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

MISSISSIPPI DIVISION OF
MEDICAID

September 18, 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

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Term Expires: June 30, 2027

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
September 18, 2025

Welcome

Old Business

Approval of June 2025 Meeting Minutes page 5

Resource Utilization Review

Enrollment Statistics page 11
Pharmacy Utilization Statistics page 11
Top 10 Drug Categories by Number of Claims page 12
Top 10 Drug Categories by Amount Paid page 13
Top 25 Drug Molecules by Number of Claims page 14
Top 25 Drug Molecules by Dollars Paid page 15
Top 25 Drug Molecules by Change in Number of Claims page 16
Top 25 Drug Molecules by Change in Dollars Paid page 17
Top 15 Solid Dosage Form High Volume Products By Percent Change In Amount Paid Per Unit page 18

Follow-up and Discussion from the Board

New Business

Elect New Vice-Chair

MS-DUR Educational Interventions page 21

Special Analysis Projects:

Influenza Annual Update page 22
RSV Annual Update page 27
Medicaid Case Mix Change page 34
Preliminary Healthcare Utilization Patterns of Members Initiating GLP-1 RA AOMs page 42

FDA Drug Safety Updates page 53

Pharmacy Program Update

Next Meeting Information
December 11, 2025

DUR Board Meeting Minutes

MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE JUNE 12, 2025 MEETING

DUR Board Roster: State Fiscal Year 2024 (July 1, 2024 – June 30, 2025)	Sep 2024	Dec 2024	Mar 2025	Jun 2025
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	✓	✓	✓	✓
Joshua Trull, DO	✓	✓	✓	
Bobbie West, MD			✓	
TOTAL PRESENT**	**7**	**5**	**11**	**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:
Dennis Smith, RPH, DUR Coordinator; Amy Ly-Ha, PharmD, Pharmacist II;

University of Mississippi School of Pharmacy - MS-DUR Staff:
Eric Pittman, PharmD, PhD, MS-DUR Project Director; Kaustuv Bhattacharya, PhD, MS-DUR Research Assistant Professor; Benjamin Banahan, PhD, MS-DUR Consultant; Connor Callahan, Student Pharmacist Intern; Colton Moore, Student Pharmacist APPE; Kenzie Schutt, Student Pharmacist Intern;

Coordinated Care Organization (CCO) Staff:
None

Gainwell Staff:
Lew Ann Snow, RN, Advisor Business Analyst; Tricia Banks, PharmD, Director of Pharmacy;

Teligen Staff:
Buddy Ogletree, PharmD, Pharmacist; Hosam Mohamed, Student Pharmacist;

Visitors: Paula Whatley, Novo Nordisk; Mark Forkner, PTL Therapeutics; Amanda Ellis, Boehringer Ingelheim; Robert Welch, University of Mississippi School of Pharmacy; Stephanie

Mueller, Mississippi Board of Pharmacy; Jennifer Gholson, Mississippi State Department of Health.

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

OLD BUSINESS:
Dr. Pierce moved to approve the minutes from the March 2025 DUR Board Meeting, seconded by Dr. Austin, and unanimously approved by the DUR Board.

Resource Utilization Review
Dr. Pittman presented the resource utilization report for March 2025. Data presented was across all pharmacy programs. Dr. Pittman took some time to compare current trends in pharmacy spend between state fiscal years 2024 and 2025. He noted that while current enrollment and the monthly number of prescription claims is lower, total spend is roughly equal to that period indicating Medicaid is spending more per member per month.

NEW BUSINESS:

Update on MS-DUR Educational Interventions
Dr. Pittman provided an overview of all DUR mailings and educational notices that occurred between March 2025 and May 2025.

Mississippi Division of Medicaid Use of Prescription Monitoring Program in DUR Activities
Dr. Banahan provided the Board a detailed explanation of the procedures MS-DUR follows when integrating prescription monitoring program (PMP) data for matched Medicaid members, noting some of the challenges with reporting claims and matching historical claims to Medicaid members. Dr. Banahan included a description of PMP data for target drug classes, which included medical cannabis. Of note, few Medicaid members with full pharmacy benefits were identified as utilizing medical cannabis. Among those that had claims for medical cannabis, most had multiple medical cannabis claims; and a large portion also had claims for other psychotropic medications, with opioids and benzodiazepines being the most common. The board extensively discussed the findings from this report. Dr. Robert Welch, Director of the National Center for Cannabis Research and Education at the University of Mississippi, Dr. Jennifer Gholson, Mississippi Department of Health, and Stephanie Mueller, Mississippi Board of Pharmacy, provided valuable insights into the Mississippi Medical Cannabis Program (MMCP). Many Board members noted the educational needs that providers and pharmacists have regarding medical cannabis. Following an extensive discussion, the following recommendation was presented:

- The Division of Medicaid (DOM) should explore medical cannabis educational opportunities to offer providers and pharmacists.

Dr. Pierce made a motion to approve the recommendation, seconded by Dr. Brown, and unanimously approved by the Board.

Update on GLP-1 Anti-obesity Medication Utilization Among Medicaid Members
Dr. Pittman presented three reports around GLP-1 receptor agonist (RA) anti-obesity medications (AOMs). The first report described the geographic characteristics of initiators of GLP-1. Using claims data, approximately 29% of Mississippi Medicaid's adult members receiving full pharmacy benefits were found to be eligible to receive GLP-1 RA AOMs under the current prior authorization criteria. Among those eligible members, 2.4% had initiated therapy as of December 2024. The geographic distribution of GLP-1 RA AOM initiators was not consistent with those counties with the most eligible members. While the counties with the highest eligible populations per 1,000 Medicaid members were located primarily along the Mississippi Delta, the counties with the highest number of initiators per 1,000 eligible members were located in pockets in southern, central, and northern regions of the state. It was noted that prescribers working in weight management clinics were the primary initiators of obesity management medications.

At the conclusion of a robust discussion of factors impacting the initiation of GLP-1 RA AOMs among Medicaid members, the following recommendation was presented:

- Medicaid should work to identify potential barriers to initiation that may be impacting members in counties or regions with the highest rates of eligible members for GLP-1 RA AOM therapy and explore opportunities to improve initiation in those areas.

Dr. Brown made a motion to approve the recommendation, seconded by Dr. Jackson, and unanimously approved by the Board.

The second report identified the utilization of obesity-related counseling services in claims data during the six-month period following GLP-1 RA AOM initiation. While obesity-related counseling is recommended by guidelines and required as part of the prior authorization criteria for medications in the treatment of obesity, documentation was identified in claims data for only a small portion of GLP-1 RA AOM initiators. The Board discussed barriers impacting both the provision of counseling-services and documentation in claims data. Dr. Brown inquired about the possibility of reimbursing pharmacists to deliver obesity-related services. The following recommendations were presented:

- DOM should explore expanding the obesity-related counseling services covered.
- DOM should explore avenues to provide more obesity-related counseling services to members, such as through digital services that can be sent directly to members.
- DOM should explore opportunities for pharmacists to receive reimbursement for providing obesity-related counseling services.

Dr. Brown made a motion to approve the recommendations, seconded by Dr. Pierce, and unanimously approved by the Board.

The third report described two research proposals for examining short- and long-term health outcomes associated with GLP-1 RA AOM use among Medicaid members with obesity or overweight diagnoses. These research plans will be utilized to generate real-world evidence describing the impact of GLP-1 RA AOMs on the Mississippi Medicaid population. MS-DUR sought Board input regarding both research plans.

No formal recommendations were made in reference to this report.

Perinatal Care Among Medicaid Members with Birth Events
Dr. Pittman presented a landscape analysis of members who experienced birth events during calendar year 2023. This analysis described characteristics of Medicaid members with birth events, including the presence of perinatal mental health and substance use disorders (PMHSUDs). The report also examined healthcare utilization throughout the perinatal period. The following recommendations were presented to the Board:

- Future research should explore the heterogeneity in care quality and outcomes among members with PMHSUD.
- Future research should evaluate the quality of postpartum care and care coordination and identify member characteristics associated with low quality of care that may put them at greater risk of adverse maternal health outcomes.

Dr. Jackson made a motion to approve the recommendations, seconded by Dr. Lavender, and unanimously approved by the Board.

FDA Drug Safety Updates:
Dr. Pittman reviewed the FDA drug safety communications published between March 2025 through May 2025.

Pharmacy Program Update:
Dr. Ly-Ha and Mr. Smith presented the Board with the pharmacy program update:

- CMS accepted Mississippi's proposal to participate in the Cell and Gene Therapy (CGT) Access Model.
- DOM is actively working on a project that will incorporate morphine milligram equivalents (MME) in determining monthly quantity limits for opioid prescriptions.
- DOM recently held a series of obesity management training sessions with care managers. DOM is also reaching out to the Mississippi State Department of Health to explore opportunities to work together in the prevention and treatment of obesity among Mississippians.

Next Meeting Information:
Remaining meeting dates for 2025:

- September 18, 2025
- December 11, 2025

Dr. Pierce adjourned the meeting at 3:27 pm.

Submitted,

Eric Pittman, PharmD, PhD
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 p.m. in the Cobb Conference Room at 550 High St, Jackson, MS (**see map**).

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

The June 12 meeting may be viewed virtually by clicking on the following link: Click Here for MS Medicaid DUR Live Broadcast on June 12, 2025, at 1:00 p.m.

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

Resource Utilizaton Review

TABLE 04A: ENROLLMENT STATISTICS FOR LAST 6 MONTHS
January 1, 2025 through June 30, 2025

			Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Total enrollment			718,033	716,366	713,887	709,299	704,586	699,440
Dual-eligibles			162,888	163,030	162,913	162,571	162,265	162,088
Pharmacy benefits			564,381	563,043	561,369	557,525	553,762	549,178
	LTC		15,787	15,773	15,773	15,702	15,609	15,341
	PLAN %	**FFS**	21.7%	21.7%	21.7%	21.5%	21.2%	20.6%
		MSCAN-UHC	29.1%	29.0%	28.7%	28.1%	27.5%	27.0%
		MSCAN-Magnolia	31.1%	31.2%	31.3%	31.7%	32.2%	32.7%
		MSCAN-Molina	18.1%	18.1%	18.3%	18.7%	19.1%	19.7%

TABLE 04B: PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS
January 1, 2025 through June 30, 2025

		Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
# Rx Fills	**FFS**	99,646	93,387	94,359	96,940	92,712	85,915
	MSCAN-UHC	143,759	132,297	130,606	131,807	121,196	108,856
	MSCAN-Mag	158,474	146,952	146,068	151,776	143,478	131,667
	MSCAN-Mol	70,270	64,792	63,394	68,533	64,633	58,349
# Rx Fills / Bene	**FFS**	0.8	0.8	0.8	0.8	0.8	0.8
	MSCAN-UHC	0.9	0.8	0.8	0.8	0.8	0.7
	MSCAN-Mag	0.9	0.8	0.8	0.9	0.8	0.7
	MSCAN-Mol	0.7	0.6	0.6	0.7	0.6	0.5
$ Paid Rx	**FFS**	$13,365,293	$12,253,005	$13,325,753	$13,337,845	$13,664,480	$13,209,208
	MSCAN-UHC	$18,582,621	$17,127,455	$19,034,575	$19,380,153	$18,771,233	$18,555,169
	MSCAN-Mag	$20,183,872	$19,075,059	$20,495,230	$21,551,494	$21,640,632	$20,923,926
	MSCAN-Mol	$7,802,545	$7,577,262	$7,741,914	$8,261,262	$8,426,155	$8,075,528
$ /Rx Fill	**FFS**	$134.13	$131.21	$141.22	$137.59	$147.39	$153.75
	MSCAN-UHC	$129.26	$129.46	$145.74	$147.03	$154.88	$170.46
	MSCAN-Mag	$127.36	$129.80	$140.31	$142.00	$150.83	$158.92
	MSCAN-Mol	$111.04	$116.95	$122.12	$120.54	$130.37	$138.40
$ /Bene	**FFS**	$109.13	$100.29	$109.39	$111.27	$116.39	$116.76
	MSCAN-UHC	$113.15	$104.89	$118.14	$123.70	$123.26	$125.14
	MSCAN-Mag	$114.99	$108.58	$116.64	$121.94	$121.36	$116.52
	MSCAN-Mol	$76.38	$74.35	$75.36	$79.24	$79.67	$74.64

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 JUN 2025 (FFS AND CCOs)

Category	Month Year	Rank Volume	# RXs	$ Paid	# Unique Benes
CNS stimulants	Jun 2025	1	18,129	$2,351,081	15,838
	May 2025	1	21,131	$2,844,714	18,387
	Apr 2025	1	24,291	$3,245,229	21,102
atypical antipsychotics	Jun 2025	2	13,371	$5,405,533	11,180
	May 2025	2	14,002	$5,243,679	11,597
	Apr 2025	2	14,236	$5,334,281	11,853
SSRI antidepressants	Jun 2025	3	12,147	$156,549	11,155
	May 2025	3	12,833	$167,934	11,651
	Apr 2025	5	13,134	$169,107	11,941
nonsteroidal anti-inflammatory agents	Jun 2025	4	10,706	$146,445	10,260
	May 2025	6	11,312	$155,948	10,783
	Apr 2025	8	12,005	$166,366	11,437
antiadrenergic agents, centrally acting	Jun 2025	5	10,533	$160,572	9,461
	May 2025	8	11,119	$171,898	9,910
	Apr 2025	9	11,659	$179,453	10,442
adrenergic bronchodilators	Jun 2025	6	10,066	$498,916	8,790
	May 2025	5	12,087	$539,831	10,597
	Apr 2025	3	13,858	$618,451	11,998
proton pump inhibitors	Jun 2025	7	9,846	$280,451	9,316
	May 2025	10	10,170	$291,887	9,498
	Apr 2025	10	10,296	$283,078	9,655
aminopenicillins	Jun 2025	8	8,819	$125,641	8,648
	May 2025	4	12,490	$181,564	12,309
	Apr 2025	4	13,718	$198,510	13,481
antihistamines	Jun 2025	9	8,570	$182,569	8,292
	May 2025	9	10,804	$198,855	10,421
	Apr 2025	6	12,711	$228,671	12,317
topical steroids	Jun 2025	10	8,515	$162,815	7,735
	May 2025	13	8,188	$155,304	7,443
	Apr 2025	12	9,012	$172,310	8,181

TABLE D: TOP 10 DRUG CATEGORIES BY DOLLARS PAID IN JUN 2025 (FFS AND CCOs)

Category	Month Year	Rank Paid Amt	# RXs	$ Paid	# Unique Benes
interleukin inhibitors	Jun 2025	1	1,010	$6,152,105	942
(ex. Dupixent, Stelara, Taltz)	May 2025	1	1,048	$6,508,044	959
	Apr 2025	1	1,056	$6,501,965	955
atypical antipsychotics	Jun 2025	2	13,371	$5,405,533	11,180
(ex. Invega Sustenna, Vraylar)	May 2025	2	14,002	$5,243,679	11,597
	Apr 2025	2	14,236	$5,334,281	11,853
GLP-1 receptor agonists for obesity	Jun 2025	3	3,074	$3,993,128	2,814
(ex. Wegovy, Saxenda)	May 2025	4	2,606	$3,367,327	2,410
	Apr 2025	4	2,558	$3,303,862	2,350
TNF alpha inhibitors	Jun 2025	4	380	$3,369,244	341
(ex. Humira)	May 2025	3	396	$3,420,304	354
	Apr 2025	3	397	$3,452,700	354
antiviral combinations	Jun 2025	5	613	$2,450,328	579
(ex. Biktarvy)	May 2025	6	633	$2,627,237	591
	Apr 2025	6	653	$2,448,254	611
GLP-1 receptor agonists for non-obesity indications	Jun 2025	6	2,499	$2,368,214	2,387
(ex. Trulicity)	May 2025	7	2,502	$2,349,122	2,339
	Apr 2025	7	2,475	$2,322,253	2,341
CNS stimulants	Jun 2025	7	18,129	$2,351,081	15,838
(ex. methylphenidate, lisdexamfetamine)	May 2025	5	21,131	$2,844,714	18,387
	Apr 2025	5	24,291	$3,245,229	21,102
CFTR combinations	Jun 2025	8	87	$2,138,738	76
(ex. Trikafta)	May 2025	9	80	$1,996,508	72
	Apr 2025	8	85	$2,184,906	74
factor for bleeding disorders	Jun 2025	9	134	$2,014,244	111
(ex. Hemlibra, antihemophilic factors)	May 2025	8	137	$2,032,079	113
	Apr 2025	9	137	$2,168,766	111
SGLT-2 inhibitors	Jun 2025	10	2,185	$1,723,316	2,087
(ex. Jardiance, Farxiga)	May 2025	10	2,295	$1,845,140	2,166
	Apr 2025	10	2,245	$1,829,588	2,143

