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

MISSISSIPPI DIVISION OF
MEDICAID

**September 10, 2026 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

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

**Terrence Brown, PharmD**
BioScrip Infusion Services
187 Country Place Pkwy, Suite C
Pearl, MS 39208
*Term Expires: June 30, 2029*

**Greg Browning, MD**
Trace Urgent Care
530 Veterans Memorial Drive
Kosciusko, MS 39090
*Term Expires: June 30, 2028*

**Rachel Burt, PharmD**
Walmart Pharmacy
2530 Jackson Avenue West
Oxford, MS 38655
*Term Expires: June 30, 2029*

**Steven Clark, MD**
Cleveland Medical Clinic
810 East Sunflower Road
Cleveland, MS 38732
*Term Expires: June 30, 2028*

**Chrysanthia Davis, PharmD**
Omnicare of Jackson Pharmacy
100 Business Park Dr, Suite D
Ridgeland, MS 39157
*Term Expires: June 30, 2028*

**Dena Jackson, MD**
King's Daughters Specialty Clinic
900 Brookway Blvd
Brookhaven, MS 39601
*Term Expires: June 30, 2029*

**Jessica Lavender, MD (Chair)**
UMMC
2500 N. State Street
Jackson, MS 39216
*Term Expires: June 30, 2028*

**Joshua Pierce, PharmD**
McGuffee Drugs
102 Main Street
Mendenhall, MS 39114
*Term Expires: June 30, 2027*

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

**Taletha Swearingen, RPh**
Ochsner Rush Medical Center
1314 19th Avenue
Meridian, MS 39301
*Term Expires: June 30, 2029*

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

## 2026 DUR Board Meeting Dates

March 19, 2026
June 11, 2026
September 10, 2026
December 10, 2026

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 10, 2026**

**Welcome**

**Old Business**



**Resource Utilization Review**



**Follow-up and Discussion from the Board**

**New Business**

Election of Chair-Elect



Special Analysis Projects:



**Pharmacy Program Update**

**Next Meeting Information**
September 10, 2026

# DUR Board Meeting Minutes

**MISSISSIPPI DIVISION OF MEDICAID**
**DRUG UTILIZATION REVIEW (DUR) BOARD**
MINUTES OF THE JUNE 11, 2026 MEETING
COBB CONFERENCE CENTER, SILLERS BUILDING, JACKSON, MS

| DUR Board Roster: State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | Sep 2025 | Dec 2025 | Mar 2026 | Jun 2026 |
|---|---|---|---|---|
| Amy Catherine Baggett, PharmD | ✓ | | ✓ | |
| Terrence Brown, PharmD | ✓ | ✓ | ✓ | ✓ |
| Greg Browning, MD | ✓ | ✓ | ✓ | ✓ |
| Rachel Burt, PharmD | ✓ | ✓ | ✓ | ✓ |
| Steven Clark, MD | ✓ | ✓ | ✓ | ✓ |
| Chrysanthia Davis, PharmD | ✓ | ✓ | ✓ | ✓ |
| Dena Jackson, MD | | ✓ | ✓ | ✓ |
| Jessica Lavender, MD | ✓ | | ✓ | ✓ |
| Holly Moore, PharmD | ✓ | | ✓ | |
| Joshua Pierce, PharmD | ✓ | ✓ | | ✓ |
| Gaylen Sanders, MD | ✓ | ✓ | ✓ | |
| Joshua Trull, DO | ✓ | ✓ | ✓ | |
| **TOTAL PRESENT**** | **11** | **9** | **11** | **8** |

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

**Also Present:**

**Division of Medicaid (DOM) Staff:**
Terri Kirby, RPH, CPM, Director of Pharmacy; Dennis Smith, RPH, DUR Coordinator; Amy Ly-Ha, PharmD, Pharmacist II; Robert Besinger, MD, Medical Director; Lindy Files, Pharmacy Intern;

**University of Mississippi School of Pharmacy - MS-DUR Staff:**
Eric Pittman, PharmD, PhD, MS-DUR Project Director; Tyler Vest, PharmD, MS, MSSCM, Research Associate Professor; Omkar Ghodke, MS, Research Analyst;

**Coordinated Care Organization (CCO) Staff:**
Jessica Lawson, PharmD, TrueCare; Thomas Nguyen, PharmD, Magnolia Health;

**Gainwell Staff:**
Tricia Banks, PharmD, Director of Pharmacy;

**Teligen Staff**:
Buddy Ogletree, PharmD, Pharmacist;

**Visitors:** Paula Whatley, Novo Nordisk; Caroline Bobinger, Novo Nordisk; Shawn Headley, Gilead; Scott Tabot, Agios.

**Call to Order/Welcome:**
The meeting was called to order at 1:03 PM by Dr. Pierce, Chair.

Mr. Smith introduced Dr. Besinger, Medicaid's new Medical Director, and Lindy Files, summer pharmacy student intern, to the Board. Dr. Pittman introduced Omkar Ghodke, research analyst with the University of Mississippi, to the Board.

Mr. Smith also introduced additional guests seated at the table. Representatives from several Medicaid pharmacy vendors were added as non-voting guests to facilitate discussion and collaboration with the DUR Board.

**OLD BUSINESS:**
Dr. Browning moved to approve the minutes from the March 2026 DUR Board Meeting, seconded by Dr. Lavender, and unanimously approved by the DUR Board.

**Resource Utilization Review**
Dr. Pittman presented the resource utilization report for March 2026. Data presented was across all pharmacy programs.

**Follow-up from Previous Board Projects**
Drafts for three planned provider communications that resulted from recent DUR projects were presented to the Board for review. The communications included:

- A letter describing the monitoring of the appropriate use of antipsychotics among adult Medicaid members enrolled in long-term care.
- The first in a series of targeted provider educational mailings addressing the need for increased prescribing of human immunodeficiency virus (HIV) pre-exposure prophylaxis among Medicaid members at risk of HIV infection.
- A packet containing tips for prescribing select anti-obesity agents.

**NEW BUSINESS:**

**Update on MS-DUR Educational Interventions**
Dr. Pittman provided an overview of all DUR mailings and educational notices that occurred between March 2026 and May 2026.

**Hepatitis C Virus (HCV) Treatment Overview**
Direct-acting antiviral (DAA) therapy has proven to be highly effective in curing individuals diagnosed with HCV. This report analyzed the use and effectiveness of DAA therapy for hepatitis C among Mississippi Medicaid members. It examined provider types, treatment regimens, therapy completion rates, and the impact of DAA therapy on liver transplant rates. While improved access due to policy changes, high completion rates for DAA therapy, and

significant reductions in liver transplants for those treated were noted, gaps remain in timely treatment initiation and therapy completion.

*Following the discussion, Dr. Brown made the following recommendations, seconded by Dr. Lavender, and unanimously approved by the Board.*

1. *DOM work with the pharmacy programs on initiatives to:*
    a. *Remind providers of the importance of screening for HCV and distribute a treatment algorithm for providers to follow.*
    b. *Improve the proportion of members initiating DAA therapy within one year of an HCV diagnosis.*
    c. *Increase the therapy completion rate of individuals prescribed DAA regimens.*

**Sickle Cell Disease Gene Therapy Modeling**
This report identified a measurable subset of Mississippi Medicaid members with sickle cell disease who meet modeled eligibility criteria for newly approved gene therapies, although final eligibility will depend on age restrictions, clinical evaluation, and prior authorization requirements. While only a small proportion of members met all combined criteria for Casgevy® or Lyfgenia®, the findings highlight the need for early planning, care coordination, and access-support services as the Mississippi Division of Medicaid implements the Cell and Gene Therapy Access Model and prepares for the potential budget and operational impact of these high-cost therapies.

This report was presented for informational purposes with no formal recommendations included.

**FDA Drug Safety Updates:**
The FDA drug safety updates issued between March 2026 and May 2026 were reviewed.

**Bylaws Update:**
*The Board reviewed the bylaws. Dr. Jackson recommended the following updates, seconded by Dr. Burt, and unanimously approved by the Board:*

*Article II. Membership*
*Section 1 – Board Composition*
*A. The DUR Board will consist of 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 physicians and at least one-third (1/3) licensed 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.*

*Article III. Meetings*

*Section 6 – Quorum*

*A majority of current active appointed voting members shall constitute a quorum. If a quorum is not present, the Board may participate in discussion and utilization analysis, but may not conduct business, such as approval of minutes, changes to by-laws, or recommendations requiring a vote. Such business shall be conducted at a subsequent meeting. Meeting minutes shall reflect that a quorum was not present.*

**Pharmacy Program Update:**

The Pharmacy Division provided the following updates to the Board:

- 340b language in the State Plan Amendment is being updated.
- Changes are being made to the specialty pharmacy dispensing fee.
- A train-the-trainer session for TrueCare care managers on GLP-1 anti-obesity medications is upcoming.
- Preferred Drug List changes are taking place around brand and generic Farxiga® (dapagliflozin) products.
- Medicaid is working through processes to ensure compliance with Senate Bill 2140 for the prior authorization provider portal.

**Next Meeting Information:**

September 10, 2026

Dr. Brown motioned to adjourn the meeting at 2:57 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 19, 2026
- June 11, 2026
- September 10, 2026
- December 10, 2026

**The March 19 meeting may be viewed virtually by clicking on the following link: Click Here for MS Medicaid DUR Live Broadcast on March 19, 2026, 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<br>January 1, 2026 through June 30, 2026 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 |
| Total enrollment | | | 713,551 | 712,114 | 710,621 | 708,288 | 705,949 | 703,283 |
| Dual-eligibles | | | 164,297 | 164,443 | 164,418 | 164,281 | 163,903 | 163,733 |
| Pharmacy benefits | | | 550,631 | 549,106 | 547,589 | 545,268 | 542,743 | 539,839 |
| | LTC | | 15,729 | 15,813 | 15,794 | 15,732 | 15,594 | 15,419 |
| | PLAN % | FFS | 18.0% | 18.0% | 18.0% | 18.0% | 18.0% | 18.0% |
| | | MSCAN-UHC | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| | | MSCAN-Magnolia | 39.7% | 39.7% | 39.7% | 39.7% | 39.7% | 39.7% |
| | | MSCAN-Molina | 25.6% | 25.7% | 25.6% | 25.6% | 25.7% | 25.7% |
| | | MSCAN-TruCare | 16.7% | 16.6% | 16.7% | 16.7% | 16.6% | 16.6% |

| TABLE 04B: PHARMACY UTILIZATION STATISTICS FOR LAST 6 MONTHS<br>January 1, 2026 through June 30, 2026 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 |
| # Rx Fills | FFS | 63,403 | 59,768 | 64,044 | 61,649 | 59,902 | 57,957 |
| | MSCAN-UHC | 176 | 162 | 145 | 163 | 128 | 131 |
| | MSCAN-Mag | 179,172 | 181,162 | 186,197 | 184,898 | 164,862 | 162,617 |
| | MSCAN-Mol | 96,187 | 98,084 | 100,635 | 100,117 | 89,777 | 87,612 |
| | MSCAN-Tru | 69,718 | 70,760 | 72,910 | 72,034 | 64,296 | 62,224 |
| # Rx Fills / Bene | FFS | 0.6 | 0.6 | 0.6 | 0.6 | 0.6 | 0.6 |
| | MSCAN-UHC | 1.1 | 1.0 | 0.9 | 1.0 | 0.8 | 0.8 |
| | MSCAN-Mag | 0.8 | 0.8 | 0.9 | 0.9 | 0.8 | 0.8 |
| | MSCAN-Mol | 0.7 | 0.7 | 0.7 | 0.7 | 0.6 | 0.6 |
| | MSCAN-Tru | 0.8 | 0.8 | 0.8 | 0.8 | 0.7 | 0.7 |
| $ Paid Rx | FFS | $10,148,397 | $10,314,842 | $11,243,170 | $11,937,838 | $10,693,613 | $11,283,943 |
| | MSCAN-UHC | $35,664 | $34,180 | $33,670 | $33,376 | $30,400 | $30,647 |
| | MSCAN-Mag | $25,368,574 | $25,694,474 | $27,736,033 | $28,032,323 | $27,117,668 | $27,663,059 |
| | MSCAN-Mol | $13,100,177 | $12,846,739 | $14,980,453 | $14,224,899 | $13,602,342 | $14,915,789 |
| | MSCAN-Tru | $9,862,355 | $10,150,518 | $10,656,439 | $10,572,423 | $10,417,108 | $10,499,310 |
| $ Paid Brand Rx | FFS | $8,432,095 | $8,698,217 | $9,416,000 | $10,145,807 | $8,936,326 | $9,579,942 |
| | MSCAN-UHC | $32,649 | $31,641 | $31,671 | $31,174 | $27,889 | $28,111 |
| | MSCAN-Mag | $21,216,349 | $21,520,391 | $23,391,144 | $23,745,776 | $23,272,857 | $23,801,030 |
| | MSCAN-Mol | $10,782,470 | $10,581,071 | $12,611,167 | $11,829,870 | $11,446,028 | $12,760,293 |
| | MSCAN-Tru | $8,210,268 | $8,516,161 | $8,835,303 | $8,817,714 | $8,825,531 | $8,941,154 |
| $ Paid Generic Rx | FFS | $1,212,707 | $1,149,827 | $1,352,872 | $1,287,960 | $1,262,831 | $1,193,734 |
| | MSCAN-UHC | $2,208 | $1,888 | $1,717 | $1,888 | $1,822 | $2,237 |
| | MSCAN-Mag | $3,614,505 | $3,645,160 | $3,757,715 | $3,674,889 | $3,295,997 | $3,250,578 |
| | MSCAN-Mol | $1,954,172 | $1,989,858 | $2,060,697 | $2,068,109 | $1,866,612 | $1,797,333 |
| | MSCAN-Tru | $1,437,598 | $1,449,997 | $1,550,880 | $1,497,487 | $1,335,453 | $1,292,130 |
| $ Paid Other Rx* | FFS | $503,596 | $466,798 | $474,298 | $504,071 | $494,455 | $510,267 |
| | MSCAN-UHC | $806 | $651 | $283 | $314 | $689 | $299 |
| | MSCAN-Mag | $537,720 | $528,923 | $587,174 | $611,659 | $548,814 | $611,451 |
| | MSCAN-Mol | $363,536 | $275,810 | $308,589 | $326,920 | $289,702 | $358,164 |
| | MSCAN-Tru | $214,490 | $184,360 | $270,256 | $257,222 | $256,119 | $266,026 |
| $ /Rx Fill | FFS | $160.06 | $172.58 | $175.55 | $193.64 | $178.52 | $194.70 |
| | MSCAN-UHC | $202.64 | $210.99 | $232.21 | $204.76 | $237.50 | $233.95 |
| | MSCAN-Mag | $141.59 | $141.83 | $148.96 | $151.61 | $164.49 | $170.11 |
| | MSCAN-Mol | $136.19 | $130.98 | $148.86 | $142.08 | $151.51 | $170.25 |
| | MSCAN-Tru | $141.46 | $143.45 | $146.16 | $146.77 | $162.02 | $168.73 |
| $ /Bene | FFS | $102.39 | $104.36 | $114.07 | $121.63 | $109.46 | $116.12 |
| | MSCAN-UHC | $215.90 | $207.49 | $204.96 | $204.03 | $186.71 | $189.24 |
| | MSCAN-Mag | $116.05 | $117.87 | $127.58 | $129.50 | $125.85 | $129.08 |
| | MSCAN-Mol | $92.93 | $91.03 | $106.86 | $101.91 | $97.52 | $107.51 |
| | MSCAN-Tru | $107.44 | $111.56 | $116.74 | $116.31 | $115.83 | $117.37 |

*NOTE:*

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

*- *Other Rx include over the counter drugs, nutritional supplies, medical supplies, and devices (durable medical equipments)*

*- CHIP claims are not included in this report*

## TABLE C: TOP 10 DRUG CATEGORIES BY NUMBER OF CLAIMS IN JUN 2026 (FFS AND CCOs)

| subcategory_top_drug | Month Year | Rank Volume | # RXs | $ Paid | # Unique Benes |
|---|---|---|---|---|---|
| CNS stimulants (e.g.,Amphetamine-Dextroamphetamine ) | Jun 2026 | 1 | 19,513 | $2,276,047 | 16,796 |
| | May 2026 | 1 | 21,288 | $2,557,398 | 18,540 |
| | Apr 2026 | 1 | 25,309 | $3,105,819 | 21,959 |
| atypical antipsychotics (e.g.,Risperidone ) | Jun 2026 | 2 | 13,822 | $5,610,999 | 11,541 |
| | May 2026 | 2 | 13,744 | $5,259,252 | 11,510 |
| | Apr 2026 | 2 | 14,382 | $5,404,863 | 11,990 |
| SSRI antidepressants (e.g.,Sertraline Hydrochloride ) | Jun 2026 | 3 | 12,991 | $174,688 | 11,993 |
| | May 2026 | 3 | 12,720 | $169,401 | 11,819 |
| | Apr 2026 | 3 | 13,572 | $179,005 | 12,489 |
| antiadrenergic agents, centrally acting (e.g.,Clonidine Hydrochloride ) | Jun 2026 | 4 | 11,528 | $193,089 | 10,282 |
| | May 2026 | 4 | 11,465 | $188,996 | 10,317 |
| | Apr 2026 | 7 | 12,263 | $203,237 | 10,997 |
| nonsteroidal anti-inflammatory agents (e.g.,Ibuprofen ) | Jun 2026 | 5 | 10,866 | $145,293 | 10,376 |
| | May 2026 | 5 | 10,757 | $143,491 | 10,311 |
| | Apr 2026 | 8 | 12,218 | $162,634 | 11,693 |
| adrenergic bronchodilators (e.g.,Albuterol Sulfate ) | Jun 2026 | 6 | 10,024 | $483,406 | 8,719 |
| | May 2026 | 6 | 10,741 | $465,227 | 9,383 |
| | Apr 2026 | 4 | 12,955 | $556,384 | 11,200 |
| proton pump inhibitors (e.g.,Pantoprazole ) | Jun 2026 | 7 | 9,788 | $292,093 | 9,363 |
| | May 2026 | 9 | 9,741 | $283,143 | 9,314 |
| | Apr 2026 | 10 | 9,951 | $295,960 | 9,494 |
| antihistamines (e.g.,Cetirizine Hydrochloride ) | Jun 2026 | 8 | 8,897 | $152,677 | 8,527 |
| | May 2026 | 8 | 10,296 | $177,615 | 9,894 |
| | Apr 2026 | 6 | 12,586 | $221,017 | 12,155 |
| narcotic analgesic combinations (e.g.,Acetaminophen-Hydrocodone Bitartrate ) | Jun 2026 | 9 | 8,453 | $501,517 | 7,846 |
| | May 2026 | 12 | 8,020 | $483,588 | 7,463 |
| | Apr 2026 | 14 | 8,463 | $501,917 | 7,853 |
| aminopenicillins (e.g.,Amoxicillin ) | Jun 2026 | 10 | 8,370 | $117,204 | 8,221 |
| | May 2026 | 7 | 10,643 | $153,938 | 10,484 |
| | Apr 2026 | 5 | 12,927 | $187,764 | 12,698 |

