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American Academy
of Value Based Care

Medicare Star Medication Adherence for Cholesterol (Statins)

Quick Reference Guide

2026

Medicare Stars Medication Adherence for Cholesterol (Statins) — Quick Reference Guide

1. MEASURE SNAPSHOT

CMS Part D Star Measure: D10 - Medication Adherence for Cholesterol (Statins)

CMS Definition: The percentage of Medicare Part D beneficiaries, 18 years and older, who adhere to their prescribed statin cholesterol medication therapy. Adherence is defined as a Proportion of Days Covered (PDC) of 80% or higher during the treatment period.[1,2]

Measure Weight: **Triple-weighted (3x)** under the Medicare Part D Star Ratings program; Medication adherence (MA) **≈30% of total Part D rating**

Exclusions: Members in hospice, palliative care, ESRD, advanced illness/frailty programs, or long-term care facilities; Contracts with 30 or fewer enrolled member-years (in the denominator of PDC calculation).[1,2]

2025 Financial Impact: **$12.7 billion** in total Quality Bonus Payments (QPBs) across all Medicare Advantage Prescription Drug (MA-PD) contracts; **$372–$438 per enrollee annually** (depending on plan performance tier).[3]

Star Thresholds[1–3]

- **Adherent Patient:** Proportion of days covered (PDC) ≥80%
- **4-Star Plan:** Historically **>80–89%** of eligible members adherent
- **5-Star Plan:** Historically **≥88–90%**, with recent years requiring substantially higher performance
- Achieving 5 stars requires very high medical adherence (MA), typically requiring that over 90% of its members achieve the ≥80% PDC threshold

CMS Cut Points 2026: [2]

Plan Type	1 Star	2 Star	3 Star	4 Star	5 Star
MA-PD	<84%	≥84% – <88%	≥88 % – <90%	≥90% – <93%	≥93%
PDP	<87%	≥87% – <89%	≥89 % – <90%	≥90% – <92%	≥92%

Current Industry Performance (2025 → 2026 Trend)[3–6]

- National Numeric and Star Averages: MA-PD 89% 3.2 and Prescription Drug Plans (PDP) 88% 2.7[2]

- **4+ Star Contracts**: Approximately **64%** of MA-PD enrollees are in contracts with 4 or more stars for 2026, a slight increase from **62%** in 2025
- **5-Star Contracts**: Enrollment remains highly restricted; approximately **2.3%** of members are in 5-star contracts for 2026, up marginally from **1.98%** in 2025. Only **18 MA-PD contracts** nationwide earned the 5-star rating for 2026
- Medication Adherence measures, including statins, experienced **some of the steepest year-over-year declines**, driven by:
  - **Rising cut points** (up to ≥92% for 5 Stars)
  - **Increased medication cost pressure**
  - Greater impact of **social risk adjustment through the Health Equity Index (HEI)**

Rating Impact & Revenue

Star Rating	Benchmark Bonus	Rebate	Marketing Rights
5 stars	5% increase + QBP	70%	Year-round enrollment
4.5 stars	5% increase + QBP	70%	Standard windows
4 stars	5% increase + eligible for QBP	65%	Standard windows
<4 stars	None	50-65%	Limited

2. PDC CALCULATION

Formula[2,5,6]

$$PDC = \frac{Total\ days\ with\ medication\ available}{Days\ in\ measurement\ period} \times 100$$

Success Threshold: ≥ 80% PDC

Calculation Rules (Non-Negotiable)[2,5,6]

Rule (2025 CMS /PQA Standard)	What CMS Is Doing	Why This Matters Operationally
Class-based, switch-tolerant logic	PDC counts days covered by **any statin** in the therapeutic class. Switching between statins (e.g., atorvastatin → rosuvastatin) is treated as **continuous coverage**	Prevents inappropriate PDC drops during clinically appropriate statin changes
Chronic-use eligibility requirement	Beneficiary must have **≥2 statin fills on unique dates of service** during the measurement year to be included in the denominator	Excludes short-term trials and one-time fills from performance calculations