TABLE E: TOP 25 DRUG MOLECULES
BY NUMBER OF CLAIMS IN JUN 2025 (FFS and CCOs)

Drug Molecule Therapeutic Category	May 2025 # Claims	Jun 2025 # Claims	Jun 2025 $ Paid	Jun 2025 # Unique Benes
albuterol / adrenergic bronchodilators	11,441	9,341	$296,967	8,231
amoxicillin / aminopenicillins	12,467	8,792	$123,903	8,621
clonidine / antiadrenergic agents, centrally acting	6,791	6,521	$83,904	6,132
amphetamine-dextroamphetamine / CNS stimulants	6,937	6,255	$191,638	5,455
methylphenidate / CNS stimulants	7,490	6,112	$1,187,364	5,494
gabapentin / gamma-aminobutyric acid analogs	6,211	5,964	$93,467	5,599
montelukast / leukotriene modifiers	6,049	5,450	$79,468	5,344
ondansetron / 5HT3 receptor antagonists	6,739	5,441	$82,075	5,216
ibuprofen / nonsteroidal anti-inflammatory agents	5,748	5,430	$68,759	5,310
cetirizine / antihistamines	7,420	5,354	$99,268	5,268
acetaminophen-hydrocodone / narcotic analgesic combinations	4,953	4,990	$88,684	4,735
sertraline / SSRI antidepressants	5,161	4,915	$59,975	4,492
triamcinolone topical / topical steroids	4,452	4,815	$86,397	4,707
fluticasone nasal / nasal steroids	6,043	4,764	$83,947	4,729
amlodipine / calcium channel blocking agents	4,624	4,535	$72,854	4,209
azithromycin / macrolides	7,957	4,472	$69,223	4,405
ergocalciferol / vitamins	4,607	4,429	$41,305	3,719
pantoprazole / proton pump inhibitors	4,218	4,125	$51,157	3,849
hydroxyzine / miscellaneous anxiolytics, sedatives and hypnotics	4,215	4,109	$74,327	3,935
omeprazole / proton pump inhibitors	4,240	4,060	$50,554	3,940
guanfacine / antiadrenergic agents, centrally acting	4,327	4,012	$76,668	3,822
atorvastatin / HMG-CoA reductase inhibitors (statins)	4,097	3,881	$47,236	3,481
amoxicillin-clavulanate / penicillins/beta-lactamase inhibitors	5,198	3,697	$74,546	3,657
famotidine / H2 antagonists	3,945	3,690	$66,616	3,485
risperidone / atypical antipsychotics	3,879	3,670	$536,712	3,296

TABLE F: TOP 25 DRUG MOLECULES
BY DOLLARS PAID IN JUN 2025 (FFS and CCOs)

Drug Molecule Therapeutic Category	May 2025 $ Paid	Jun 2025 $ Paid	Jun 2025 # Claims	Jun 2025 # Unique Benes
semaglutide / GLP-1 receptor agonists for obesity	$3,334,553	$3,956,114	3,043	2,786
dupilumab / interleukin inhibitors	$3,038,084	$2,975,075	743	685
adalimumab / TNF alpha inhibitors	$2,608,590	$2,664,784	277	250
paliperidone / atypical antipsychotics	$2,170,909	$2,174,871	682	623
elexacaftor/ivacaftor/tezacaftor / CFTR combinations	$1,868,282	$1,975,285	81	71
dulaglutide / GLP-1 receptor agonists for non-obesity indications	$1,876,332	$1,865,879	1,958	1,884
aripiprazole / atypical antipsychotics	$1,483,578	$1,587,216	3,517	3,258
bictegravir/emtricitabine/tenofovir / antiviral combinations	$1,512,614	$1,373,361	313	299
methylphenidate / CNS stimulants	$1,477,525	$1,187,364	6,112	5,494
empagliflozin / SGLT-2 inhibitors	$953,892	$920,917	1,117	1,063
ixekizumab / interleukin inhibitors	$1,072,534	$866,254	99	97
emicizumab / factor for bleeding disorders	$1,028,676	$805,902	28	26
dapagliflozin / SGLT-2 inhibitors	$887,732	$798,884	1,062	1,022
cariprazine / atypical antipsychotics	$754,991	$745,961	519	500
ustekinumab / interleukin inhibitors	$839,093	$698,277	30	30
apixaban / factor Xa inhibitors	$600,337	$635,314	1,242	1,090
antihemophilic factor / factor for bleeding disorders	$372,551	$621,541	15	10
etanercept / TNF alpha inhibitors	$702,652	$603,396	88	80
risperidone / atypical antipsychotics	$449,239	$536,712	3,670	3,296
somatropin / growth hormones	$494,339	$530,054	115	104
upadacitinib / antirheumatics	$477,298	$519,635	76	71
cannabidiol / miscellaneous anticonvulsants	$512,318	$514,865	154	144
teduglutide / miscellaneous GI agents	$375,232	$469,040	10	10
lisdexamfetamine / CNS stimulants	$555,501	$468,872	2,575	2,526
sacubitril-valsartan / angiotensin receptor blockers and neprilysin inhibitors	$456,910	$465,394	726	694

TABLE G: TOP 25 DRUG MOLECULES
BY CHANGE IN NUMBER OF CLAIMS FROM APR 2025 TO JUN 2025 (FFS and CCOs)

Drug Molecule	Apr 2025 # Claims	May 2025 # Claims	Jun 2025 # Claims	Jun 2025 $ Paid	Jun 2025 # Unique Benes
semaglutide / GLP-1 receptor agonists for obesity	2,533	2,577	3,043	$3,956,114	2,786
ofloxacin otic / otic anti-infectives	1,205	1,265	1,631	$34,702	1,611
hydrocortisone/neomycin/polymyxin b otic / otic steroids with anti-infectives	375	432	662	$39,736	658
mupirocin topical / topical antibiotics	3,406	3,340	3,530	$53,384	3,458
acetaminophen-hydrocodone / narcotic analgesic combinations	4,883	4,953	4,990	$88,684	4,735
chlorhexidine topical / mouth and throat products	758	758	854	$11,177	850
dexamethasone / glucocorticoids	446	418	495	$5,807	488
dulaglutide / GLP-1 receptor agonists for non-obesity indications	1,910	1,979	1,958	$1,865,879	1,884
ezetimibe / cholesterol absorption inhibitors	576	602	624	$8,127	601
metronidazole / miscellaneous antibiotics	2,229	2,182	2,277	$26,955	2,229
nitrofurantoin / urinary anti-infectives	1,519	1,564	1,562	$38,020	1,536
insulin lispro / insulin	740	790	773	$110,823	718
buprenorphine-naloxone / narcotic analgesic combinations	911	929	943	$335,886	811
multivitamin, prenatal / vitamin and mineral combinations	446	431	475	$8,449	470
estradiol / estrogens	461	496	489	$13,348	474
betamethasone-clotrimazole topical / topical steroids with anti-infectives	382	408	410	$7,798	403
oxybutynin / urinary antispasmodics	696	709	724	$10,390	662
mirabegron / urinary antispasmodics	179	208	206	$81,799	180
spinosad topical / topical anti-infectives	181	153	208	$59,455	201
insulin aspart / insulin	1,010	1,007	1,036	$193,051	941
ethinyl estradiol-norelgestromin / contraceptives	1,716	1,701	1,741	$184,858	1,575
sodium chloride / minerals and electrolytes	78	92	102	$4,208	79
lvp solution / intravenous nutritional products	124	142	148	$3,718	103
glipizide / sulfonylureas	339	329	363	$6,006	348
tirzepatide / GLP-1 receptor agonists for non-obesity indications	171	180	193	$200,539	179

TABLE H: TOP 25 DRUG MOLECULES
BY CHANGE IN AMOUNT PAID FROM APR 2025 TO JUN 2025 (FFS and CCOs)

Drug Molecule	Apr 2025 $ Paid	May 2025 $ Paid	Jun 2025 $ Paid	Jun 2025 # Claims	Jun 2025 # Unique Benes
semaglutide / GLP-1 receptor agonists for obesity	$3,278,562	$3,334,553	$3,956,114	3,043	2,786
antihemophilic factor / factor for bleeding disorders	$468,104	$372,551	$621,541	15	10
teduglutide / miscellaneous GI agents	$328,328	$375,232	$469,040	10	10
diazepam / benzodiazepines	$156,983	$270,092	$286,984	678	644
eteplirsen / miscellaneous uncategorized agents	$57,623	$300,868	$179,245	4	2
cenegermin ophthalmic / miscellaneous ophthalmic agents	$0	$0	$115,410	2	1
deutivacaftor/tezacaftor/vanzacaftor / CFTR combinations	$0	$56,831	$113,662	4	4
nintedanib / multikinase inhibitors	$61,912	$116,069	$169,649	13	10
lanadelumab / hereditary angioedema agents	$52,717	$105,434	$158,150	3	2
aripiprazole / atypical antipsychotics	$1,482,828	$1,483,578	$1,587,216	3,517	3,258
odevixibat / miscellaneous GI agents	$0	$0	$101,394	3	2
upadacitinib / antirheumatics	$420,117	$477,298	$519,635	76	71
somatropin / growth hormones	$438,282	$494,339	$530,054	115	104
risperidone / atypical antipsychotics	$450,456	$449,239	$536,712	3,670	3,296
burosumab / miscellaneous metabolic agents	$73,394	$165,128	$155,958	6	5
cabozantinib / VEGF/VEGFR inhibitors	$117,093	$90,781	$196,035	8	7
crinecerfont / adrenal corticosteroid inhibitors	$38,344	$115,033	$115,033	3	3
guselkumab / interleukin inhibitors	$154,827	$284,350	$226,020	15	15
pancrelipase / digestive enzymes	$315,404	$376,106	$385,211	159	149
bimekizumab / interleukin inhibitors	$94,521	$181,707	$157,938	8	8
dulaglutide / GLP-1 receptor agonists for non-obesity indications	$1,810,676	$1,876,332	$1,865,879	1,958	1,884
immune globulin intravenous and subcutaneous / immune globulins	$191,899	$254,910	$243,301	24	19
adalimumab / TNF alpha inhibitors	$2,618,395	$2,608,590	$2,664,784	277	250
eplontersen / miscellaneous metabolic agents	$0	$0	$42,842	1	1
dolutegravir-lamivudine / antiviral combinations	$115,905	$154,981	$157,146	46	41

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 APR 2025 TO JUN 2025 (FFS and CCOs)

Drug Product Therapeutic Category	Jun 2025 # Claims	Jun 2025 $ Paid	Jun 2025 Avr. Paid Per Rx	Jun 2025 Avr. Units Per Rx	Apr 2025 Paid Per Unit	May 2025 Paid Per Unit	Jun 2025 Paid Per Unit	Percent Change
dexmethylphenidate 30 mg capsule, extended release / CNS stimulants (Y)	182	$11,684	$64.20	30	$1.50	$1.55	$1.77	18.1%
dexmethylphenidate 5 mg capsule, extended release / CNS stimulants (Y)	136	$6,098	$44.84	30	$1.06	$1.10	$1.13	6.6%
lisdexamfetamine 20 mg capsule / CNS stimulants (Y)	252	$33,866	$134.39	30	$3.90	$4.12	$4.12	5.6%
dexmethylphenidate 20 mg capsule, extended release / CNS stimulants (Y)	282	$16,778	$59.50	30	$1.53	$1.56	$1.60	4.7%
dexmethylphenidate 25 mg capsule, extended release / CNS stimulants (Y)	174	$12,445	$71.53	30	$1.96	$2.08	$2.03	3.4%
dexmethylphenidate 10 mg capsule, extended release / CNS stimulants (Y)	334	$16,292	$48.78	30	$1.23	$1.24	$1.26	2.5%
Eliquis (apixaban) 2.5 mg tablet / factor Xa inhibitors (Y)	154	$69,224	$449.51	46	$8.96	$8.88	$9.11	1.7%
Entresto (sacubitril-valsartan) 24 mg-26 mg tablet / angiotensin receptor blockers and neprilysin inhibitors (Y)	328	$203,907	$621.67	56	$10.80	$10.94	$10.96	1.4%
Linzess (linaclotide) 72 mcg capsule / guanylate cyclase-C agonists (Y)	137	$75,091	$548.11	30	$17.64	$17.95	$17.89	1.4%
Biktarvy (bictegravir/emtricitabine/tenofovir) 50 mg-200 mg-25 mg tablet / antiviral combinations (Y)	313	$1,373,361	$4,387.73	37	$120.60	$122.75	$122.14	1.3%
Trintellix (vortioxetine) 20 mg tablet / miscellaneous antidepressants (Y)	122	$59,250	$485.65	29	$16.05	$16.06	$16.25	1.2%
Linzess (linaclotide) 145 mcg capsule / guanylate cyclase-C agonists (Y)	250	$137,939	$551.76	30	$17.64	$17.68	$17.80	0.9%
Farxiga (dapagliflozin) 10 mg tablet / SGLT-2 inhibitors (Y)	917	$694,405	$757.26	42	$18.43	$18.37	$18.58	0.8%

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

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 APR 2025 TO JUN 2025 (FFS and CCOs)

Drug Product Therapeutic Category	Jun 2025 # Claims	Jun 2025 $ Paid	Jun 2025 Avr. Paid Per Rx	Jun 2025 Avr. Units Per Rx	Apr 2025 Paid Per Unit	May 2025 Paid Per Unit	Jun 2025 Paid Per Unit	Percent Change
Qelbree (viloxazine) 200 mg capsule, extended release / noradrenergic uptake inhibitors for ADHD (Y)	341	$160,582	$470.92	38	$11.81	$11.81	$11.87	0.5%
Januvia (sitagliptin) (as phosphate) 100 mg tablet / dipeptidyl peptidase 4 inhibitors (Y)	188	$77,731	$413.46	38	$10.19	$10.15	$10.23	0.4%

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

MARCH 2025 – MAY 2025

Ongoing Mailings:

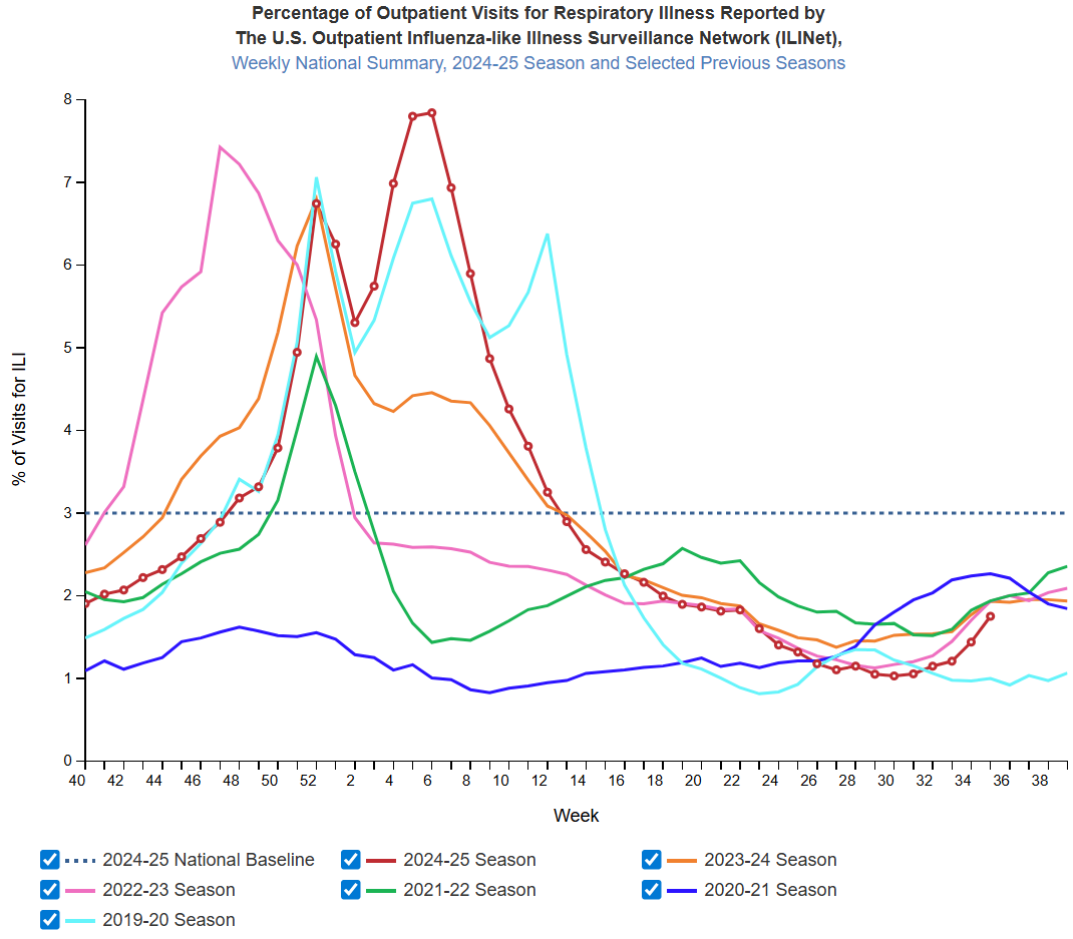
PROVIDER SHOPPING FOR OPIOIDS (≥4 Prescribers AND ≥4 Pharmacies)				CONCOMITANT USE OF OPIOIDS AND ANTIPSYCHOTICS			SABA MONOTHERAPY		
Month	Prescribers Mailed	Pharms Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed	Month	Prescribers Mailed	Members Addressed
Jun-24	5	5	10	Jun-24	30	32	Jun-24	NA	NA
Jul-24	4	3	7	Jul-24	29	32	Jul-24	NA	NA
Aug-24	4	4	8	Aug-24	52	65	Aug-24	NA	NA
Sep-24	3	4	7	Sep-24	36	40	Sep-24	NA	NA
Oct-24	5	5	10	Oct-24	46	48	Oct-24	NA	NA
Nov-24	4	4	8	Nov-24	59	67	Nov-24	NA	NA
Dec-24	2	2	4	Dec-24	44	54	Dec-24	NA	NA
Jan-25	2	2	4	Jan-25	51	57	Jan-25	150	216
Feb-25	1	1	2	Feb-25	41	47	Feb-25	150	190
Mar-25	1	1	2	Mar-25	32	38	Mar-25	150	208
Apr-25	2	2	4	Apr-25	35	39	Apr-25	150	191
May-25	1	2	3	May-25	37	39	May-25	150	203

INFLUENZA VACCINATION AND TREATMENT UPDATE
2024-2025 SEASON

BACKGROUND

Influenza (Flu) is a contagious respiratory illness that can cause mild to severe illness and can even lead to death. While infection from the influenza virus can occur at any time, influenza viruses typically circulate in the United States (US) from late fall through early spring. In recent years, beginning with the COVID-19 pandemic, influenza activity did not follow typical trends. The 2024-2025 season was classified as a severe season, one of the most severe in recent years. The 2024-2025 season exhibited two peaks, late December and again in early February. (Figure 1) This past flu season was characterized by high rates of outpatient visits for flu-like illnesses and hospitalizations.[1] Multiple factors played a role in last year's extremely severe season, including decreased vaccine efficacy and lower vaccination rates compared to previous years. [1,2]

Figure 1: Nationwide Percent of Visits for Influenza Like-Illness (ILI)[3]



METHODS

Pharmacy and medical claims data for fee-for-service and all CCOs [UnitedHealthcare (UHC), Magnolia Health (MAG), and Molina Healthcare (MOL)] for influenza vaccines and anti-influenza agents were extracted for state fiscal year (SFY) 2025 (July 1, 2024 to June 30, 2025). This analysis included pharmacy claims for influenza vaccines and all anti-influenza agents listed on the MS Division of Medicaid's Universal Preferred Drug List (Tamiflu®, oseltamivir, Flumadine®, rimantadine, Rapivab®, Relenza®, Xofluza®). The number of beneficiaries receiving these agents, the number of prescriptions filled, and the amounts paid for these claims were determined for SFY 2025.

RESULTS

Table 1 displays the number of Medicaid members with documented influenza vaccinations through pharmacy and medical claims for SFY 2025.

- 58,438 members had documented flu vaccinations through claims data. The majority (54.6%) of individuals receiving flu vaccinations were 18 years and younger.
- Members enrolled in FFS had the highest number of claims with Molina having the lowest.
- 93.1% of flu vaccinations were provided through medical claims (ex. medical clinic visits).
- 4,006 members had pharmacy claims for flu vaccinations. Although the total number of members administered flu vaccines in the pharmacy setting rose, the number of adults 19 years and older vaccinated in a pharmacy setting decreased for the second year in a row.

Table 1: Influenza Vaccine Utilization in Mississippi Medicaid for State Fiscal Year 2025 (July 1, 2024 – June 30, 2025)							
Age of time of vaccination	Plan at Index Flu Vaccination	Number of Members receiving flu vaccinations*	Pharmacy Claims		Medical Claims		
			# of Members	Average Cost/Member	# of Members	Average Vaccine Cost/Member**	Average Vaccine Admin Cost/Member**
<19	FFS	5,181	207	$39.0	4,974	$22.6	$30.9
	UHC	9,721	209	$40.3	9,512	$25.2	$32.4
	MAG	11,464	227	$39.7	11,237	$26.2	$30.1
	MOL	5,525	86	$40.3	5,439	$32.0	$31.6
	Total	31,891	729	$39.7	31,162	$26.0	$31.2
≥19	FFS	14,917	473	$49.5	14,444	$20.7	$17.3
	UHC	3,818	1,090	$52.0	2,728	$27.6	$23.0
	MAG	4,005	1,277	$52.9	2,728	$25.5	$23.2
	MOL	3,807	437	$52.8	3,370	$23.7	$22.1
	Total	26,547	3,277	$52.1	23,270	$25.0	$21.9
Total (across all plans and age groups)		**58,438**	**4,006**	**$49.9**	**54,432**	**$25.1**	**$29.4**

Note: FFS = Fee-For-Service, UHC = United Health Care, MAG = Magnolia, MOL = Molina,

*Members with Medical or Pharmacy claims were identified. These totals do not represent unique members.

**Only medical claims for flu vaccination or vaccine administration with a paid amount >$.0.01 were included in the analysis.

CPT codes for influenza vaccines included: 90630, 90685-90688, 90660-90662, 90664, 90666-90668, 90672-90674, 90756, 90682, 90686, Q2035.

CPT codes for vaccine administration included: 90460-90461, 90471-90474.

Reference:

1. www.immunize.org/catg.d/p4072.pdf
2. http://www.aapc.com/blog/44189-code-the-shots-for-flu-vaccine/

TABLE 1b. Total Influenza Vaccine Utilization by State Fiscal Year (Point of Sale Pharmacy Claims Only) SFY 2023- SFY2025			
Age at time of vaccination	SFY 2023	SFY 2024	SFY 2025
18 yrs and younger	422	157	729
19 years and older	4556	3650	3277
Total	4,978	3,807	4006
Note: SFY = State Fiscal State			

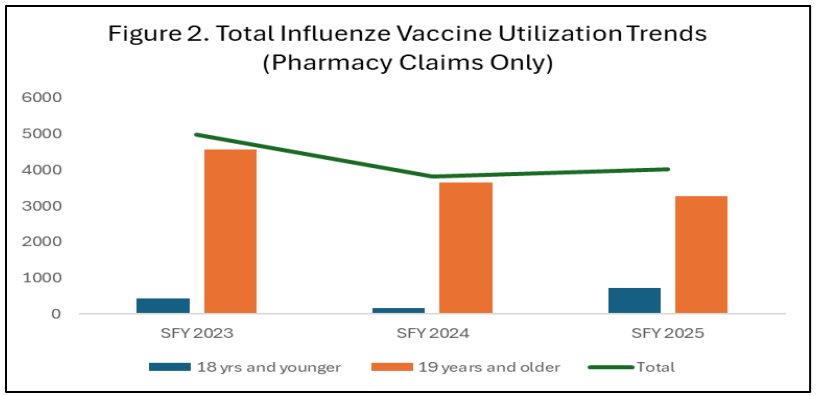


Table 2 displays the number of anti-influenza prescriptions filled, members treated, and the amounts paid for each antiviral agent during SFY 2025.

- A total of 51,054 claims for anti-influenza agents were paid during SFY 2025.
- The number of claims, number of members treated, and dollars paid during SFY 2025 were lower than totals reported for SFY 2024.

Table 2: Utilization of Anti-Influenza Agents In Mississippi Medicaid (July 1, 2024 – June 30, 2025)

Drug	Plan	Prescription Filled	Members	Paid Amount
Oseltamivir Phosphate	FFS	8263	7915	$219,104.56
	UHC	15773	15092	$412,787.83
	MAG	17114	16289	$448,496.58
	MOL	9900	9455	$258,894.61
Xofluza	FFS	1	1	$168.47
	UHC	0	0	$0.00
	MAG	2	2	$337.43
	MOL	1	1	$186.62
Grand Total		**51,054**	**48,755**	**$1,339,976.10**

Note: FFS = Fee-for Service, UHC = United HealthCare, MAG = Magnolia, MOL = Molina

Other anti-influenza agents, namely Rapivab (peramivir), Flumadine(rimantadine), and Relenza (zanamivir) did not have any pharmacy or medical claims during this study period.

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

The total number of members may not equal the sum of members for each product and plan, since certain members may have had utilization of multiple products or enrolled in multiple pharmacy plans during the analysis period.

CONCLUSIONS AND RECOMMENDATIONS

This report for the DUR Board on influenza vaccinations and treatment utilization trends in the four pharmacy programs is for information and discussion purposes only. No action is being sought at this time.

REFERENCES

1. Tori L. Fournier Bs. Under the Weather: Unpacking the Impact of the 2024-2025 Influenza Season. Published online July 21, 2025. Accessed September 8, 2025. https://www.pharmacytimes.com/view/under-the-weather-unpacking-the-impact-of-the-2024-2025-influenza-season

2. Al-Hajjar S. The 2024–2025 influenza season: Decoding the rise in severe illness and hospitalizations. *International Journal of Pediatrics and Adolescent Medicine*. 2025;12(1):1. doi:10.4103/ijpam.ijpam_51_25

3. CDC. Weekly US Influenza Surveillance Report: Key Updates for Week 35, ending August 30, 2025. FluView. September 4, 2025. Accessed September 8, 2025. https://www.cdc.gov/fluview/surveillance/2025-week-35.html

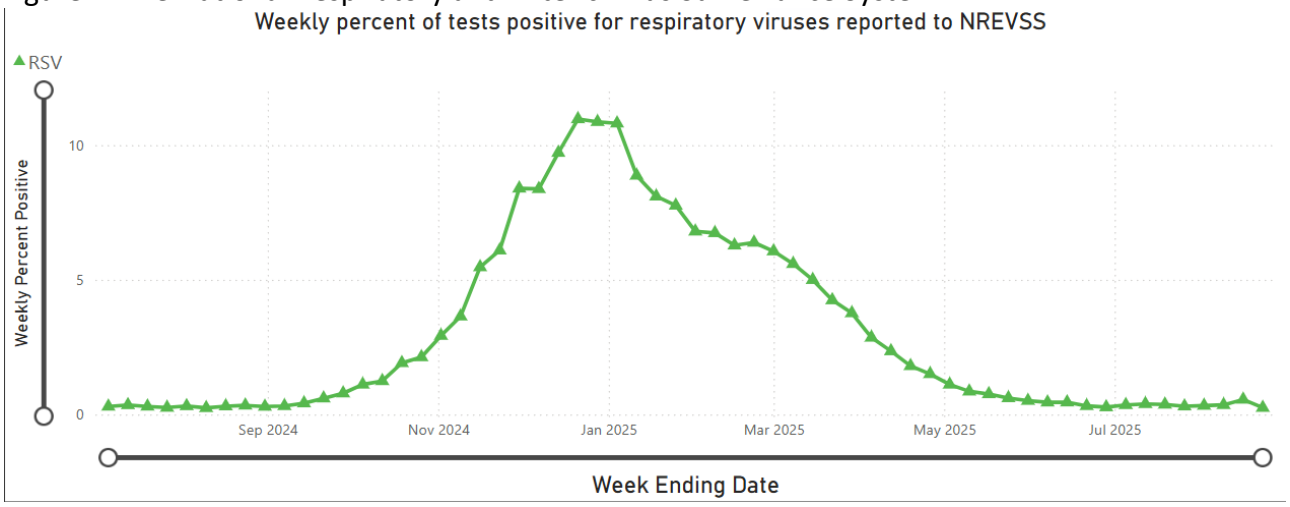
RSV ANNUAL UPDATE: 2024-2025 SEASON

BACKGROUND

Respiratory syncytial virus (RSV) is a virus infecting the lungs that typically causes mild, cold-like symptoms, but can cause severe illness in vulnerable populations such as infants and older adults. RSV can lead to the development of bronchiolitis and pneumonia that may require hospitalization in these populations. It is estimated that RSV is associated with 2.1 million outpatient visits among children less than 5 years, up to 80,000 hospitalizations annually among children under the age of 5 years, and 180,000 hospitalizations among adults 50 years and older.[1]

Traditionally, the onset of RSV season begins between mid-September to mid-November, peaks late December to mid-February, and ends mid-April to mid-May. In the years immediately following the COVID-19 pandemic, these trends changed, and RSV circulation began to rise in the spring months and peak mid-summer. The National Respiratory and Enteric Virus Surveillance System (NREVSS) monitors viral activity for common viruses, including RSV, in the United States. For the 2023-2024 season, RSV circulation exhibited a traditional pattern. (Figure 1)

Figure 1. The National Respiratory and Enteric Virus Surveillance System[2]



To help protect against the highly contagious virus, preventing RSV is critical. The pharmacotherapeutic landscape in RSV prevention has changed dramatically in recent years. Originally approved in 1998, palivizumab (Synagis), a humanized monoclonal antibody, was the mainstay preventive treatment for RSV in the U.S. Palivizumab was approved for the prevention of serious lower respiratory tract disease (LRTD) caused by RSV in children at increased risk of severe disease.[3,4] In 2023, three new products received FDA approval for the prevention of RSV marking a major shift in RSV prevention. The agents included a long-acting monoclonal antibody and two RSV vaccines. In 2024, an additional RSV vaccine received FDA approval, and this market continues to expand with multiple agents for the prevention of RSV in various stages of development.

This report describes the utilization of agents for the prevention of RSV among individuals with Medicaid coverage during the 2024-2025 RSV season.

METHODS

Pharmacy and medical claims from fee-for-service and all CCOs [UnitedHealthcare (UHC), Magnolia Health (MAG) and Molina Healthcare (MOL)] for agents used in the prevention of RSV were extracted for state fiscal year (SFY) 2025 (July 1, 2024 to June 30, 2025). For nirsevimab (Beyfortus) and each RSV vaccine (Abrysvo, Arexvy and mRESVIA), all pharmacy and medical claims were extracted. In medical claims, vaccine and vaccine administration current procedural terminology (CPT) codes associated with each agent were used to identify the number of claims and beneficiaries who received each agent. (Appendix A)

The proportion of infants who received protection against RSV in SFY 2025, either through direct administration of Beyfortus or passive immunization by maternal RSV vaccination, was estimated. Eligible infants were defined as those born between March 2024 and March 2025 with at least one month of Medicaid coverage. From the eligible infant population, infants were classified as directly protected if they received Beyfortus before six months of age. Indirect protection via maternal immunization was assigned to infants whose mothers received Abrysvo during pregnancy in SFY 2025 and subsequently had a live birth between October 2024 and April 2025. The overall proportion of infants with RSV protection was calculated by summing those with direct and maternal-derived protection and dividing by the total number of eligible infants.

RESULTS

Palivizumab Utilization:
With the entrance of RSV vaccines and a long-acting monoclonal antibody, the use of palivizumab has dramatically declined. For the 2023/2024 season, there were a total of 536 palivizumab claims representing 136 unique beneficiaries totaling almost $1.7 million, a 57% decrease from the previous year. For this past RSV season (2024/2025), MS Medicaid implemented prior authorization criteria for palivizumab limiting its use to situations where nirsevimab (Beyfortus) was unavailable. **There were no paid claims palivizumab during the 2024/2025 RSV season.** Palivizumab will be discontinued as of December 31, 2025. MS Medicaid will maintain PA criteria for palivizumab during the 2025/2026 RSV season allowing for use only in circumstances when long-acting monoclonal antibody agents are not available.