## TABLE D: TOP 10 DRUG CATEGORIES BY DOLLARS PAID IN JUN 2026 (FFS AND CCOs)

| subcategory_top_drug | Month Year | Rank Paid Amt | # RXs | $ Paid | # Unique Benes |
|---|---|---|---|---|---|
| interleukin inhibitors (e.g.,Dupixent Pre-Filled Pen ) | Jun 2026 | 1 | 1,223 | $7,127,586 | 1,104 |
| | May 2026 | 1 | 1,101 | $6,394,193 | 1,026 |
| | Apr 2026 | 1 | 1,185 | $6,819,150 | 1,067 |
| GLP-1 receptor agonists for obesity (e.g.,Wegovy Pen ) | Jun 2026 | 2 | 4,893 | $6,292,110 | 4,578 |
| | May 2026 | 2 | 4,637 | $5,979,009 | 4,334 |
| | Apr 2026 | 2 | 4,583 | $5,905,345 | 4,257 |
| atypical antipsychotics (e.g.,Invega Sustenna ) | Jun 2026 | 3 | 13,822 | $5,610,999 | 11,541 |
| | May 2026 | 3 | 13,744 | $5,259,252 | 11,510 |
| | Apr 2026 | 3 | 14,382 | $5,404,863 | 11,990 |
| TNF alpha inhibitors (e.g.,Humira Pen ) | Jun 2026 | 4 | 351 | $3,206,908 | 306 |
| | May 2026 | 5 | 305 | $2,742,479 | 275 |
| | Apr 2026 | 5 | 308 | $2,822,153 | 280 |
| CFTR combinations (e.g.,Trikafta ) | Jun 2026 | 5 | 106 | $2,676,414 | 89 |
| | May 2026 | 4 | 115 | $2,945,735 | 95 |
| | Apr 2026 | 8 | 98 | $2,406,660 | 86 |
| antiviral combinations (e.g.,Biktarvy ) | Jun 2026 | 6 | 641 | $2,576,285 | 587 |
| | May 2026 | 8 | 592 | $2,422,358 | 560 |
| | Apr 2026 | 7 | 608 | $2,477,174 | 569 |
| GLP-1 receptor agonists for non-obesity indications (e.g.,Trulicity Pen ) | Jun 2026 | 7 | 2,655 | $2,563,276 | 2,511 |
| | May 2026 | 6 | 2,672 | $2,568,553 | 2,519 |
| | Apr 2026 | 6 | 2,691 | $2,592,474 | 2,538 |
| CNS stimulants (e.g.,Quillichew Er ) | Jun 2026 | 8 | 19,513 | $2,276,047 | 16,796 |
| | May 2026 | 7 | 21,288 | $2,557,398 | 18,540 |
| | Apr 2026 | 4 | 25,309 | $3,105,819 | 21,959 |
| factor for bleeding disorders (e.g.,Hemlibra ) | Jun 2026 | 9 | 144 | $1,959,893 | 126 |
| | May 2026 | 10 | 127 | $1,652,116 | 113 |
| | Apr 2026 | 9 | 137 | $1,955,077 | 115 |
| antirheumatics (e.g.,Enbrel Sureclick ) | Jun 2026 | 10 | 363 | $1,764,814 | 334 |
| | May 2026 | 9 | 354 | $1,689,735 | 326 |
| | Apr 2026 | 10 | 388 | $1,832,715 | 346 |

## TABLE E: TOP 25 DRUG MOLECULES
## BY NUMBER OF CLAIMS IN JUN 2026 (FFS and CCOs)

| Drug Molecule<br>Therapeutic Category | May 2026<br># Claims | Jun 2026<br># Claims | Jun 2026<br>$ Paid | Jun 2026<br># Unique Benes |
|---|---|---|---|---|
| Albuterol Sulfate / adrenergic bronchodilators | 10,116 | 9,267 | $273,168 | 8,128 |
| Amoxicillin / aminopenicillins | 10,624 | 8,345 | $116,753 | 8,197 |
| Clonidine Hydrochloride / antiadrenergic agents, centrally acting | 7,142 | 7,199 | $114,170 | 6,721 |
| Methylphenidate Hydrochloride Er / CNS stimulants | 7,397 | 6,649 | $1,225,362 | 5,903 |
| Amphetamine-Dextroamphetamine / CNS stimulants | 6,740 | 6,406 | $185,626 | 5,479 |
| Gabapentin / gamma-aminobutyric acid analogs | 5,730 | 5,845 | $90,807 | 5,530 |
| Ondansetron Hydrochloride / 5HT3 receptor antagonists | 7,029 | 5,826 | $88,602 | 5,556 |
| Cetirizine Hydrochloride / antihistamines | 7,074 | 5,764 | $103,069 | 5,663 |
| Ibuprofen / nonsteroidal anti-inflammatory agents | 5,358 | 5,405 | $68,189 | 5,287 |
| Sertraline Hydrochloride / SSRI antidepressants | 5,002 | 5,130 | $66,216 | 4,753 |
| Montelukast Sodium / leukotriene modifiers | 5,326 | 4,990 | $73,475 | 4,878 |
| Acetaminophen-Hydrocodone Bitartrate / narcotic analgesic combinations | 4,560 | 4,826 | $84,946 | 4,559 |
| Ergocalciferol / vitamins | 4,823 | 4,819 | $46,931 | 4,215 |
| Wegovy Pen / GLP-1 receptor agonists for obesity | 4,523 | 4,780 | $6,170,277 | 4,471 |
| Triamcinolone Acetonide Topical / topical steroids | 4,324 | 4,721 | $82,657 | 4,607 |
| Fluticasone Propionate / nasal steroids | 5,390 | 4,662 | $82,115 | 4,606 |
| Guanfacine Hydrochloride / antiadrenergic agents, centrally acting | 4,320 | 4,325 | $77,207 | 4,089 |
| Hydroxyzine Hydrochloride / miscellaneous anxiolytics, sedatives and hypnotics | 4,210 | 4,323 | $71,155 | 4,166 |
| Pantoprazole / proton pump inhibitors | 4,240 | 4,312 | $54,716 | 4,143 |
| Amlodipine Besylate / calcium channel blocking agents | 4,192 | 4,268 | $82,639 | 4,097 |
| Amoxicillin-Clavulanate / penicillins/beta-lactamase inhibitors | 4,613 | 3,928 | $76,921 | 3,875 |
| Famotidine / H2 antagonists | 3,779 | 3,925 | $62,195 | 3,723 |
| Azithromycin / macrolides | 5,993 | 3,885 | $58,842 | 3,816 |
| Omeprazole / proton pump inhibitors | 3,893 | 3,882 | $50,991 | 3,761 |
| Risperidone / atypical antipsychotics | 3,859 | 3,824 | $507,318 | 3,442 |

## TABLE F: TOP 25 DRUG MOLECULES
## BY DOLLARS PAID IN JUN 2026 (FFS and CCOs)

| Drug Molecule<br>Therapeutic Category | May 2026<br>$ Paid | Jun 2026<br>$ Paid | Jun 2026<br># Claims | Jun 2026<br># Unique<br>Benes |
|---|---|---|---|---|
| Wegovy Pen / GLP-1 receptor agonists for obesity | $5,856,923 | $6,170,277 | 4,780 | 4,471 |
| Dupixent Pre-Filled Pen / interleukin inhibitors | $3,249,702 | $3,649,006 | 883 | 801 |
| Humira Pen / TNF alpha inhibitors | $2,666,580 | $3,117,419 | 336 | 292 |
| Trikafta / CFTR combinations | $2,689,995 | $2,421,325 | 97 | 82 |
| Invega Sustenna / atypical antipsychotics | $2,160,512 | $2,410,172 | 730 | 622 |
| Trulicity Pen / GLP-1 receptor agonists for non-obesity indications | $1,988,991 | $1,958,399 | 2,006 | 1,897 |
| Abilify Maintena Prefilled Syringe / atypical antipsychotics | $1,523,076 | $1,642,118 | 3,735 | 3,446 |
| Biktarvy / antiviral combinations | $1,490,527 | $1,635,006 | 374 | 347 |
| Quillichew Er / CNS stimulants | $1,390,127 | $1,225,362 | 6,649 | 5,903 |
| Hemlibra / factor for bleeding disorders | $757,961 | $1,127,978 | 31 | 27 |
| Taltz Autoinjector / interleukin inhibitors | $894,146 | $1,012,222 | 126 | 110 |
| Enbrel Sureclick / antirheumatics | $620,527 | $671,432 | 88 | 81 |
| Bimzelx Autoinjector / interleukin inhibitors | $567,068 | $653,091 | 30 | 27 |
| Vraylar / atypical antipsychotics | $660,564 | $633,162 | 420 | 402 |
| Norditropin Flexpro Pen / growth hormones | $416,073 | $588,764 | 123 | 112 |
| Jardiance / SGLT-2 inhibitors | $551,641 | $583,447 | 1,149 | 1,119 |
| Epidiolex / miscellaneous anticonvulsants | $567,118 | $569,496 | 160 | 147 |
| Panzyga / immune globulins | $497,689 | $515,519 | 31 | 28 |
| Uzedy / atypical antipsychotics | $537,020 | $507,318 | 3,824 | 3,442 |
| Symbicort / bronchodilator combinations | $467,474 | $486,045 | 2,066 | 2,027 |
| Farxiga / SGLT-2 inhibitors | $533,078 | $469,500 | 1,190 | 1,147 |
| Rinvoq / antirheumatics | $435,087 | $466,698 | 73 | 67 |
| Creon / digestive enzymes | $439,378 | $442,311 | 166 | 155 |
| Cosentyx Unoready Pen / interleukin inhibitors | $396,421 | $412,243 | 38 | 34 |
| Eliquis / factor Xa inhibitors | $403,444 | $409,914 | 1,326 | 1,208 |

## TABLE G: TOP 25 DRUG MOLECULES
## BY CHANGE IN NUMBER OF CLAIMS FROM APR 2026 TO JUN 2026 (FFS and CCOs)

| Drug Molecule | Apr 2026 # Claims | May 2026 # Claims | Jun 2026 # Claims | Jun 2026 $ Paid | Jun 2026 # Unique Benes |
|---|---|---|---|---|---|
| Ofloxacin Otic / otic anti-infectives | 1,187 | 1,133 | 1,732 | $32,360 | 1,698 |
| Mupirocin / topical antibiotics | 3,260 | 3,273 | 3,785 | $55,685 | 3,704 |
| Wegovy Pen / GLP-1 receptor agonists for obesity | 4,458 | 4,523 | 4,780 | $6,170,277 | 4,471 |
| Hydrocortisone/Neomycin/Polymyxin B, Otic / otic steroids with anti-infectives | 348 | 340 | 639 | $34,696 | 635 |
| Cephalexin Monohydrate / first generation cephalosporins | 2,513 | 2,489 | 2,739 | $43,967 | 2,688 |
| Clotrimazole, Topical / topical antifungals | 454 | 447 | 565 | $9,563 | 556 |
| Rosuvastatin Calcium / HMG-CoA reductase inhibitors (statins) | 1,656 | 1,648 | 1,747 | $23,867 | 1,697 |
| Sulfamethoxazole-Trimethoprim Ds / sulfonamides | 2,171 | 2,054 | 2,249 | $33,968 | 2,212 |
| Acetaminophen-Oxycodone Hydrochloride / narcotic analgesic combinations | 2,183 | 2,134 | 2,255 | $46,083 | 2,132 |
| Oxycodone Hydrochloride / narcotic analgesics | 673 | 681 | 743 | $19,994 | 695 |
| Ciprofloxacin Ophthalmic / ophthalmic anti-infectives | 189 | 180 | 258 | $5,140 | 255 |
| Celecoxib / cox-2 inhibitors | 371 | 379 | 430 | $6,223 | 423 |
| Cyanocobalamin / vitamins | 851 | 887 | 909 | $17,464 | 871 |
| Nystatin Topical / topical antifungals | 1,841 | 1,763 | 1,897 | $32,945 | 1,784 |
| Slynd / progestins | 263 | 281 | 316 | $80,604 | 296 |
| Ropinirole Hydrochloride / dopaminergic antiparkinsonism agents | 252 | 271 | 303 | $3,819 | 279 |
| Chlorhexidine Gluconate / antiseptic and germicides | 860 | 693 | 905 | $11,772 | 901 |
| Humira Pen / TNF alpha inhibitors | 291 | 291 | 336 | $3,117,419 | 292 |
| Valacyclovir Hydrochloride / purine nucleosides | 1,120 | 1,121 | 1,161 | $22,686 | 1,096 |
| Invega Sustenna / atypical antipsychotics | 689 | 648 | 730 | $2,410,172 | 622 |
| Epinephrine (Eqv-Epipen) Auto-Injector / adrenergic bronchodilators | 666 | 573 | 707 | $205,610 | 705 |
| Sacubitril-Valsartan / angiotensin receptor blockers and neprilysin inhibitors | 699 | 714 | 738 | $37,301 | 702 |
| Heplisav-B / viral vaccines | 41 | 57 | 80 | $13,612 | 80 |
| Farxiga / SGLT-2 inhibitors | 1,153 | 1,049 | 1,190 | $469,500 | 1,147 |
| Estradiol / estrogens | 494 | 483 | 530 | $14,563 | 502 |

## TABLE H: TOP 25 DRUG MOLECULES
## BY CHANGE IN AMOUNT PAID FROM APR 2026 TO JUN 2026 (FFS and CCOs)

| Drug Molecule | Apr 2026 $ Paid | May 2026 $ Paid | Jun 2026 $ Paid | Jun 2026 # Claims | Jun 2026 # Unique Benes |
|---|---|---|---|---|---|
| Humira Pen / TNF alpha inhibitors | $2,702,891 | $2,666,580 | $3,117,419 | 336 | 292 |
| Wegovy Pen / GLP-1 receptor agonists for obesity | $5,765,536 | $5,856,923 | $6,170,277 | 4,780 | 4,471 |
| Trikafta / CFTR combinations | $2,127,670 | $2,689,995 | $2,421,325 | 97 | 82 |
| Bimzelx Autoinjector / interleukin inhibitors | $398,942 | $567,068 | $653,091 | 30 | 27 |
| Dupixent Pre-Filled Pen / interleukin inhibitors | $3,486,526 | $3,249,702 | $3,649,006 | 883 | 801 |
| Abilify Maintena Prefilled Syringe / atypical antipsychotics | $1,502,703 | $1,523,076 | $1,642,118 | 3,735 | 3,446 |
| Forzinity / miscellaneous uncategorized agents | $61,055 | $61,055 | $183,165 | 3 | 2 |
| Zycubo / minerals and electrolytes | $56,021 | $280,084 | $168,053 | 2 | 2 |
| Avlayah / lysosomal enzymes | $0 | $0 | $104,034 | 3 | 3 |
| Biktarvy / antiviral combinations | $1,538,171 | $1,490,527 | $1,635,006 | 374 | 347 |
| Hemlibra / factor for bleeding disorders | $1,036,998 | $757,961 | $1,127,978 | 31 | 27 |
| Novoseven Rt With Mixpro / factor for bleeding disorders | $0 | $107,000 | $80,250 | 1 | 1 |
| Gomekli / multikinase inhibitors | $20,795 | $28,089 | $99,837 | 6 | 2 |
| Ojemda / multikinase inhibitors | $77,428 | $77,428 | $154,857 | 4 | 3 |
| Fintepla / anorexiants | $284,389 | $289,424 | $361,632 | 25 | 23 |
| Daptomycin / miscellaneous antibiotics | $64,411 | $114,898 | $137,794 | 38 | 17 |
| Evrysdi / miscellaneous uncategorized agents | $318,168 | $289,888 | $388,873 | 16 | 12 |
| Actimmune / interferons | $0 | $0 | $70,328 | 1 | 1 |
| Sofosbuvir-Velpatasvir / antiviral combinations | $72,073 | $79,552 | $142,090 | 21 | 16 |
| Invega Sustenna / atypical antipsychotics | $2,341,947 | $2,160,512 | $2,410,172 | 730 | 622 |
| Imcivree / melanocortin receptor agonists | $238,615 | $337,093 | $306,802 | 10 | 9 |
| Ruconest / hereditary angioedema agents | $0 | $66,571 | $66,571 | 1 | 1 |
| Yeztugo / miscellaneous antivirals | $16,483 | $46,497 | $78,613 | 10 | 5 |
| Voranigo / miscellaneous antineoplastics | $114,315 | $155,941 | $176,286 | 5 | 4 |
| Winrevair / agents for pulmonary hypertension | $168,370 | $260,205 | $229,586 | 10 | 9 |