Minimum observation window ("91-day rule")	First statin fill must occur **≥91 days before** the earliest of disenrollment, death, or end of the measurement year	Ensures adequate time to meaningfully assess adherence
Overlapping days' supply handling	Overlapping refill days are **shifted forward**; days are **not double-counted**	Prevents artificially inflated PDC values (>100%)
Inpatient/SNF adjustment	Inpatient or SNF days (>7 consecutive days) are **removed from the denominator**, and days' supply is shifted forward	Avoids penalizing patients during facility-based medication administration
Claims-based measurement	PDC is calculated using **paid Medicare Part D pharmacy claims only**	Cash fills, samples, and many 340B transactions do **not** count toward Stars

Included Medication Classes[2]

Statins (HMG-CoA Reductase Inhibitors):

- Atorvastatin (Lipitor)
- Rosuvastatin(Crestor)
- Simvastatin (Zocor)
- Pravastatin (Pravachol)
- Lovastatin (Altoprev, Mevacor)
- Fluvastatin (Lescol XL)
- Pitavastatin (Livalo, Zypitamag)

Note: Non-statin lipid-lowering agents (e.g., ezetimibe (Zeitia), PCSK9 inhibitors (Repatha, Praluent), bempedoic acid (Nexletol), fibrates (Fenofibrate, Gemfibrozil), omega-3 products (Lovaza, Vascepa), Bile Acid Sequestrants (Colesevelam, Cholestyramine)) are not included in the D10 Statins adherence measure and do not contribute to PDC.

The "Combination Product" Exception: While non-statin agents like ezetimibe do not count on their own, the **Pharmacy Quality Alliance (PQA)** (sets these standards) includes fixed-dose combinations that contain one of the statins listed above. If a patient is on these, they contribute to the Proportion of Days Covered (PDC):

- Atorvastatin + Ezetimibe (Roszet) — Counts
- Simvastatin + Ezetimibe (Vytorin) — Counts
- Atorvastatin + Amlodipine (Caduet) — Counts
- Lovastatin + Niacin (Advicor) — Counts
- Simvastatin + Niacin (Simcor) — Counts

3. CRITICAL BARRIERS & EVIDENCE-BASED SOLUTIONS[7-11]

Primary Adherence Barriers [7–18]

Barrier	Patient Impact	Evidence-Based Intervention
Forgetfulness/routine disruption	Accounts for ~30–40% of nonadherence in chronic disease populations; highly prevalent among older adults taking statins for primary prevention where symptoms are absent	90-day fills; medication synchronization; automated refill reminders; pill organizers; pharmacy outreach after missed refills
Medication cost burden	~25–30% of beneficiaries report cost-related nonadherence; even low-cost statins contribute when layered onto polypharmacy	Tier-1 generic statin optimization; $0-copay preventive medication programs; MTM-based cost review; Low-Income Subsidy (LIS) enrollment support
Perceived or actual adverse effects (myalgias, fatigue, liver concerns)	One of the leading causes of statin discontinuation; nocebo effect significantly contributes to early drop-off	Switch within statin class (e.g., hydrophilic vs lipophilic); dose reduction with gradual re-titration; alternate-day dosing where appropriate; pharmacist counseling to address misconceptions
Low perceived benefit (asymptomatic condition)	Patients taking statins for risk reduction often underestimate benefit, leading to early nonpersistence	Clear ASCVD risk framing; visual risk reduction tools; shared decision-making reinforced by consistent messaging from PCP and pharmacist

Access, Literacy, and System Barriers [7–18]

Barrier	Patient Impact	Evidence-Based Intervention
Access & pharmacy logistics	15–20% of beneficiaries report transportation or pharmacy access limitations	Mail-order or home delivery enrollment; auto-refill programs
Low health literacy	Strong predictor of poor adherence, particularly among LIS and dual-eligible populations	Culturally tailored education; plain-language counseling; teach-back method; simplified written instructions
Transitions of care (hospital discharge)	Statins are frequently omitted or delayed after hospitalization, creating early PDC gaps	Discharge medication reconciliation; pharmacy follow-up within 7 days; refill bridging