Nirsevimab Utilization:

Nirsevimab (Beyfortus), a long-acting monoclonal antibody indicated for the prevention of RSV LRTD, is approved for infants born or entering their first RSV season and for children up to 24 months who remain vulnerable to severe RSV through their second RSV season.[5] Beyfortus is covered under the Vaccines for Children Program (VFC), therefore, Medicaid does not pay for the cost of the drug. Beyfortus utilization was identified by claims containing either the vaccine or vaccine administration CPT codes. If a beneficiary had claims for both the vaccine and vaccine administration codes, they were only counted once. Table 1 displays the total number of Medicaid members who received Beyfortus during SFY 2025. A total of 6,129 unique members were identified through medical claims data as receiving Beyfortus during SFY 2025, up from 2,810 members during SFY 2024. Approximately 83% of members who received Beyfortus were less than 6 months of age at the time of administration.

Table 1. Beyfortus Utilization in Mississippi Medicaid State Fiscal Year 2025 (July 1, 2024 - June 30, 2025)

Age (in months)	Plan	Number of members with Beyfortus claims**	Claims for Beyfortus
< 6	FFS	44	44
	UHC	1653	1655
	MAG	1812	1817
	MOL	1560	1567
	Total	5069	5083
6 to 12	FFS	5	5
	UHC	296	297
	MAG	350	354
	MOL	245	248
	Total	896	904
13 to 18	FFS	7	7
	UHC	13	13
	MAG	18	18
	MOL	20	20
	Total	58	58
19 to 24	FFS	2	2
	UHC	7	7
	MAG	5	5
	MOL	5	5
	Total	19	19
> 24	FFS	17	17
	UHC	26	26
	MAG	20	20
	MOL	24	24
	Total	87	87
Total (across all plans and age groups)		6129	6151

Note: FFS = Fee-for-Service, UHC = United Health Care, MAG = Magnolia, MOL = Molina, POS = point of sale (pharmacy)

*CPT codes for Beyfortus included: 90380, 90381

*CPT codes for Beyfortus administration included: 96380, 96381

**The total number of members does not add to the sum total of claims because 22 members had multiple vaccine or vaccine administration claims within the current evaluation period

For the upcoming 2025/2026 RSV season, a second long-acting monoclonal antibody agent has been approved by the FDA. Clesrovimab-cfor (Enflonsia) is indicated for the prevention of RSV LRTD in neonates and infants who are born during or entering their first RSV season.

RSV Vaccine Utilization:

Abrysvo

The RSV vaccine, Abrysvo, is approved for pregnant individuals at 32 through 36 weeks gestational age for the prevention of LRTD caused by RSV in infants. Abrysvo is also approved for the prevention of LRTD caused by RSV in individuals 60 years and older and individuals 18 to 59 years who are increased risk of LRTD caused by RSV.[6] A total of 530 members received Abrysvo during SFY 25, up from 117 in SFY 2024. (Table 2) Of the 530 members who received Abrysvo, 461 could be considered childbearing age.

Table 2. Abrysvo Vaccine Utilization in Mississippi Medicaid State Fiscal Year 2025 (July 1, 2024 - June 30, 2025)

Age (in years)	Plan	Number of members with Abrysvo vaccine claims**	POS claims for Abrysvo	Medical claims for Abrysvo
< 19	FFS	1		1
	UHC	5		5
	MAG	7		7
	MOL	4		5
	Total	17		18
19 - 49	FFS	37	1	36
	UHC	142	8	134
	MAG	139	8	131
	MOL	126	4	123
	Total	444	21	423
> 50	FFS	21	20	1
	UHC	19	18	1
	MAG	23	23	
	MOL	6	6	
	Total	69	67	2
Total (across all plans and age groups)		530	88	444

Note: FFS = Fee-for-Service, UHC = United Health Care, MAG = Magnolia, MOL = Molina, POS = point of sale (pharmacy)

*CPT codes for Abrysvo vaccine included: 90678

**The total number of members does not add to the sum total of POS and Medical claims.

Proportion of infants protected from RSV by receipt of Beyfortus and Abrysvo

MS-DUR identified 25,031 infants with at least one month Medicaid eligibility who were born between March 2024 and March 2025 and were thus eligible to receive RSV protection during their first RSV season. Among those 25,031 infants, 5,021 received Beyfortus. Additionally, 442 individuals who received Abrysvo had a live birth between October 2024 and April 2025. It is assumed that these 442 infants received RSV protection from maternal vaccination. Therefore, approximately 21.8% [(5,021 + 442)/25,031] of eligible infants covered by Mississippi Medicaid received RSV protection by either Beyfortus or Abrysvo during their first RSV season.

Arexvy Utilization:

Arexvy, another RSV vaccine, is indicated for individuals aged 60 years and older and adults 50 to 59 years who are at increased risk to prevent LRTD caused by RSV.[7] A total of 182 members received Arexvy in SFY 2025, nearly equal to the amount administered in SFY 2024.

Table 3. Arexvy Vaccine Utilization in Mississippi Medicaid
State Fiscal Year 2025
(July 1, 2024 - June 30, 2025)

Age (in years)	Plan	Number of members with Arexvy vaccine claims*	POS claims for Arexvy	Medical claims for Arexvy
< 65 years	FFS	33	26	7
	UHC	41	34	7
	MAG	77	64	14
	MOL	16	13	3
	Total	167	137	31
65 years and older	FFS	15	0	15
	UHC	0	0	0
	MAG	0	0	0
	MOL	0	0	0
	Total	15	0	15
Total (across all plans and age groups)		182	137	46

Note: FFS = Fee-for-Service, UHC = United Health Care, MAG = Magnolia, MOL = Molina, POS = point of sale (pharmacy)
*CPT codes for Arexvy vaccine included: 90679
**The total number of members does not add to the sum total of POS and Medical claims.

mResvia Utilization:

In 2024, a third RSV vaccine, mResvia, was approved for individuals 60 years and older and those 18 to 59 years who are at increased risk for LRTD caused by RSV.[8] There was one claim for mResvia during SFY 2025.

CONCLUSION

For the 2024/2025 RSV season, MS Medicaid saw a dramatic increase in the proportion of infants who received RSV protection during their first RSV season. During this past season, approximately 21.8% of eligible newborns received RSV protection, up from 10% in the 2023/2024 RSV season. While encouraging, efforts should be undertaken to continue increasing the proportion of newborns protected from RSV.

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RECOMMENDATION

1) DOM should communicate with prescribers the importance of RSV protection for newborns, including in this communication the process for Medicaid billing for these agents.

APPENDIX A

APPENDIX A

CPT Codes Associated with RSV Agents		
Agent	**Vaccine Code**	**Vaccine Administration Code**
Abrysvo	90678	90471/90472
Arexvy	90679	90471/90472
Beyfortus	90380/90381	96380/96381
mRESVIA	90683	90471/90472
Note: 90471 and 90472 are nonspecific vaccine administration codes		

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MEDICAID CASE MIX CHANGE

BACKGROUND

Medicaid program enrollment has changed considerably over the past few years, with numbers rising from the pre-COVID-19 period to the COVID-19 era, while states were legally required to keep members continuously enrolled during the Public Health Emergency (PHE). State Medicaid programs resumed member eligibility redetermination on April 1, 2023, known as 'unwinding,' which caused a notable decline in Medicaid enrollment.[1–3]

While enrollment increased during the PHE period, state Medicaid program spending did not necessarily increase proportionately due to members who would have ordinarily lost eligibility being low healthcare utilizers. A recent study, using two-year linked samples of the Current Population Survey Annual Social and Economic Supplement data, reported that almost 50% of the 5.9 million Medicaid enrollees who would have typically lost Medicaid coverage reported that they thought they had already lost eligibility the second year.[4]

Moreover, several high-cost therapies have been approved or received on-label indications, especially in chronic conditions such as autoimmune disorders, cardiometabolic disorders, and dermatological conditions etc., imposing significant burden on Medicaid programs. A recent report from the Kaiser Family Foundation reported sharp increases in state Medicaid spending in state fiscal year 2024 compared to previous years.[5]

The significant shifts in enrollment as well as spending in the recent years need to be evaluated in the Mississippi Medicaid population to gain a better understanding of how enrollment and spending has changed in the period. Additionally, it is important to assess how the underlying clinical characteristics of Mississippi Medicaid enrolled members may have changed over the past several years, and how these factors may have driven the spending growth post expiration of the PHE freeze.

METHODS

Study Design and Data Source
This observational analysis utilized Mississippi Medicaid administrative claims data from January 2018 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).

Study Population
For each study year, Medicaid members were included if they met the following three criteria (see Tables 1 & 2):

1. No Medicare/Medicaid dual eligibility during any month of the given year.
2. Age below 65 years in the given year.

3. At least six months of Medicaid enrollment in the given year.

Outcomes

The primary outcomes of interest were the annual prevalence of the following comorbidities:

1. Cardiovascular and Cerebral Conditions (Acute Myocardial Infarction, Atrial Fibrillation, Ischemic Heart Disease, Heart Failure, Stroke and Transient Ischemic Attack, Peripheral Vascular Disease [PVD], Hypertension, Hyperlipidemia, Congestive Heart Failure, Angina, Arrhythmia)
2. Neurological Conditions (Epilepsy and Seizure, Migraine, Alzheimer's Disease, Alzheimer's Related Disorder or Senile Dementia, Multiple Sclerosis, Dravet Syndrome [DS], Tardive Dyskinesia, Lennox–Gastaut Syndrome)
3. Mental/Mood Disorders (Bipolar Disorder, Depression, Depressive Disorder, Anxiety, Schizophrenia, Schizophrenia-Related Disorder, Post-Traumatic Stress Disorder)
4. Behavior Disorders (Attention-Deficit Hyperactivity Disorder [ADHD], Autism Spectrum Disorder [ASD])
5. Liver Diseases (Liver Disease Except Hepatitis, Hepatitis C Acute, Hepatitis C Chronic, Hepatitis B, Cirrhosis, Alcohol-Related Liver Disease, Liver Failure, Metabolic Dysfunction-Associated Steatotic Liver Disease [MASLD])
6. Kidney Diseases (Chronic Kidney Disease, Kidney Failure, Transplantation)
7. Respiratory Diseases (Asthma, COPD and Bronchitis, Emphysema, Chronic Rhinosinusitis with Nasal Polyps, COVID)
8. Cancer (Non-Melanoma Skin Cancer, Cancer Except Non-Melanoma Skin Cancer)
9. Bone/Muscle-Related Conditions (Hip or Pelvic Fracture, Osteoporosis, Muscular Dystrophy, Fibromyalgia)
10. Metabolic Conditions (Type 1 Diabetes, Type 2 Diabetes, Obesity)
11. Autoimmune Diseases (Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis, Crohn's Disease)
12. Dermatological Conditions (Plaque Psoriasis, Hidradenitis Suppurativa, Uveitis, Atopic Dermatitis, Prurigo Nodularis, Chronic Spontaneous Urticaria, Bullous Pemphigoid)
13. Other Conditions (Cystic Fibrosis, HIV, Sickle Cell Disease, Hemophilia, Anemia, Eosinophilic Esophagitis)

In addition, total healthcare expenditures, including medical costs (inpatient and outpatient) and pharmacy costs, were calculated for each study year.

Statistical Analysis

Annual medical, pharmacy, and total costs per eligible member were summarized using mean and median values. All cost components were inflation-adjusted to 2024 U.S. dollars using the medical component of the Bureau of Labor Statistics Consumer Price Index.[6] In subgroup analysis, the annual medical, pharmacy, and total costs per member with full Medicaid benefits were included.

RESULTS

The number of members with at least one month of Medicaid eligibility grew approximately 14% between 2020 and 2023, the years impacted by restrictions on disenrollment due to the PHE. Following the end of the PHE, enrollment began returning to near pre-COVID numbers. (Table 1) Throughout the entire observation period, the proportion of Medicaid members with 6 months or more of Medicaid eligibility each year was high, peaking in 2023 during the PHE at approximately 96%. (Table 2) Examining those members with 6 months or more of eligibility each year who were below 65 years and were not dual eligible, over 600,000 MS Medicaid members were identified each year on average, the majority of whom were younger than 18 years (~65%), female (~57%) and Black (~52%). Across the observation period, proportions of members enrolled in each pharmacy program fluctuated substantially, with the pause in unwinding during the Public Health Emergency (PHE) period impacting these figures. The vast majority of members (~88%) had full pharmacy and medical benefits each year. (Table 3)

TABLE 1. Annual Medicaid Enrollment Figures

	2018	2019	2020	2021	2022	2023	2024
Number of members with at least 1 month of Medicaid enrollment	885,846	859,461	847,023	891,802	930,296	964,733	903,229
After excluding members with dual eligibility	708,145	680,816	668,610	712,847	749,674	781,928	718,691
After exclusion of members > 65 years	706,162	679,185	667,363	711,882	748,299	780,265	717,229

TABLE 2. Proportion of Months in Each Calendar Year Members had Full Benefits

Months with full benefits	2018	2019	2020	2021	2022	2023	2024
1	2.37	2.4	2.44	1.08	1.2	0.93	1.89
2	2.59	2.27	2.32	0.97	1.07	0.8	2.99
3	2.54	2.53	1.43	1.02	1.05	0.83	4.94
4	2.6	2.58	1.41	1.1	1.05	0.83	4.04
5	2.92	2.7	1.59	1.19	1.15	0.97	4.01
6	3.08	2.94	1.64	1.37	1.03	3.4	3.89
7	3.28	3.04	1.53	1.35	1.07	3.17	2.36
8	3.55	3.19	1.5	1.31	1.07	3.55	2.53
9	3.52	3.28	1.68	1.41	1.01	3.37	2.64
10	3.64	3.43	1.74	1.35	1.01	3.06	2.74
11	3.35	3.42	1.78	1.29	0.91	3.65	3.04
12	66.55	68.2	80.93	86.57	88.38	75.45	64.91
≥ 6 months	**86.97**	**87.5**	**90.8**	**94.65**	**94.48**	**95.65**	**82.11**

TABLE 3. Characteristics of Medicaid Members with ≥ 6 Months of Enrollment by Calendar Year								
Baseline Characteristics		2018 (n =614,193)	2019 (n = 594,387)	2020 (n = 606,015)	2021 (n = 673,731)	2022 (n = 707,004)	2023 (n = 746,276)	2024 (n = 588,986)
Age	<18 years	423,252 (68.91%)	408,244 (68.68%)	410,304 (67.71%)	435,009 (64.57%)	436,354 (61.72%)	444,374 (59.55%)	384,022 (65.20%)
	18 - 44 years	145,933 (23.76%)	141,665 (23.83%)	151,759 (25.04%)	192,579 (28.58%)	222,828 (31.52%)	252,489 (33.83%)	164,611 (27.95%)
	45 - 64 years	45,008 (7.33%)	44,478 (7.48%)	43,952 (7.25%)	46,143 (6.85%)	47,822 (6.76%)	49,413 (6.62%)	40,353 (6.85%)
Gender	Male	268,156 (43.66%)	258,880 (43.55%)	262,458 (43.31%)	286,948 (42.59%)	297,973 (42.15%)	313,040 (41.95%)	250,575 (42.54%)
	Female	346,037 (56.34%)	335,507 (56.45%)	343,557 (56.69%)	386,783 (57.41%)	409,031 (57.85%)	433,236 (58.05%)	338,411 (57.46%)
Race	White	190,415 (31.00%)	179,550 (30.21%)	185,653 (30.64%)	211,594 (31.41%)	223,755 (31.65%)	239,271 (32.06%)	180,066 (30.57%)
	Black	329,563 (53.66%)	313,364 (52.72%)	317,108 (52.33%)	351,321 (52.15%)	368,744 (52.16%)	389,520 (52.20%)	308,843 (52.44%)
	Other	94,215 (15.34%)	101,473 (17.07%)	103,254 (17.04%)	110,816 (16.45%)	114,505 (16.20%)	117,485 (15.74%)	100,077 (16.99%)
Pharmacy Program	FFS	143,806 (23.41%)	133,708 (22.50%)	145,178 (23.96%)	270,639 (40.17%)	332,563 (47.04%)	311,089 (41.69%)	119,481 (20.29%)
	MAG	239,450 (38.99%)	206,300 (34.71%)	194,490 (32.09%)	166,273 (24.68%)	151,448 (21.42%)	170,801 (22.89%)	184,722 (31.36%)
	MOL	20,193 (3.29%)	75,280 (12.67%)	87,762 (14.48%)	80,576 (11.96%)	77,813 (11.01%)	97,388 (13.05%)	109,373 (18.57%)
	UHC	210,744 (34.31%)	179,099 (30.13%)	178,585 (29.47%)	156,243 (23.19%)	145,180 (20.53%)	166,997 (22.38%)	175,410 (29.78%)
Full Medicaid Benefit	No	79,763 (12.99%)	78,017 (13.13%)	72,230 (11.92%)	74,860 (11.11%)	68,261 (9.65%)	80,080 (10.73%)	73,953 (12.56%)
	Yes	534,430 (87.01%)	516,370 (86.87%)	533,785 (88.08%)	598,871 (88.89%)	638,743 (90.35%)	666,196 (89.27%)	515,033 (87.44%)
Notes: FFS - Fee-for-Service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare								

Medicaid costs across each calendar year for members with 6 months or more of eligibility each year who were below 65 years and were not dual eligible were compared. Annual values were displayed in two formats: unadjusted (Table 4a) and inflation-adjusted to 2024 U.S. dollars using the medical component of the Bureau of Labor Statistics Consumer Price Index (Table 4b). From the inflation-adjusted figures, total costs rose between 2018 and 2023 but retracted slightly in 2024 following the end of the PHE. This resulted in an inflation-adjusted increase in total costs from 2018 to 2024 of approximately 3%. Throughout the entire period, the proportion of the total costs attributed to pharmacy costs remained between 20-23%.