## 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 2026 TO JUN 2026 (FFS and CCOs)

| Drug Product<br>Therapeutic Category | Jun 2026<br># Claims | Jun 2026<br>$ Paid | Jun 2026<br>Avr. Paid<br>Per Rx | Jun 2026<br>Avr.<br>Units<br>Per Rx | Apr 2026<br>Paid<br>Per Unit | May 2026<br>Paid<br>Per Unit | Jun 2026<br>Paid<br>Per Unit | Percent<br>Change |
|---|---|---|---|---|---|---|---|---|
| dexmethylphenidate 30 mg capsule, extended release / CNS stimulants (Y) | 161 | $9,738 | $60.48 | 30 | $1.47 | $1.57 | $1.65 | 12.3% |
| asenapine 5 mg tablet / atypical antipsychotics (Y) | 126 | $14,622 | $116.05 | 42 | $2.21 | $2.28 | $2.46 | 11.4% |
| ethinyl estradiol-norelgestromin 35 mcg-150 mcg/24 hr film, extended release / contraceptives (Y) | 384 | $36,305 | $94.54 | 3 | $26.44 | $27.10 | $27.81 | 5.2% |
| Eliquis (apixaban) 2.5 mg tablet / factor Xa inhibitors (Y) | 150 | $44,836 | $298.91 | 53 | $5.09 | $5.26 | $5.33 | 4.7% |
| lisdexamfetamine 20 mg capsule / CNS stimulants (Y) | 353 | $32,504 | $92.08 | 30 | $2.62 | $2.56 | $2.73 | 4.3% |
| lisdexamfetamine 30 mg capsule / CNS stimulants (Y) | 631 | $64,487 | $102.20 | 30 | $2.96 | $3.04 | $3.05 | 3.2% |
| lisdexamfetamine 70 mg capsule / CNS stimulants (Y) | 203 | $19,987 | $98.46 | 30 | $2.84 | $2.91 | $2.92 | 2.5% |
| dexmethylphenidate 20 mg capsule, extended release / CNS stimulants (Y) | 318 | $22,472 | $70.67 | 30 | $1.94 | $1.96 | $1.98 | 2.4% |
| lisdexamfetamine 50 mg capsule / CNS stimulants (Y) | 427 | $40,971 | $95.95 | 30 | $2.80 | $2.79 | $2.83 | 1.1% |
| Januvia (sitagliptin) (as phosphate) 100 mg tablet / dipeptidyl peptidase 4 inhibitors (Y) | 152 | $66,632 | $438.37 | 43 | $10.24 | $10.23 | $10.34 | 1.0% |
| Eliquis (apixaban) 5 mg tablet / factor Xa inhibitors (Y) | 1,164 | $360,378 | $309.60 | 56 | $5.24 | $5.24 | $5.28 | 0.7% |
| Biktarvy (bictegravir/emtricitabine/tenofovir) 50 mg-200 mg-25 mg tablet / antiviral combinations (Y) | 373 | $1,630,894 | $4,372.37 | 36 | $122.41 | $121.38 | $123.20 | 0.6% |
| dexmethylphenidate 25 mg capsule, extended release / CNS stimulants (Y) | 178 | $13,082 | $73.49 | 30 | $2.06 | $2.08 | $2.07 | 0.6% |
| Xarelto (rivaroxaban) 20 mg tablet / factor Xa inhibitors (Y) | 308 | $171,283 | $556.11 | 29 | $18.74 | $18.90 | $18.83 | 0.5% |
| Jardiance (empagliflozin) 10 mg tablet / SGLT-2 inhibitors (Y) | 635 | $307,021 | $483.50 | 43 | $10.74 | $10.70 | $10.77 | 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**

**JUNE - AUGUST 2026**

## 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 |
| Sep-25 | 1 | 1 | 2 | Sep-25 | 41 | 42 | Sep-25 | 150 | 183 |
| Oct-25 | 1 | 1 | 2 | Oct-25 | 48 | 51 | Oct-25 | 150 | 182 |
| Nov-25 | 2 | 2 | 4 | Nov-25 | 36 | 40 | Nov-25 | 150 | 183 |
| Dec-25 | 1 | 1 | 2 | Dec-25 | 33 | 35 | Dec-25 | 150 | 184 |
| Jan-26 | 1 | 1 | 2 | Jan-26 | 44 | 47 | Jan-26 | 150 | 187 |
| Feb-26 | 2 | 2 | 4 | Feb-26 | 40 | 44 | Feb-26 | 150 | 193 |
| Mar-26 | 0 | 0 | 0 | Mar-25 | 37 | 43 | Mar-25 | 150 | 193 |
| Apr-26 | 0 | 0 | 0 | Apr-25 | 36 | 39 | Apr-25 | 150 | 179 |
| May-26 | 2 | 2 | 4 | May-25 | 30 | 32 | May-25 | 148 | 188 |
| Jun-26 | 0 | 0 | 0 | Jun-26 | 32 | 38 | Jun-26 | 150 | 183 |
| Jul-26 | 0 | 0 | 0 | Jul-26 | 38 | 43 | Jul-26 | 150 | 191 |
| Aug-26 | 1 | 1 | 2 | Aug-26 | 37 | 42 | Aug-26 | 150 | 200 |

## One-time Mailings:

| HIV PrEP Awareness | | |
|---|---|---|
| | Prescribers Mailed | Benes Addressed |
| Jul-26 | 405 | NA |

| Appropriate Prescribing of AP in LTC Setting | | |
|---|---|---|
| | Prescribers Mailed | Benes Addressed |
| Jul-26 | 456 | NA |

{date}

## IMPORTANT INFORMATION REGARDING HIV PrEP (HUMAN IMMUNODEFICIENCY VIRUS PRE-EXPOSURE PROPHYLAXIS)


Dear {Provider Name},

**Medicaid, in collaboration with the Mississippi State Department of Health, is launching an educational campaign to increase awareness and utilization of PrEP among at-risk individuals.**

**DID YOU KNOW?**

- **Mississippi has one of the highest rates of new HIV infections in the United States**.
- HIV disproportionately affects individuals living in rural communities.
- PrEP involves the routine use of antiretroviral medications by individuals who are HIV-negative and at an increased risk of HIV exposure. PrEP is safe and, when taken consistently, is highly effective in preventing HIV infection. Despite its proven safety and efficacy, utilization among eligible individuals remains low.
- According to **AIDSVu.org, Mississippi has the lowest "PrEP-to-need ratio" in the U.S., defined as the ratio of the number of PrEP users to the number of people with newly diagnosed HIV in the state.** Multiple factors limit the uptake of PrEP, but access has been identified as a major barrier. Medicaid data revealed that 37 counties in Mississippi had no providers prescribe PrEP to Medicaid members between 2015-2024.
- **Mississippi Medicaid is committed to reducing new HIV infections and supports the use of PrEP medications for eligible members.** Both oral and long-acting injectable PrEP formulations are covered as preferred agents under Medicaid's Universal Preferred Drug List (PDL), **https://medicaid.ms.gov/preferred-drug-list/**.

Individuals recently diagnosed with a sexually transmitted infection are at increased risk of HIV exposure. You and/or your practice have been identified as a high-volume STI care provider for Mississippi Medicaid members in 2025. As a trusted provider in this space, you are well-positioned to take the next step in comprehensive sexual health care - offering HIV testing and discussing PrEP with your patients. Research shows that integrating these services into STI visits significantly improves health outcomes and helps end the HIV epidemic.

This letter is the first in a series of PrEP-focused provider outreach initiatives planned for the coming year. Please look for additional communications on this important topic.

Thank you for your continued commitment to providing high-quality, comprehensive care to Mississippi Medicaid members. Your efforts to expand access to HIV prevention services are essential to reducing new infections statewide.

Sincerely,

Terri R. Kirby, RPh, CPM
Director, Office of Pharmacy
Mississippi Division of Medicaid

Eric Pittman, PharmD, PhD
Project Director, MS-DUR
University of Mississippi School of Pharmacy

{date}

## IMPORTANT INFORMATION REGARDING THE APPROPRIATE PRESCRIBING OF ANTIPSYCHOTICS FOR MEDICAID MEMBERS IN LONG-TERM CARE

Dear {Provider Name},

Monitoring appropriate antipsychotic (AP) prescribing in long-term care (LTC) and other institutional settings is an important patient safety priority. Due to concerns about inappropriate use in vulnerable populations, federal oversight has increased. Beginning this year, state Medicaid programs must report their efforts to monitor the appropriate prescribing of APs for adults (≥ 18 years) who are institutionalized to the Centers for Medicare & Medicaid Services.

**Recent Medicaid Drug Utilization Review (DUR) Data:**

- Three metrics were evaluated among members in LTC settings who received APs: the concurrent use of multiple APs, the presence of appropriate clinical indications, and the completion of routine metabolic monitoring.
- From January 2022 – December 2025:
  - 98.5% of members had an **appropriate clinical diagnosis in claims data for use of APs**
  - 15.5% of members had **concurrent use of at least 60 days with two or more distinct APs**
  - 77.8% of members received **monitoring for blood glucose and cholesterol** within the period beginning 12 months before and extending through one month after the index AP prescription
- Most Medicaid members receiving AP therapy while residing in LTC settings had an appropriate diagnosis for treatment, were not prescribed multiple APs concurrently, and received recommended metabolic monitoring.

You are receiving this letter because you prescribed an AP to one or more Medicaid members in an LTC facility in 2025.

Mississippi Medicaid will begin issuing quarterly reports identifying LTC residents who do not meet these quality measures. You will receive a report only if a member under your care does not meet one of the measures during the reporting period. Each report will include member-specific details to support clinical review and quality improvement.

Thank you for your continued commitment to providing high-quality, evidence-based care to Mississippi Medicaid members. If you have any questions regarding this initiative, please do not hesitate to contact us.

Sincerely,

Terri R. Kirby, RPh, CPM
Director, Office of Pharmacy
Mississippi Division of Medicaid

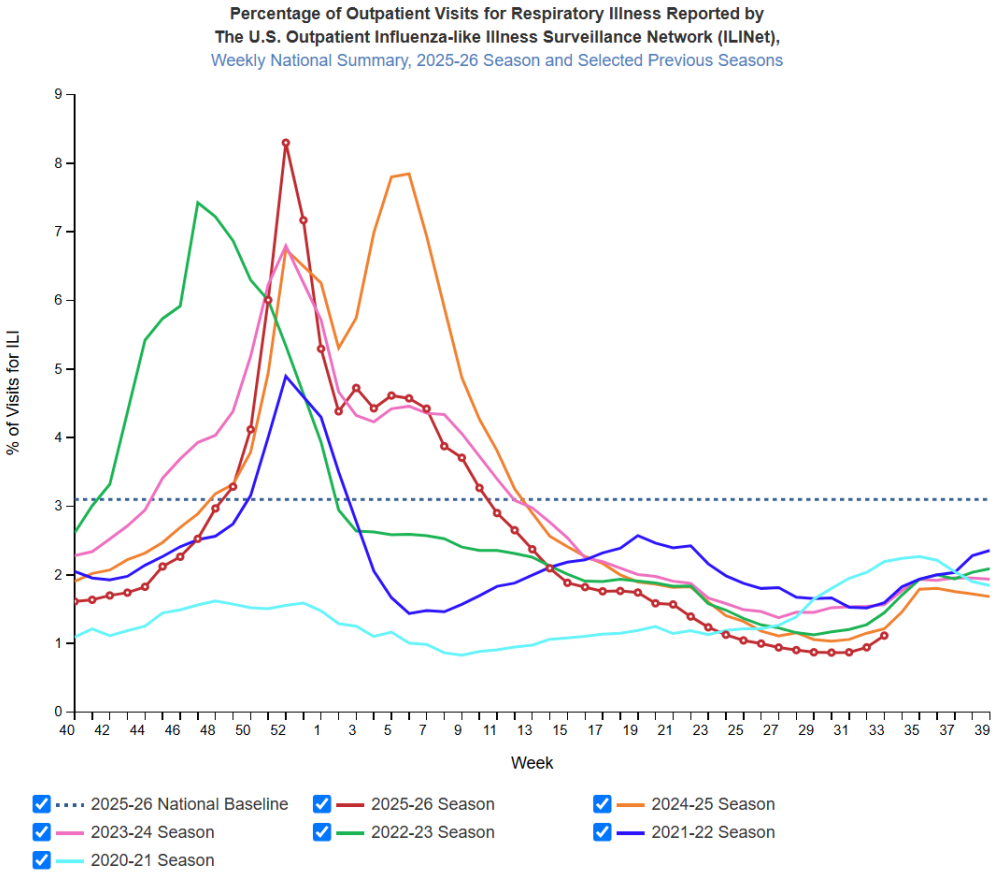
Eric Pittman, PharmD, PhD
Project Director, MS-DUR
University of Mississippi School of Pharmacy

# INFLUENZA VACCINATION AND TREATMENT UPDATE
# 2025-2026 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. The 2025–2026 US flu season was an early, moderately severe season that generated substantial illnesses and hospitalizations, but was less severe overall than the exceptionally severe 2024–2025 season. The season was dominated by influenza A(H3N2), including the emergence of subclade K, which differed from the vaccine strain selected earlier in 2025. Vaccine effectiveness was modest but clinically meaningful—particularly in preventing hospitalization—and remained an important tool for reducing the health burden of influenza. The 2025-2026 season began earlier than is typical, with influenza activity peaking in late November and December 2025.[1] (Figure 1)

FIGURE 1: Nationwide Percent of Visits for Influenza-Like Illness (ILI)[2]



**METHODS**

Pharmacy and medical claims data for fee-for-service and all CCOs [Magnolia Health (MAG), Molina Healthcare (MOL), TrueCare (TRU), and UnitedHealthcare (UHC)] for influenza vaccines and anti-influenza agents were extracted for state fiscal year (SFY) 2026 (July 1, 2025 to June 30, 2026). 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 Medicaid members receiving these agents, the number of prescriptions filled, and the amounts paid for these claims were determined for SFY 2026.

**RESULTS**

Table 1 displays the number of Medicaid members with documented influenza vaccinations through pharmacy and medical claims for SFY 2026.

- 53,787 members had documented flu vaccinations through claims data. The majority (53.4%) of individuals receiving flu vaccinations were 18 years and younger.
- Members enrolled in MAG had the highest number of claims.
- 91.5% of flu vaccinations were provided through medical claims (ex. medical clinic visits).
- 4,104 members had pharmacy claims for flu vaccinations, marking a slight improvement over SFY 2025. (Figure2)

| TABLE 1a: Influenza Vaccine Utilization in Mississippi Medicaid for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age (in years) | Plan | Members Receiving Flu Vaccinations* | Pharmacy Claims | | Medical Claims | | |
| | | | Members | Average Cost/Member | Members | Average Vaccine Cost/Member** | Avg. Vaccine Admin Cost/Member** |
| <19 | FFS | 852 | 27 | $42.4 | 825 | $36.9 | $26.4 |
| | UHC | 0 | 0 | $0.0 | 0 | $0.0 | $0.0 |
| | MAG | 13,130 | 230 | $48.4 | 12,900 | $24.5 | $27.5 |
| | MOL | 6,992 | 90 | $48.1 | 6,903 | $37.6 | $30.6 |
| | TRU | 4,703 | 81 | $45.5 | 4,622 | $36.1 | $28.5 |
| | MSCAN CHIP | 3,039 | 125 | $46.2 | 2,914 | $26.7 | $22.7 |
| | **Total** | **28,716** | **553** | **$47.1** | **28,164** | **$26.0** | **$27.9** |
| ≥19 | FFS | 15,522 | 556 | $63.6 | 14,972 | $24.9 | $18.7 |
| | UHC | 12 | 2 | $59.0 | 10 | $16.7 | $16.3 |
| | MAG | 5,285 | 1,615 | $66.2 | 3,695 | $24.4 | $20.1 |
| | MOL | 2,465 | 771 | $64.8 | 1,706 | $26.0 | $22.1 |
| | TRU | 1,783 | 606 | $63.6 | 1,185 | $25.3 | $19.8 |
| | MSCAN CHIP | 4 | 1 | $37.9 | 3 | $16.7 | $19.8 |
| | **Total** | **25,071** | **3,551** | **$65.0** | **21,571** | **$24.9** | **$20.2** |
| **Total (across all plans and age groups)** | | **53,787** | **4,104** | **$62.6** | **49,197** | **$25.1** | **$26.4** |

Note: FFS = Fee-For-Service, UHC = United Health Care, MAG = Magnolia, MOL = Molina, TRU = TrueCare, MSCAN = Mississippi Coordinated Access Network, CHIP = Children's Health Insurance Plan

*Members with Medical or Pharmacy claims were identified. These totals do not represent unique members. (52 members had both claims)

**Only medical claims for flu vaccination or vaccine administration with a paid amount >$.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.

| TABLE 1b: Total Influenza Vaccine Utilization by State Fiscal Year (Point of Sale Pharmacy Claims Only) SFY 2023 - SFY 2026 | | | | |
|---|---|---|---|---|
| Age | SFY 2023 | SFY 2024 | SFY 2025 | SFY 2026 |
| < 19 years | 422 | 157 | 729 | 553 |
| ≥ 19 years | 4,556 | 3,650 | 3,277 | 3,551 |
| **Total** | **4,978** | **3,807** | **4,006** | **4,104** |

Note: SFY = State Fiscal Year

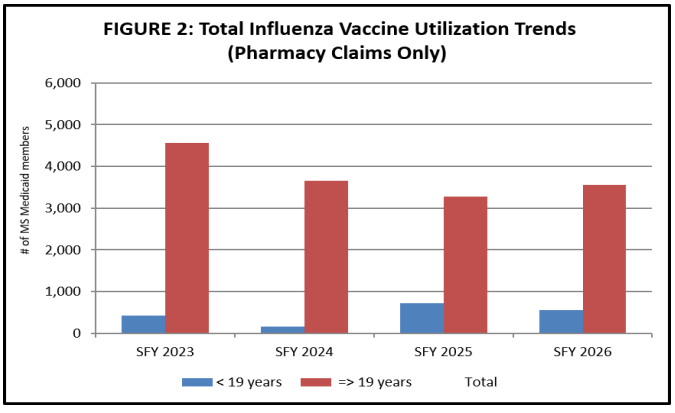


Table 2 displays the number of anti-influenza prescriptions filled, members treated, and the amounts paid for each antiviral agent during SFY 2026.

- A total of 43,482 claims for anti-influenza agents were paid during SFY 2026. This is down from 51,054 claims in SFY 2025.
- The number of members treated and the dollars paid during SFY 2026 were also lower than the totals reported for SFY 2025.

**TABLE 2: Utilization of Influenza Antiviral Agents In Mississippi Medicaid (July 1, 2025 – June 30, 2026)**

| Drug | Plan | # of Prescription Claims | # of Members | Paid Amount |
|---|---|---|---|---|
| Oseltamivir Phosphate* | FFS | 966 | 924 | $22,354.39 |
| | MAG | 18,379 | 17,358 | $461,230.66 |
| | MOL | 11,088 | 10,532 | $279,757.60 |
| | TRU | 7,449 | 7,052 | $187,509.93 |
| | MSCAN CHIP | 5,600 | 5,340 | $143,906.02 |
| **Grand Total**** | | **43,482** | **41,206** | **$1,094,758.60** |

Note: FFS = Fee-for Service, MAG = Magnolia, MOL = Molina, TRU = TrueCare, MSCAN = Mississippi Coordinated Access Network, CHIP = Children's Health Insurance Plan

*Only oseltamivir phosphate appeared in the SFY 2026 pharmacy claims data provided.