Disparity Gaps Requiring Targeted Action [7–18]

Population Segment	Patient Impact	Interventions
Black and Hispanic beneficiaries	7–10 percentage-point lower adherence even in ≥4-star plans	Community pharmacist partnerships, trust-building outreach, BP self-monitoring support, $0-copay/tier-reduction/subsidy programs; MTM cost review
American Indian/ Alaska Native beneficiaries	lowest adherence rates, with gaps as large as 16%	Bilingual refill messaging, family-centered education; $0-copay/tier-reduction/subsidy programs; CHR (Community Health Representative) collaboration
Southern states (CMS regions 4,6,8,9)	~13% higher non-adherence rates	Mail-order enablement, low-cost generic campaigns
Low-trust index (all groups)	One of the strongest adherence predictor	Continuity with same prescriber/pharmacy, motivational interviewing, pharmacist follow-up calls
Low-income subsidy (LIS) & dual-eligible beneficiaries	Cost-driven nonadherence disproportionately high; SGLT2i/GLP-1 classes amplify gaps	Subsidy optimization; MTM cost review; lower-cost therapeutic alternatives; refill coordination; HEI-focused outreach

4. HIGH-YIELD INTERVENTIONS TO IMPROVE MA PERFORMANCE

High-Yield System-Level Interventions [7–18]

Action / Strategy	Evidence Summary	Estimated PDC Increase	Operational Cue
Convert to 90-day supplies	Reduces refill frequency and gap risk; strongly recommended by CMS and PQA for adherence-sensitive medications such as statins	**+15–20%**	Target members ≥2 fills behind schedule; consider 100-day supply where plan policy allows
Activate auto-refill & medication synchronization	Refill disruption is a leading cause of statin PDC failure; synchronization can reduce refill gaps by ~50–60%	**+25–30%**	Auto-enroll at point of sale or during MTM outreach

Action / Strategy	Evidence Summary	Estimated PDC Increase	Operational Cue
Generic statin substitution review	Even modest copays contribute to nonadherence in polypharmacy; generic optimization improves refill persistence	**+20–25%**	Pharmacist review at every refill and therapy change
Enroll in text/app refill reminders	Reminder-supported cohorts show meaningfully higher adherence even within ≥4-Star plans	**+15–20%**	Use HIPAA-compliant SMS, app notifications, or EHR-linked alerts
PDC discrepancy reconciliation	Corrects undercounted adherence due to early refills, short days' supply, or claims lag; critical for accurate Stars scoring	**+5–10%**	Flag claims where days supplied <80 or refill is delayed beyond expected run-out; reconcile with pharmacy and clinical notes

Targeted Clinical & Behavioral Interventions[7–18]

Action/Strategy	Target Cohort (How to Select)	Typical 30-Day PDC Effect	Implementation Notes
Pharmacist MTM (telephonic or embedded)	Prior gaps, polypharmacy, near-miss (PDC 70–79%)	↑↑ adherence ↑↑ persistence ↓ gap-days	Weekly or bi-weekly touchpoints for high-risk members; document barrier, action, and outcome (MEAT)
Smart pill bottles/ digital adherence monitors	Forgetfulness-flagged, cognitively at-risk, caregiver-supported	↑ adherence ↓ late refills ↑ reminder response	Reserve for highest-risk decile; pair with SMS/app reminders
Copay assistance & LIS navigation	OOP cost above plan benchmark; prior claim abandonment; LIS-eligible	↑–↑↑ adherence via affordability ↓ abandonment	Use standardized navigator scripts; confirm enrollment success with pharmacy
Mail-order auto-enrollment	Transportation barriers, travel, stable statin regimen	↑–↑↑ adherence ↓ gap days ↑ on-time refills	Offer at refill or MTM call; confirm address stability; align with 90-day supply
90-day supply + refill synchronization	Any member with ≥2 fills and no complex titration	↑↑ adherence ↓ refill friction ↑ PDC ≥80%	Default to 90-day when clinically appropriate; synchronize all chronic meds
Text/app reminders (HIPAA-compliant)	Non-adherent members without cost or clinical barriers	↑ adherence as adjunct ↓ late refills	Pair with auto-refill or sync; culturally and linguistically tailored messaging