TABLE 4a. Medicaid Costs by Calendar Year - Unadjusted							
Cost	2018	2019	2020	2021	2022	2023	2024
Sum of total cost	$2,620,446,904	$2,680,810,961	$2,449,335,756	$2,799,498,561	$3,201,677,465	$3,320,013,154	$3,138,408,236
Sum of medical cost	$2,090,880,593	$2,126,236,763	$1,905,266,656	$2,158,119,492	$2,524,876,929	$2,649,363,663	$2,481,573,982
Sum of pharmacy cost	$529,566,310	$554,574,198	$544,069,101	$641,379,069	$676,800,536	$670,649,491	$656,834,254
Proportion of total cost attributed to pharmacy cost	**20.21%**	**20.69%**	**22.21%**	**22.91%**	**21.14%**	**20.20%**	**20.93%**

TABLE 4b. Medicaid Costs by Calendar Year - Adjusted							
Cost	2018	2019	2020	2021	2022	2023	2024
Sum of total cost	$3,048,265,040	$3,032,728,145	$2,661,591,444	$3,005,033,674	$3,302,943,577	$3,409,240,729	$3,138,408,236
Sum of medical cost	$2,432,240,930	$2,405,353,518	$2,070,374,148	$2,316,565,487	$2,604,736,463	$2,720,567,085	$2,481,573,982
Sum of pharmacy cost	$616,024,109	$627,374,627	$591,217,296	$688,468,187	$698,207,114	$688,673,645	$656,834,254
Proportion of total cost attributed to pharmacy cost	**20.21%**	**20.69%**	**22.21%**	**22.91%**	**21.14%**	**20.20%**	**20.93%**

Costs were then calculated at the per member per month (PMPM) level. Unadjusted (Table 5a) and inflation-adjusted (Table 5b) mean and median per member per month totals were calculated each year. During the COVID-19 pandemic, mean PMPM total costs dipped, but PMPM total costs climbed to their highest level in 2024, surpassing pre-pandemic levels. These figures follow national trends indicating that members who were removed from Medicaid as part of the unwinding process were predominantly low utilizers of care. As they were disenrolled from Medicaid after the PHE ended, Medicaid's PMPM costs began rising. Again, this mirrors patterns seen in other state Medicaid programs during fiscal year 2024, where enrollees with higher health care needs retained coverage during unwinding.[5]

TABLE 5a. Medicaid Costs per Member per Month by Calendar Year- Unadjusted

Cost	2018	2019	2020	2021	2022	2023	2024
Mean total cost	$379.91	$401.15	$353.43	$360.90	$392.58	$389.08	$466.03
Median total cost	$92.67	$98.96	$69.59	$77.88	$89.82	$88.42	$111.06
Mean medical cost	$305.91	$321.33	$277.49	$280.55	$312.01	$312.26	$370.55
Median medical cost	$70.53	$75.83	$54.15	$62.61	$75.14	$75.39	$94.53
Mean pharmacy cost	$74.00	$79.82	$75.94	$80.35	$80.57	$76.81	$95.47
Median pharmacy cost	$8.03	$8.51	$4.51	$4.80	$4.49	$3.76	$4.77

TABLE 5b. Medicaid Costs per Member per Month by Calendar Year- Adjusted

Cost	2018	2019	2020	2021	2022	2023	2024
Mean total cost	$441.94	$453.81	$384.06	$387.40	$404.99	$399.54	$466.03
Median total cost	$107.80	$111.95	$75.62	$83.59	$92.66	$90.80	$111.06
Mean medical cost	$355.86	$363.51	$301.53	$301.15	$321.88	$320.66	$370.55
Median medical cost	$82.04	$85.79	$58.85	$67.20	$77.51	$77.42	$94.53
Mean pharmacy cost	$86.08	$90.29	$82.53	$86.25	$83.11	$78.88	$95.47
Median pharmacy cost	$9.34	$9.63	$4.90	$5.15	$4.63	$3.86	$4.77

Changes in the prevalence of several chronic conditions with high-cost therapies that have been approved or received on-label indications in recent years were tracked between 2018 and 2024. (Table 6) The conditions with the largest changes in prevalence among Medicaid members during the observation period were mental/mood disorders, respiratory disorders, metabolic disorders, behavioral disorders, and dermatologic disorders.

TABLE 6. Disease Prevalence by Calendar Year

Cost	2018	2019	2020	2021	2022	2023	2024
Cardiovascular and Cerebral Disorders	9.63%	9.93%	9.36%	9.51%	9.68%	9.47%	10.14%
Neurological Disorders	3.57%	3.73%	3.36%	3.60%	3.78%	3.80%	4.14%
Mental/Mood Disorders	10.95%	11.48%	11.13%	11.74%	12.31%	13.29%	15.38%
Behavior Disorders	9.02%	9.26%	8.43%	8.01%	8.57%	8.89%	10.83%
Liver Disorders	1.14%	1.21%	1.11%	1.16%	1.17%	1.15%	1.29%
Kidney Disorders	2.63%	2.78%	2.69%	2.72%	2.66%	2.66%	2.97%
Respiratory Disorders	9.31%	9.57%	10.13%	15.90%	18.59%	12.12%	13.64%
Cancer	0.76%	0.79%	0.70%	0.68%	0.66%	0.65%	0.68%
Bone/Muscle Related Disorders	4.85%	4.91%	4.48%	4.74%	5.58%	5.22%	5.51%
Metabolic Disorders	8.03%	8.38%	7.92%	8.73%	9.21%	9.78%	10.53%
Autoimmune Disorders	3.42%	3.52%	3.18%	3.09%	3.08%	2.92%	3.11%
Dermatologic Disorders	4.16%	4.37%	3.95%	3.94%	4.11%	4.27%	5.13%
Other	5.76%	6.00%	5.36%	5.56%	5.64%	5.70%	6.55%

1. Cardiovascular and Cerebral Conditions (Acute Myocardial Infarction, Atrial Fibrillation, Ischemic Heart Disease, Heart Failure, Stroke and Transient Ischemic Attack, Peripheral Vascular Disease [PVD], Hypertension, Hyperlipidemia, Congestive Heart Failure, Angina, Arrhythmia);
2. Neurological Conditions (Epilepsy and Seizure, Migraine, Alzheimer's Disease, Alzheimer's Related Disorder or Senile Dementia, Multiple Sclerosis, Dravet Syndrome [DS], Tardive Dyskinesia, Lennox–Gastaut Syndrome);
3. Mental/Mood Disorders (Bipolar Disorder, Depression, Depressive Disorder, Anxiety, Schizophrenia, Schizophrenia-Related Disorder, Post-Traumatic Stress Disorder);
4. Behavior Disorders (Attention-Deficit Hyperactivity Disorder [ADHD], Autism Spectrum Disorder [ASD]);
5. Liver Diseases (Liver Disease Except Hepatitis, Hepatitis C Acute, Hepatitis C Chronic, Hepatitis B, Cirrhosis, Alcohol-Related Liver Disease, Liver Failure, Metabolic Dysfunction-Associated Steatotic Liver Disease [MASLD]);
6. Kidney Diseases (Chronic Kidney Disease, Kidney Failure, Transplantation);
7. Respiratory Diseases (Asthma, COPD and Bronchitis, Emphysema, Chronic Rhinosinusitis with Nasal Polyps, COVID);
8. Cancer (Non-Melanoma Skin Cancer, Cancer Except Non-Melanoma Skin Cancer);
9. Bone/Muscle-Related Conditions (Hip or Pelvic Fracture, Osteoporosis, Muscular Dystrophy, Fibromyalgia);
10. Metabolic Conditions (Type 1 Diabetes, Type 2 Diabetes, Obesity);
11. Autoimmune Diseases (Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis, Crohn's Disease);
12. Dermatological Conditions (Plaque Psoriasis, Hidradenitis Suppurativa, Uveitis, Atopic Dermatitis, Prurigo Nodularis, Chronic Spontaneous Urticaria, Bullous Pemphigoid);
13. Other Conditions (Cystic Fibrosis, HIV, Sickle Cell Disease, Hemophilia, Anemia, Eosinophilic Esophagitis);

The mean PMPM total costs by comorbidity were calculated for each year in the observation period. The top five most costly comorbidities in 2024 were cancer, liver disorders, kidney disorders, autoimmune disorders, and neurological disorders. The comorbidities with the largest increase in per member per month total costs between 2018 and 2024 were autoimmune disorders and dermatologic disorders. These two categories have had multiple high-cost biologic agents approved or received additional on-label indications during the observation period.

TABLE 7. Mean Per Member Per Month Total Costs by Comorbidity

Type of comorbidity	2018	2019	2020	2021	2022	2023	2024
Cardiovascular and Cerebral Disorders	$1,690	$1,747	$1,595	$1,571	$1,588	$1,575	$1,722
Neurological Disorders	$2,030	$2,126	$2,032	$1,901	$1,871	$1,795	$2,024
Mental/Mood Disorders	$1,392	$1,383	$1,250	$1,206	$1,158	$1,109	$1,164
Behavior Disorders	$810	$810	$733	$763	$765	$804	$862
Liver Disorders	$3,090	$3,060	$2,722	$2,740	$2,832	$2,726	$2,829
Kidney Disorders	$2,911	$2,941	$2,717	$2,652	$2,748	$2,732	$2,814
Respiratory Disorders	$1,077	$1,097	$1,043	$801	$779	$911	$938
Cancer	$3,979	$4,048	$3,852	$3,836	$3,752	$3,811	$3,919
Bone/Muscle Related Disorders	$1,647	$1,709	$1,608	$1,530	$1,428	$1,477	$1,645
Metabolic Disorders	$1,437	$1,452	$1,360	$1,302	$1,247	$1,213	$1,340
Autoimmune Disorders	$1,877	$1,923	$1,824	$1,923	$1,952	$2,026	$2,111
Dermatologic Disorders	$585	$638	$589	$668	$692	$730	$788
Other	$2,051	$2,083	$2,010	$1,982	$1,949	$1,890	$1,940

1. Cardiovascular and Cerebral Conditions (Acute Myocardial Infarction, Atrial Fibrillation, Ischemic Heart Disease, Heart Failure, Stroke and Transient Ischemic Attack, Peripheral Vascular Disease [PVD], Hypertension, Hyperlipidemia, Congestive Heart Failure, Angina, Arrhythmia);
2. Neurological Conditions (Epilepsy and Seizure, Migraine, Alzheimer's Disease, Alzheimer's Related Disorder or Senile Dementia, Multiple Sclerosis, Dravet Syndrome [DS], Tardive Dyskinesia, Lennox–Gastaut Syndrome);
3. Mental/Mood Disorders (Bipolar Disorder, Depression, Depressive Disorder, Anxiety, Schizophrenia, Schizophrenia-Related Disorder, Post-Traumatic Stress Disorder);
4. Behavior Disorders (Attention-Deficit Hyperactivity Disorder [ADHD], Autism Spectrum Disorder [ASD]);
5. Liver Diseases (Liver Disease Except Hepatitis, Hepatitis C Acute, Hepatitis C Chronic, Hepatitis B, Cirrhosis, Alcohol-Related Liver Disease, Liver Failure, Metabolic Dysfunction-Associated Steatotic Liver Disease [MASLD]);
6. Kidney Diseases (Chronic Kidney Disease, Kidney Failure, Transplantation);
7. Respiratory Diseases (Asthma, COPD and Bronchitis, Emphysema, Chronic Rhinosinusitis with Nasal Polyps, COVID);
8. Cancer (Non-Melanoma Skin Cancer, Cancer Except Non-Melanoma Skin Cancer);
9. Bone/Muscle-Related Conditions (Hip or Pelvic Fracture, Osteoporosis, Muscular Dystrophy, Fibromyalgia);
10. Metabolic Conditions (Type 1 Diabetes, Type 2 Diabetes, Obesity);
11. Autoimmune Diseases (Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis, Crohn's Disease);
12. Dermatological Conditions (Plaque Psoriasis, Hidradenitis Suppurativa, Uveitis, Atopic Dermatitis, Prurigo Nodularis, Chronic Spontaneous Urticaria, Bullous Pemphigoid);
13. Other Conditions (Cystic Fibrosis, HIV, Sickle Cell Disease, Hemophilia, Anemia, Eosinophilic Esophagitis);

CONCLUSION

Understanding how Medicaid enrollment has changed in recent years is vital in explaining shifts in spending as well as in preparing future budgeting models. Factoring inflation-adjustments into annual costs, MS Medicaid saw modest increases in spending during the observation period. During the COVID-19 pandemic, enrollment numbers climbed as a result of the PHE. Following the end of the PHE and unwinding in 2023, Medicaid enrollment declined, however, the remaining members were those with higher utilization of services. Coupling the decline in enrollment with the retention of higher utilizers of services drove the PMPM costs up in 2024. Upon examining total costs by comorbid conditions, conditions where high-cost biologic agents were approved or received additional on-label indications, such as dermatology and autoimmune disorders, saw the largest PMPM increases.

RECOMMENDATIONS

This report is primarily for informational purposes. No formal recommendations are sought as part of this report.

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PRELIMINARY HEALTHCARE UTILIZATION PATTERNS AMONG MISSISSIPPI MEDICAID MEMBERS INITIATING GLP-1 RECEPTOR AGONISTS AS ANTI-OBESITY MEDICATIONS

BACKGROUND

Obesity is a chronic, complex condition that poses a significant burden to individuals, communities, and health systems across the United States. Mississippi (MS) ranks among the highest of US states in the percentage of adults that are obese, with recent data indicating that over 40% of adults in the state are classified as obese.[1–3] This health crisis disproportionately affects low-income populations, including Medicaid enrollees, who often face barriers to accessing effective, evidence-based treatments for obesity.[4] Despite the well-established health risks and economic implications, sustainable and accessible treatment approaches for obesity remain underutilized. Comprehensive management of obesity includes a combination of lifestyle modifications, pharmacologic therapy, and surgery.

Glucagon-like peptide-1 receptor agonists (GLP-1 RA) as anti-obesity medications (AOMs) have emerged as a transformative therapeutic option for obesity and obesity-related conditions. Initially approved in 2005 for patients with type 2 diabetes mellitus (T2DM), GLP-1 RAs have demonstrated substantial benefits in promoting weight loss and reducing cardiovascular risk, even among individuals without T2DM.[5] The first weight loss indication for a GLP-1 RA was approved in 2014.[6] Several randomized controlled trials (RCTs), including the STEP and SELECT studies, have shown that GLP-1 RAs can reduce body weight by 10–20% and lower the incidence of major adverse cardiovascular events (MACE), signaling a paradigm shift in obesity pharmacotherapy.[5,7] Treatment with injectable GLP-1 RAs has also been associated with improvements in obesity-related complications such as knee osteoarthritis, metabolic-associated steatohepatitis (MASH), heart failure with preserved ejection fraction, chronic kidney disease, and obstructive sleep apnea. Consequently, national guidelines increasingly support the use of GLP-1 RA AOMs as part of comprehensive obesity management.

