AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Statin Use in Persons with Diabetes (SUPD)

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part D Star Measure: D12 – Statin Use in Persons with Diabetes (SUPD)

CMS Definition: This measure evaluates the percentage of patients aged **40–75** with at least **two diabetes medication fills** on unique dates of service who also received at least **one statin medication fill** during the measurement period.[1]

FIELD	ENTRY
CMS measure name	Statin Use in Persons with Diabetes (SUPD), SUPD
Domain	Drug Safety and Accuracy of Drug Pricing
CMS weighting category	Process Measure
Weight	**1, standard-weighted**
Primary data source	Prescription Drug Event (PDE) data, Part D pharmacy claims
Unit of measurement	CMS contract-level measure; individual clinicians and practices do not receive a D12 Star Rating
Trend direction	**Higher is better**
Case-mix adjusted	No[1]
Measurement period	01/01/2024 – 12/31/2024[1]
Star measure credit	One Part D pharmacy claim for a statin during the measurement year. There are no intensity requirements, any statin fill counts,[1] in contrast to **C19** (Statin Therapy for Patients with Cardiovascular Disease), where only moderate- or high-intensity qualifies. A written prescription, an office sample, a VA fill, or a cash or discount-card fill **not submitted to the plan** earns no credit. The **PDE claim** is the entire numerator[1,2]
One fill, not days covered	SUPD asks whether statin therapy was started or continued at all, and a single qualifying fill satisfies it.[1] The proportion-of-days-covered work (PDC ≥ 80%) belongs to **D10** (Medication Adherence for Cholesterol) which the same patient enters once statin therapy is established[1]
Denominator trigger	**Pharmacy fills:** Two diabetes-medication fills on unique dates of service qualify a patient for the measure, regardless of whether a diabetes diagnosis appears anywhere in the chart.[1] The **index prescription start date (IPSD)**, the earliest diabetes-medication fill of the year, must occur at least **90 days** before the end of the measurement period. Continuous Part D enrollment is required, with one allowable gap of up to **one calendar month**[1]

FIELD	ENTRY
Statistical method	Clustering. Cut points are recalculated each year from the distribution of contract scores and are not fixed targets[1]
Not reported for	Medical Savings Account (MSA) contracts. Reported for MA-PD contracts and stand-alone Prescription Drug Plans, each against its own cut-point row[1]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; IPSD = index prescription start date; MA-PD = Medicare Advantage Prescription Drug; MSA = Medical Savings Account; PDC = proportion of days covered; PDE = prescription drug event; SUPD = Statin Use in Persons with Diabetes; VA = Veterans Affairs

How The Years Line Up

Care Delivered
Diabetes-medication and statin fills dispensed across calendar year 2024. **One** qualifying statin claim anywhere in the year creates the credit

↓

Data Reported
Final-action PDE records submitted by drug plans and accepted by the 2024 PDE submission deadline for annual Part D payment reconciliation

↓

Published Rating
Reported in the 2026 Star Ratings, published October 2025

↓

Payment Year
Contributes to the Star Rating used for 2027 quality bonus payment determinations

The 2026 Star Rating reflects pharmacy claims from **2024**. Two timing rules apply within any measurement year. First, the window closes on **December 31**. Second, a patient whose first diabetes-medication fill occurs within the **final 90 days** of the year does not enter the denominator at all. Statin counseling initiated that late is still clinically valid, but the measured credit is applied to the following year.[1]

In One Sentence

Among a health plan's patients aged **40–75** who filled diabetes medications at least **twice** during the year, this measure reports the share who also filled a **statin** at least once.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024 measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.[1]

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA-PD	<81%	≥81% to <85%	≥85% to <89%	≥89% to <93%	≥93%
PDP	<82%	≥82% to <83%	≥83% to <84%	≥84% to <86%	≥86%

ABBREVIATIONS: MA-PD = Medicare Advantage Prescription Drug; PDP = Prescription Drug Plan

2026 Industry Performance

- **National numeric average (2026): 88%** for MA-PD contracts, **84%** for PDP health plans. Average measure rating: **3.3 Stars for both**[1]
- **(2025 → 2026 Trend):**The average measure rating for this measure rose from **2.8 Stars in 2025** to **3.3 Stars in 2026**, for both MA-PD and PDP health plans[4]
- **Broader MA market context:** Approximately **64%** of MA-PD enrollees are in health plans rated four Stars or higher for 2026, and **18** MA-PD contracts earned an overall 5-Star rating[4]