5. WORKFLOW OPTIMIZATION

Efficient adherence improvement requires coordinated action across clinical teams, pharmacies, and patients. High-reliability workflows reduce refill gaps, strengthen documentation, support HEI performance, and improve Star Ratings.[2,13,15,16]

A. Clinical Workflow Optimization

- Embed **PDC dashboards and auto-alerts** for < 80% or post-discharge members and rapid PDC declines (≥10% drop month-over-month)
- Enable **standing refill protocols** (90-day supply, mail-order conversion, automatic synchronization) for all clinically appropriate diabetes medications
- Review **near-miss (PDC 75–79%)** patients in weekly cross-team huddles
- Use **monthly multidisciplinary review** to close high-risk gaps, especially among LIS and dual-eligible members

B. Pharmacy Engagement Strategies

- Create **preferred pharmacy partnerships** with adherence incentives
- Trigger **pharmacist Medication Therapy Management (MTM) calls** for URGENT/PRIORITY tiers
- Schedule **10–14-day pre-refill outreach** to prevent late refills and gap days
- Integrate **community-pharmacy notes** into care-management platforms

C. Patient Education & Engagement

- Use **brief motivational interviewing** scripts that normalize common statin barriers (cost concerns, muscle symptoms, low perceived benefit)
- Provide **plain-language, bilingual materials** explaining:
  - What **"PDC ≥80%"** means
  - Why consistent statin use reduces heart attack and stroke risk
- Frame adherence around **cardiovascular risk reduction**, which patients understand more readily than abstract adherence metrics
- **Celebrate adherence milestones** at each refill contact for reinforcement

D. Simplification of Medication Regimens

- Prefer **once-daily statins** when clinically appropriate
- Align refill schedules across **statins, antihypertensives, and diabetes medications** to reduce confusion and pharmacy trips
- Deprescribe **duplicate or no-longer-indicated lipid therapies**
- Minimize unnecessary regimen complexity to support persistence

E. Use of Technology & Reminders

- Auto-enroll **sub-80%** PDC members in **SMS/app reminders**
- Offer **smart caps** or **digital packaging** for forgetfulness/cognitive risk
- Send **portal or IVR confirmations** pre-refill; track completion monthly
- Analyze reminder data to adjust outreach volume

Risk Stratification Protocol[2,13,15,16]

Tier	Improvement in Adherent Cohorts	Response Time	Recommended Actions
URGENT	PDC <40% OR Discharged <7 days OR ≥ 3 missed fills OR >10 active meds	<24 hours	Pharmacist call; refill + barrier review; coordinate with discharging provider; document MEAT & refill action
PRIORITY	PDC 40–60% OR cost concern OR recent side effect OR new therapy <90 days	48–72 hours	Outreach for refill sync, copay/LIS check, or ARB switch if ACE cough. Add reminder enrollment
ROUTINE	PDC 60–79% OR stable but suboptimal OR single barrier	Weekly review	Auto-refill setup; 90-day conversion; mail-order or reminder text; monitor PDC ≥80% progress
MAINTENANCE	PDC ≥80% AND no current barriers AND stable >6 months	Monthly	Reinforce adherence success; review at annual wellness or med sync cycle; document continued stability.

Re-score all members monthly; automatic escalation if ≥10 % PDC drop or hospital discharge event detected.

Sample Outreach Script

Initial Greeting & Normalize Common Barriers

“Hi [Name], this is [Your Name] calling from [Health Plan/Pharmacy].
I’m calling about your *diabetes medication*. I noticed there may be a gap in your refills, and I want to help make sure you have what you need to stay on track.”