However, access to GLP-1 RA AOM therapy varies widely across states, particularly within Medicaid programs.[8] MS Medicaid began covering select GLP-RAs for obesity on July 1, 2023. These agents are also covered for members who are overweight with certain co-occurring chronic conditions [e.g., hypertension, hyperlipidemia, glucose dysregulation, obstructive sleep apnea, coronary artery disease, heart failure, prior myocardial infarction (MI) or cerebrovascular accident (CVA), metabolic dysfunction-associated steatotic liver disease (MASLD), formerly known as non-alcoholic fatty liver disease (NAFLD)]. Given the profound health disparities and resource constraints in MS, understanding how GLP-1 RA AOM use affects health outcomes and costs within this population is both timely and essential.

While clinical trials provide robust evidence for the efficacy of GLP-1 agents, real-world data remains sparse. Medicaid members often differ substantially from clinical trial participants in terms of socioeconomic status, comorbidity profiles, medication adherence, and health system access. As a result, there is a critical need to examine how GLP-1 RA AOMs perform in real-world

settings among low-income populations, particularly in states like MS, where obesity and chronic disease burdens are disproportionately high. Furthermore, most existing research has focused on short-term outcomes such as weight loss. There is limited information on the long-term effects of GLP-1 RA AOM use in routine clinical practice, including the progression of obesity-related complications. Ongoing studies in our Medicaid population will provide valuable insights into the effectiveness of GLP-1 RA AOMs outside of RCTs, while accounting for the unique sociodemographic and healthcare access challenges faced by this high-risk population.

The Institute for Clinical and Economic Review (ICER) recently weighed in on the topic by issuing a draft report examining the effectiveness and value of semaglutide and tirzepatide for obesity.[9] Because of the "substantial weight loss and improvement in metabolic risk factors" demonstrated by these agents, the expert panel noted a high level of certainty that these agents have "substantial health benefit over lifestyle modifications alone." While noting their cost-effectiveness, ICER acknowledged their significant potential budget impact.

MS-DUR's work to examine the utilization of GLP-1 RA AOMs among Mississippi Medicaid members continues. The primary objective of this study is to provide a preliminary assessment of healthcare expenditure patterns among MS Medicaid members initiating GLP-1 RAs as anti-obesity medications. This report is an early snapshot of a larger, ongoing project to comprehensively examine healthcare utilization associated with GLP-1 RA AOMs among MS Medicaid members.

METHODS

Study Design and Data Source
This observational analysis utilized Mississippi Medicaid administrative claims data from July 2022 to June 2025. 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).

Study Population
Initiators of GLP-1 RA AOMs were identified between July 2023 and June 2024. The date of the first prescription fill was defined as the index date. Eligible members were required to have continuous enrollment in Mississippi Medicaid during both the 12-month baseline period and the 12-month follow-up period. Members younger than 18 years were excluded. Pharmacy claims data were used to identify all GLP-1 RA AOM initiations during the study period.

Outcomes
The primary outcome was total healthcare costs defined as the sum of medical and pharmacy expenditures. Medical costs included both inpatient and outpatient expenditures. Post-initiation costs were presented excluding the cost of the GLP-1 RA AOM agent. GLP-1 costs were excluded from pharmacy costs because their net cost to the state (after federal and supplemental rebates

are collected from their manufacturers) is highly confidential per CMS US Code 1396. All costs were presented in US dollars.

Statistical Analysis

Medical, pharmacy, and total costs in the 12 months before and after initiation of GLP-1 RA AOM were summarized using mean, standard deviation, median, and interquartile range. Subgroup analyses were conducted based on patients' clinical characteristics identified during the 12-month baseline period. For both the overall cohort and the clinical subgroups, pre- and post-costs were stratified based on members' adherence to GLP-1 RA AOMs using proportion of days covered (PDC) in the 12-month post initiation period. The subgroups were based on a composite comorbidity burden score (Elixhauser Comorbidity Index)[10] and members' clinical characteristics, which included type 2 diabetes mellitus, sleep apnea, metabolic dysfunction-associated steatotic liver disease (MASLD), hypertension, hyperlipidemia, cardiovascular diseases (atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, stroke/transient ischemic attack, peripheral artery disease, and aortic atherosclerotic disease), and kidney-related diseases (chronic kidney disease, acute kidney injury, and end-stage renal disease).

RESULTS

Total Sample Population

Between July 2023 and June 2024, a total of 2,082 individuals initiated GLP-1 RA AOMs. Of these, 1,252 maintained continuous enrollment during both the 12-month baseline and 12-month follow-up periods. After excluding 157 individuals younger than 18 years, the final analytic sample comprised 1,095 Medicaid members. Among the 1095 members included in this study, the majority were aged 18-39 years, female, and enrolled in a CCO. The overwhelming majority initiated semaglutide (Wegovy®) and had no prior use of GLP-1 RAs. (Table 1)

TABLE 1. Characteristics of GLP-1 RA AOM Initiators

Member Characteristics		Total cohort (n = 1,095)
Age (years)	18-39	651 (59.45%)
	40-64	444 (40.55%)
Gender	Female	1,002 (91.51%)
	Male	93 (8.49%)
Race	White	399 (36.44%)
	Black	519 (47.40%)
	Other	177 (16.16%)
Medicaid program	FFS	117 (10.68%)
	MAG	413 (37.72%)
	MOL	216 (19.73%)
	UHC	349 (31.87%)
Type of GLP-1 RA AOM	Saxenda® (liraglutide)	143 (13.06%)
	Wegovy® (semaglutide)	952 (86.94%)
Prior GLP-1 RA ADM use	Yes	121 (11.05%)
	No	974 (88.95%)

Note: FFS - Fee for Service; MAG - Magnolia Health; MOL - Molina Healthcare; UHC - UnitedHealthcare; GLP-1 RA AOM - glucagon-like peptide-1 receptor agonist; AOM - anti-obesity medication; ADM - antidiabetic medication

When comparing the mean difference in healthcare expenditures in 12 months pre- and post-GLP-1 RA AOM initiation across the entire study cohort, a slight increase in expenditures was noted. Medical costs increased $72 per member and pharmacy costs (excluding the cost of the GLP-1 RA AOM) increased $404 per member, leading to a total cost increase of $476 per member. (Table 2) Examining the median difference in healthcare expenditures 12 months pre- and post-GLP-1 RA AOM initiation, the median of differences in total costs showed a slight decrease of -$50 per member. (Supplemental Table 1)

TABLE 2. Overall Healthcare Expenditures in One Year Pre- and Post-GLP-1 RA AOM Initiation (Mean Costs in US Dollars)

	One year pre-initiation Mean (SD)	One year post-initiation (excluding GLP-1 RA AOM cost) Mean (SD)	Difference
Medical cost*			
Total cohort (n= 1,095)	10,536.76 (54,058.76)	10,608.95 (65,187.84)	72.19 (16,943.49)
Pharmacy cost			
Total cohort (n= 1,095)	4,284.95 (12,428.12)	4,689.34 (17,873.25)	404.39 (15,153.85)
Total cost**			
Total cohort (n= 1,095)	14,821.71 (56,113.86)	15,298.29 (67,846.47)	476.58 (22,345.44)

Note: NA - not applicable; SD - Standard Deviation.
*Medical cost includes inpatient and outpatient cost.
**Total cost includes medical cost and pharmacy cost.

Subgroup Analysis

Comorbidities and Adherence

To account for factors that could result in variations in healthcare expenditures among members, subgroup analyses were conducted. Members were initially categorized based on their Elixhauser Comorbidity Index score and stratified by their adherence to the GLP-1 RA AOM during their 12-month post initiation period. No patterns in healthcare expenditures were noted using this method. (Supplemental Table 2)

Next, members were categorized based on the presence of several comorbidities in which GLP-1 RAs have been shown to impact: type 2 diabetes mellitus (T2DM), sleep apnea, metabolic dysfunction-associated steatotic liver disease (MASLD), hypertension, hyperlipidemia, cardiovascular diseases (atrial fibrillation, heart failure, myocardial infarction, coronary heart disease, stroke/transient ischemic attack, peripheral artery disease, and aortic atherosclerotic disease), and kidney-related diseases (chronic kidney disease, acute kidney injury, and end-stage renal disease). For each clinical comorbidity, members were stratified based on their adherence to the GLP-1 RA AOM during their 12-month post initiation period.

Total Costs

While examining the primary outcome of total healthcare costs by comorbidities, some patterns were noted. Comparing the difference in 12 month pre- and post-initiation costs, decreases in total costs (excluding the cost of the GLP-1 RA AOM) were seen among members with T2DM and MASLD, with mean overall differences of -$1,464 and -$1,939, respectively. These differences in total costs included all adherence groups. While decreases in total costs were not seen overall across all comorbidities, when factoring in adherence, savings in total costs were seen among members at higher adherence levels for several comorbidities. For example, members with kidney-related conditions, those with PDC 50%-79% experienced a mean decrease in total costs of -$16,412, while total costs in those with PDC 80% and above had a mean decrease of -$6,029. To be noted, the mean differences estimated are impacted by the group sample sizes and presence of outliers (individuals, who may be sicker or have specific healthcare goals, may have a high level of adherence even though their post-initiation healthcare expenditure patterns may deviate from others in that adherence category). Median differences for the same group (kidney-related conditions) are higher for the group with PDC 80% and above (-$4,503) as compared to those with PDC 50%-79% (-$2,649). Since medians are less susceptible to outliers than means, they are often considered a more accurate measure of central tendency, especially considering skewed data.

Members with hyperlipidemia, cardiovascular disease, and hypertension also experienced mean decreases in total costs for those with PDC of 50% or above. (Table 3) The median of differences in total costs (excluding the cost of the GLP-1 RA AOM) decreased, overall, in every comorbidity category examined except among those with cardiovascular conditions. (Supplemental Table 3)

Medical and Pharmacy Costs

When exploring medical and pharmacy costs, mean and median values were also calculated. The mean differences in medical costs 12 months pre- and post-GLP-1 RA AOM initiation revealed a decrease in costs overall for those with T2DM (-$130), sleep apnea (-$807), and MASLD (-$2,717). Among those with hypertension, hyperlipidemia, cardiovascular conditions, and kidney-related conditions, mean decreases in costs were seen in members with higher adherence. When looking at mean differences in pharmacy costs (excluding the cost of the GLP-1 RA AOM), decreases in overall costs were observed for members with hypertension (-$400), T2DM (-$1,335), and kidney-related disorders (-$2,499). (Table 3) The median of differences in medical costs revealed decreases overall for those with MASLD, kidney-related conditions, sleep apnea, and cardiovascular conditions. The median of differences in pharmacy costs (excluding the cost of the GLP-1 RA AOM) showed decreases overall among all comorbidities examined, except MASLD. (Supplemental Table 3)

TABLE 3. Healthcare Expenditures in One Year Pre- and Post- GLP-1 RA AOM Initiation, Stratified by Comorbidities and Adherence

