $\geq$ 15.
Anchor Date for Age	Age is calculated for first day of the measurement year.
Continuous Enrollment	Member must be enrolled for entire measurement year with no more than one gap in continuous enrollment of up to 45 days.
Index Prescription Start Date (IPSD)	The member's first fill of an opioid prescription (IPSD) must occur before December 2 of the measurement year.
Exclusions	Members are excluded if they have any diagnosis of cancer or sickle cell, or receive any hospice and palliative services during the observation year.
Numerator	Any members in denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

Outcome

The key outcome of the study was the identification of additional members with concurrent opioid and benzodiazepine use for 30 or more cumulative days, using both MS Medicaid and MS PMP data beyond what was captured in Medicaid data alone. Initially, the numerator of the measure was determined using only MS Medicaid data for the 2021 measurement year. It was then recalculated using both MS Medicaid and MS PMP data. The members who were identified in both datasets (MS Medicaid and MS PMP, MS Medicaid only) were categorized into one group, while those additionally identified with the addition of MS PMP data beyond MS Medicaid alone were categorized into another group.

Predictor Variables

Sociodemographic predictors such as age as of cohort entry date, sex, urban residence, and race were included in the study. Likewise, key clinical factors assessed during the measurement year, including opioid overdose, opioid use disorder, alcohol use disorder, depression, and the presence of chronic non-cancer pain (CNCP) were incorporated. Opioid-related variables examined in the study comprised opioid formulation, average daily MME, and the concomitant use of opioids with other psychotropic medications. Furthermore, prescriber and pharmacy level factors were considered, such as whether the distance between the prescriber and patient was greater than the average distance for opioid claims within a given ZIP code, whether the pharmacy was farther than the average distance, and provider shopping behavior—defined as obtaining opioid prescription claims from at least four prescribers and four pharmacies.

Statistical Analysis

Descriptive statistics were used to characterize the study cohort. For categorical variables, frequency and percentage distributions were reported, whereas for continuous variables, mean and standard deviation (SD) were reported. The chi-square test was used for statistical comparisons of the characteristics between the outcome groups. The relationship between predictor variables and the outcome was tested using logistic regression. All data management and analyses were conducted using SAS version 9.4 (Cary, NC).

RESULTS

Table 2a shows the number of eligible members included in the denominator and the number of members excluded for each of the inclusion/exclusion criteria when using only Medicaid claims data. Table 2b displays the same information with the MS PMP data included. A total of 975,628 members age 18 and above were enrolled in Mississippi Medicaid for some period during the measurement year (January 1, 2021 – December 31, 2021). Of those, 9,367 members met the criteria for inclusion in the denominator for the quality measure using only Medicaid data while 14,067 met the criteria when MS PMP data was added. This represents an additional 4,700 members for inclusion in the denominator who were identified when MS PMP data was included.

TABLE 2a. Number of Members in Measure Denominator Selection

Mississippi Medicaid January 1, 2021 - December 31, 2021

Includes Medicaid ONLY - No CHIP

Step in Denominator Selection	TOTAL	Medicaid Program			
		FFS	UHC	MAG	MOL
Total population 18 and older enrolled	**975,628**	**878,337**	**37,919**	**39,844**	**19,528**
Not Continuously enrolled for measurement year	-726,559	-716,263	-3,891	-3,181	-3,224
Did not have 2+ opioid claims on different dates with 15+ days supply	-238,039	-159,165	-30,050	-33,283	-15,541
Did not have initial prescription start date (IPSD) for opioid prior to December 2 of measurement year	-11	-4	-5	-2	0
Had diagnosis of cancer or sickle cell or hospice and palliative services	-1,652	-476	-499	-539	-138
- Cancer diagnosis	1,295	390	377	410	118
- Sickle cell diagnosis	317	57	110	130	20
- Hospice services	104	55	24	24	1
- Palliative services	71	21	23	19	8
DENOMINATOR FOR MEASURE	**9,367**	**2,429**	**3,474**	**2,839**	**625**

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

TABLE 2b. Number of Members in Measure Denominator Selection Incorporating MS PMP Data

Mississippi Medicaid January 1, 2021 - December 31, 2021

Includes Medicaid ONLY - No CHIP

Step in Denominator Selection	TOTAL	Medicaid Program			
		FFS	UHC	MAG	MOL
Total population 18 and older enrolled	**975,628**	**878,337**	**37,919**	**39,844**	**19,528**
Not Continuously enrolled for measurement year	-726,559	-716,263	-3,891	-3,181	-3,224
Did not have 2+ opioid claims on different dates with 15+ days supply	-232,869	-157,098	-29,188	-31,574	-15,009
Did not have initial prescription start date (IPSD) for opioid prior to December 2 of measurement year	-34	-17	-8	-6	-3
Had diagnosis of cancer or sickle cell or hospice and palliative services	-2,099	-677	-587	-669	-166
- Cancer diagnosis	1,599	525	435	501	138
- Sickle cell diagnosis	341	65	115	141	20
- Hospice services	242	125	50	55	12
- Palliative services	157	64	36	43	14
DENOMINATOR FOR MEASURE	**14,067**	**4,282**	**4,245**	**4,414**	**1,126**

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

Table 3a shows the characteristics of members included in the denominator for the COB-AD quality measure when only Medicaid claims were used. Table 3b displays member characteristics for those included in the denominator when MS PMP data was included.