“Many of our members tell us that things like cost, side effects, or simply forgetting can make it hard to refill on time. What has your experience been?”

Follow-up flow:

1. **Listen → validate → summarize barrier**
2. **Offer tailored solutions** (e.g., 90-day supply, mail-order, copay help).
3. **Confirm next refill date + preferred pharmacy**
4. **Document resolution** (date/time, intervention type, new PDC trajectory)

6. DOCUMENTATION REQUIREMENTS

Accurate, time-stamped documentation is the single most important determinant of Star measure validation during CMS audits. Every statin adherence encounter must clearly demonstrate **who was reviewed, what was identified, what action was taken, when it occurred, and the outcome** — structured for traceability and MEAT compliance.[1]

Must-Have Elements

Element	Documentation
Member identifiers	Member ID + full medication name, strength, and dose
Current PDC status	Calculated % with start/end dates of measurement period
Barriers identified	List specific causes (cost, forgetfulness, side effects, access)
Interventions	Each action with an implementation date (e.g., auto-refill, 90-day mail, ARB switch)
Follow-up plan	Defined timeline (e.g., "Next PDC check in 30 days")
Outcome metrics	Post-intervention PDC or refill confirmation noted

Documentation Examples

Level	Example Documentation	Why It Matters
Insufficient	"Counseled patient on importance of cholesterol medication."	No objective monitoring. No barrier exploration. No risk assessment. No defined intervention or follow-up. Does not reflect active cardiovascular risk management or MEAT standards
Acceptable	"Patient with hyperlipidemia prescribed atorvastatin 20mg daily. Reports missing doses due to $38 copay and muscle aches. Discussed benefits of statin therapy. Prescription renewed."	Identifies medication and barrier but lacks objective monitoring (PDC or LDL trend), formal ASCVD risk context, structured assessment of symptoms, and defined follow-up plan. Demonstrates partial MEAT but not longitudinal management
✔ Exemplary (MEAT-Complete)	**Monitor:** 72-year-old with ASCVD and diabetes on atorvastatin 20mg daily. PDC 46% over prior 6 months with the 24-day refill gap. LDL increased from 82mg/dL to 124mg/dL **Evaluate:** Reports cost barrier and mild muscle soreness without weakness **Assess:** High cardiovascular risk given ASCVD. Symptoms mild and not consistent	Demonstrates longitudinal monitoring, barrier identification, clinical interpretation, and defined follow-up. Clearly reflects cardiovascular risk management, shared decision-making, and continuity of care. Fully aligned with MEAT framework and Star measure intent

	with statin intolerance. Risk–benefit discussion completed. Patient willing to continue if cost is addressed **Treat/Track:** Switched to lower-cost generic option. 90-day supply initiated. Education provided regarding muscle symptoms. LDL recheck in 8 weeks. Care team follow-up in 30 days to reassess tolerance and refill status	

Clinical Documentation Optimization

- Use SOAP or **MEAT** structure for every contact:
  - **Monitor:** Patient with established ASCVD and type 2 diabetes currently prescribed atorvastatin 40mg daily. Pharmacy adherence report shows PDC 74% over past 6 months with 21-day refill gap in December. LDL increased from 82mg/dL (May) to 118mg/dL (January). Reports intermittent muscle soreness without weakness
  - **Evaluate:** Patient states he stopped medication temporarily due to concern about muscle symptoms and uncertainty about long-term need. No cost barrier identified
  - **Assess:** High cardiovascular risk given ASCVD history and diabetes. Symptoms consistent with possible statin-associated myalgias but mild. Risk–benefit discussion held. Patient agreeable to medication continuation with adjustment
  - **Treat / Track:** Transition to rosuvastatin 10mg daily. Provided education on cardiovascular risk reduction and expected tolerance profile. 90-day prescription sent. LDL to be rechecked in 8 weeks. Care team follow-up call in 30 days to assess tolerance and refill status

Documentation Integrity: The goal is not to document adherence for measurement alone.
The goal is to demonstrate:

- Active cardiovascular risk management
- Shared decision-making
- Thoughtful response to barriers
- Clear continuity of care

When documentation reflects real clinical reasoning, measurement accuracy follows naturally.