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 plan, since certain members may have been enrolled in multiple pharmacy plans during the analysis period.

## CONCLUSIONS AND RECOMMENDATIONS

This report for the DUR Board on influenza vaccination 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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# RSV ANNUAL UPDATE: 2025-2026 SEASON

## BACKGROUND

Respiratory syncytial virus (RSV) is a common respiratory pathogen that typically causes mild, cold-like symptoms but can result in serious lower respiratory tract disease, particularly among infants and older adults. RSV is the leading cause of hospitalization among U.S. infants, with the greatest risk of severe disease occurring during the first months of life. Historically, RSV has been associated with an estimated 58,000–80,000 hospitalizations annually among children younger than 5 years in the United States.[1,2]

Following substantial disruption of RSV seasonality during the COVID-19 pandemic, RSV circulation has generally returned toward its traditional pattern of increasing in the fall, peaking in the winter, and declining in the spring. For the 2025–2026 season, RSV activity followed this general seasonal pattern but peaked later than typically observed, with the national hospitalization rate reaching approximately 3.0 hospitalizations per 100,000 population during the week ending February 21, 2026. This peak was lower than the peak observed during the 2024–2025 season, indicating that the 2025–2026 season was not as severe as the previous season.[3,4]

The availability of effective RSV prevention products has substantially changed the approach to protecting infants from severe RSV disease. For the 2025–2026 RSV season, the CDC recommended that infants be protected through either maternal RSV vaccination with Pfizer's Abrysvo® during weeks 32–36 of pregnancy or administration of a long-acting RSV monoclonal antibody to the infant. In 2025, clesrovimab (Enflonsia®) became an additional option alongside nirsevimab (Beyfortus®) for infants younger than 8 months who were born during or entering their first RSV season and who were not adequately protected through maternal vaccination. For most infants, either maternal vaccination or administration of an infant RSV antibody is recommended, rather than both.[5]

The introduction of these preventive therapies provides an important opportunity to reduce RSV-associated morbidity and hospitalization among infants. For Medicaid programs, monitoring uptake of maternal vaccination and infant RSV antibodies is particularly important given the high burden of RSV among young children and the potential for prevention to reduce healthcare utilization. Additionally, RSV vaccination is recommended for all adults ages 75 and older, as well as those ages 50-74 years who are at increased risk of severe disease.[6]

This report examines RSV prevention among Mississippi Medicaid-enrolled infants and adults during the 2025–2026 RSV season, including utilization of maternal vaccination and infant RSV antibody products, to assess the reach of these interventions and identify opportunities to improve protection among eligible members.

## METHODS

This observational study utilized Mississippi Medicaid administrative claims data from both the Fee-for-Service program and all participating managed care organizations (MCOs) [Magnolia Health (MAG), Molina Healthcare (MOL), and TrueCare (TRU)]. Pharmacy point-of-sale (POS) and medical claims for RSV preventive agents were extracted for state fiscal year (SFY) 2026 (July 1, 2025 to June 30, 2026). For each monoclonal antibody and RSV vaccine approved for the prevention of RSV, all pharmacy and medical claims were extracted. In medical claims, current procedural terminology (CPT) codes associated with each agent were used to identify the number of claims and members who received each agent.

The proportion of infants who received protection against RSV in SFY 2026, either through direct administration of RSV monoclonal antibodies or passive immunization by maternal RSV vaccination, was estimated. Eligible infants were defined as those born between March 2025 and March 2026 with at least one month of Medicaid coverage. From the eligible infant population, infants were classified as directly protected if they received a monoclonal antibody product before eight months of age. Indirect protection via maternal immunization was assigned to infants whose mothers received Abrysvo® during pregnancy in SFY 2026 and who subsequently had a live birth between October 2025 and April 2026. 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

### Monoclonal Antibody Utilization:

Nirsevimab (Beyfortus®), a long-acting monoclonal antibody indicated for the prevention of RSV lower respiratory tract disease (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.[7] Table 1 displays the total number of Medicaid members who received nirsevimab during SFY 2026. A total of 5,874 unique members were identified through medical claims data as receiving nirsevimab during SFY 2026. Approximately 36% received nirsevimab by one month of age, and 85% were less than 6 months of age at the time of administration.

| TABLE 1: Nirsevimab Utilization in Mississippi Medicaid for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | | | |
|---|---|---|---|
| **Age (in months)** | **Plan** | **Number of Members with Nirsevimab Claims*** | **Number of Claims** |
| 0-1 | FFS | 12 | 12 |
| | MAG | 1009 | 1075 |
| | MOL | 729 | 810 |
| | TRU | 379 | 413 |
| | MSCAN CHIP | 4 | 4 |
| | **Total** | **2,133** | **2,314** |
| 2-5 | FFS | 14 | 15 |
| | MAG | 1,423 | 1,535 |
| | MOL | 1,082 | 1,134 |
| | TRU | 349 | 373 |
| | MSCAN CHIP | 4 | 4 |
| | **Total** | **2,872** | **3,061** |
| 6-12 | FFS | 4 | 4 |
| | MAG | 445 | 476 |
| | MOL | 345 | 353 |
| | TRU | 17 | 17 |
| | MSCAN CHIP | 2 | 2 |
| | **Total** | **813** | **852** |
| 13-24 | FFS | 1 | 1 |
| | MAG | 12 | 13 |
| | MOL | 9 | 10 |
| | TRU | 7 | 8 |
| | MSCAN CHIP | 0 | 0 |
| | **Total** | **29** | **32** |
| >24** | FFS | 4 | 5 |
| | MAG | 9 | 9 |
| | MOL | 7 | 8 |
| | TRU | 6 | 6 |
| | MSCAN CHIP | 1 | 2 |
| | **Total** | **27** | **30** |
| **Total (across all plans and age groups)** | | **5,874** | **6,289** |

Note: FFS = Fee-For-Service, MAG = Magnolia, MOL = Molina, TRU = TrueCare, MSCAN = Mississippi Coordinated Access Network, CHIP = Children's Health Insurance Program

CPT codes for Nirsevimab included: 90380, 90381

*The total number of members does not add to sum total of claims.

** Among the 27 members > 24 months to receive Nirsevimab, 22 had a live birth during SFY2026, indicating the claim was likely for the infant the mother gave birth to.

Clesrovimab (Enflonsia®), a second long-acting monoclonal antibody approved in 2025, is indicated for the prevention of RSV LRTD in neonates and infants who are born during or entering their first RSV season.[8] For SFY 2026, a total of 208 unique members received clesrovimab during their first RSV season. Nearly half of the infants who received clesrovimab were one month or younger at the time of administration.

| TABLE 2: Clesrovimab Utilization in Mississippi Medicaid for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | | | |
|---|---|---|---|
| **Age (in months)** | **Plan** | **Number of Members with Clesrovimab Claims*** | **Number of Claims** |
| 0-1 | FFS | 1 | 1 |
| | MAG | 46 | 47 |
| | MOL | 35 | 38 |
| | TRU | 17 | 17 |
| | MSCAN CHIP | 0 | 0 |
| | **Total** | **99** | **103** |
| 2-5 | FFS | 0 | 0 |
| | MAG | 34 | 35 |
| | MOL | 27 | 27 |
| | TRU | 4 | 4 |
| | MSCAN CHIP | 1 | 1 |
| | **Total** | **66** | **67** |
| 6-12 | FFS | 1 | 11 |
| | MAG | 20 | 21 |
| | MOL | 21 | 21 |
| | TRU | 1 | 1 |
| | MSCAN CHIP | 0 | 0 |
| | **Total** | **43** | **54** |
| **Total (across all plans and age groups)** | | **208** | **224** |

Note: FFS = Fee-For-Service, MAG = Magnolia, MOL = Molina, TRU = TrueCare, MSCAN = Mississippi Coordinated
CPT codes for Clesrovimab included: 90382
* The total number of members does not add to the sum total of claims.

**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 in individuals 18 to 59 years who are at increased risk of LRTD caused by RSV.[9] A total of 975 members received Abrysvo® during SFY 2026, up from 530 in SFY 2025. Of the 975 members who received Abrysvo®, 90% could be considered childbearing age. (Table 3)

| TABLE 3: Abrysvo® Utilization in Mississippi Medicaid for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | | | | |
|---|---|---|---|---|
| **Age (in years)** | **Plan** | **Number of Members with Abrysvo® claims*** | **Pharmacy claims for Abrysvo®** | **Medical claims for Abrysvo®** |
| <19 | FFS | 0 | 0 | 0 |
| | MAG | 27 | 3 | 27 |
| | MOL | 10 | 2 | 10 |
| | TRU | 1 | 0 | 1 |
| | **Total** | **38** | **5** | **38** |
| 19-49 | FFS | 34 | 3 | 35 |
| | MAG | 364 | 38 | 404 |
| | MOL | 334 | 42 | 352 |
| | TRU | 106 | 14 | 96 |
| | **Total** | **838** | **97** | **887** |
| ≥50 | FFS | 18 | 17 | 1 |
| | MAG | 43 | 43 | 0 |
| | MOL | 18 | 17 | 2 |
| | TRU | 20 | 20 | 0 |
| | **Total** | **99** | **97** | **3** |
| **Total (across all plans and age groups)** | | **975** | **199** | **928** |
| Note: FFS = Fee-For-Service, MAG = Magnolia, MOL = Molina, TRU= TrueCare<br>CPT codes for Abrysvo® vaccine included: 90678<br>* The total number of members does not add to the sum total of Pharmacy and Medical claims | | | | |

***Arexvy®***

Arexvy®, another RSV vaccine, is indicated for individuals aged 60 years and older and adults 18 to 59 years who are at increased risk to prevent LRTD caused by RSV.[10] A total of 110 members received Arexvy® in SFY 2026, down from 182 in SFY 2025.

| TABLE 4: Arexvy® Utilization in Mississippi Medicaid for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026) | | | | |
|---|---|---|---|---|
| **Age (in years)** | **Plan** | **Number of Members with Arexvy® claims*** | **Pharmacy claims for Arexvy®** | **Medical claims for Arexvy®** |
| <65 | FFS | 18 | 15 | 6 |
| | MAG | 45 | 42 | 5 |
| | MOL | 23 | 22 | 1 |
| | TRU | 14 | 12 | 3 |
| | **Total** | **100** | **91** | **15** |
| ≥65 | FFS | 10 | 0 | 10 |
| | MAG | 0 | 0 | 0 |
| | MOL | 0 | 0 | 0 |
| | TRU | 0 | 0 | 0 |
| | **Total** | **10** | **0** | **10** |
| **Total (across all plans and age** | | **110** | **91** | **25** |
| Note: FFS = Fee-For-Service, MAG = Magnolia, MOL = Molina, TRU = TrueCare<br>CPT codes for Arexvy® vaccine included: 90679<br>* The total number of members does not add to the sum total of Pharmacy and Medical claims | | | | |

**Proportion of infants protected from RSV by receipt of monoclonal antibodies or maternal vaccination:**

MS-DUR identified 23,984 infants with at least one month Medicaid eligibility who were born between March 2025 and March 2026 and were thus eligible to receive RSV protection during their first RSV season. Among those 23,984 infants, 5,855 were administered monoclonal antibodies (nirsevimab or clesrovimab). Additionally, 801 individuals who received Abrysvo® had a live birth between October 2025 and April 2026. Therefore, approximately 27.8% [(5855 + 801) /23,984] of eligible infants covered by Mississippi Medicaid received RSV protection by either monoclonal antibody administration or maternal vaccination during their first RSV season. The proportion of infants receiving RSV protection increased from 21.8% during the previous RSV season. For comparison, the CDC reported 65.1% of infants nationally were protected against RSV for the 2025-2026 season.

FIGURE 1: RSV Protection Among MS Medicaid Enrolled Infants for 2025-2026 RSV Season

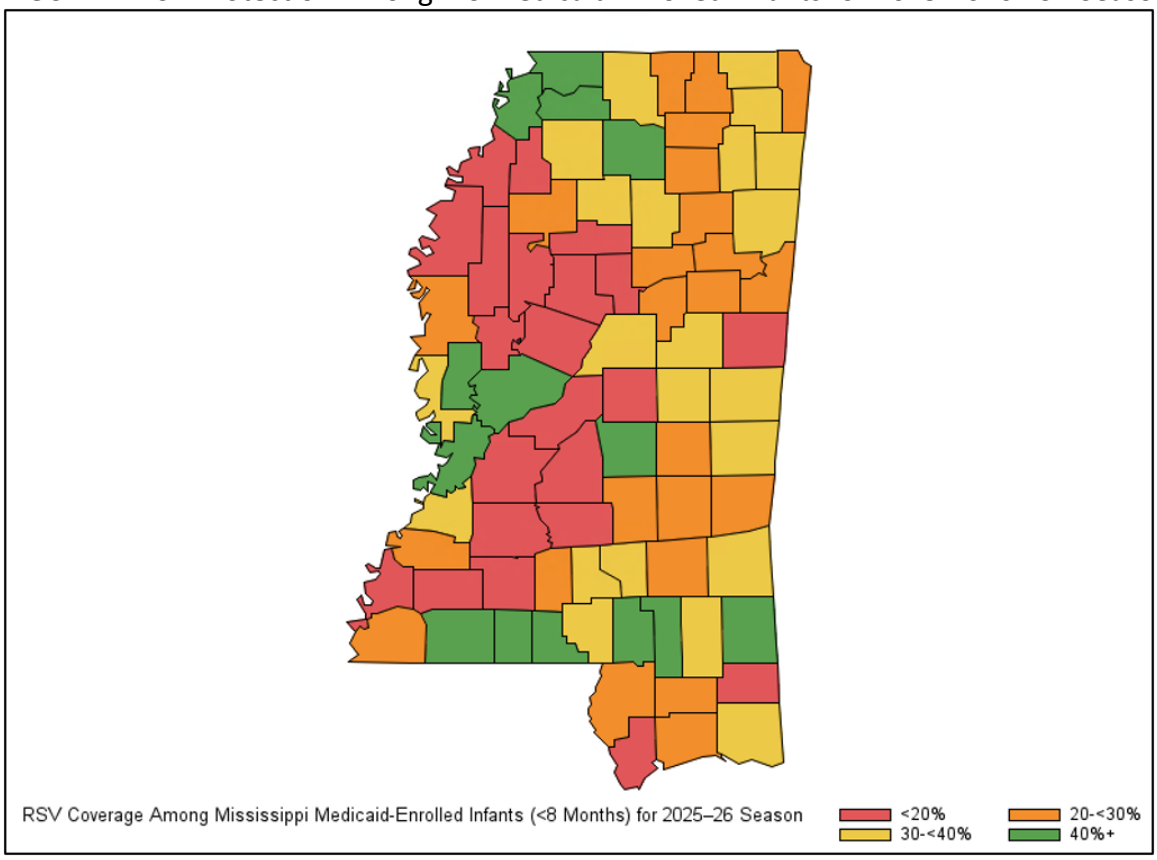


Figure 1 displays a county level map of the proportion of infants enrolled in Medicaid during the 2025-2026 RSV season who were protected against RSV by either monoclonal antibody administration or maternal vaccination during their first RSV season. The counties with the highest coverage were Amite, Desoto, Forrest, Greene, Lafayette, Lamar, Pike, Sharkey, Scott, Tate, Tunica, Walthall, Warren, Yazoo.

**CONCLUSION**

For the 2025-2026 RSV season, MS Medicaid continued to see improvements in the proportion of infants protected against RSV. During this past season, approximately 27.8% of eligible newborns received RSV protection, up from 21.8% in the 2024-2025 RSV season. While improved, these figures continue to lag behind numbers reported nationally by the CDC.

**RECOMMENDATION**

1) DOM should continue working with prescribers to improve RSV protection among infants, older adults, and immunocompromised individuals.

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# COVID-19 VACCINATION AND TREATMENT UPDATE

**BACKGROUND**

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) produced the largest infectious disease mortality event in the United States (US) in more than a century. In 2020 alone, coronavirus disease 2019 (COVID-19) was recorded as an underlying or contributing cause on approximately 375,000 death certificates and ranked as the third leading cause of death nationally.[1] Cumulative national mortality has since surpassed one million deaths, and COVID-19 continues to contribute to respiratory season hospitalization and death, with the greatest burden concentrated among older adults and persons with chronic medical conditions.[2]

Mississippi absorbed a disproportionate share of this burden. Mississippi reported the nation's highest cumulative age-adjusted mortality rate related to COVID-19 from 2020-2023.[3] Provisional state vital statistics show that mortality was concentrated among older adults and among Black residents, who accounted for a share of COVID-19 deaths substantially exceeding their share of the state population.[4] The state is predominantly rural, and the Medicaid enrolled population carries a high burden of cardiometabolic and respiratory comorbidity, both of which are established risk factors for severe COVID-19 outcomes.

Vaccines against SARS-CoV-2 became available in the final weeks of 2020. The Food and Drug Administration (FDA) issued the first emergency use authorization (EUA) on December 11, 2020, with the authorization of two additional vaccines shortly following. [5–7] Eligibility expanded progressively during the first half of 2021, first to prioritized groups defined by age, occupation, and clinical risk, and subsequently to all adults and to adolescents. Booster and additional dose recommendations followed beginning in the fall of 2021, a bivalent formulation was recommended in September 2022, and annually updated formulations have been recommended since the fall of 2023.

The vaccine uptake pattern in the US has been strongly front loaded. Primary series administration peaked during the spring of 2021 and declined sharply thereafter, and each successive booster or updated dose recommendation has achieved lower coverage than the one preceding it. Coverage has been consistently lower among Medicaid enrolled populations than among the commercially insured. The Medicaid and CHIP Payment and Access Commission has documented that adults covered by Medicaid have lower vaccination rates than adults with private insurance across nearly all recommended vaccines.[8] Geographic and regional disparities compound the insurance-related gap. Vaccination coverage with at least one dose was substantially lower in rural counties than in urban counties nationally, 58.5 percent compared with 75.4 percent through January 2022.[9] These factors point to Mississippi Medicaid members experiencing low COVID-19 vaccination coverage.