	PDC	One year pre-initiation Mean (SD) [US dollars]	One year post-initiation (excluding GLP-1 RA AOM cost) Mean (SD) [US dollars]	Difference Mean (SD) [US dollars]
		Medical cost*		
Type 2 diabetes mellitus	Overall (n = 150)	12,380.49 (17,116.26)	12,250.91 (20,358.02)	-129.59 (12,714.35)
	Less than 50% (n = 64)	12,776.02 (14,273.83)	11,996.87 (14,890.03)	-779.16 (14,900.84)
	50% - 79% (n = 51)	12,983.26 (23,063.68)	14,870.15 (29,875.67)	1,886.89 (12,480.31)
	80% or above (n = 35)	10,778.92 (10,982.95)	8,898.82 (8,418.96)	-1,880.10 (7,609.59)
Sleep apnea	Overall (n = 228)	16,950.94 (24,729.89)	16,143.75 (26,280.17)	-807.19 (19,346.47)
	Less than 50% (n = 82)	17,774.81 (20,112.04)	16,726.55 (25,037.64)	-1,048.26 (22,596.75)
	50% - 79% (n = 76)	18,870.85 (33,701.98)	18,808.32 (32,937.44)	-62.53 (22,006.58)
	80% or above (n = 70)	13,901.38 (16,977.47)	12,568.09 (18,325.29)	-1,333.29 (10,225.85)
MASLD	Overall (n = 101)	18,594.4 (27,259.73)	15,877.81 (23,906.07)	-2,716.58 (22,503.99)
	Less than 50% (n = 46)	18,239.31 (20,196.23)	16,572.38 (27,083.68)	-1,666.93 (23,988.46)
	50% - 79% (n = 32)	22,105.69 (41,314.37)	19,094.65 (25,752.54)	-3,011.04 (27,283.38)
	80% or above (n = 23)	14,419.28 (10,090.24)	10,013.08 (10,526.94)	-4,406.20 (8,401.50)
Hypertension	Overall (n = 569)	14,646.88 (74,382.52)	15,025.09 (89,939.29)	378.20 (22,381.01)
	Less than 50% (n = 231)	18,249.02 (11,3781.16)	203,79.01 (138,917.05)	2,129.99 (29,980.99)
	50% - 79% (n = 171)	13,577.6 (27,069.66)	13,017.95 (24,989.96)	-559.65 (19,488.87)
	80% or above (n = 167)	10,759.18 (14,459.06)	9,674.58 (15,092.23)	-1,084.61 (8,500.01)
Hyperlipidemia	Overall (n = 185)	25,884.1 (128,223.73)	27,116.42 (155,285.27)	1,232.32 (34,995.83)
	Less than 50% (n = 75)	35,252.37 (198,406.89)	41,989.03 (242,186.89)	6,736.66 (47,956.70)
	50% - 79% (n = 59)	22,269.55 (37,879.24)	19,785.79 (28,390.14)	-2,483.77 (28,487.02)
	80% or above (n = 51)	16,288.78 (18,386.38)	13,725.48 (20,396.74)	-2,563.30 (9,239.44)
Cardiovascular conditions***	Overall (n = 157)	31,639.37 (139,454.72)	34,011.18 (169,015.46)	2,371.81 (37,979.25)
	Less than 50% (n = 68)	42,616.26 (208,236.67)	50,775.36 (253,980.29)	8,159.11 (50,212.22)
	50% - 79% (n = 49)	27,383.46 (45,070.81)	25,214.00 (39,791.37)	-2,169.46 (31,410.72)
	80% or above (n = 40)	18,192.16 (19,427.83)	16,288.63 (24,265.15)	-1,903.53 (10,995.91)
Kidney-related conditions****	Overall (n = 73)	42,415.16 (20,1310.19)	45,018.84 (245,029.64)	2,603.68 (49,090.29)
	Less than 50% (n = 33)	69,719.23 (29,8127.86)	84,233.02 (363,183.54)	14,513.80 (66,993.19)
	50% - 79% (n = 21)	24,137.68 (33,268.21)	13,977.03 (15,358.98)	-10,160.65 (31,528.14)
	80% or above (n = 19)	15,193.72 (18,040.35)	11,219.36 (15,929.99)	-3,974.36 (7,766.52)
		Pharmacy cost		
Type 2 diabetes mellitus	Overall (n = 150)	8,116.68 (11,083.71)	6,781.81 (13,107.87)	-1,334.88 (11,665.23)
	Less than 50% (n = 64)	8,208.93 (13,090.42)	6,035.39 (8,164.22)	-2,173.54 (10,775.24)
	50% - 79% (n = 51)	8,661.99 (9,467.61)	8,443.31 (17,584.64)	-218.68 (11,709.15)
	80% or above (n = 35)	7,153.42 (9,360.21)	5,725.64 (12,976.16)	-1,427.78 (13,280.70)
Sleep apnea	Overall (n = 228)	8,454.77 (18,741.45)	9,270.3 (3,1691.41)	815.53 (30,363.18)
	Less than 50% (n = 82)	11,424.93 (25,792.00)	7,840.72 (16,169.04)	-3,584.22 (15,801.98)
	50% - 79% (n = 76)	7,751.08 (12,916.64)	9,310.27 (22,816.39)	1,559.19 (18,797.42)
	80% or above (n = 70)	5,739.45 (13,219.67)	10,901.56 (49,257.08)	5,162.12 (48,093.81)
MASLD	Overall (n = 101)	7,437.41 (14,530.47)	8,214.56 (15,263.39)	777.15 (12,129.27)
	Less than 50% (n = 46)	4,845.18 (7,986.79)	4,518.65 (7,293.21)	-326.52 (3,340.50)
	50% - 79% (n = 32)	10,542.8 (15,810.89)	10,030.51 (15,982.17)	-512.30 (16,713.01)
	80% or above (n = 23)	8,301.35 (21,168.78)	13,079.86 (23,067.97)	4,778.51 (15,185.55)
Hypertension	Overall (n = 569)	5,588.64 (14,030.62)	5,188.7 (14,398.49)	-399.93 (10,135.97)
	Less than 50% (n = 231)	5,573.85 (15,177.56)	4,907.72 (13,446.36)	-666.13 (11,718.53)
	50% - 79% (n = 171)	7,167.03 (15,788.89)	6,691.6 (18,100.42)	-475.43 (10,038.00)
	80% or above (n = 167)	3,992.89 (9,694.92)	4,038.47 (10,934.95)	45.59 (7,600.98)
Hyperlipidemia	Overall (n = 185)	7,469.78 (15,155.52)	7,527.24 (16,738.72)	57.45 (8,663.62)
	Less than 50% (n = 75)	5,391.78 (10,820.41)	4,986.45 (9,515.57)	-405.33 (5,898.90)
	50% - 79% (n = 59)	10,965.13 (22,076.62)	11,343.31 (24,602.19)	378.18 (9,495.50)
	80% or above (n = 51)	6,482.05 (9,204.96)	6,849.01 (12,947.02)	366.97 (10,935.44)
Cardiovascular conditions***	Overall (n = 157)	7,684.04 (17,311.28)	8,165.03 (17,743.27)	480.99 (13,701.66)
	Less than 50% (n = 68)	7,022.1 (16,659.58)	6,821.63 (13,289.83)	-200.47 (18,555.31)
	50% - 79% (n = 49)	9,793.22 (22,949.38)	11,443.73 (26,072.04)	1,650.51 (9,322.39)
	80% or above (n = 40)	6,225.6 (8,072.83)	6,432.4 (9,976.11)	206.80 (7,062.95)
Kidney-related conditions****	Overall (n = 73)	10,816.46 (23,521.22)	8,317.35 (22,360.23)	-2,499.11 (10,082.18)
	Less than 50% (n = 33)	4,995.84 (8,519.23)	4,628.91 (7,376.73)	-366.94 (3,113.56)
	50% - 79% (n = 21)	20,945.59 (35,198.85)	14,693.94 (35,885.02)	-6,251.65 (17,578.49)
	80% or above (n = 19)	9,730.59 (22,897.34)	7,675.79 (19,988.75)	-2,054.80 (4,588.96)
		Total cost**		
Type 2 diabetes mellitus	Overall (n = 150)	20,497.18 (21,860.91)	19,032.71 (25,445.78)	-1,464.47 (17,262.47)
	Less than 50% (n = 64)	20,984.95 (20,178.51)	18,032.25 (19,348.23)	-2,952.70 (17,861.12)
	50% - 79% (n = 51)	21,645.25 (26,867.51)	23,313.46 (35,457.38)	1,668.21 (17,313.05)
	80% or above (n = 35)	17,932.34 (16,404.19)	14,624.46 (15,672.51)	-3,307.88 (15,861.96)
Sleep apnea	Overall (n = 228)	25,405.72 (31,841.66)	25,414.05 (41,864.36)	8.34 (35,340.21)
	Less than 50% (n = 82)	29,199.74 (31,547.94)	24,567.26 (30,696.28)	-4,632.48 (27,191.26)
	50% - 79% (n = 76)	26,621.93 (38,567.11)	28,118.59 (4,1275.96)	1,496.66 (27,631.68)
	80% or above (n = 70)	19,640.83 (22,315.4)	23,469.66 (52,869.19)	3,828.83 (48,663.19)
MASLD	Overall (n = 101)	26,031.81 (32,518.2)	24,092.38 (31,456.92)	-1,939.43 (24,978.96)
	Less than 50% (n = 46)	23,084.49 (23,202.82)	21,091.04 (29,230.14)	-1,993.45 (24,824.85)
	50% - 79% (n = 32)	32,648.49 (46,680.95)	29,125.16 (38,139.79)	-3,523.34 (29,973.43)
	80% or above (n = 23)	22,720.63 (23,268.67)	23,092.94 (25,373.53)	372.31 (17,331.83)
Hypertension	Overall (n = 569)	20,235.52 (76,348.79)	20,213.79 (91,233.08)	-21.73 (24,034.33)
	Less than 50% (n = 231)	23,822.87 (114,629.85)	25,286.72 (139,369.28)	1,463.85 (31,755.93)
	50% - 79% (n = 171)	20,744.63 (36,498.31)	19,709.55 (33,234.2)	-1,035.08 (20,696.94)
	80% or above (n = 167)	14,752.07 (18,077.73)	13,713.05 (18,924.14)	-1,039.02 (11,638.03)
Hyperlipidemia	Overall (n = 185)	33,353.89 (129,594.52)	34,643.66 (155,869.82)	1,289.77 (34,767.93)
	Less than 50% (n = 75)	40,644.15 (198,344.82)	46,975.47 (241,963.64)	6,331.33 (47,932.47)
	50% - 79% (n = 59)	33,234.68 (50,657.83)	31,129.1 (38,862.36)	-2,105.58 (25,659.31)
	80% or above (n = 51)	22,770.82 (20,240.17)	20,574.49 (23,704.00)	-2,196.33 (14,839.62)
Cardiovascular conditions***	Overall (n = 157)	39,323.42 (141,017.4)	42,176.21 (169,581.25)	2,852.80 (38,723.88)
	Less than 50% (n = 68)	49,638.36 (20,8061.7)	57,596.99 (253,578.05)	7,958.63 (52,512.54)
	50% - 79% (n = 49)	37,176.68 (59,048.09)	36,657.73 (49,794.1)	-518.95 (27,928.68)
	80% or above (n = 40)	24,417.76 (21,534.1)	22,721.03 (25,908.15)	-1,696.73 (14,826.18)
Kidney-related conditions****	Overall (n = 73)	53,231.62 (203,045.79)	53,336.19 (245,246.84)	104.58 (50,326.07)
	Less than 50% (n = 33)	74,715.07 (297,606.91)	88,861.93 (362,705.21)	14,146.86 (66,857.15)
	50% - 79% (n = 21)	45,083.27 (66,262.48)	28,670.97 (40,003.91)	-16,412.30 (35,185.86)
	80% or above (n = 19)	24,924.31 (28,369.05)	18,895.15 (25,584.78)	-6,029.16 (9,450.01)

Note: PDC - proportion of days covered; NA - not applicable; MASLD - metabolic dysfunction-associated steatotic liver disease
Comorbid conditions are listed in no particular order.
*Medical cost includes inpatient and outpatient cost.
**Total cost includes medical cost and pharmacy cost.
***Cardiovascular diseases include AFib, HF, MI, coronary heart disease, cerebrovascular disease, peripheral artery disease, and aortic atherosclerotic disease.
****Kidney-related conditions include CKD, AKI, ESRD.

CONCLUSIONS

Upon comparing healthcare expenditures during the 12 month pre- and post-GLP-1 RA AOM initiation, comorbid conditions and adherence patterns may influence potential cost savings. It should be noted that the current study sample includes approximately 17% of the total number of Medicaid members who have initiated GLP-1 RA AOMs to date. Additionally, supply-chain issues potentially impacted adherence patterns for members during the study period. Given these considerations, these preliminary findings, especially in certain specific adherence-stratified clinical subgroups, are limited by small sample size and presence of outlier data.

Despite the above-mentioned considerations and limitations, in this sample of the MS Medicaid population who initiated GLP-1 RA AOMs, the data suggests specific patient groups where potential impacts on healthcare utilization may be seen in a relatively short period of time. Members with comorbidities of T2DM and MASLD saw mean total cost savings, excluding the cost of the GLP-1 RA AOM, in one-year post-initiation, regardless of adherence. Additionally, those with kidney-related conditions, hyperlipidemia, cardiovascular disease, and hypertension saw savings among those with higher adherence. Further work needs to be done examining additional factors that may impact cost savings associated with GLP-1 RA AOM use among Mississippi Medicaid members.

RECOMMENDATIONS

1. MS DUR is seeking guidance from the Board on additional factors to consider as we expand our outcomes analysis of GLP-1 RA AOMs in the future.

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SUPPLEMENTAL TABLES

Supplemental Table 1. Overall Healthcare Expenditures in One Year Pre- and Post- GLP-1 RA AOM Initiation (Median Costs in US Dollars)			
	One year pre-initiation Median [IQR]	**One year post-initiation (excluding GLP-1 RA AOM cost) Median [IQR]**	**Difference+**
	Medical cost*		
Total cohort (n= 1,095)	4,382.76 [1,896.77 - 10,190.12]	4,237.38 [1,937.49 - 9,069.33]	23.96 [-2,836.38 - 2,311.02]
	Pharmacy cost		
Total cohort (n= 1,095)	813.38 [289.57 - 2,985.58]	721.46 [277.61 - 2,471.24]	-0.70 [-362.76 - 304.96]
	Total cost**		
Total cohort (n= 1,095)	6,795.15 [2,779.74 - 14,630.59]	6,002.59 [2,664.58 - 13,871.85]	-49.58 [-3,575.18 - 2,775.17]

Note: IQR - Interquartile Range; GLP-1 RA AOM - glucagon-like peptide-1 receptor agonist anti-obesity medication
*Medical cost includes inpatient and outpatient cost.
**Total cost includes mediacal cost and pharmacy cost.
+ Median of differences is reported.

Supplemental Table 2. Healthcare Expenditures in One Year Pre- and Post- GLP-1 RA AOM Initiation, Stratified by Elixhauser Score and Adherence

		One year pre-initiation Mean (SD) *[US dollars]*	One year post-initiation (excluding GLP-1 RA AOM cost) Mean (SD) *[US dollars]*	Difference Mean (SD) *[US dollars]*
	PDC	**Medical cost***		
0 to 2	Overall (n = 388)	4,373.02 (6,926.44)	4,339.12 (6,216.05)	-33.90 (6,661.33)
	Less than 50% (n = 174)	3,718.98 (4,617.14)	3,796.31 (4,551.31)	77.33 (6,180.47)
	50% - 79% (n = 117)	5,069.62 (8,472.03)	4,301.81 (4,966.49)	-767.81 (7,135.46)
	Above 80% (n = 97)	4,706.05 (8,171.75)	5,357.84 (9,329.87)	651.79 (6,882.41)
3 or 4	Overall (n = 368)	6,531.67 (8,267.64)	6,911.36 (11,781.13)	379.69 (9,658.04)
	Less than 50% (n = 154)	5,703.16 (5,264.43)	6,938.33 (12,614.36)	1,235.17 (12,401.83)
	50% - 79% (n = 107)	6,462.84 (8,628.09)	6,316.22 (9,696.25)	-146.62 (5,583.12)
	Above 80% (n = 107)	7,792.94 (10,936.41)	7,467.7 (12,497.22)	-325.24 (8,242.21)
5 and above	Overall (n = 339)	21,939.13 (95,593.43)	21,798.93 (11,5644.32)	-140.20 (27,873.76)
	Less than 50% (n = 156)	26,848.75 (137,989.65)	28,685.13 (168,317.55)	1,836.39 (35,040.12)
	50% - 79% (n = 98)	20,448.76 (33,760.86)	19,221.7 (30,786.5)	-1,227.06 (25,290.68)
	Above 80% (n = 85)	14,646.83 (14,737.3)	12,132.1 (15,840.37)	-2,514.73 (10,379.61)
		Pharmacy cost		
0 to 2	Overall (n = 388)	1,331.93 (5,020.9)	1,373.62 (5,764.37)	41.69 (3,882.14)
	Less than 50% (n = 174)	1,075.99 (5,221.3)	1,075.24 (5,393.62)	-0.75 (1,386.68)
	50% - 79% (n = 117)	1,844.28 (6,200.35)	1,707.33 (7,016.13)	-136.95 (5,155.47)
	Above 80% (n = 97)	1,173.07 (2,362.06)	1,506.37 (4,661.45)	333.30 (5,004.55)
3 or 4	Overall (n = 368)	3,446.86 (9,224.59)	4,677.6 (23,251.16)	1,230.74 (22,169.33)
	Less than 50% (n = 154)	3,390.27 (11,100.62)	2,692.55 (10,200.65)	-697.72 (6,494.25)
	50% - 79% (n = 107)	3,362.86 (6,259.92)	2,958.75 (5,747.9)	-404.11 (4,344.32)
	Above 80% (n = 107)	3,612.31 (8,804.98)	9,253.44 (40,726.96)	5,641.13 (39,926.77)
5 and above	Overall (n = 339)	8,574.59 (18,693.43)	8,497.07 (19,538.71)	-77.52 (13,828.92)
	Less than 50% (n = 156)	8,349.64 (20,459.88)	7,802.08 (16,922.65)	-547.55 (13,596.84)
	50% - 79% (n = 98)	10,587.12 (19,720.95)	11,603.43 (26,262.36)	1,016.31 (17,319.87)
	Above 80% (n = 85)	6,667.12 (13,268.86)	6,191.13 (13,918.12)	-475.99 (8,944.41)
		Total cost**		
0 to 2	Overall (n = 388)	5,704.96 (8,848.13)	5,712.75 (8,917.72)	7.79 (8,185.08)
	Less than 50% (n = 174)	4,794.96 (7,469.74)	4,871.55 (7,285.18)	76.58 (6,556.36)
	50% - 79% (n = 117)	6,913.89 (10,729.5)	6,009.13 (8,811.36)	-904.76 (9,004.51)
	Above 80% (n = 97)	5,879.12 (8,522.61)	6,864.21 (11,331.38)	985.09 (9,625.51)
3 or 4	Overall (n = 368)	9,978.53 (12,642.57)	11,588.97 (2,6421.63)	1,610.44 (23,859.90)
	Less than 50% (n = 154)	9,093.43 (12,611.77)	9,630.88 (16,423.31)	537.45 (14,224.52)
	50% - 79% (n = 107)	9,825.7 (10,137.27)	9,274.97 (10,924.84)	-550.73 (7,125.67)
	Above 80% (n = 107)	11,405.25 (14,758.97)	16,721.13 (43,252.52)	5,315.89 (40,099.55)
5 and above	Overall (n = 339)	30,513.72 (97,777.61)	30,296 (117,063.34)	-217.72 (30,317.57)
	Less than 50% (n = 156)	35,198.38 (138,902.79)	36,487.22 (168,613.53)	1,288.84 (36,960.73)
	50% - 79% (n = 98)	31,035.88 (45,151.48)	30,825.13 (41,968.01)	-210.75 (28,901.47)
	Above 80% (n = 85)	21,313.95 (19,662.07)	18,323.23 (20,737.28)	-2,990.72 (14,183.46)

Note: PDC - proportion of days covered; GLP-1 RA AOM - glucagon-like peptide-1 receptor agonist anti-obesity medication

*Medical cost includes inpatient and outpatient cost.