Best Practices

- Auto-populate **PDC fields directly from Part D claims data** to reduce transcription errors
- Attach standardized **intervention codes** (e.g., *MTM-STATIN*, *MAIL-90*, *COPAY-AID*, *AUTO-REFILL*)
- Ensure documentation links **intervention → expected PDC improvement**, not just education

Comprehensive documentation transforms adherence outreach from “soft counseling” into verifiable, revenue-protecting Star performance evidence.

7. PERFORMANCE MANAGEMENT

Effective performance management transforms statin adherence from a retrospective reporting exercise into a **real-time, risk-managed operational process**. High-performing organizations continuously monitor PDC at the **member, provider, and contract level**, intervene early, and escalate risk before Star thresholds are breached.

Continuous, data-driven monitoring ensures adherence programs stay aligned with CMS cut-points and financial targets. This measure is **100% determined by claims data** (pharmacy fills). No manual chart review or provider submission can change the score. If the member didn't fill it, the score drops.

Use daily, weekly, and monthly review tiers to maintain focus and accountability across pharmacy, clinical, and quality teams.[1, 4–6]

Core Performance Metrics to Monitor[4,5,13,17]

Metric	Definition	Why It Matters
Overall Statin PDC	Mean and median PDC across eligible members	Primary driver of Star score
% Members PDC ≥80%	Proportion meeting adherence threshold	Determines Star cutpoint placement
Near-Miss Rate	% with PDC 75–79%	Most recoverable cohort
High-Risk Nonadherence Rate	% with PDC <60%	Early indicator of systemic failure
Refill Gap Days	Average days late per refill	Predicts future PDC decline
Post-Discharge Gap Rate	% with >7-day delay after discharge	Major leakage point for statins
LIS / Dual Adherence Gap	Difference vs non-LIS population	HEI performance signal

Daily Monitor List- Frontline Focus

Monitor List	Actionable Criteria	Operational Response
Near-miss members (PDC 75–79%)	Identify via daily PDC feed	Outreach within 48h; refill or mail-order enrollment (eligible for 5–10pt lift)
Recent hospital discharges on RAS	≤7 days post-discharge	Verify med reconciliation + 90-day fill initiation
Upcoming refill windows	Fills due within 10 days	Trigger auto-refill or text reminder
Failed intervention follow-ups	No response within 7 days of outreach	Escalate to pharmacist/care coordinator

Focus on high-yield, high-risk members for rapid action.

Weekly Dashboard Metrics

Metric	Target/Insight	Operational Response
Overall PDC trend	Track plan-level movement toward ≥88% adherence	Escalate cohorts trending <78%
Interventions completed vs pending	Ensure ≥90% follow-through within 5 days.	Redistribute outreach workload
Cost per successful intervention	Target <$50 per member per quarter	Prioritize low-cost, high-yield methods (auto-refill, mail)
Provider-level performance	Identify top and bottom deciles	Targeted feedback, educational resources
Demographic gap analysis	Detect race/region PDC variance >5pts	Deploy equity-focused outreach

Aggregate performance indicators for operational leaders.

Monthly STAR Projections

Indicator	Calculation/Action
Current rate vs CMS cut-points	Compare to latest benchmarks
Members needed to "move the needle"	Estimate count to reach the next Star threshold
Revenue at risk	Project bonus variance per 1,000 members
Resource allocation ROI	Rank interventions by PDC impact per $ spent

Performance Stratification & Escalation

Align performance management with the **risk stratification tiers** defined in Section 5:

- **URGENT:** Same-day pharmacist outreach; leadership visibility
- **PRIORITY:** 48–72 hour intervention; MTM + cost or AE mitigation
- **ROUTINE:** Automated optimization (90-day, auto-refill, reminders)
- **MAINTENANCE:** Reinforcement and monitoring only

Consistent daily tracking, weekly analytics, and monthly Star projections convert adherence management into predictable financial performance — turning data visibility into sustained Star performance.