In parallel with vaccine development, a series of antiviral therapies received FDA authorization or approval. Remdesivir (Veklury®), an intravenous agent, was approved on October 22, 2020 for patients aged 12 years and older requiring hospitalization, making it the first drug approved for

the treatment of COVID-19.[10] The first oral antiviral, nirmatrelvir and ritonavir, packaged as Paxlovid®, received an EUA on December 22, 2021 for outpatients aged 12 years and older.[11] Subsequently, on May 25, 2023, the FDA granted full approval to Paxlovid® for high risk adults, with the EUA retained for patients aged 12 to 18 years.[12] Throughout the authorization period the federal government purchased and distributed COVID-19 vaccines and antivirals. The government transitioned from a fully federally funded program to commercial purchase and distribution during the fall of 2023.[13]

In June 2026, the FDA approved ensitrelvir (Xocova®) as the first oral agent indicated for post-exposure prophylaxis of COVID-19 in adults and adolescents. Ensitrelvir is a 5-day treatment that should be initiated within 72 hours following contact with an individual with COVID-19.[14,15]

The objectives of this study were to characterize the number and proportion of enrolled members who received a COVID-19 vaccine and to describe temporal trends in vaccine receipt across the study period, to characterize members who received nirmatrelvir and ritonavir (Paxlovid®), and to describe variation in vaccination and antiviral receipt by demographic, geographic, clinical, and plan characteristics.

**METHODS**

Pharmacy and medical claims from the Fee-for-Service (FFS) program and all managed care organizations (MCOs) [Magnolia Health (MAG), Molina Healthcare (MOL), TrueCare (TRU), and UnitedHealthcare (UHC)] for agents used in the prevention of COVID-19 were extracted for state fiscal years (SFYs) 2022 through 2026 (each running July 1 through June 30). Events were captured using National Drug Codes (NDC) on pharmacy claims and Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes on medical claims, thereby capturing vaccinations delivered through both pharmacy and medical claims. For each member, the earliest recorded date of vaccine receipt was designated as the index date, and the descriptive characteristics were assessed as of index date. COVID-19-related hospitalizations were identified for SFYs 2022-2026 using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 CM) codes U07.1 as the principal diagnosis for inpatient visits.

Paxlovid® (nirmatrelvir/ritonavir) utilization was identified from pharmacy claims using product-specific NDC codes. Utilization was measured by the number of members receiving these agents, the number of prescriptions filled, and the amounts paid for these claims for SFYs 2022-2026.

**RESULTS**

COVID-19 vaccination peaked in the early stages of the pandemic. In SFY 2022, there were 93,536 claims for 58,681 members. This was during the strong primary vaccination push. In the succeeding years when booster doses were recommended, vaccination numbers decreased dramatically, dropping to 1,253 claims for 1,228 members in SFY 2026. (Figure 1, Table 1) During

SFY 2022, almost 44% of claims for COVID-19 vaccines were medical claims. In contrast, all claims in SFY 2026 were pharmacy claims.

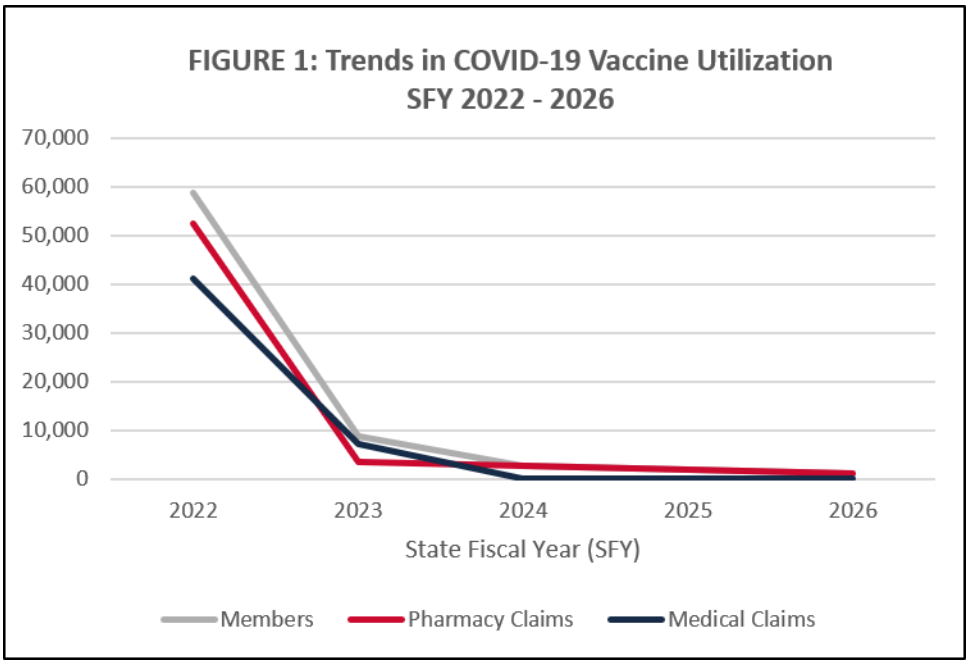


**TABLE 1: COVID-19 Vaccine Utilization Trends SFY 2022 to 2026**

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Members | 58,681 | 8,868 | 2,741 | 1,957 | 1,228 |
| Pharmacy Claims | 52,483 | 3,509 | 2,625 | 1,985 | 1,253 |
| Medical Claims | 41,053 | 7,291 | 145 | 3 | 0 |

Note: SFY = State Fiscal Year

When examining vaccination trends by demographic characteristics, some patterns can be observed. (Table 2) During the initial years of COVID-19 vaccination (SFY 2022 and 2023), younger members less than 18 years composed the largest portion of those vaccinated; but by SFY 2026, the vast majority of claims were for adults 18 years and older. Multiple factors could account for this dramatic shift, including the transition in purchasing and distribution of COVID-19 vaccines and the impacts on billing that occurred in late 2023. Females made up the majority of members receiving COVID-19 vaccines across all years. Black members consistently composed the largest racial group to receive vaccinations, but that proportion has dropped throughout the years from 62% in SFY 2022 to 48% in SFY 2026. Distribution across pharmacy plans varied slightly through the years, but members enrolled in MAG composed the largest overall group to receive COVID-19 vaccines.

| TABLE 2: COVID-19 Vaccine Utilization Trends Stratified by Demographic Characteristics SFY 2022 to 2026 | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | | **2022** | **2023** | **2024** | **2025** | **2026** |
| **≤17 years** | Members | 34,090 | 5,721 | 510 | 207 | 54 |
| | Pharmacy Claims | 31,659 | 1,614 | 380 | 207 | 54 |
| | Medical Claims | 26,181 | 5,748 | 135 | 0 | 0 |
| **≥ 18 years** | Members | 24,591 | 3,147 | 2,231 | 1,750 | 1,147 |
| | Pharmacy Claims | 20,824 | 1,895 | 2,245 | 1,778 | 1,165 |
| | Medical Claims | 14,872 | 1,543 | 10 | 3 | 0 |
| **Gender** | | **2022** | **2023** | **2024** | **2025** | **2026** |
| **Female** | Members | 34,528 | 5,137 | 1,710 | 1,199 | 687 |
| | Pharmacy Claims | 31,198 | 2,219 | 1,656 | 1,220 | 696 |
| | Medical Claims | 23,279 | 4,006 | 70 | 1 | 0 |
| **Male** | Members | 24,153 | 3,731 | 1,031 | 758 | 514 |
| | Pharmacy Claims | 21,285 | 1,290 | 969 | 765 | 523 |
| | Medical Claims | 17,774 | 3,285 | 75 | 2 | 0 |
| **Race** | | **2022** | **2023** | **2024** | **2025** | **2026** |
| **White** | Members | 12,138 | 1,467 | 679 | 459 | 284 |
| | Pharmacy Claims | 11,739 | 778 | 674 | 469 | 291 |
| | Medical Claims | 7,405 | 965 | 11 | 1 | 0 |
| **Black** | Members | 36,451 | 5,597 | 1,426 | 930 | 572 |
| | Pharmacy Claims | 33,164 | 2,087 | 1,334 | 938 | 581 |
| | Medical Claims | 25,492 | 4,744 | 107 | 2 | 0 |
| **Other** | Members | 10,092 | 1,804 | 636 | 568 | 345 |
| | Pharmacy Claims | 7,580 | 644 | 617 | 578 | 347 |
| | Medical Claims | 8,156 | 1,582 | 27 | 0 | 0 |
| **Plan** | | **2022** | **2023** | **2024** | **2025** | **2026** |
| **FFS** | Members | 13011 | 2,631 | 703 | 407 | 311 |
| | Pharmacy Claims | 9064 | 897 | 686 | 416 | 324 |
| | Medical Claims | 10,396 | 2,142 | 21 | 3 | 0 |
| **MAG** | Members | 17,694 | 2,377 | 881 | 758 | 506 |
| | Pharmacy Claims | 14,192 | 761 | 844 | 765 | 513 |
| | Medical Claims | 14,057 | 2,815 | 46 | 0 | 0 |
| **MOL** | Members | 6,527 | 931 | 248 | 201 | 213 |
| | Pharmacy Claims | 6,100 | 388 | 219 | 203 | 214 |
| | Medical Claims | 4,129 | 823 | 33 | 0 | 0 |
| **TRU** | Members | 0 | 0 | 0 | 0 | 183 |
| | Pharmacy Claims | 0 | 0 | 0 | 0 | 187 |
| | Medical Claims | 0 | 0 | 0 | 0 | 0 |
| **UHC** | Members | 17,657 | 2,392 | 831 | 552 | 1 |
| | Pharmacy Claims | 17,018 | 1,135 | 802 | 562 | 1 |
| | Medical Claims | 12,145 | 1,792 | 35 | 0 | 0 |
| **MSCAN CHIP** | Members | 3,793 | 537 | 78 | 39 | 14 |
| | Pharmacy Claims | 6,111 | 349 | 74 | 39 | 14 |
| | Medical Claims | 326 | 328 | 4 | 0 | 0 |

Notes: SFY = State Fiscal Year, FFS = Fee-For-Service, MAG = Magnolia, MOL = Molina, UHC = UnitedHealthcare, TRU = TrueCare, MSCAN = Mississippi Coordinated Access Network, CHIP = Children's Health Insurance Program

Paxlovid®, an oral antiviral, was first authorized for use in late 2021. Utilization of Paxlovid peaked in SFY 2023 with 3,946 doses dispensed. It should be noted that the paid amount dramatically increased between SFY 2023 and SFY 2024. This change was the result of changes in the purchasing and distribution of COVID-19 antivirals away from a federally funded program. The primary cost associated with Paxlovid® prior to late 2023 was the dispensing fee. (Table 3)

**TABLE 3: Utilization of Paxlovid® In Mississippi Medicaid SFY 2022 to 2026**

| Drug | Plan | Prescription Claims | Members | Paid Amount |
|---|---|---|---|---|
| **Paxlovid® 2022*** | FFS | 122 | 61 | $1,058.46 |
| | MAG | 158 | 79 | $1,569.20 |
| | MOL | 54 | 27 | $481.24 |
| | TRU | 0 | 0 | $0.00 |
| | MSCAN CHIP | 14 | 7 | $143.48 |
| | UHC | 196 | 91 | $1,701.32 |
| **Total 2022**** | | **544** | **265** | **$4,953.70** |
| **Paxlovid® 2023*** | FFS | 928 | 464 | $8,395.44 |
| | MAG | 1,082 | 533 | $11,479.70 |
| | MOL | 480 | 238 | $4,556.14 |
| | TRU | 0 | 0 | $0.00 |
| | MSCAN CHIP | 178 | 87 | $1,921.68 |
| | UHC | 1,278 | 614 | $13,074.74 |
| **Total 2023**** | | **3,946** | **1,936** | **$39,427.70** |
| **Paxlovid® 2024*** | FFS | 682 | 341 | $358,432.14 |
| | MAG | 1,086 | 538 | $487,316.98 |
| | MOL | 506 | 252 | $225,869.46 |
| | TRU | 0 | 0 | $0.00 |
| | MSCAN CHIP | 152 | 74 | $77,136.72 |
| | UHC | 1,172 | 577 | $549,145.24 |
| **Total 2024**** | | **3,598** | **1,782** | **$1,697,900.54** |
| **Paxlovid® 2025*** | FFS | 240 | 118 | $340,962.64 |
| | MAG | 794 | 392 | $1,112,604.54 |
| | MOL | 424 | 211 | $586,137.76 |
| | TRU | 0 | 0 | $0.00 |
| | MSCAN CHIP | 86 | 41 | $121,981.88 |
| | UHC | 754 | 374 | $1,061,823.64 |
| **Total 20205**** | | **2,298** | **1,136** | **$3,223,510.46** |
| **Paxlovid® 2026*** | FFS | 104 | 52 | $151,458.16 |
| | MAG | 406 | 1 | $578,887.16 |
| | MOL | 248 | 199 | $358,817.40 |
| | TRU | 164 | 119 | $239,246.22 |
| | MSCAN CHIP | 48 | 82 | $69,907.32 |
| | UHC | 2 | 24 | $2,893.20 |
| **Total 2026**** | | **972** | **477** | **$1,401,209.46** |

Note: SFY = State Fiscal Year, FFS = Fee-for Service, MAG = Magnolia, MOL = Molina, TRU = TrueCare, MSCAN = Mississippi Coordinated Access Network, CHIP = Children's Health Insurance Plan, UHC = United HealthCare

*Paxlovid® claims were identified only using pharmacy claims data.

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

**The total number of members may not equal the sum of members for each plan, since certain members may have had

COVID-19-related hospitalizations peaked in SFY 2022 at 2,483. In each subsequent year, the number of hospitalizations attributed to COVID-19 decreased substantially compared to the prior year. While hospitalizations related to COVID-19 have dramatically declined, the virus continues to impact the public, particularly those considered high-risk, such as older adults, racial and ethnic minority groups, and those with underlying medical conditions.[16]

**Table 4: COVID-19 Hospitalizations SFY 2022 to 2026**

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Hospitalizations* | 2,483 | 1,720 | 835 | 511 | 277 |

Notes: SFY = State Fiscal Year,
*COVID-19-related hospitalizations were identified using U07.1 ICD-10-CM codes as the principal diagnosis for the inpatient visit.

## CONCLUSIONS

The COVID-19 pandemic peaked in SFY 2022, causing major global disruption. Since that time, vaccination, antiviral treatment, and COVID-19-related hospitalizations have decreased substantially. COVID-19 continues to circulate and can have significant impacts on individuals, chiefly those in high-risk groups.

## RECOMMENDATIONS

MS-DUR recommends DOM work with healthcare providers and pharmacists to improve education on the continued risks associated with COVID-19 and encourage continued vaccination, particularly among those at higher risk for severe complications.

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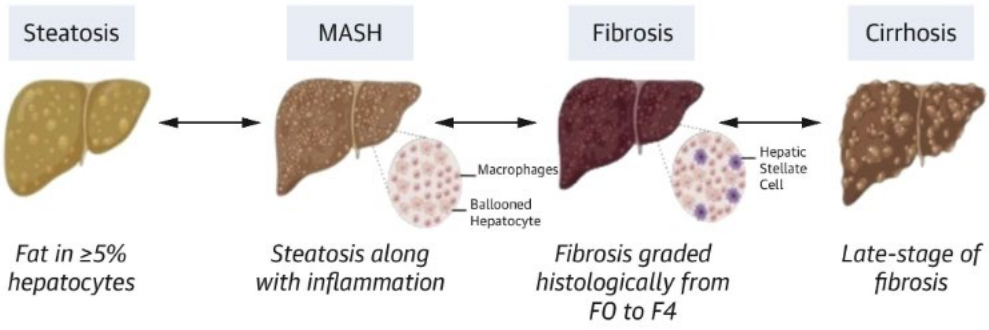
# METABOLIC DYSFUNCTION-ASSOCIATED STEATOTIC LIVER DISEASE LANDSCAPE ASSESSMENT

## BACKGROUND

Metabolic dysfunction-associated steatotic liver disease (MASLD) is defined as hepatic steatosis in the presence of at least one cardiometabolic risk factor, without another identifiable cause of steatosis. Its progressive form, metabolic dysfunction-associated steatohepatitis (MASH), is characterized by steatosis with lobular inflammation and hepatocellular ballooning. These terms were adopted in 2023 by multi-society consensus and replaced non-alcoholic fatty liver disease (NAFLD) and non-alcoholic steatohepatitis (NASH), respectively. The underlying conditions are unchanged, and nearly all patients previously classified as NAFLD meet MASLD criteria.[1]

Metabolic dysfunction-associated steatotic liver disease spans a spectrum of severity. Isolated hepatic steatosis may progress to MASH, which in turn drives hepatic fibrosis, staged F0 (none) through F1 (mild), F2 (moderate), F3 (advanced), and F4 (cirrhosis), the latter which is classified as compensated or decompensated. (Figure 1) Fibrosis stage is the principal determinant of prognosis. Relative to stages F0-F1, the risk of progression to cirrhosis is 3.7-fold higher at F2 and 18.7-fold higher at F3, and the hazard ratio of all-cause mortality reaches 14.6 with compensated cirrhosis and 33.5 with decompensated cirrhosis.[2,3] Because MASLD is typically asymptomatic until late stages, disease severity rather than diagnosis alone determines clinical and economic burden.

FIGURE 1: MASLD Disease Progression[4]




It has been estimated that in 2020, MASH affected 14.9 million adults, of whom 6.7 million had clinically significant fibrosis (≥F2). Liver-related deaths are projected to triple and liver transplants to nearly quadruple by 2050.[5] Burden concentrates in populations with obesity and type 2 diabetes, with MASLD prevalence reaching 61.4% among US adults with diabetes.[6] Diagnosed prevalence also appears higher in publicly insured populations with claims-based pediatric MASH prevalence more than three-fold higher in Medicaid than in commercially insured children.[7]

Management was limited to lifestyle modification until March 2024, when the US Food and Drug Administration (FDA) granted accelerated approval to resmetirom (Rezdiffra®) for adults with

noncirrhotic MASH and moderate to advanced fibrosis (F2-F3).[8,9] On August 15, 2025, semaglutide (Wegovy®) 2.4 mg received accelerated approval for the same population, becoming the first glucagon-like peptide-1 receptor agonist (GLP-1 RA) indicated for MASH.[10,11] Several additional agents are in the late stages of development.[12–14] Notably, both currently approved indications are restricted by fibrosis stage, making disease severity, not the MASLD diagnosis itself, the determinant of treatment eligibility and coverage.

Mississippi (MS) ranks among the states with the highest prevalence of adult obesity and type 2 diabetes, the principal drivers of MASLD; and MS Medicaid covers GLP-1 RA anti-obesity medications for members who are overweight with qualifying co-occurring conditions, including MASLD. The availability of fibrosis-restricted pharmacotherapy, together with an expanding pipeline, is expected to increase diagnosis, treatment eligibility, and expenditures within the program. However, the size, severity distribution, and resource use among the MASLD population in MS Medicaid have not been characterized.