TABLE 3a. Characteristics of Members in Denominator for COB-AD Quality Measure

Mississippi Medicaid January 1, 2021 - December 31, 2021

Includes all Medicaid Beneficiaries Meeting Inclusion Criteria

- DOES NOT include CHIP -

Member Characteristics		TOTAL		Medicaid Program							
				FFS		UHC		MAG		MOL	
TOTAL		9,367		2,429		3,474		2,839		625	
Age	18 - 65	9,343	99.7%	2,415	99.4%	3,467	99.8%	2,836	99.9%	625	100%
	65+	24	0.3%	14	0.6%	7	0.2%	3	0.1%	0	0.0%
Gender	Female	6,766	72.2%	1,779	73.2%	2,486	71.6%	2,047	72.1%	454	72.6%
	Male	2,601	27.8%	650	26.8%	988	28.4%	792	27.9%	171	27.4%
Race	White	3,272	34.9%	908	37.4%	1,208	34.8%	900	31.7%	256	41.0%
	Black	5,094	54.4%	1,317	54.2%	1,869	53.8%	1,616	56.9%	292	46.7%
	Amer. Indian	13	0.1%	6	0.2%	2	0.1%	3	0.1%	2	0.3%
	Hispanic	21	0.2%	6	0.2%	10	0.3%	3	0.1%	2	0.3%
	Other	967	10.3%	192	7.9%	385	11.1%	317	11.2%	73	11.7%

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

TABLE 3b. Characteristics of Members in Denominator for COB-AD Quality Measure Incorporating MS PMP Data

Mississippi Medicaid January 1, 2021 - December 31, 2021

Includes all Medicaid Members Meeting Inclusion Criteria

- DOES NOT include CHIP -

Member Characteristics		TOTAL		Medicaid Program							
				FFS		UHC		MAG		MOL	
TOTAL		**14,067**		**4,282**		**4,245**		**4,414**		**1,126**	
Age	18 - 65	14,027	99.7%	4,253	99.3%	4,237	99.8%	4,411	99.9%	1,126	100%
	65+	40	0.3%	29	0.7%	8	0.2%	3	0.1%	0	0.0%
Gender	Female	10,223	72.7%	3,132	73.1%	3,053	71.9%	3,213	72.8%	825	73.3%
	Male	3,844	27.3%	1,150	26.9%	1,192	28.1%	1,201	27.2%	301	26.7%
Race	White	5,176	36.8%	1,628	38.0%	1,567	36.9%	1,511	34.2%	470	41.7%
	Black	7,340	52.2%	2,224	51.9%	2,202	51.9%	2,391	54.2%	523	46.4%
	Amer. Indian	38	0.3%	27	0.6%	2	0.0%	7	0.2%	2	0.2%
	Hispanic	28	0.2%	7	0.2%	11	0.3%	8	0.2%	2	0.2%
	Other	1,485	10.6%	396	9.2%	463	10.9%	497	11.3%	129	11.5%

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

Tables 4a and 4b show the COB-AD quality measure rates for CY 2021 for all Mississippi Medicaid members meeting the inclusion criteria for the denominator using both methodologies. The overall rate using only Medicaid claims data was 3.7%, while the rate when MS PMP data was incorporated more than doubled to 8.0%. When MS PMP data was incorporated, rates varied across age groups, gender, race, and pharmacy program. As a point of reference, the mean rate for all states reporting the COB-AD measure for CY 2021 was 12.6%.[2]

TABLE 4a. COB-AD Concurrent Use of Opioids and Benzodiazepines

Mississippi Medicaid January 1, 2021 - December 31, 2021
Includes all Medicaid Beneficiaries Meeting Inclusion Criteria
- DOES NOT include CHIP -

Member Characteristics		Denominator	Numerator	Rate
TOTAL		9,367	350	3.7%
Age	18 - 65	9,343	348	3.7%
	65+	24	2	8.3%
Gender	Female	6,766	264	3.9%
	Male	2,601	86	3.3%
Race	White	3,272	167	5.1%
	Black	5,094	156	3.1%
	Amer. Indian	13	0	0.0%
	Hispanic	21	0	0.0%
	Other	967	27	2.8%
Pharmacy Program	FFS	2,429	97	4.0%
	UHC	3,474	140	4.0%
	MAG	2,839	97	3.4%
	MOL	625	16	2.6%

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

TABLE 4b. COB-AD Concurrent Use of Opioids and Benzodiazepines - Incorporating MS PMP Data

Mississippi Medicaid January 1, 2021 - December 31, 2021
Includes all Medicaid Members Meeting Inclusion Criteria
- DOES NOT include CHIP -