8. FINANCIAL MODELING

Investment Requirements (per 1,000 members)

Indicator	Calculation/Action	Estimated Annual Cost
Personnel	0.5 FTE Pharmacist ($65 K) 1.0 FTE Pharmacy Tech ($35 K) for adherence outreach and monitoring	$100K
Technology	Tools for PDC dashboards, refill alerts, SMS outreach, mail-order automation. Estimate count to reach the next Star threshold.	$50K
Materials	Member engagement packets; multilingual diabetes education; adherence reminder materials; Project bonus variance per 1,000 members	$10K
Resource allocation ROI	Rank interventions by PDC impact per $ spent	**≈$160K per 1,000 members**

Real-world example scenario

Scenario: A 50,000-member MA-PD plan launched a pharmacist-led adherence program in Q1 2025.

Investment: $8 million (total scaled).

Interventions: 90-day conversion, auto-refill activation +synchronization, and copay LIS navigation + tier reduction + copay assistance.

Outcomes at 12 months:

- RAS PDC rose from 76% → 87%
- Plan Star rating improved from 3.5 → 4.5
- Annual quality bonus increase ≈ $18 million
- Net ROI ≈5.1× within the first year

Operational Insight: The plan retained over 96 % of members year-over-year and cut avoidable hospital admissions by ~18%.

Targeted investment in MA generates one of the highest ROIs across all Star Rating measures, often approaching a 5:1 return within the first year. This makes diabetes medication adherence a core lever for financial sustainability, clinical quality, and equity performance in Medicare Advantage.

In real-world Medicare Advantage programs, that translates to **multi-million-dollar quality bonuses and measurable reductions in avoidable hospitalizations**, making MA one of the **highest-yield investments in the Star Ratings portfolio.**

9. REGULATORY REQUIREMENTS

A. Measurement Integrity and Stewardship[4,5,17]

Ensuring statin adherence measurement accurately reflects patient care and access.

For statin adherence programs, systems and documentation should support **consistent, transparent, and reproducible measurement** of medication use and care team engagement across settings.

- **Measurement logic:** Routine validation of PDC calculations to confirm appropriate inclusion, correct numerator/denominator alignment, and timely claim capture
- **Data completeness:** Ongoing monitoring of pharmacy claim feeds for completeness, including days-covered fields, with periodic reconciliation to adherence summaries
- **Care engagement records:** Clear documentation of outreach and support activities, including date, member identifier, barrier addressed, action taken, and outcome
- **Clarification pathways:** Defined process for timely review and resolution of questions related to adherence status or data discrepancies
- **Information stewardship:** Retention of claims, intervention documentation, and analytic outputs in accordance with organizational and regulatory standards

2025-2026 Changes to Monitor[2,4,5]

- The **Health Equity Index (HEI)** or equivalent measure is now a formal part of the Star Ratings framework for measurement year 2025 (impacting the 2027 rating) and will carry increasing weight
- **Cut-points raised** for many Part D adherence and outcome measures in 2026, meaning the bar for "4-star" and "5-star" is higher (by ~3-12 percentage points in some cases)
- **Telehealth interventions** and virtual pharmacist encounters are now explicitly counted as valid "interventions" under outreach/engagement components and should be captured in workflow logs
- **Increased CMS focus on disparity reduction** means plans must stratify adherence by demographics and SDOH (social determinants of health) and document targeted corrective actions

Implications for MA Statins Programs[2,4,5,17]

- **Prioritize Clinical Complexity, Not Cost Alone:** While affordability remains important, many nonadherent statin users, especially **LIS beneficiaries**, have already received basic cost relief. Remaining gaps often reflect:
  - Polypharmacy
  - Perceived or actual statin intolerance
  - Low perceived benefit in asymptomatic patients
  - Direct MTM and pharmacist time toward members with:
    - Polypharmacy (five or more chronic medications)
    - Prior statin discontinuation or class switching