The objectives of this project are to: 1) describe the prevalence and characteristics of Medicaid members with a diagnosis of MASLD, including distribution across the disease severity spectrum; and 2) describe healthcare resource utilization in this population.

## METHODS

A retrospective analysis was conducted using Mississippi Medicaid claims to identify Medicaid members who met eligibility criteria for metabolic dysfunction-associated steatotic liver disease (MASLD) between January 1, 2023, and June 30, 2026. Members were required to have at least two outpatient or medical claims or at least one inpatient claim to be eligible for inclusion. The date of the most recent qualifying diagnosis was defined as the index date. Members were required to have 12 months of continuous enrollment, no dual Medicare eligibility, and full pharmacy benefits coverage during the 12-month period preceding the index date. Members with evidence of toxic liver disease, alcoholic liver disease, or hepatocellular carcinoma (HCC) during the 12 months before the index date were excluded from the study.

### *MASLD*

MASLD was identified based on ICD-10 diagnosis codes K75.81, K76.0, K74.01, K74.02, K74.60, K74.69, K72.x, K76.7, P78.81, I85.x, K65.2, R18.x in any position during the identification period. To assess differences in disease severity, members were further stratified into six mutually exclusive categories based on their most recent qualifying diagnosis code: fatty liver disease, metabolic dysfunction-associated steatohepatitis (MASH), early fibrosis, advanced fibrosis, compensated cirrhosis, and decompensated cirrhosis. These categories were ranked from least severe to most severe according to the severity of the most recent diagnosis. Patients with multiple qualifying diagnosis codes on their most recent diagnosis date were categorized into the most severe applicable category.

*Baseline Characteristics*
Baseline characteristics, including demographics, clinical characteristics, medication use, all-cause healthcare utilization, and MASLD-related healthcare utilization, were assessed for members diagnosed with MASLD. Demographic characteristics were assessed as of the most recent diagnosis date, while clinical characteristics, medication use, all-cause healthcare utilization, and MASLD-related healthcare utilization were assessed during the 12-month identification period prior to the most recent diagnosis date. Clinical characteristics, including the Charlson Comorbidity Index (CCI) and individual comorbidities, were identified based on at least one diagnosis code recorded during the identification period. Medication use was identified based on at least one prescription fill during the identification period. All-cause healthcare utilization was assessed based on distinct visits and transactions. MASLD-related healthcare utilization was identified based on the principal diagnosis code recorded for each visit.

**RESULTS**

Between January 1, 2023, and December 31, 2025, 6,482 Medicaid members were identified as having an MASLD diagnosis. Overall, women were more impacted by MASLD than men, but the proportion of men increased as the disease severity increased. While MASLD diagnosis was spread across all adult age categories, the proportion of adults ages 55-64 years was higher among the more severe MASLD categories. The majority of those diagnosed with MASLD (68.3%) were categorized as having isolated hepatic steatosis, commonly referred to as fatty liver. (Table 1)

As MASLD severity increased, the comorbidity burden increased, with 64% of those diagnosed with decompensated cirrhosis having a CCI score of three or more. (Table 2) As expected, obesity and type 2 diabetes were common comorbidities. The most common comorbidity identified among the study cohort was hypertension. Hyperlipidemia, anxiety, and depression were also common comorbidities among members diagnosed with MASLD.

Medication use among those diagnosed with MASLD reflected the common comorbidities associated with MASLD. (Table 3) Nearly 63% of individuals with MASLD received antihypertensive medications. Diabetic, lipid-lowering, antidepressant, and antianxiety medications were also common among those with MASLD. Resmetirom (Rezdiffra®), the first agent specifically approved to treat MASLD, was used by 31 members, less than 0.5% of those diagnosed with MASLD; and just over 11% of those with MASLD received a GLP-1 RA.

To estimate the economic and clinical impact of MASLD, all-cause and MASLD-related healthcare utilization were examined. (Tables 4 & 5) Differences in the number of healthcare visits and healthcare costs were noted across MASLD disease severity groups. In general, as disease severity increased, healthcare visits and costs increased. While some fluctuations were noted across disease severity categories, those variations could be partially attributed to small sample sizes in some disease severity categories and delays associated with diagnosis of MASLD.

| TABLE 1: Demographic Characteristics of Medicaid Members with MASLD Diagnosis between January 1, 2023 - December 31, 2025 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Characteristics** | | **Overall (N = 6,482)** | **Disease Severity** | | | | | |
| | | | **Fatty Liver (N = 4,428)** | **MASH (N = 296)** | **Early Fibrosis (N = 21)** | **Advanced Fibrosis (N = 19)** | **Compensated Cirrhosis (N = 699)** | **Decompensated Cirrhosis (N = 1,019)** |
| **Sex** | Female | 4,400 (67.88%) | 3,187 (71.97%) | 196 (66.22%) | 16 (76.19%) | 12 (63.16%) | 399 (57.08%) | 590 (57.90%) |
| | Male | 2,082 (32.12%) | 1,241 (28.03%) | 100 (33.78%) | 5 (23.81%) | 7 (36.84%) | 300 (42.92%) | 429 (42.10%) |
| **Age (in years)** | 0-17 | 561 (8.65%) | 358 (8.08%) | 48 (16.22%) | 4 (19.05%) | 0 (0.00%) | 12 (1.72%) | 139 (13.64%) |
| | 18-34 | 1,342 (20.70%) | 1,042 (23.53%) | 60 (20.27%) | 3 (14.29%) | 0 (0.00%) | 50 (7.15%) | 187 (18.35%) |
| | 35-44 | 1,241 (19.15%) | 955 (21.57%) | 55 (18.58%) | 6 (28.57%) | 1 (5.26%) | 82 (11.73%) | 142 (13.94%) |
| | 45-54 | 1,344 (20.73%) | 898 (20.28%) | 61 (20.61%) | 4 (19.05%) | 3 (15.79%) | 184 (26.32%) | 194 (19.04%) |
| | 55-64 | 1,943 (29.98%) | 1,152 (26.02%) | 69 (23.31%) | 3 (14.29%) | 15 (78.95%) | 359 (51.36%) | 345 (33.86%) |
| | ≥ 65 | 51 (0.79%) | 23 (0.52%) | 3 (1.01%) | 1 (4.76%) | 0 (0.00%) | 12 (1.72%) | 12 (1.18%) |
| **Race** | White | 2,650 (40.88%) | 1,912 (43.18%) | 152 (51.35%) | 10 (47.62%) | 4 (21.05%) | 287 (41.06%) | 285 (27.97%) |
| | Black | 2,028 (31.29%) | 1,357 (30.65%) | 66 (22.30%) | 6 (28.57%) | 8 (42.11%) | 167 (23.89%) | 424 (41.61%) |
| | Other/Unknown | 1,804 (27.83%) | 1,159 (26.17%) | 78 (26.35%) | 5 (23.81%) | 7 (36.84%) | 245 (35.05%) | 310 (30.42%) |
| **Plan** | FFS | 1,369 (21.12%) | 836 (18.88%) | 50 (16.89%) | 4 (19.05%) | 2 (10.53%) | 200 (28.61%) | 277 (27.18%) |
| | UHC | 1,022 (15.77%) | 714 (16.12%) | 33 (11.15%) | 5 (23.81%) | 1 (5.26%) | 93 (13.30%) | 176 (17.27%) |
| | MAG | 2,480 (38.26%) | 1,759 (39.72%) | 123 (41.55%) | 7 (33.33%) | 9 (47.37%) | 234 (33.48%) | 348 (34.15%) |
| | MOL | 1,135 (17.51%) | 783 (17.68%) | 59 (19.93%) | 3 (14.29%) | 3 (15.79%) | 119 (17.02%) | 168 (16.49%) |
| | TRU | 476 (7.34%) | 336 (7.59%) | 31 (10.47%) | 2 (9.52%) | 4 (21.05%) | 53 (7.58%) | 50 (4.91%) |
| **Enrolled in June 2026** | | **4544 (70.10%)** | **3272 (73.89%)** | **227 (76.69%)** | **17 (80.95%)** | **17 (89.47%)** | **473 (67.67%)** | **538 (52.80%)** |

***Notes:*** *FFS = Fee-for-service; UHC = UnitedHealthcare; MAG= Magnolia Health; MOL = Molina Healthcare; TRU = TrueCare; MASLD = Metabolic Dysfunction-Associated Steatotic Liver Disease; MASH = Metabolic Dysfunction Associated Steatohepatitis*

*1. MASLD status was identified based on ≥2 outpatient/medical claims or ≥1 inpatient claim with a qualifying diagnosis code between 2023 and 2025.*

*2. Disease severity was based on the most recent MASLD diagnosis code, ranging from fatty liver disease as the least severe to decompensated cirrhosis as the most severe.*

*3. Demographic characteristics were assessed during the 12-month period preceding the most recent diagnosis code.*

**TABLE 2: Clinical Characteristics of Medicaid Members with MASLD Diagnosis between January 1, 2023 - December 31, 2025**

| Characteristics | | Overall (N = 6,482) | Disease Severity | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Fatty Liver (N = 4,428) | MASH (N = 296) | Early Fibrosis (N = 21) | Advanced Fibrosis (N = 19) | Compensated Cirrhosis (N = 699) | Decompensated Cirrhosis (N = 1,019) |
| **CCI Category** | 0 | 1,761 (27.17%) | 1,378 (31.12%) | 96 (32.43%) | 7 (33.33%) | 2 (10.53%) | 111 (15.88%) | 167 (16.39%) |
| | 1 - 2 | 2,040 (31.47%) | 1,527 (34.49%) | 101 (34.12%) | 8 (38.10%) | 8 (42.11%) | 197 (28.18%) | 199 (19.53%) |
| | ≥ 3 | 2,681 (41.36%) | 1,523 (34.39%) | 99 (33.45%) | 6 (28.57%) | 9 (47.37%) | 391 (55.94%) | 653 (64.08%) |
| **Baseline Comorbidities** | Obesity | 3,899 (60.15%) | 2,984 (67.39%) | 232 (78.38%) | 12 (57.14%) | 7 (36.84%) | 315 (45.06%) | 349 (34.25%) |
| | Overweight | 312 (4.81%) | 229 (5.17%) | 15 (5.07%) | 1 (4.76%) | 0 (0.00%) | 30 (4.29%) | 37 (3.63%) |
| | Type 2 Diabetes | 2,667 (41.14%) | 1,810 (40.88%) | 139 (46.96%) | 6 (28.57%) | 7 (36.84%) | 328 (46.92%) | 377 (37.00%) |
| | Type 1 Diabetes | 262 (4.04%) | 169 (3.82%) | 8 (2.70%) | 0 (0.00%) | 1 (5.26%) | 26 (3.72%) | 58 (5.69%) |
| | Hyperlipidemia | 3,271 (50.46%) | 2,260 (51.04%) | 188 (63.51%) | 11 (52.38%) | 14 (73.68%) | 373 (53.36%) | 425 (41.71%) |
| | Hypertension | 4,528 (69.85%) | 2,991 (67.55%) | 206 (69.59%) | 15 (71.43%) | 17 (89.47%) | 569 (81.40%) | 730 (71.64%) |
| | ASCVD | 1,445 (22.29%) | 769 (17.37%) | 55 (18.58%) | 3 (14.29%) | 7 (36.84%) | 252 (36.05%) | 359 (35.23%) |
| | Heart Failure | 1,198 (18.48%) | 527 (11.90%) | 32 (10.81%) | 3 (14.29%) | 5 (26.32%) | 204 (29.18%) | 427 (41.90%) |
| | Chronic Kidney Disease | 1,180 (18.20%) | 553 (12.49%) | 44 (14.86%) | 2 (9.52%) | 6 (31.58%) | 187 (26.75%) | 388 (38.08%) |
| | Acute Kidney Injury | 1,049 (16.18%) | 401 (9.06%) | 23 (7.77%) | 1 (4.76%) | 3 (15.79%) | 173 (24.75%) | 448 (43.96%) |
| | End-Stage Renal Disease | 274 (4.23%) | 62 (1.40%) | 4 (1.35%) | 1 (4.76%) | 0 (0.00%) | 48 (6.87%) | 159 (15.60%) |
| | Depression | 2,733 (42.16%) | 1,887 (42.62%) | 129 (43.58%) | 7 (33.33%) | 8 (42.11%) | 307 (43.92%) | 395 (38.76%) |
| | Anxiety | 2,933 (45.25%) | 2,068 (46.70%) | 143 (48.31%) | 13 (61.90%) | 8 (42.11%) | 312 (44.64%) | 389 (38.17%) |
| | Sleep Apnea | 1,259 (19.42%) | 916 (20.69%) | 86 (29.05%) | 4 (19.05%) | 4 (21.05%) | 120 (17.17%) | 129 (12.66%) |
| | Alcohol Use Disorder | 706 (10.89%) | 401 (9.06%) | 15 (5.07%) | 2 (9.52%) | 3 (15.79%) | 149 (21.32%) | 136 (13.35%) |
| | Hepatitis | 453 (6.99%) | 184 (4.16%) | 9 (3.04%) | 1 (4.76%) | 6 (31.58%) | 177 (25.32%) | 76 (7.46%) |
| | PMOS | 160 (2.47%) | 140 (3.16%) | 12 (4.05%) | 0 (0.00%) | 0 (0.00%) | 3 (0.43%) | 5 (0.49%) |
| | Smoking | 2,381 (36.73%) | 1,498 (33.83%) | 76 (25.68%) | 7 (33.33%) | 9 (47.37%) | 353 (50.50%) | 438 (42.98%) |
| | Liver Transplant | 7 (0.11%) | 2 (0.05%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 2 (0.29%) | 3 (0.29%) |

*Note: MASLD = Metabolic Dysfunction-Associated Steatotic Liver Disease; CCI = Charlson Comorbidity Index; ASCVD = Atherosclerotic Cardiovascular Disease; PMOS = Polyendocrine Metabolic Ovarian Syndrome; MASH = Metabolic Dysfunction-Associated Steatohepatitis*

*1. Clinical characteristics were assessed during the 12-month period preceding the most recent MASLD diagnosis code.*

| Characteristics | | Overall (N = 6,482) | Disease Severity | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Fatty Liver (N = 4,428) | MASH (N = 296) | Early Fibrosis (N = 21) | Advanced Fibrosis (N = 19) | Compensated Cirrhosis (N = 699) | Decompensated Cirrhosis (N = 1,019) |
| **Antihypertensive Medications/ Cardio-related Medication** | **Total** | 4,063 (62.68%) | 2,707 (61.13%) | 195 (65.88%) | 10 (47.62%) | 14 (73.68%) | 497 (71.10%) | 640 (62.81%) |
| | RASI | 1,760 (27.15%) | 1,155 (26.08%) | 81 (27.36%) | 5 (23.81%) | 9 (47.37%) | 211 (30.19%) | 299 (29.34%) |
| | Beta Blocker | 197 (3.04%) | 149 (3.36%) | 11 (3.72%) | 0 (0.00%) | 0 (0.00%) | 24 (3.43%) | 13 (1.28%) |
| | CCB | 1,394 (21.51%) | 928 (20.96%) | 55 (18.58%) | 4 (19.05%) | 5 (26.32%) | 157 (22.46%) | 245 (24.04%) |
| | MRA | 5 (0.08%) | 2 (0.05%) | 2 (0.68%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 1 (0.10%) |
| | Diuretics | 1,666 (25.70%) | 953 (21.52%) | 71 (23.99%) | 2 (9.52%) | 8 (42.11%) | 253 (36.19%) | 379 (37.19%) |
| | Antiadrenergic | 411 (6.34%) | 278 (6.28%) | 26 (8.78%) | 0 (0.00%) | 0 (0.00%) | 37 (5.29%) | 70 (6.87%) |
| | Vasodilators | 351 (5.41%) | 172 (3.88%) | 8 (2.70%) | 0 (0.00%) | 2 (10.53%) | 51 (7.30%) | 118 (11.58%) |
| | HTN Combination Therapy[1] | 702 (10.83%) | 553 (12.49%) | 31 (10.47%) | 2 (9.52%) | 2 (10.53%) | 67 (9.59%) | 47 (4.61%) |
| **Lipid-Lowering Medications** | **Total** | 2,162 (33.35%) | 1,540 (34.78%) | 126 (42.57%) | 5 (23.81%) | 10 (52.63%) | 228 (32.62%) | 253 (24.83%) |
| | Statins | 1,957 (30.19%) | 1,381 (31.19%) | 112 (37.84%) | 5 (23.81%) | 10 (52.63%) | 210 (30.04%) | 239 (23.45%) |
| | PCSK9 Inhibitors | 34 (0.52%) | 25 (0.56%) | 3 (1.01%) | 0 (0.00%) | 0 (0.00%) | 4 (0.57%) | 2 (0.20%) |
| | Bile Acid Sequestrants | 86 (1.33%) | 60 (1.36%) | 5 (1.69%) | 0 (0.00%) | 0 (0.00%) | 11 (1.57%) | 10 (0.98%) |
| | Cholesterol Absorption Inhibitors | 195 (3.01%) | 148 (3.34%) | 13 (4.39%) | 1 (4.76%) | 0 (0.00%) | 19 (2.72%) | 14 (1.37%) |
| | Fibrate | 175 (2.70%) | 143 (3.23%) | 13 (4.39%) | 0 (0.00%) | 0 (0.00%) | 12 (1.72%) | 7 (0.69%) |
| | Other Lipid-Lowering Medication[2] | 6 (0.09%) | 5 (0.11%) | 1 (0.34%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) | 0 (0.00%) |
| | Lipid Combination Therapy[3] | 4 (0.06%) | 2 (0.05%) | 1 (0.34%) | 0 (0.00%) | 0 (0.00%) | 1 (0.14%) | 0 (0.00%) |
| **Diabetes Medications** | **Total** | 2,261 (34.88%) | 1,608 (36.31%) | 131 (44.26%) | 5 (23.81%) | 6 (31.58%) | 245 (35.05%) | 266 (26.10%) |
| | GLP-1 RA | 719 (11.09%) | 563 (12.71%) | 57 (19.26%) | 0 (0.00%) | 1 (5.26%) | 61 (8.73%) | 37 (3.63%) |
| | SGLT2 Inhibitor | 778 (12.00%) | 486 (10.98%) | 49 (16.55%) | 1 (4.76%) | 4 (21.05%) | 104 (14.88%) | 134 (13.15%) |
| | Antidiabetic Combination[4] | 99 (1.53%) | 77 (1.74%) | 8 (2.70%) | 0 (0.00%) | 0 (0.00%) | 6 (0.86%) | 8 (0.79%) |
| | Metformin | 1,148 (17.71%) | 890 (20.10%) | 79 (26.69%) | 3 (14.29%) | 0 (0.00%) | 103 (14.74%) | 73 (7.16%) |
| | DPP4i | 135 (2.08%) | 102 (2.30%) | 3 (1.01%) | 0 (0.00%) | 0 (0.00%) | 14 (2.00%) | 16 (1.57%) |
| | Insulin | 927 (14.30%) | 616 (13.91%) | 55 (18.58%) | 1 (4.76%) | 4 (21.05%) | 116 (16.60%) | 135 (13.25%) |
| | Sulfonylurea | 350 (5.40%) | 252 (5.69%) | 17 (5.74%) | 0 (0.00%) | 1 (5.26%) | 41 (5.87%) | 39 (3.83%) |
| | TZD | 71 (1.10%) | 55 (1.24%) | 5 (1.69%) | 0 (0.00%) | 0 (0.00%) | 6 (0.86%) | 5 (0.49%) |
| | Other Antidiabetic Medication[5] | 9 (0.14%) | 6 (0.14%) | 1 (0.34%) | 0 (0.00%) | 0 (0.00%) | 1 (0.14%) | 1 (0.10%) |
| **Other Medications** | Anti-obesity Medication[6] | 461 (7.11%) | 367 (8.29%) | 59 (19.93%) | 3 (14.29%) | 0 (0.00%) | 22 (3.15%) | 10 (0.98%) |
| | Anxiolytics, Sedatives, and Hypnotics[7] | 1,891 (29.17%) | 1,367 (30.87%) | 89 (30.07%) | 9 (42.86%) | 6 (31.58%) | 198 (28.33%) | 222 (21.79%) |
| | Antidepressant[8] | 2,886 (44.52%) | 2,102 (47.47%) | 138 (46.62%) | 7 (33.33%) | 7 (36.84%) | 313 (44.78%) | 319 (31.31%) |
| | **Rezdiffra®** | **31 (0.48%)** | **15 (0.34%)** | **12 (4.05%)** | **2 (9.52%)** | **2 (10.53%)** | **0 (0.00%)** | **0 (0.00%)** |