Member Characteristics		Denominator	Numerator	Rate
TOTAL		14,067	1,120	8.0%
Age	18 - 65	14,027	1,116	8.0%
	65+	40	4	10.0%
Gender	Female	10,223	873	8.5%
	Male	3,844	247	6.4%
Race	White	5,176	566	10.9%
	Black	7,340	438	6.0%
	Amer. Indian	38	4	10.5%
	Hispanic	28	0	0.0%
	Other	1,485	112	7.5%
Pharmacy Program	FFS	4,282	344	8.0%
	UHC	4,245	296	7.0%
	MAG	4,414	407	9.2%
	MOL	1,126	73	6.5%

NOTE: FFS - Fee-for-service; UHC - UnitedHealthcare; MAG - Magnolia; MOL - Molina;
Members are reported under the Pharmacy Program they were enrolled in at the end of measurement year.

The 1120 members included in Table 4b were included in the study cohort for identifying additional members who were identified when incorporating MS PMP data. The majority of members in the full cohort were female (77.9%), aged above 50 years (47.9%), White (50.5%), and residing in rural areas (62.5%). (Table 5) About 74.7% had chronic non-cancer pain (CNCP), 54.2% had depression, and 15.0% had opioid use disorder (OUD). Additionally, 86.2% had concomitant use of opioids and other psychotropic medications. The majority (92.2%) were prescribed short-acting opioids, and 54.9% had an average daily morphine milligram equivalent (MME) between 20 and less than 50. In terms of prescriber and pharmacy factors, 24.6% of individuals had a prescriber located farther than the average distance, and 32.9% had their prescriptions filled at a pharmacy farther than the average distance. Provider shopping was observed in 3.3% of the cohort.

Logistic regression modeling (Table 6) showed that Black members had significantly lower odds of being additionally identified as COB members with the addition of MS PMP data to MS Medicaid data compared to White members (aOR = 0.68, 95% CI: 0.51 – 0.89). Likewise, individuals with concomitant use of opioids and other psychotropic medications were also less likely to be additionally identified as COB members than those without (aOR = 0.56, 95% CI: 0.36 – 0.84). In contrast, members with an average daily MME of 20 to less than 50 (aOR = 1.68, 95% CI: 1.25 – 2.26) and those with 50 or more MME (aOR = 1.56, 95% CI: 1.02 – 2.40) had greater odds of being additionally identified as COB members compared to those with an MME of less than 20 with the use of both MS PMP data and MS Medicaid.

TABLE 5. Descriptive Characteristics of Study Cohort						
Characteristics	**Full cohort**	**%**	**COB members identified using both methodologies**	**%**	**Additional COB members identified using MS PMP and MS Medicaid**	**%**
N	**1120**		**349**	**31.2%**	**771**	**68.8%**
Age						
18-34	172	15.4%	52	30.2%	120	69.8%
35-49	412	36.8%	125	30.3%	287	69.7%
50+	536	47.9%	172	32.1%	364	67.9%
Gender						
Female	873	77.9%	263	30.1%	610	69.9%
Male	247	22.1%	86	34.8%	161	65.2%
Race						
White	566	50.5%	166	29.3%	400	70.7%
Black	438	39.1%	156	35.6%	282	64.4%
Other	116	10.4%	27	23.3%	89	76.7%
Rural or Urban						
Rural	700	62.5%	224	32.0%	476	68.0%
Urban	420	37.5%	125	29.8%	295	70.2%
Opioid overdose	14	1.3%	2	14.3%	12	85.7%
OUD	168	15.0%	60	35.7%	108	64.3%
Alcohol use disorder	52	4.6%	20	38.5%	32	61.5%
CNCP	837	74.7%	268	32.0%	569	68.0%
Depression	607	54.2%	181	29.8%	426	70.2%
Concomitant use of opioid and other psychotropics	965	86.2%	314	32.5%	651	67.5%
Formulation of opioids						
Long acting & Combination	87	7.8%	34	39.1%	53	60.9%
Short acting	1033	92.2%	315	30.5%	718	69.5%
Average MME						
Less than 20	325	29.0%	125	38.5%	200	61.5%
20 to less than 50	615	54.9%	167	27.2%	448	72.8%
50 or more	180	16.1%	57	31.7%	123	68.3%
Prescriber far from average distance						
Yes	360	32.1%	115	31.9%	245	68.1%
No	760	67.9%	234	30.8%	526	69.2%
Pharmacy far from average distance						
Yes	334	29.8%	92	27.5%	242	72.5%
No	786	70.2%	257	32.7%	529	67.3%
Provider shopping						
Yes	37	3.3%	9	24.3%	28	75.7%
No	1083	96.7%	340	31.4%	743	68.6%

Notes: PMP - prescription monitoring program, OUD - Opioid use disorder, CNCP - Chronic noncancer pain, MME - Morphine Milligram Equivalents, COB - Concomitant use of opioid and benzodiazepine

TABLE 6. Factors Associated with the Identification of Additional Medicaid Members in the COB Quality Measure with the Incorporation of MS PMP Data