**Total cost includes medical cost and pharmacy cost.

Supplemental Table 3. Healthcare Expenditures in One Year Pre- and Post- GLP-1 RA AOM Initiation, Stratified by Comorbidities and Adherence (Median Cost)

	PDC	One year pre-initiation Median [IQR] *(US dollars)*	One year post-initiation (excluding GLP-1 RA AOM cost) Median [IQR] *(US dollars)*	Difference+[IQR] *(US dollars)*
		Medical cost*		
Type 2 diabetes mellitus	Overall (n = 150)	7,155.3 [3,346.1 - 14,224.34]	7,278.37 [3,099.74 - 12,823.73]	52.60 [-2,936.24 - 2,611.24]
	Less than 50% (n = 64)	7,747.2 [3,389.54 - 15,041.1]	8,122.97 [2,867.33 - 13,233.25]	-185.69 [-3,164.91 - 2,944.76]
	50% - 79% (n = 51)	6,535.48 [3,383.07 - 12,593.59]	6,403.46 [3,642.97 - 14,400.39]	320.48 [-1,509.20 - 3,142.19]
	80% or above (n = 35)	6,262.55 [2,205.98 - 14,804.81]	6,124.06 [2,579.45 - 11,743.69]	173.01 [-7,369.63 - 2,242.18]
Sleep apnea	Overall (n = 228)	8,336.65 [4,531.71 - 18,382.58]	7,941.19 [4,338.19 - 14,414.86]	-133.79 [-5,334.51 - 3,097.50]
	Less than 50% (n = 82)	10,074.38 [4,672.39 - 22,410.84]	7,974.41 [4,311.51 - 17,062.85]	-407.59 [-6,686.20 - 3,390.12]
	50% - 79% (n = 76)	8,336.65 [4,653.67 - 15,612.8]	8,085.21 [4,854.09 - 15,752.94]	-27.73 [-3,939.44 - 2,979.27]
	80% or above (n = 70)	7,081.69 [3,909.39 - 15,503.75]	7,403.36 [3,789.29 - 13,780.23]	85.56 [-5,496.16 - 2,806.25]
MASLD	Overall (n = 101)	10,623.72 [5,130.04 - 21,765.94]	7,154.47 [3,977.09 - 14,578.34]	-1,457.21 [-7,485.41 - 1,595.46]
	Less than 50% (n = 46)	10,809.98 [5,467.09 - 24,172.13]	6,100.89 [3,229.52 - 16,001.67]	-1,986.05 [-8,988.64 - 1,442.06]
	50% - 79% (n = 32)	10,680.25 [4,817.77 - 17,579.44]	8,686.45 [3,897.60 - 17,214.56]	-841.54 [-2,537.08 - 2,195.31]
	80% or above (n = 23)	10471.75 [7127.19 - 21765.94]	7,154.47 [4,472.51 - 10,443.95]	-910.35 [-10,289.51 - 1,148.20]
Hypertension	Overall (n = 569)	5,746.04 [2,484.56 - 12,230.71]	5,129.99 [2,502.93 - 11,438.73]	0.00 [-3,270.86 - 2,496.74]
	Less than 50% (n = 231)	5,796.41 [2,548.96 - 12,324.91]	5,129.30 [2,344.55 - 11,441.15]	-141.84 [-3,251.03 - 2,919.69]
	50% - 79% (n = 171)	5,182.5 [2,565.82 - 12,487.89]	5,472.26 [2,752.19 - 11,682.74]	10.46 [-2,559.92 - 2,262.42]
	80% or above (n = 167)	5,736.1 [2,205.98 - 11,993.00]	5,015.74 [2,359.94 - 10,968.09]	173.01 [-4,149.11 - 2,675.03]
Hyperlipidemia	Overall (n = 185)	7,591.74 [4,004.86 - 17,811.41]	7,563.65 [3,720.44 - 14,702.45]	17.14 [-4,359.61 - 3,161.10]
	Less than 50% (n = 75)	6,429.28 [3,352.82 - 15,293.38]	7,445.39 [2,771.38 - 12,694.18]	543.11 [-3,410.46 - 4,878.85]
	50% - 79% (n = 59)	8,665.76 [4,299.06 - 21,581.46]	8,255.11 [4,286.63 - 23,379.39]	87.76 [-4,359.61 - 2,480.81]
	80% or above (n = 51)	10,370.9 [5,130.04 - 19,141.41]	7,464.21 [3,623.07 - 13,781.70]	-1,569.91 [-7,550.02 - 2,253.48]
Cardiovascular conditions***	Overall (n = 157)	9,652.07 [5,299.33 - 21,581.46]	9,701.32 [4,633.52 - 21,287.37]	-131.16 [-4,868.77 - 4,894.96]
	Less than 50% (n = 68)	9,840.2 [4,312.5 - 22,361.94]	9,912.67 [4,017.20 - 23,014.52]	25.99 [-3,077.65 - 5,727.86]
	50% - 79% (n = 49)	8,686.42 [5,316.43 - 21,581.46]	9,912.34 [5,313.49 - 34,733.01]	193.18 [-4,744.86 - 3,370.83]
	80% or above (n = 40)	10,809.05 [6,087.16 - 21,536.91]	7,716.69 [4,591.56 - 13,997.99]	-2,820.82 [-9,383.72 - 4,796.96]
Kidney-related conditions****	Overall (n = 73)	10,736.78 [3,909.39 - 23,730.98]	10,328.00 [4,189.93 - 17,535.85]	-440.38 [-4,633.49 - 3,073.95]
	Less than 50% (n = 33)	10,769.03 [3,426.25 - 23,730.98]	12,399.02 [4,582.33 - 30,115.26]	1,806.66 [-1,642.30 - 7,628.48]
	50% - 79% (n = 21)	12,072.94 [5,316.43 - 30,486.17]	9,912.34 [6,020.64 - 14,702.45]	-1,509.20 [-11,434.80 - 437.17]
	80% or above (n = 19)	8,459.55 [3,884.17 - 22,630.19]	7,004.01 [3,423.74 - 12,787.88]	-2,897.14 [-9,564.64 - 1,179.93]
		Pharmacy cost		
Type 2 diabetes mellitus	Overall (n = 150)	4,399.68 [1,213.17 - 9,998.67]	2,952.41 [797.63 - 8,177.73]	-588.33 [-3,559.30 - 403.15]
	Less than 50% (n = 64)	3,324.36 [1,190.73 - 9,276.06]	3,403.51 [982.12 - 8,741.97]	-36.10 [-1,909.65 - 785.25]
	50% - 79% (n = 51)	6,236.67 [2,553.41 - 11,713.07]	4,270.60 [974.68 - 8,458.54]	-1,657.83 [-5,090.78 - 291.26]
	80% or above (n = 35)	2,209.62 [920.27 - 12,630.16]	1,240.19 [459.49 - 5,084.94]	-948.09 [-5,304.52 - -16.91]
Sleep apnea	Overall (n = 228)	1,985.13 [830.395 - 7,902.2]	1,770.53 [631.59 - 7,150.77]	-92.27 [-1,574.60 - 519.28]
	Less than 50% (n = 82)	2,610.3 [898.77 - 8,297.57]	2,355.90 [634.07 - 8,273.62]	-73.76 [-1,491.37 - 914.21]
	50% - 79% (n = 76)	2,213.67 [939.07 - 7,902.2]	1,844.30 [596.78 - 6,967.92]	-72.84 [-2,667.65 - 383.57]
	80% or above (n = 70)	1,248.07 [672.45 - 6,549.37]	1,039.20 [648.29 - 4,454.16]	-158.60 [-1,124.79 - 304.96]
MASLD	Overall (n = 101)	2,407.45 [816.28 - 7,389.86]	2,282.76 [630.44 - 7,664.12]	44.41 [-1,420.93 - 1,141.54]
	Less than 50% (n = 46)	2,048.67 [738.65 - 6,530.37]	1,982.38 [620.49 - 3,981.02]	93.78 [-1,487.37 - 872.53]
	50% - 79% (n = 32)	3,875.4 [1,181.02 - 16,204.04]	3,186.18 [778.52 - 11,688.97]	-32.40 [-3,215.97 - 1,399.02]
	80% or above (n = 23)	1,989.81 [766.83 - 7,449.33]	2,654.88 [834.39 - 13,626.35]	62.56 [-459.28 - 5,756.43]
Hypertension	Overall (n = 569)	1,108.57 [485.55 - 4,705.04]	1,004.43 [485.38 - 3,679.66]	-47.12 [-666.58 - 343.42]
	Less than 50% (n = 231)	1,065.31 [445.49 - 3,663.49]	1,076.34 [426.51 - 3,613.31]	44.08 [-352.05 - 570.59]
	50% - 79% (n = 171)	1,952.21 [599.73 - 7,404.41]	1,302.61 [537.63 - 5,810.88]	-104.67 [-1,871.14 - 301.05]
	80% or above (n = 167)	975.38 [456.18 - 3,151.08]	820.43 [457.18 - 2,622.39]	-95.03 [-496.19 - 132.27]
Hyperlipidemia	Overall (n = 185)	1,904.85 [879.77 - 8,511.68]	1,753.16 [729.12 - 7,717.97]	-71.80 [-948.09 - 355.08]
	Less than 50% (n = 75)	1,246.46 [722.91 - 6,027.9]	1,288.98 [655.82 - 6,996.64]	-54.59 [-666.58 - 570.59]
	50% - 79% (n = 59)	5,897.72 [1,036.34 - 10,738.11]	4,772.76 [1,069.50 - 8,458.54]	-22.27 [-2,153.00 - 372.68]
	80% or above (n = 51)	1,868.77 [879.77 - 10,305.73]	1,573.79 [650.85 - 7,993.35]	-163.91 [-1,048.34 - 124.52]
Cardiovascular conditions***	Overall (n = 157)	2,674.63 [960.22 - 8,649.92]	2,731.57 [885.99 - 8,682.75]	-32.26 [-1,262.57 - 1,128.80]
	Less than 50% (n = 68)	2,113.96 [734.615 - 7,654.94]	2,602.82 [901.00 - 8,743.65]	217.52 [-764.73 - 1,279.31]
	50% - 79% (n = 49)	3,934.7 [1,168.88 - 9,278.84]	4,772.76 [1,089.20 - 7,825.96]	-22.27 [-2,062.36 - 542.22]
	80% or above (n = 40)	2,085.23 [884.27 - 11,207.87]	2,454.50 [749.95 - 8,166.75]	-179.51 [-1,368.97 - 140.80]
Kidney-related conditions****	Overall (n = 73)	2,706.23 [696.82 - 10,288.55]	2,367.76 [849.41 - 7,158.31]	-200.32 [-2,645.53 - 427.04]
	Less than 50% (n = 33)	1,536.59 [564.5 - 6,284.37]	1,294.61 [720.47 - 6,442.65]	-127.16 [-1,014.71 - 870.46]
	50% - 79% (n = 21)	10,176.72 [1,083.64 - 17,413.96]	3,878.41 [1,265.92 - 11,189.41]	-334.86 [-7,250.22 - 542.22]
	80% or above (n = 19)	2,733.63 [591.12 - 10,305.73]	2,510.86 [648.29 - 6,475.74]	-200.32 [-3,147.42 - 187.88]
		Total cost**		
Type 2 diabetes mellitus	Overall (n = 150)	13,903.32 [7,168.17 - 26,913.7]	12,221.90 [5,203.35 - 22,764.35]	-601.20 [-7,038.24 - 2,936.26]
	Less than 50% (n = 64)	13,709.76 [7,569.24 - 26,952.37]	11,541.37 [5,707.09 - 20,512.95]	-249.62 [-6,675.15 - 3,703.60]
	50% - 79% (n = 51)	13,874.59 [7,583.65 - 30,725.9]	12,875.63 [5,298.02 - 23,847.14]	-652.87 [-3,982.61 - 4,277.80]
	80% or above (n = 35)	14,586.04 [3,690.83 - 26,913.7]	12,184.53 [4,119.75 - 18,219.43]	-605.56 [-9,461.23 - 1,273.64]
Sleep apnea	Overall (n = 228)	13,435.1 [7,016.62 - 32,117.17]	12,967.60 [6,135.15 - 24,641.81]	-713.07 [-7,876.75 - 3,591.15]
	Less than 50% (n = 82)	16,596.98 [7,820.92 - 40,341.23]	13,674.90 [6,312.30 - 27,592.35]	-1,182.00 [-11,847.19 - 3,830.66]
	50% - 79% (n = 76)	13,304.97 [7,255.30 - 27,919.90]	13,343.83 [6,671.74 - 27,729.85]	-25.70 [-4,500.66 - 4,883.60]
	80% or above (n = 70)	11,732.92 [5,166.06 - 27,421.33]	11,329.30 [5,410.20 - 20,106.99]	-522.32 [-6,631.78 - 2,721.56]
MASLD	Overall (n = 101)	14,711.29 [8,474.66 - 32,300.38]	12,100.50 [6,619.08 - 24,697.38]	-1,382.35 [-9,461.23 - 2,462.58]
	Less than 50% (n = 46)	14,898.56 [7,184.23 - 28,565.82]	9,341.67 [5,176.27 - 21,566.84]	-2,196.83 [-10,497.30 - 973.93]
	50% - 79% (n = 32)	14,591.02 [8,763.35 - 37,895.52]	12,971.59 [7,506.26 - 43,018.28]	-174.29 [-4,898.73 - 2,321.95]
	80% or above (n = 23)	13,749.11 [9,637.92 - 32,566.87]	13,647.69 [7,557.89 - 24,697.38]	-714.41 [-10,420.52 - 3,599.29]
Hypertension	Overall (n = 569)	9,132.56 [4,091.53 - 17,640.93]	7,741.65 [3,695.66 - 16,792.11]	-224.18 [-4,398.32 - 2,848.92]
	Less than 50% (n = 231)	8,818.8 [3,647.57 - 16,952.98]	7,741.65 [3,245.13 - 17,752.08]	-258.73 [-4,143.93 - 3,254.42]
	50% - 79% (n = 171)	9,876.32 [4,412.79 - 18,477.95]	8,868.84 [4,558.19 - 17,846.62]	-311.11 [-4,358.00 - 2,188.96]
	80% or above (n = 167)	8,504.93 [3,629.59 - 17,369.91]	7,256.50 [3,758.01 - 15,275.27]	-11.79 [-5,024.43 - 2,926.02]
Hyperlipidemia	Overall (n = 185)	14,694.54 [7,563.92 - 30,360.58]	13,063.28 [6,159.48 - 26,659.78]	-311.11 [-6,162.14 - 3,746.65]
	Less than 50% (n = 75)	9,801.62 [5,216.92 - 26,695.65]	9,814.16 [4,692.53 - 19,924.75]	806.84 [-4,132.79 - 5,041.46]
	50% - 79% (n = 59)	14,754.63 [9,870.77 - 37,053.44]	15,836.51 [8,209.94 - 43,429.16]	-311.11 [-7,052.07 - 2,775.17]
	80% or above (n = 51)	16,865.74 [9,099.87 - 30,360.58]	13,270.21 [5,410.20 - 22,607.97]	-2,311.17 [-9,461.23 - 3,746.65]
Cardiovascular conditions***	Overall (n = 157)	15,628.86 [8,489.89 - 33,290.23]	15,123.73 [8,282.88 - 39,094.89]	247.13 [-6,318.56 - 5,748.73]
	Less than 50% (n = 68)	16,111.38 [7,920.55 - 34,584.08]	15,773.04 [9,062.47 - 39,160.82]	763.00 [-3,283.28 - 7,257.63]
	50% - 79% (n = 49)	14,037.06 [9,870.77 - 31,667.46]	15,765.00 [8,634.89 - 45,214.13]	39.29 [-6,654.28 - 4,621.60]
	80% or above (n = 40)	18,323.71 [8,950.74 - 33,724.42]	13,793.80 [7,091.56 - 26,194.59]	-2,583.43 [-11,548.83 - 5,501.59]
Kidney-related conditions****	Overall (n = 73)	16,144.95 [7,943.79 - 37,034.09]	15,275.27 [7,146.04 - 23,847.14]	-805.13 [-8,740.03 - 4,445.00]
	Less than 50% (n = 33)	15,853.73 [5,668.03 - 37,034.09]	15,657.20 [6,854.21 - 39,226.74]	2,648.68 [-3,468.26 - 8,104.61]
	50% - 79% (n = 21)	24,500.01 [9,923.79 - 53,500.34]	15,771.95 [9,973.08 - 23,847.14]	-2,648.74 [-19,269.46 - 102.31]
	80% or above (n = 19)	17,640.93 [7,302.78 - 33,290.23]	12,184.53 [4,201.14 - 18,219.43]	-4,502.56 [-12,350.22 - 1,020.09]

Note: IQR - Interquartile Range; PDC - proportion of days covered; NA - not applicable; MASLD - metabolic dysfunction-associated steatotic liver disease; GLP-1 RA AOM - glucagon-like peptide-1 receptor agonist anti-obesity medication
Comorbid conditions are presented in no particular order.
+ Median of differences is reported.
*Medical cost includes inpatient and outpatient cost.
**Total cost includes medical cost and pharmacy cost.
*** Cardiovascular diseases include AFib, HF, MI, coronary heart disease, cerebrovascular disease, peripheral artery disease, and aortic atherosclerotic disease.
****Kidney-related conditions include CKD, AKI, ESRD.

FDA DRUG SAFETY COMMUNICATIONS

June 2025 – August 2025

- 08-28-2025 - FDA to recommend additional, earlier MRI monitoring for patients with Alzheimer's disease taking Leqembi (lecanemab)

- 08-27-2025 - FDA removes risk evaluation and mitigation strategy (REMS) program for the antipsychotic drug Clozapine

- 07-31-2025 - FDA is requiring opioid pain medicine manufacturers to update prescribing information regarding long-term use

- 06-30-2025 - FDA requires expanded labeling about weight loss risk in patients younger than 6 years taking extended-release stimulants for ADHD

- 06-18-2025 - FDA adds warning about serious risk of heat-related complications with antinausea patch Transderm Scōp (scopolamine transdermal system)

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