***Notes:*** *MASLD: Metabolic Dysfunction-Associated Steatotic Liver Disease; MASH : Metabolic Dysfunction Associated Steatohepatitis; RASI = Renin-Angiotensin System Inhibitors ; CCB = Calcium Channel Blockers; MRA = Mineralocorticoid Receptor Antagonists ; HTN = Hypertension; PCSK9 = Proprotein Convertase Subtilisin/Kexin Type 9; GLP-1 RA = Glucagon-like Peptide 1 Receptor Agonist; SGLT2 = Sodium-glucose Cotransporter 2; DPP4i = Dipeptidyl Peptidase 4 Inhibitors; TZD = Thiazolidinediones;*

** Medication use was assessed during the 12-month period preceding the most recent MASLD diagnosis code.*

*1. HTN Combination Therapy: amiloride-hydrochlorothiazide, amlodipine-benazepril, amlodipine-olmesartan, amlodipine-valsartan, amlodipine/hydrochlorothiazide/valsartan, atenolol-chlorthalidone, benazepril-hydrochlorothiazide, bisoprolol-hydrochlorothiazide, enalapril-hydrochlorothiazide, hydralazine-isosorbide dinitrate, hydrochlorothiazide-irbesartan, hydrochlorothiazide-lisinopril, hydrochlorothiazide-losartan, hydrochlorothiazide-metoprolol, hydrochlorothiazide-olmesartan, hydrochlorothiazide-spironolactone, hydrochlorothiazide-telmisartan, hydrochlorothiazide-triamterene, hydrochlorothiazide-valsartan.*

*2. Lipid Combination Therapy: bempedoic acid-ezetimibe, ezetimibe-simvastatin.*

*3. Other Lipid-Lowering Medication: icosapent, niacin.*

*4. Antidiabetic Combination:canagliflozin-metformin, dapagliflozin-metformin, empagliflozin-metformin, empagliflozin/linagliptin/metformin, glipizide-metformin, glyburide-metformin, insulin degludec-liraglutide, insulin glargine-lixisenatide, metformin-pioglitazone, metformin-sitagliptin.*

*5. Other Antidiabetic Medication: acarbose, bromocriptine, nateglinide, repaglinide.*

*6. Antiobesity Medication: liraglutide, semaglutide, tirzepatide.*

*7. Anxiolytics, Sedatives, and Hypnotics: alprazolam, buspirone, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, diphenhydramine, doxepin, eszopiclone, hydroxyzine, lemborexant, lorazepam, melatonin, midazolam, oxazepam, phenobarbital, ramelteon, suvorexant, temazepam, zaleplon, zolpidem.*

*8. Antidepressant: amitriptyline, bupropion, citalopram, desvenlafaxine, doxepin, duloxetine, escitalopram, fluoxetine, fluvoxamine, imipramine, levomilnacipran, milnacipran, mirtazapine, nortriptyline, paroxetine, sertraline, st. john's wort, trazodone, venlafaxine, vilazodone, vortioxetine.*

**TABLE 4: All-Cause Healthcare Utilization Among Medicaid Members with MASLD Diagnosis between January 1, 2023 - December 31, 2025**

| | | Overall (N = 6,482) | Disease Severity | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Fatty Liver (N = 4,428) | MASH (N = 296) | Early Fibrosis (N = 21) | Advanced Fibrosis (N = 19) | Compensated Cirrhosis (N = 699) | Decompensated Cirrhosis (N = 1,019) |
| **All-Cause Healthcare Visits (Mean, SD)** | Outpatient/medical visit | 41.00 (41.88) | 36.55 (37.87) | 37.56 (36.88) | 35.90 (23.10) | 42.37 (34.56) | 42.95 (42.18) | 60.11 (53.14) |
| | Inpatient visits | 1.67 (5.62) | 0.93 (3.98) | 1.15 (5.92) | 2.38 (8.07) | 0.37 (1.21) | 2.92 (8.09) | 4.18 (8.12) |
| | ER visits | 0.70 (1.56) | 0.39 (1.07) | 0.34 (1.13) | 0.24 (0.70) | 0.32 (1.00) | 0.91 (1.53) | 2.02 (2.53) |
| | Length of stay, days | 14.00 (46.39) | 7.28 (35.18) | 8.54 (43.36) | 22.05 (73.10) | 2.11 (6.34) | 25.61 (67.43) | 36.88 (61.02) |
| **All-Cause Healthcare Visits (Median, IQR)** | Outpatient/medical visit | 28 (16 - 51) | 26 (15 - 44) | 26 (16.5 - 45) | 28 (20 - 55) | 29 (19 - 47) | 29 (16 - 56) | 45 (22 - 77) |
| | Inpatient visits | 0 (0 - 1) | 0 (0 - 1) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 1 (0 - 2) | 2 (1 - 4) |
| | ER visits | 0 (0 - 1) | 0 (0 - 1) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 1) | 1 (1 - 3) |
| | Length of stay, days | 0 (0 - 6) | 0 (0 - 2) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 2 (0 - 14) | 14 (4 - 40) |
| **All-Cause Healthcare Costs (Mean, SD)** | All-cost | $46,137.00 ($76,622.65) | $34,672.48 ($51,020.12) | $48,896.61 ($102,882.74) | $80,967.52 ($148,694.92) | $39,491.96 ($34,689.26) | $53,133.80 ($62,378.28) | $89,760.23 ($131,636.81) |
| | Inpatient cost | $10,704.01 ($40,022.80) | $4,950.66 ($16,621.01) | $5,643.87 ($21,568.73) | $13,294.08 ($32,437.27) | $2,013.43 ($6,426.87) | $14,220.75 ($26,552.36) | $34,870.98 ($87,239.85) |
| | Pharmacy cost | $18,323.15 ($46,694.34) | $16,460.13 ($37,158.85) | $30,941.56 ($94,297.37) | $56,823.65 ($144,836.30) | $20,902.39 ($26,620.29) | $20,648.54 ($40,763.69) | $20,316.74 ($60,298.31) |
| | ER cost | $5,245.18 ($15,845.24) | $2,387.74 ($8,139.66) | $2,648.68 ($12,117.53) | $6,407.28 ($20,639.60) | $2,013.43 ($6,426.87) | $6,072.70 ($12,422.13) | $17,884.86 ($30,899.24) |
| | Outpatient/medical cost | $17,109.83 ($29,832.60) | $13,261.69 ($22,135.40) | $12,311.19 ($21,725.72) | $10,849.79 ($8,899.56) | $16,576.14 ($15,705.93) | $18,264.51 ($24,345.88) | $34,572.51 ($51,069.03) |
| **All-Cause Healthcare Costs (Median, IQR)** | All-cost | $22,710.27 ($9,870.69 - $52,516.93) | $18,848.37 ($8,263.33 - $39,655.10) | $21,285.36 ($9,417.59 - $45,084.83) | $23,515.51 ($12,119.28 - $97,995.37) | $27,535.21 ($15,817.80 - $60,277.86) | $31,202.04 ($14,635.29 - $69,500.85) | $53,312.93 ($23,277.71 - $112,074.57) |
| | Inpatient cost | $0.00 ($0.00 - $7,079.48) | $0.00 ($0.00 - $1,169.38) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $14,302.61) | $14,639.59 ($3,974.30 - $40,445.77) |
| | Pharmacy cost | $6,928.82 ($1,693.71 - $17,928.04) | $6,794.78 ($1,652.20 - $17,196.51) | $10,667.73 ($3,090.05 - $23,724.99) | $8,393.91 ($2,180.03 - $30,773.99) | $11,423.97 ($3,418.08 - $27,215.07) | $8,542.45 ($2,262.74 - $22,411.27) | $5,527.32 ($1,300.36 - $16,325.89) |
| | ER cost | $0.00 ($0.00 - $3,777.99) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $7,284.28) | $8,004.88 ($0.00 - $22,190.38) |
| | Outpatient/medical cost | $8,200.12 ($3,782.55 - $18,328.37) | $7,014.62 ($3,400.04 - $14,694.14) | $6,456.74 ($3,254.70 - $12,515.89) | $10,741.53 ($3,377.02 - $14,899.07) | $11,468.75 ($4,297.72 - $28,114.73) | $9,243.58 ($3,934.81 - $22,068.49) | $19,202.81 ($8,208.46 - $41,661.34) |

*Note: MASLD = Metabolic Dysfunction-Associated Steatotic Liver Disease; MASH = Metabolic Dysfunction-Associated Steatohepatitis; IQR - Interquartile Range; SD - Standard Deviation*

*1. All-cause healthcare utilization was assessed during the 12-month period preceding the most recent MASLD diagnosis code*

**TABLE 5: MALSD-Related Healthcare Utilization Among Medicaid Members with MASLD Diagnosis between January 1, 2023 - December 31, 2025**

| Characteristics | | Overall (N = 6,482) | Disease Severity | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Fatty Liver (N = 4,428) | MASH (N = 296) | Early Fibrosis (N = 21) | Advanced Fibrosis (N = 19) | Compensated Cirrhosis (N = 699) | Decompensated Cirrhosis (N = 1,019) |
| **Healthcare Utilization (Mean, SD)** | Outpatient/medical visits | 1.43 (3.33) | 1.04 (1.47) | 1.59 (1.76) | 1.90 (1.09) | 2.21 (1.75) | 2.61 (6.32) | 2.27 (5.51) |
| | Inpatient visits | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| | ER visits | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| | Length of stay, days | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| **Healthcare Utilization (Median, IQR)** | Outpatient/medical visits | 1 (0 - 2) | 1 (0 - 2) | 1 (0 - 2) | 2 (1 - 2) | 2 (1 - 3) | 1 (0 - 3) | 1 (0 - 2) |
| | Inpatient visits | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) |
| | ER visits | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) |
| | Length of stay, days | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) | 0 (0 - 0) |
| **Healthcare Costs (Mean, SD)** | All-cost | $308.27 ($2,545.69) | $113.43 ($701.20) | $256.70 ($515.59) | $282.01 ($575.25) | $466.44 ($732.38) | $1,021.44 ($6,136.46) | $678.30 ($3,543.24) |
| | Inpatient cost | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) |
| | ER cost | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) | $0.00 ($0.00) |
| | Outpatient/medical cost | $308.27 ($2,545.69) | $113.43 ($701.20) | $256.70 ($515.59) | $282.01 ($575.25) | $466.44 ($732.38) | $1,021.44 ($6,136.46) | $678.30 ($3,543.24) |
| **Healthcare Costs (Median, IQR)** | All-cost | $24.72 ($0.00 - $149.46) | $23.06 ($0.00 - $117.32) | $93.83 ($0.00 - $252.80) | $114.19 ($25.64 - $195.15) | $148.08 ($0.00 - $533.20) | $78.90 ($0.00 - $387.16) | $48.60 ($0.00 - $207.28) |
| | Inpatient cost | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) |
| | ER cost | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) | $0.00 ($0.00 - $0.00) |
| | Outpatient/medical cost | $24.72 ($0.00 - $149.46) | $23.06 ($0.00 - $117.32) | $93.83 ($0.00 - $252.80) | $114.19 ($25.64 - $195.15) | $148.08 ($0.00 - $533.20) | $78.90 ($0.00 - $387.16) | $48.60 ($0.00 - $207.28) |

*Note: MASLD = Metabolic Dysfunction-Associated Steatotic Liver Disease; MASH = Metabolic Dysfunction-Associated Steatohepatitis; IQR = Interquartile Range; SD = Standard Deviation*
*1. MASLD-related healthcare utilization was assessed during the 12-month period preceding the most recent MASLD diagnosis code*

## CONCLUSIONS

These findings demonstrate that MASLD represents a substantial clinical and economic burden among Mississippi Medicaid members. Increasing disease severity was associated with greater comorbidity burden, healthcare utilization, and costs, highlighting the potential value of early identification and intervention. Despite the availability of resmetirom and growing use of GLP-1 receptor agonists, utilization of these therapies remained limited during the study period. These results underscore the importance of strategies to promote early diagnosis, address modifiable risk factors, and optimize treatment to potentially reduce progression to more severe disease and its associated healthcare burden.

## RECOMMENDATIONS

This report is for information and discussion purposes only. No formal action is being sought at this time.

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# *MINI REPORT*
# TRENDS IN CLAIMS FOR DIABETIC SUPPLIES

## BACKGROUND

Mississippi Medicaid covers a range of diabetic equipment and supplies to support glucose monitoring and diabetes management. Covered supplies include blood glucose meters and test strips, continuous glucose monitors (CGMs) and components, disposable insulin pumps and components, insulin pen needles, and syringes.[1] Effective July 1, 2024, the State Plan Amendment (SPA) 24-0014 expanded the avenues through which certain diabetic supplies could be reimbursed, allowing eligible supplies to be billed through pharmacy claims in addition to the existing medical claims submitted by qualified durable medical equipment (DME) providers.[2] Prior to this SPA, only members in Medicaid managed care organizations (MCOs) were eligible to obtain diabetic supplies through either a DME provider or a pharmacy. Beginning January 1, 2027, Mississippi Medicaid plans to shift coverage of most diabetic supplies to the pharmacy venue only.

This preliminary analysis aimed to characterize monthly utilization patterns of six types of diabetic supplies among Mississippi (MS) Medicaid members from January 2023 through December 2025.

## METHODS

### Study Design and Data Source

This observational study utilized Mississippi Medicaid administrative claims data from January 2023 through December 2025. The data included claims from both the Fee-for-Service (FFS) program and all participating MCOs, including Magnolia Health (MAG), Molina Healthcare (MOL), TrueCare (TRU), and UnitedHealthcare (UHC).

### Study Population and Diabetes Supply Utilization

The study population included Mississippi Medicaid members with at least one claim for any of the six diabetic supply categories during the study period. The supplies examined were: (1) blood glucose meters, (2) blood glucose test strips, (3) CGMs, (4) disposable insulin pumps, (5) insulin pen needles, and (6) insulin syringes.

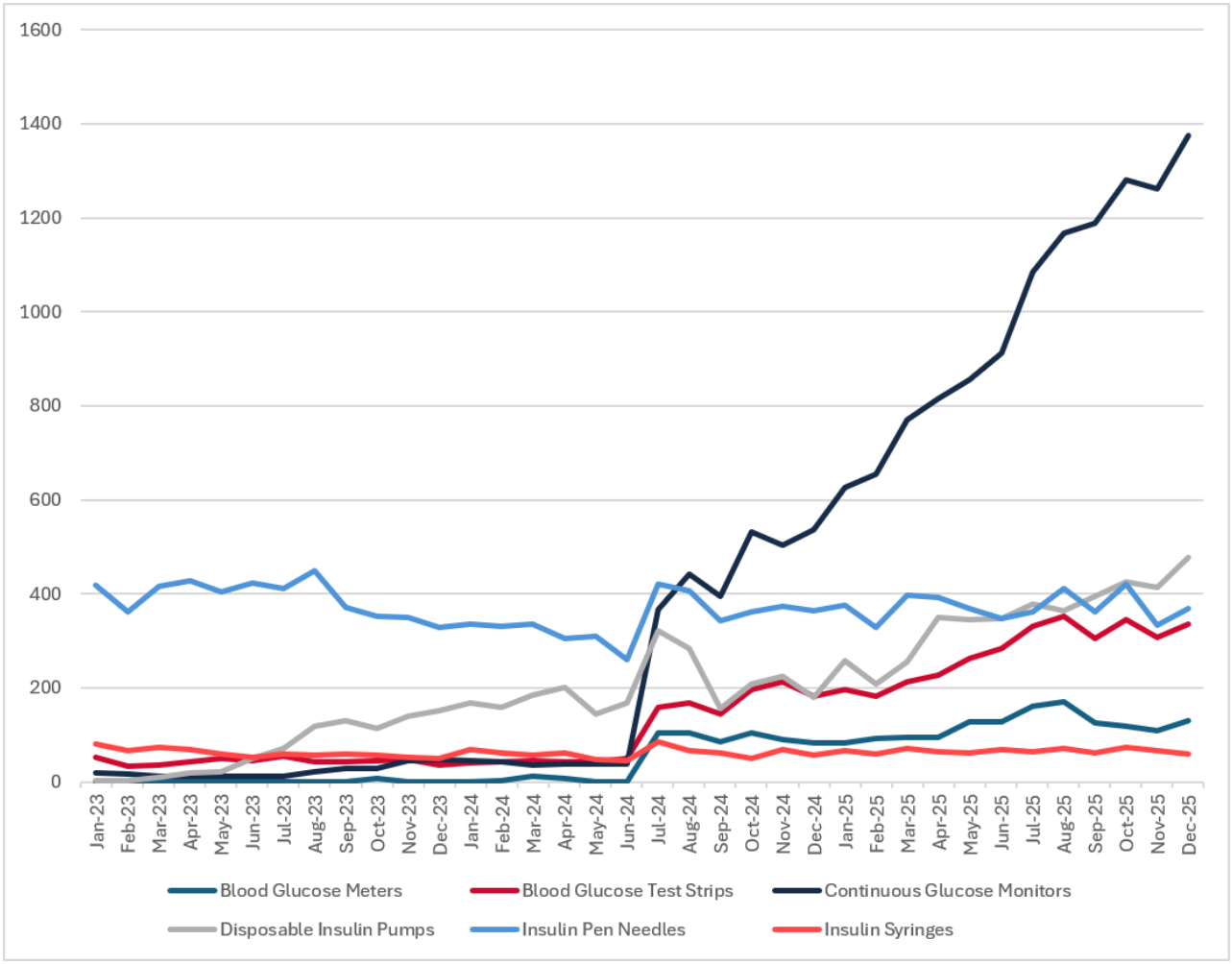
Diabetic supply utilization was assessed separately using medical claims and pharmacy point-of-sale (POS) claims. For each supply category, utilization within each claims setting was evaluated on a monthly basis from January 2023 through December 2025. Medical and pharmacy claims were analyzed independently and were not combined.