Characteristics	Adjusted OR (95% CI)	*p* -value
Age		
18-34	Reference	
35-49	0.98 (0.65 - 1.45)	0.9
50+	0.86 (0.58 - 1.26)	0.44
Gender		
Female	1.29 (0.93 - 1.78)	0.12
Male	Reference	
Race		
White	Reference	
Black	**0.68 (0.51 - 0.89)**	**0.006**
Other	1.59 (0.99 - 2.63)	0.06
Rural or Urban		
Rural	Reference	
Urban	1.22 (0.93 - 1.61)	0.16
Opioid overdose	3.49 (0.88 - 23.35)	0.12
OUD	0.71 (0.49 - 1.04)	0.08
Alcohol use disorder	0.76 (0.42 - 1.43)	0.39
CNCP	0.81 (0.59 - 1.11)	0.19
Depression	1.29 (0.98 - 1.69)	0.07
Concomitant use of opioid and other psychotropics	**0.56 (0.36 - 0.84)**	**0.006**
Formulation of opioids		
Long acting & Combination	Reference	
Short acting	0.62 (0.38 - 1.04)	0.07
Average MME		
Less than 20	Reference	
20 to less than 50	**1.68 (1.25 - 2.26)**	**0.001**
50 or more	**1.56 (1.02 - 2.40)**	**0.04**
Prescriber far from average distance		
Yes	0.95 (0.72 - 1.27)	0.74
No	Reference	
Pharmacy far from average distance		
Yes	1.20 (0.90 - 1.62)	0.22
No	Reference	
Provider shopping		
Yes	1.25 (0.59 - 1.93)	0.58
No	Reference	

OUD - Opioid use disorder, CNCP - Chronic noncancer pain, MME - Morphine Milligram Equivalents, OR - Odds Ratio, CI - Confidence Interval

CONCLUSIONS

Prior to this study, it was unknown what impact incorporating MS PMP data into Medicaid prescription claims data for members would have on member monitoring parameters and routine reporting metrics related to controlled substance prescribing. Incorporating MS PMP data not only increased the number of members included in the COB-AD quality measure denominator but also increased the overall rate from 3.7% to 8.0%. Further analysis revealed that factors associated with members being additionally identified in the COB-AD when MS PMP data was incorporated into claims data included being White and having a daily MME of 20 or above. Incorporating MS PMP data is critical for monitoring the appropriate prescribing of controlled substances; however, diligence should be taken in determining which routine reporting metrics should incorporate MS PMP data.

RECOMMENDATIONS

This study revealed the impact that incorporating MS PMP data into Medicaid claims data had on the COB-AD quality measure. The DUR Board should consider the potential implications of incorporating MS PMP data into future controlled substance monitoring parameters and reporting by DOM, such as the high-risk beneficiaries report.

REFERENCES

1. Mississippi Prescription Monitoring Program. Accessed August 23, 2023. https://pmp.mbp.ms.gov/

2. Adult Health Care Quality Measures | Medicaid. Accessed May 24, 2022. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html

MINI-REPORT
SULFONYLUREA UTILIZATION AND CONSIDERATIONS

BACKGROUND

Sulfonylureas are a class of medications used to treat type 2 diabetes mellitus through the stimulation of insulin release from pancreatic beta cells. While these agents are no longer considered first-line choices, sulfonylureas continue to have a role in glycemic control.[1] Agents in this class include, but are not limited to, glipizide, glimepiride, and glyburide.

Recently, a new 3 mg dosage strength of glimepiride became available at a high cost. This prompted a discussion of whether sulfonylureas should be a class listed on the Preferred Drug List (PDL) to promote not only cost-effective, but also appropriate use. To address these concerns, the following DUR study presents data to help determine whether the inclusion of sulfonylureas on the PDL would be beneficial.

METHODS

A retrospective analysis was conducted using Mississippi Medicaid administrative claims data for calendar year (CY) 2024. This analysis included data from both the Fee-for-Service (FFS) program and the Coordinated Care Organizations (CCOs), which include Magnolia Health (MAG), Molina Healthcare (MOL), and UnitedHealthcare (UHC). Pharmacy claims data were assessed to identify members with claims for sulfonylureas during the analysis period. Demographic characteristics, including age, sex, race, and the type of Medicaid plan at the time of the first claim during the study period, were collected.

RESULTS

During CY 2024, 2,610 members had 8,288 claims for sulfonylureas. (Tables 1 and 2) The majority of members were between the ages of 45-64 years (71.7%), Black (50.6%), and were enrolled in a CCO plan (UHC – 37.5%, MAG – 30.5%). Most claims were for glipizide (51.1%) and were written by either a nurse practitioner (45.4%) or a family physician (32.5%).