    - Post-discharge statin gaps
- Key focus areas
    - Regimen simplification using **once-daily dosing** when appropriate
    - Fixed-dose combination options when clinically appropriate
    - Active management of adverse effects such as metformin GI intolerance

Clinical nuance:

Some patients with documented statin intolerance may require non-daily statin regimens (e.g., alternate-day or intermittent dosing). These regimens remain compliant with CMS adherence methodology *when*:

- The prescribing clinician explicitly documents the dosing schedule and clinical rationale in the medical record
- The pharmacy prescription is updated to accurately reflect the modified regimen

When correctly prescribed and dispensed, these regimens are **appropriately reflected in PDC calculations** and should **not be misclassified as nonadherence**.

- **Integrate Health Equity Index (HEI) as a Core Operational Requirement:** Statin adherence programs should be concentrated on LIS beneficiaries, dual-eligible members, and Black and Hispanic beneficiaries. Plans must document meaningful cost and access interventions
    - Copay support for 90-day supplies
    - Preferred generic substitutions
    - Mail-order or home delivery for members facing transportation or stability barriers
- **Move From Auto-Refill to Full Medication Synchronization:** Make medication synchronization the default for members with stable regimens. Sync non-insulin diabetes medications, hypertension medications, and statins to one pickup date. Synchronization addresses forgetfulness, access barriers, and regimen complexity across all three triple-weighted adherence measures simultaneously
- **Proactively Manage the Near-Miss Cohort (PDC 70–79 Percent):** With MA cut points approaching or exceeding 92 percent, converting near-miss members is essential for 4- and 5-Star attainment
- Flag members as the top-priority operational segment. These members often need only one timely refill to reach adherence. Assign the most intensive outreach such as pharmacist calls, MTM sessions, LIS navigation, and refill synchronization. Track weekly conversions from near-miss to adherent status to optimize Star Rating impact

KEY TAKEAWAYS

1. **MA Satins is triple-weighted and high stakes:** Medication Adherence for Cholesterol (Statins) (MA, D10) is a 3x weighted Part D Star measure, contributing **~30% of total Part D rating**.
2. **Cut points are very high (and rising):** To earn 5 Stars, plans now typically need ≥92% of members adherent (PDC ≥80%).
3. **PDC is class-based and switch-tolerant**: Statin adherence is calculated at the **therapeutic class level**. Switching between statins (e.g., atorvastatin to rosuvastatin) **does not reset adherence** if coverage is continuous.
4. **Key barriers are cost, complexity, and disparities**: The most common drivers include cost burden, polypharmacy and regimen complexity, perceived or actual side effects, low perceived benefit in asymptomatic patients, and access or logistics barriers.
5. **High-yield levers are well known and repeatable** 90-day supplies, auto-refill + med sync, mail-order, LIS/copay help, and pharmacist MTM consistently deliver the largest PDC lifts.
6. **Workflow and risk tiers must be explicit:** Near-miss members (PDC 70–79%) are the most cost-effective group to convert to adherent.
7. **Quality documentation is comprehensive:** Every contact should show who/what/when/barrier/intervention/outcome using MEAT/SOAP structure and standard codes (MTM-1, MAIL-90, COPAY-AID, SYNC-Rx).
8. **Financial ROI is large and fast:** A focused MADM program (pharmacist-led, tech-enabled) can yield ≈5:1 ROI within one year
9. **HEI makes equity work non-optional:** Plans must stratify MADM by SRF groups, document targeted actions, and show gap closure across LIS, dual-eligible, and minority members to protect future Star ratings

Medication adherence remains the most profitable, measurable, and controllable driver of Star success. When coupled with equity-focused outreach and airtight documentation, it delivers unmatched ROI, sustained audit compliance, and long-term competitive advantage in the 2026 Part D environment.

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