**RESULTS**

On average, just over 10,000 claims for diabetic supplies were filled monthly between January 1, 2023 and December 31, 2025 across both pharmacy and medical claims. Since the SPA allowing claims for diabetic supplies to be processed through pharmacy and medical claims in all programs (FFS and MCOs), the average number of monthly claims has decreased approximately 6.7%.

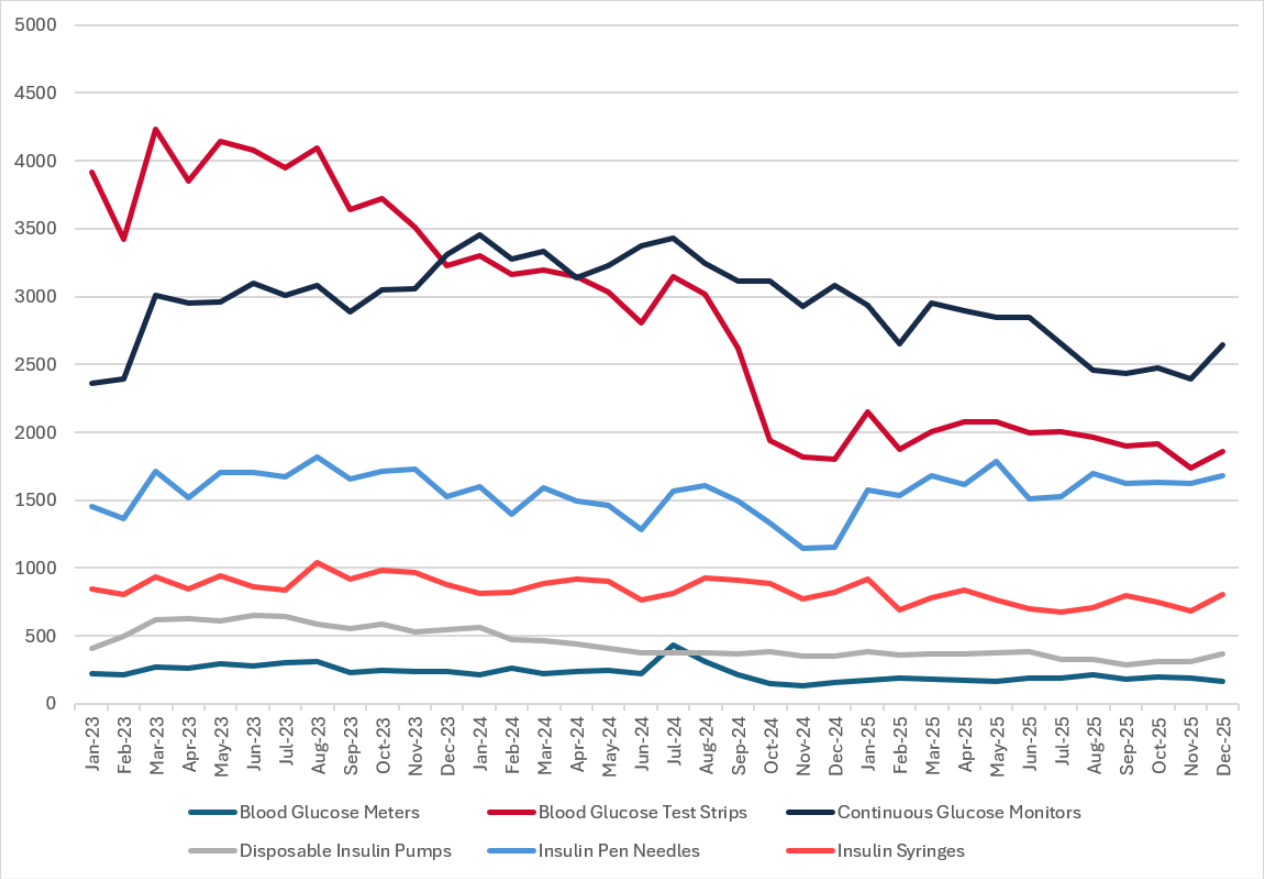
Prior to the coverage change that occurred in July 2024, monthly pharmacy claims for diabetic supplies averaged 602. Since the change in coverage, average monthly pharmacy claims have risen to 1,925. This increase was driven largely by the increase in pharmacy claims for CGMs, which jumped from an average of 28 prior to the change to over 1,300 in December of 2025. (Figure 1)

***FIGURE 1: Monthly Pharmacy POS Claims for Diabetic Supplies (2023-2025)***



While pharmacy claims have risen substantially, medical claims decreased slightly over 20% from an average of 9,883 claims monthly before the coverage change to 7,838 after the change. Blood glucose test strips saw the largest decrease in monthly claims between 2023 and 2025. (Figure 2)

***FIGURE 2: Monthly Medical Claims for Diabetic Supplies (2023-2025)***



## CONCLUSION

The findings demonstrate a clear shift in Mississippi Medicaid diabetic supply utilization following the July 2024 SPA. Although overall monthly diabetic supply claims declined modestly, pharmacy utilization more than tripled, driven primarily by increased access to CGMs through the pharmacy benefit. At the same time, medical claims for diabetic supplies declined by approximately 20%, suggesting a gradual transition from the DME venue to the pharmacy venue. These trends provide important baseline information for Mississippi Medicaid as it prepares to transition most diabetic supply coverage exclusively to the pharmacy benefit beginning January 1, 2027. Provider communication and continued monitoring of utilization, member access, and changes in product mix will be important following implementation to assess the impact of this transition.

## RECOMMENDATION

MS-DUR recommends DOM distribute communication of the upcoming diabetic supply coverage changes to prescribers, pharmacies, DME providers, and members, as appropriate.

## REFERENCES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## FDA DRUG SAFETY COMMUNICATIONS

**June 2026 – August 2026**

- **9-1-2026: FDA Adds Boxed Warning to Labeling for Ferric Carboxymaltose Injection (Injectafer) to Describe Risk of Low Phosphate Levels**
- **6-10-2026: FDA Approves Labeling Changes for Over-the-Counter (OTC) Weight Loss Drug Alli (orlistat) to Warn of Risk of Kidney Stones and Kidney Injury**

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### FDA Adds Boxed Warning to Labeling for Ferric Carboxymaltose Injection (Injectafer) to Describe Risk of Low Phosphate Levels

#### What Is FDA Doing?

The Food and Drug Administration has approved revisions to the labeling for ferric carboxymaltose injection (currently marketed as Injectafer) that adds a boxed warning, the agency's most prominent safety warning. This boxed warning describes the risk for symptomatic hypophosphatemia (low levels of phosphate in the blood) associated with ferric carboxymaltose injection and recommends phosphate monitoring in patients at risk of hypophosphatemia and in any patient who receives a repeat course of therapy within three months of the prior course.

Clinical manifestations depend on the severity and duration of hypophosphatemia. Symptoms may include muscle weakness or pain, fatigue, tremors, confusion, seizures, and cardiac arrhythmias. Chronic severe hypophosphatemia may lead to osteomalacia (bone softening) and bone fractures.

FDA has previously approved other labeling updates for Injectafer that describe this risk. In 2019, FDA determined that ferric carboxymaltose injection can cause serious symptomatic hypophosphatemia. As a result, in February 2020, FDA approved labeling revisions that, along with other changes, added a warning about this risk. In 2023, the warning was revised to include recommendations for serum phosphate level monitoring in patients at risk for hypophosphatemia and in any patient who receives a repeat course of treatment within three months. The revised warning also included osteomalacia and fractures as potential long-term complications and added inflammatory bowel disease as a possible risk factor for hypophosphatemia. In 2025, the warning was further revised to include additional risk factors for hypophosphatemia.

In 2026, FDA conducted an assessment of hypophosphatemia in association with ferric carboxymaltose injection using multiple data sources, including the FDA Adverse Event Reporting System (FAERS) database (which has been incorporated into the FDA Adverse Event Monitoring System [AEMS] database), literature reports, and FDA's Sentinel System. FDA found that symptomatic hypophosphatemia continues to be reported with ferric carboxymaltose injection and serum phosphate testing levels are low despite labeling changes in February 2020 and May 2023.

## What Is Ferric Carboxymaltose Injection (Injectafer)?

Ferric carboxymaltose injection (Injectafer) is a prescription iron replacement medicine originally approved in 2013 to treat iron deficiency anemia. Ferric carboxymaltose injection is given intravenously (through the vein). Iron deficiency anemia is a common type of anemia that can cause fatigue, weakness, shortness of breath, and other symptoms. Injectafer is approved for patients one year of age and older who cannot tolerate or do not fully respond to oral iron. It is also approved for iron deficiency in adults who have non-dialysis-dependent chronic kidney disease, and for iron deficiency in adults with heart failure and New York Heart Association class II/III to improve exercise capacity. Certain strengths of Injectafer are also approved as ferric carboxymaltose injection generic products. Generic application holders are expected to update their labeling to incorporate this change after this approval.

## What Should Patients Do?

Patients should immediately report any new or worsening symptoms of low phosphate levels (e.g., muscle weakness or pain, fatigue, bone and joint pain, confusion) to their health care provider. Some of these symptoms may mimic those of iron deficiency anemia.

## What Should Health Care Providers Do?

Health care providers should inform patients of the risk of hypophosphatemia with ferric carboxymaltose injection use. Health care providers should also:

- Check serum phosphate levels prior to a repeat course of treatment if the patient is at risk for low serum phosphate or if the patient will receive a repeat course of therapy within three months of the prior course.
- Correct pre-existing hypophosphatemia prior to administering Injectafer.
- Monitor serum phosphate levels in patients at risk for chronic low serum phosphate.
- Treat hypophosphatemia as medically indicated.
- Consider permanent discontinuation of Injectafer for severe symptomatic hypophosphatemia or persistent hypophosphatemia.

## What Did FDA Find?

FDA found that symptomatic hypophosphatemia continues to be reported with ferric carboxymaltose injection, despite labeling changes in February 2020 and May 2023 adding and strengthening the warning about this risk. The FAERS case series included reports of symptomatic hypophosphatemia that occurred after both single and multiple infusions of ferric carboxymaltose injection. Consequences included hospitalization, need for phosphate replacement therapy over weeks to months, and extensive monitoring with regular follow-up medical visits.

Data from the FDA's Sentinel System indicate that serum phosphate laboratory testing occurs in fewer than 20% of ferric carboxymaltose administration episodes.

Hypophosphatemia associated with ferric carboxymaltose can lead to serious outcomes including hospitalization, a need for prolonged phosphate replacement therapy, osteomalacia, and fractures. This serious adverse reaction can be prevented or reduced in severity through appropriate phosphate level monitoring and early intervention. Therefore, FDA has required a boxed warning be added to the Injectafer labeling describing the risk for symptomatic hypophosphatemia and recommending mitigation strategies. This action highlights the warning already in the Injectafer labeling.

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**6-10-2026: FDA Approves Labeling Changes for Over-the-Counter (OTC) Weight Loss Drug Alli (orlistat) to Warn of Risk of Kidney Stones and Kidney Injury**

## What Is FDA Doing?

The Food and Drug Administration (FDA) has approved changes to the Drugs Facts Label of the over-the-counter (OTC) weight loss drug, Alli (orlistat) 60 mg capsules, to warn of risks of acute kidney injury, which is a rare side effect of the medication. The labeling now advises consumers to ask a health care provider before using Alli if they have ever had kidney disease or kidney stones. The labeling changes also tell consumers to stop using Alli and ask a doctor if they develop symptoms of kidney injury or kidney stones, such as back or groin pain, painful urination, blood in the urine, feet and leg swelling, or less frequent urination.

The risk of renal (kidney) injury is now described consistently across the labeling for all FDA-approved orlistat products, including those available OTC and those available in a higher strength by prescription.

## What Is Alli?

Alli (orlistat) 60 mg capsules are approved for nonprescription use for weight loss in overweight adults 18 years and older, when used along with a reduced-calorie and low-fat diet. Alli is the only FDA-approved OTC (nonprescription) weight loss aid. A higher-strength orlistat product, Xenical (orlistat) 120 mg capsules, is available by prescription. Xenical is indicated for obesity management, including weight loss and weight maintenance, when used in conjunction with a reduced-calorie diet and to reduce the risk for weight regain after prior weight loss.

Orlistat is a lipase inhibitor that works by binding to enzymes that break down fats. As a result, people absorb less dietary fat from the digestive tract.

## What Should Consumers Do?

- Consumers should read the Drugs Facts Label carefully before starting Alli. It is important for consumers to read the labeling of all OTC medications because they may not have seen a health care provider before deciding to take the medication.
- Consumers should be aware there have been rare reports of the following side effects in people taking Alli:
    - acute kidney injury (kidneys suddenly cannot filter waste products from the blood and harmful levels of waste may build up). Mild cases may be reversible, but untreated severe cases can be fatal.
    - hyperoxaluria (high urinary levels of the waste product oxalate, a compound made by the liver and ingested through the diet)
    - calcium oxalate nephrolithiasis (kidney stones that form when oxalate combines with calcium in the urinary tract)
    - oxalate nephropathy (calcium oxalate crystals form inside the kidneys and interfere with normal kidney function)
- If consumers ever had kidney disease or kidney stones, they should ask a health care provider before taking Alli.
- If consumers experience symptoms of acute kidney injury or kidney stones, they should stop taking Alli and consult a health care provider for further guidance. Symptoms may include:
    - back or groin pain

    - painful urination
    - blood in the urine
    - feet and leg swelling
    - less frequent urination
- If consumers experience side effects or do not respond well to Alli, they should talk to a health care provider to consider next steps, including whether other treatment options might be right for them.

## What Should Health Care Providers Do?

Health care providers who counsel patients about weight loss should inform them about the rare reports of acute kidney injury, hyperoxaluria, calcium oxalate nephrolithiasis, or oxalate nephropathy associated with orlistat products. If a patient taking Alli presents with signs of acute kidney injury or nephrolithiasis, providers should advise them to stop the drug and proceed with appropriate evaluation and management.

## What Did FDA Find?

FDA received periodic safety reports of acute kidney injury associated with Alli, which prompted a revaluation of this safety signal in the nonprescription product. Specifically, FDA searched the FDA Adverse Event Monitoring System (AEMS) and the medical literature to identify cases of acute kidney injury, oxalate nephropathy, hyperoxaluria, and/or calcium oxalate kidney stones that occurred following use of Alli. Search dates were from Alli's approval date on February 9, 2007, through December 31, 2023.

We identified 12 cases of kidney complications associated with Alli use, including nine from AEMS and three from the literature. The median patient age was 61 years (range 36-76 years), and there were slightly more females (7) than males (5). Among the eight patients who reported Alli use prior to kidney injury, the median exposure time was 2.5 months (range 0.7-17 months). The types of kidney complications varied among the 12 cases: eight reported acute kidney injury, two reported acute kidney injury with oxalate nephropathy, and two had hyperoxaluria with calcium oxalate kidney stones. The severity of these cases was substantial, with eight patients requiring hospitalization and five requiring dialysis. Seven patients experienced improvement in their conditions, one had not improved at the time the report was made, and four reports did not describe the outcomes. Dosing information was available for four patients, all of whom reported taking either 60 mg or 120 mg of orlistat three times daily.

Our data analysis also suggests that orlistat-associated oxalate nephropathy and kidney injury may not be dose-dependent, as the difference in dietary fat

absorption inhibition between the 120 mg (Xenical) and 60 mg (Alli) doses is 5%, indicating the risk exists at both prescription and nonprescription doses. Based on these postmarketing cases demonstrating evidence of kidney injury associated with oxalate crystals in individuals using Alli and biological plausibility — as well as findings that the risks may not be dose-dependent — the risk of kidney injury was added to Drug Facts Label for Alli, aligning labeling for all FDA-approved orlistat products.

There are limitations to the information available to FDA. The actual number of cases involving kidney problems after Alli use may be higher, as consumers and health care professionals do not always report side effects to FDA. Many reports were missing information, including clinical details such as kidney stone composition and past medical history. Several people had other possible reasons for their kidney diagnoses besides taking Alli, including obesity, diabetes, high blood pressure, and history of kidney disease or kidney stones. These conditions could also have increased the risk of kidney problems associated with the use of Alli.


# 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 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 physicians and at least one-third (1/3) licensed 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 majority of current active appointed voting members shall constitute a quorum. If a quorum is not present, the Board may participate in discussion and utilization analysis, but may not conduct business, such as approval of minutes, changes to by-laws, or recommendations requiring a vote. Such business shall be conducted at a subsequent meeting. 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 move to close 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 declare 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 |