Table 1. Demographic Characteristics of Members with Sulfonylurea Use
January 1, 2024 - December 31, 2024
(n = 2,610)

Member Characteristics		Number	%
Age	<18 years	13	0.5%
	18 - 44 years	707	27.1%
	45 - 64 years	1,872	71.7%
	>65 years	18	0.7%
Gender	Female	1,788	68.5%
	Male	822	31.5%
Race	White	606	23.2%
	Black	1,321	50.6%
	Other	683	26.2%
Pharmacy Program	FFS	554	21.2%
	UHC	980	37.5%
	MAG	281	10.8%
	MOL	795	30.5%

Notes: FFS - Fee-for-Service; UHC - UnitedHealthcare; MAG - Magnolia Health; MOL - Molina Healthcare

[1] Melanie J. Davies, Vanita R. Aroda, Billy S. Collins, Robert A. Gabbay, Jennifer Green, Nisa M. Maruthur, Sylvia E. Rosas, Stefano Del Prato, Chantal Mathieu, Geltrude Mingrone, Peter Rossing, Tsvetalina Tankova, Apostolos Tsapas, John B. Buse; Management of Hyperglycemia in Type 2 Diabetes, 2022. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care* 1 November 2022; 45 (11): 2753–2786. https://doi.org/10.2337/dci22-0034

Table 2. Demographic Characteristics of Members with Sulfonylurea Use at the Claim Level
January 1, 2024 - December 31, 2024
(n = 8,288)

Member Characteristics		Number	%
Age	<18 years	51	0.6%
	18 - 44 years	1,858	22.4%
	45 - 64 years	6,307	76.1%
	>65 years	72	0.9%
Gender	Female	5,474	66.0%
	Male	2,814	34.0%
Race	White	1,942	23.4%
	Black	4,111	49.6%
	Other	2,235	27.0%
Pharmacy Program	FFS	1,975	23.8%
	UHC	3,073	37.1%
	MAG	697	8.4%
	MOL	2,543	30.7%
Type of sulfonylurea	Glimepiride	3109	37.5%
	Glipizide	4238	51.1%
	Glyburide	941	11.4%
Prescriber type	Nurse practitioner	3,763	45.4%
	Family physician	2,696	32.5%
	Internal medicine	1,038	12.5%
	Physician assistant	136	1.6%
	Endocrinologist	122	1.5%
	Emergency medicine	119	1.4%
	General practitioner	105	1.3%
	OB/GYN	91	1.1%
	Hospital physician	61	0.7%
	Pediatrics	75	0.9%
	infectious disease (ID) doctor	26	0.3%
	Physical medicine and rehabilitation	15	0.2%
	other	41	0.5%

Notes: FFS - Fee-for-Service; UHC - UnitedHealthcare; MAG - Magnolia Health; MOL - Molina Healthcare

FDA DRUG SAFETY COMMUNICATIONS

December 2024 – March 2025

- 01-22-2025 FDA adds Boxed Warning about a rare but serious allergic reaction called anaphylaxis with the multiple sclerosis medicine glatiramer acetate (Copaxone, Glatopa)

- 12-12-2024 Serious liver injury being observed in patients without cirrhosis taking Ocaliva (obeticholic acid) to treat primary biliary cholangitis

- Clozapine REMS Modification:
  February 24, 2025 - Beginning today, FDA does not expect prescribers, pharmacies, and patients to participate in the risk evaluation and mitigation strategies (REMS) program for clozapine or to report results of absolute neutrophil count (ANC) blood tests before pharmacies dispense clozapine. FDA still recommends that prescribers monitor patients' ANC according to the monitoring frequencies described in the prescribing information. Information about severe neutropenia will remain in the prescribing information for all clozapine medicines, including in the existing Boxed Warnings.

  Although the risk of severe neutropenia with clozapine still exists, FDA has determined that the REMS program for clozapine is no longer necessary to ensure the benefits of the medicine outweigh that risk. Eliminating the REMS is expected to decrease the burden on the health care delivery system and improve access to clozapine. FDA has notified the manufacturers that the clozapine REMS must be eliminated. FDA has instructed the clozapine manufacturers to formally submit a modification to eliminate the Clozapine REMS and to update the prescribing information, including removing mandatory reporting of ANC blood tests to the REMS program.

  In the coming months, FDA will work with the clozapine manufacturers to update the prescribing information and eliminate the Clozapine REMS.

Division of Medicaid
Drug Utilization Review Board
By-Laws

Article I. Purpose

The Drug Utilization Review Board (DUR) is a requirement of the Social Security Act, Section 1927. The purpose of the DUR Board is to provide clinical guidance to the Division of Medicaid (DOM) regarding the utilization of pharmaceutical products within the Mississippi Medicaid program. The DUR Board makes recommendations to DOM to promote patient safety and cost effective care in the Mississippi Medicaid program. The DUR Board shall advise DOM with respect to the content of medical criteria and standards for utilization management strategies including prospective drug prior authorization (PA), concurrent patient management, retrospective drug utilization review, and educational intervention programs. DOM retains the authority to accept or reject the recommendations by the DUR Board.

Article II. Membership

Section 1 – Board Composition

A. The DUR Board will consist of not less than twelve (12) voting members.
B. The DUR Board voting members will be comprised of at least one-third (1/3), but no more than fifty-one percent (51%), licensed and actively practicing physicians and at least one-third (1/3) licensed and actively practicing pharmacists. Voting members may consist of health care professionals with knowledge/expertise in one or more of the following:
   1) Prescribing of drugs,
   2) Dispensing and monitoring of drugs,
   3) Drug use review, evaluation, and intervention,
   4) Medical quality assurance.
C. Non-voting board members consist of the Division of Medicaid (DOM) Executive Director, Office of Pharmacy pharmacists, DUR Coordinator, the DUR contractor and Medical Director.

Section 2 – Appointment selection methodology

A. DOM's Office of Pharmacy in consultation with officially recognized state professional healthcare associations recommends potential, qualified new candidates for appointment or reappointment of existing board members to DOM's Executive Director.
B. Nominations are considered internally and appointments are given final approval by the DOM Executive Director.
C. Board members are appointed by the Governor of the State of Mississippi, or Governor's designee, pursuant to state law.

Section 3 - Term of Office

A. All members are appointed for three year terms following a staggered appointment fulfillment as follows: one-third of DUR Board members shall be appointed each term. All subsequent appointments shall be for terms of three years from the expiration date of the previous term.
B. Members may serve up to three consecutive three-year terms (for a total of nine consecutive years).
C. Members may serve for either an extended term or a fourth consecutive term at the discretion of the Executive Director and by recommendation of both the DUR Coordinator and Division of Medicaid Office of Pharmacy in the event that no qualified, willing candidate is found in sufficient time. Members, including those filling vacated positions, may be re-appointed by the Executive Director for a subsequent term.
D. In the event of an unexpected or expected vacancy, the DUR Coordinator and Office of Pharmacy may recommend a qualified replacement candidate to DOM's Executive Director for emergency approval.
E. The Executive Director shall fill any vacancy before the end of the term, and the person appointed to fill the vacancy shall serve for the remainder of the unexpired term. Members, including those filling vacated positions, may be re-appointed by the Executive Director for a subsequent term.

Section 4 - Attendance

A. Members are required to attend at least fifty percent of the meetings per year. Failure to attend meetings without an explanation of extenuating circumstances will result in the termination of the member's appointment.
B. Members are asked to give advance notice regarding any planned absences so that a quorum may be determined prior to meetings.

Section 5 - Resignation

A member of the DUR Board may resign by giving a 30 day written advance notice to the DUR Board Chair and DUR Coordinator.

Section 6 - Removal

A member of the DUR Board may be removed by either the DUR Board Chair or majority vote of the DUR Board for good cause. Good cause may be defined as one or more of the following conditions:

A. Lack of attendance –failure to attend at least 50% of the scheduled DUR meetings shall constitute a resignation by said DUR Board member,
B. Identified misconduct or wrongdoing during any DUR Board term, or

C. Not disclosing a conflict of interest either upon initial disclosure or throughout the rest of the term.

Section 7 - Board Officers

At the first meeting of the state fiscal year, which constitutes July 1 through June 30, board members shall select two members to serve as Chair and Chair-Elect of the board, respectively. The Chair and Chair-Elect shall both serve one year terms. At the end of the serving year, the Chair-Elect assumes the role of Chair, and a new Chair-Elect will be chosen.

If the persons serving as Chair and Chair-Elect have either previously served as Chair or Chair-Elect, that person may be reelected to either posting.

The Chair-Elect will serve as Chair in absentia of the Chair or by the Chair's request.

Section 8 – Reimbursement

The Division of Medicaid will reimburse DUR Board members for travel related expenses.

Article III. Meetings

Section 1 – Frequency

The DUR Board shall meet at least quarterly, and may meet at other times as necessary for the purpose of conducting business that may be required. The DUR Board Chair, a majority of the members of the board, or the Division of Medicaid Office of Pharmacy and DUR Coordinator, shall maintain the authority of calling DUR meetings.

Section 2 – Regular Meetings

The DUR Board will hold regular quarterly meetings in the city of Jackson, Mississippi. Meetings will occur at the predesignated time and place. Dates for the upcoming year's quarterly meetings will be posted before the first quarterly meeting of the upcoming year.

Section 3 – Special Meetings

The DUR Board may meet at other times other than regular quarterly meetings as deemed necessary and appropriate. The DUR Coordinator and Office of Pharmacy must notify DUR Board members of any special meeting at least two weeks, i.e., ten (10) days, prior to the requested meeting date. Special meetings may be requested by the following officials:

A. Division of Medicaid Executive Director,
B. DUR Coordinator and Office of Pharmacy,
C. DUR Board Chair, or
D. Majority of DUR Board members via communication to DUR Coordinator and/or DUR Board Chair.

Section 4 – Meeting Notice

DUR Board members will be notified of the location for the meeting a minimum of ten (10) days in advance. Notification may include one or a combination of the following methods: e-mail, fax, or other written communication. DUR Board members are required to keep on file with
DOM Office of Pharmacy his or her address, primary phone number, alternate phone number (i.e., cell), fax number, and email address to which notices and DUR related communications may be submitted.

Meetings may be cancelled due to lack of quorum, severe inclement weather, or other reasons as determined by the DUR Coordinator and Office of Pharmacy. In the event of a cancellation, the DUR Coordinator and DOM Pharmacy staff will communicate with DUR Board members regarding the meeting cancellation as soon as circumstances permit. Notifications shall also be posted with DFA and on DOM's website to ensure that the public is notified of any meeting cancellation.

DUR Board Meetings shall be open to the public and conducted in accordance with state law, specifically the Open Meetings Act. Notice of any meetings held shall be provided at least five (5) days in advance of the date scheduled for the meeting. The notice shall include the date, time, place and purpose for the meeting and shall identify the location of the meeting to the general public.

Section 5 – Meeting Sign-In

All meeting attendees will be required to sign-in at the meeting entrance for DUR meetings. Sign-in sheets will be logged, scanned and transferred to electronic medium for official records. All attendees shall include participant's name and entity represented (as applicable).

Section 6 – Quorum

A simple majority of voting board members shall constitute a quorum and must be present for the transaction of any business of the board. For a fully-appointed 12-person DUR Board as required by state law, seven voting board members constitutes a quorum. If a quorum is not present, the Chair, Chair-Elect or DUR Coordinator maintains the responsibility to conclude meeting proceedings. Meeting minutes shall reflect that a quorum was not present.

Section 7 – Voting

The voting process shall be conducted by the Chair or the Chair-Elect in absentia of the Chair.

All board recommendations shall begin with a motion by a voting board member. The motion may then be seconded by a voting board member. If a recommendation does not receive a second motion, the motion shall not pass. If a recommendation receives a second motion, then the board shall vote on the motion. A motion shall be considered as passed if the motion carries a majority of votes if a quorum of the board is present.

In the event that a motion receives a tie vote in the presence of a quorum, the motion shall not pass. The motion can be brought up for further discussion after which a subsequent motion may be made to vote on the issue again during the same meeting, or a motion can be made to table the issue and discussion until the next quarterly DUR Board meeting.

A vote abstention occurs when a voting member is present for the meeting and the action but has chosen not to vote on the current motion. An abstention is a vote with the majority on the measure. A recusal, on the other hand, is necessitated when a voting member has a conflict of interest or potential pecuniary benefit resulting from a particular measure. In order to properly and completely recuse oneself from a matter, the DUR Board member must leave the room or area where discussions, considerations, or other actions take place

before the matter comes up for discussion. The member must remain absent from the meeting until the vote is concluded. The minutes will state the recusing member left the room before the matter came before the DUR Board and did not return until after the vote.

Section 8 – Minutes

A public body speaks only through its minutes. State law, specifically the Open Meetings Act, requires minutes be kept of all meetings of a public body, whether in open or executive session, showing the following:

A. Members present or absent,
B. Date, time and place of meeting,
C. Accurate recording of any final actions taken,
D. Record, by individual member, of how s/he voted on any final action, and
E. Any other information that the public body requests is reflected in the minutes.

The minutes shall be finalized no later than thirty (30) days after the adjournment of the DUR Board meeting and shall be made available for public inspection. DOM Office of Pharmacy posts all DUR Board Minutes on the DUR webpage.

Section 9 – Speakers & Special Topics

DUR Board members may request various healthcare, industry, or specialized professionals to present at DUR meetings regarding a posted topic on an upcoming DUR agenda.

A. The DUR Board may allow up to 20 minutes for topic presentation by an invited speaker.
B. DUR Board Members may ask a member of the audience to provide information on a topic being discussed by the Board. Invited participants may be asked to disclose any potential conflicts of interests if applicable. (See Article IV, Section 1).
C. Members of the audience may not speak unless so designated at the appropriate time by a DUR Board member.
D. DUR Board Members, both voting and non-voting, maintain speaking privileges at DUR meetings.
E. Contracted employees of DOM and employees of other DOM vendors are considered members of the audience.

Section 10 – Executive Session

During special circumstances, the DUR Board may go into executive session at the conclusion of normal meeting proceedings; however, all DUR Board meetings must commence as an open meeting. In order for executive session to be called, the following procedure must be followed in accordance with the Open Meetings Act:

A. A member may <u>move to close</u> the meeting to determine whether board needs to go into executive session; vote in open meeting with vote recorded in minutes, majority rules.
B. Closed meeting: vote taken on whether to <u>declare</u> executive session, requires 3/5 of all members present.
C. Board comes back into open session and states statutory reason for executive session. The reason for the executive session shall be recorded in the meeting minutes.
D. Board members then will go into executive session where action may be taken on stated subject matter only.

E. Minutes must be kept in accordance with the Open Meetings Act.

Section 11 – Conduct of Participants

Pursuant to state law, specifically the Open Meetings Act, the DUR Board may make and enforce reasonable rules and regulations for the conduct of persons attending the DUR meetings. The following is a non-exhaustive list of rules for DUR Board meetings:

A. Attendees should please remain silent and allow for the efficient transaction of business.
B. Cell phones should be placed on silent or vibrate.
C. Laptop computers are discouraged from being utilized during meetings as frequent typing may distract board members.
D. Food and drink are not allowed in the meeting room.
E. Security is provided by the state. Guests not following proper decorum may be asked to leave by security.

Article IV. Public Participation

Section 1 - Disclosure of Persons Appearing Before DUR Board

The DUR Board may ask individuals appearing before the board to disclose either in writing or verbally their relationship, as applicable, including but not limited to pharmaceutical companies or special interest groups. Any such disclosures should be recorded as a matter of public record in the documented meeting minutes.

Article V. Conflicts of Interest

DUR Board members are expected to maintain the highest professional, ethical standards. A conflict of interest may exist when a DUR Board member maintains a financial/pecuniary, personal, or professional interest that may compete or interfere with the DUR Board member's ability to act in a fair, impartial manner while acting in the best interests of the Division of Medicaid and the beneficiaries that it serves.

As such, DUR Board members are required to complete and submit annually a Conflict of Interest disclosure statement with the DOM Office of Pharmacy and DUR Coordinator. Statements shall be maintained by the Office of Pharmacy. Members have an ongoing responsibility to update and revise said statements, disclosing any new conflicts of interest to the DUR Coordinator and DOM Office of Pharmacy.

It is the sole responsibility and requirement of each board member to review the agenda of each forthcoming board meeting to determine any if any potential conflicts of interest exist. If so, an aforementioned Disclosure statement must be updated indicating the conflict of interest. The board member should notify the Chair or Chair-Elect of the conflict of interest prior to the meeting.

A DUR Board member shall recuse himself/herself from any vote, action, or discussion pertaining to any product or product class if there is documentation stating an actual or perceived conflict of interest. Please refer to the procedure outlined in Article III, Section 7.

Article VI. Confidentiality

DUR Board members are required to safeguard all confidential and proprietary information, including but not limited to pricing information, which is disclosed by the Mississippi Division of Medicaid for purposes of conducting DUR Board activities. Any provider or patient specific information discussed by the DUR Board shall also be kept strictly confidential in accordance with state and federal law.

Article VII. Amendments

Proposed Amendments of By-Laws

A. Proposed amendments must be submitted to the DUR Coordinator at least thirty (30) days prior to the next scheduled DUR meeting and the proposed amendments will be disseminated to the DUR Board en masse for consideration at said DUR Board meeting.
B. Proposed amendments will be distributed to board members no less than five (5) business days prior to next DUR Board meeting.
C. Proposed amendments will be initiated by the Chair, or the Chair-Elect in absentia of the Chair, prior to Next Meeting Information announcements.
D. Proposed amendments will be voted upon at the next scheduled DUR Board meeting. If majority of DUR Board votes to ratify amendment, the amendment will take effect immediately at the conclusion of the meeting.

MS-DUR BOARD
COMMON ABBREVIATIONS

AWP	Any Willing Provider, Average Wholesale Price
BENE	Beneficiary
CAH	Critical Access Hospital
CCO	Coordinated Care Organization
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CMS	Center for Medicare and Medicaid Services
COB	Coordination of Benefits
CPC	Complex Pharmaceutical Care
DME	Durable Medical Equipment
DOC	Department of Corrections
DOM	Division of Medicaid
DUR	Drug Utilization Review
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FA	Fiscal Agent
FFS	Fee For Service
FPW	Family Planning Waiver
FQHC	Federally Qualified Health Clinic
FY	Fiscal Year
HB	House Bill
HCPCS/ HEIDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability
IDD	Intellectual and Developmental Disabilities
LTC	Long Term Care
MAG	Magnolia Health
MEDD	Morphine Equivalent Daily Dose
MOL	Molina Healthcare
MPR	Medication Possession Ratio
MSCAN	Mississippi Coordinated Access Network
MSDH	Mississippi State Department of Health
NADAC	National Average Drug Acquisition Cost
NDC	National Drug Code
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PDC	Proportion of Days Covered
PDL	Preferred Drug List
PI	Program Integrity
PIP	Performance Improvement Program
POS	Point of Sale, Place of Service, Point of Service
Pro-DUR	Prospective Drug Use Review
OTC	Over the Counter
QI	Quality Indicator
QIO	Quality Improvement Organization
QM	Quality Management
RA	Remittance Advise
REOMB	Recipient's Explanation of Medicaid Benefits
Retro-DUR	Retrospective Drug Utilization Review
RFI	Request for Information
RFP	Request for Proposal
RHC	Rural Health Clinic
SB	Senate Bill
SCHIP	State Child Health Insurance Program
SMART PA	Conduent's Pharmacy Application (SmartPA) is a proprietary electronic prior authorization system used for Medicaid fee for service claims
SPA	State Plan Amendment
UHC	United Healthcare
UM/QIO	Utilization Management and Quality Improvement Organization
UPDL	Universal Preferred Drug List
UR	Utilization Review
VFC	Vaccines for Children
WAC	Wholesale Acquisition Cost
WIC	Women, Infants, Children
340B	Federal Drug Discount Program