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE

For adults aged **40 to 75** with diabetes, statin therapy is recommended regardless of cholesterol panel results. In diabetes, LDL threshold does not determine statin eligibility. **Cardiovascular disease is the leading cause of death in patients with diabetes, and statins lower that risk by reducing LDL and stabilizing existing arterial plaque.**[5] Because diabetes itself drives this risk, the diagnosis alone is the indication for statin therapy, even when LDL results are normal. A patient with a normal lipid panel who has not been prescribed a statin has not been appropriately managed. This remains the measure's most common gap.[7]

In Plain Language

This measure evaluates whether the patient received at least one statin dispensation through their **Part D benefit** during the measurement year. A clinical discussion, a written prescription, or an office sample does not satisfy this evaluation. Only a **pharmacy claim** confirming dispensation does. Most measure failures occur between the clinical decision to prescribe and the patient's completion of the fill.[1]

Why it Exists

Cardiovascular disease is the leading cause of death among people with diabetes. Clinical guidelines recommend **moderate- or high-intensity statin therapy** for adults aged 40 to 75 with diabetes, regardless of baseline LDL.[5] The supporting evidence is diabetes-specific: in the CARDS trial, atorvastatin reduced major cardiovascular events by **37%** compared with placebo in patients with type 2 diabetes and no prior cardiovascular disease.[6] Despite this evidence, registry data show that **59.2%** of statin-eligible adults not on therapy reported that no clinician had ever offered it to them.[7] This measure sets a minimum standard of one fill because even that minimum is not consistently met.[1,7]

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance. What follows is the part of this measure a care team can influence directly.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Checking every patient with diabetes aged **40 to 75** for statin therapy at the visit, based on the diabetes diagnosis • Explaining to the patient that the statin offers vascular protection • **E-prescribing** before the patient leaves the room • Routing the fill through the Part D benefit, **never a cash discount card** • Coding **true exclusions precisely**, on a claim, every measurement year	• **The first fill occuring**. Copay, pharmacy counter friction, and patient hesitation are factors at this stage • **Pharmacist outreach** and collaborative practice agreements • Continuing a hospital-initiated statin regimen **without interruption** after discharge • **Caregiver support** for complex regimens	• The PQA medication lists that define **qualifying drugs** • Denominator eligibility rules, IPSD rule, enrollment criteria • Cut points, clustering, and the **Categorical Adjustment Index**

ABBREVIATIONS: IPSD = index prescription start date; PQA = Pharmacy Quality Alliance

MEASURE SPECIFICATION

Part D Pharmacy-Claims Measure — PDE Only

ELEMENT	SPECIFICATION
Denominator	Part D beneficiaries **40–75** years old with at least **two diabetes-medication fills** on unique dates of service during the measurement year, continuously enrolled with one allowable gap of up to one calendar month, whose IPSD falls at least 90 days before the end of the measurement period[1]
The trigger, not the diagnosis	**No diabetes diagnosis code is required.** The fills alone qualify the beneficiary.[1] Metformin prescribed for prediabetes or polycystic ovary syndrome pulls a patient without diabetes into the denominator, which is why the pre-diabetes and PCOS exclusions exist[1]
Numerator	At least **one statin medication fill** during the measurement period, identified from PDE claims against the PQA-maintained NDC lists[1,2]
Exclusions	Applied for any time during the measurement period: hospice enrollment; ESRD diagnosis or dialysis coverage dates; rhabdomyolysis and myopathy; pregnancy, lactation, and fertility; cirrhosis; pre-diabetes; and polycystic ovary syndrome. Contracts with 30 or fewer continuously enrolled beneficiaries are excluded[1]
Data collection	Administrative only: final-action PDE records for numerator and denominator, CMS enrollment data for hospice and ESRD status, and medical claims for exclusion diagnoses. No chart abstraction, no supplemental submission[1]
Measurement window	January 1 – December 31, 2024 for the 2026 Star Ratings. Fill activity locks at year end[1]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CWF = Common Working File; ESRD = end-stage renal disease; HCPCS = Healthcare Common Procedure Coding System; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; IPSD = index prescription start date; NDC = National Drug Code; PCOS = polycystic ovary syndrome; PDE = prescription drug event; PQA = Pharmacy Quality Alliance

⚠ RED FLAG — THE DENOMINATOR INCLUDES PATIENTS WITHOUT DIABETES

A patient taking metformin for **prediabetes (R73.03)** or **PCOS (E28.2)** registers as an open statin gap in the denominator. Prescribing a statin in response is not appropriate, since this patient lacks the diabetes indication. The correct response is **accurate coding**: documenting the condition actually being treated, prediabetes or PCOS, on the claim. This applies the **exclusion** CMS built for this circumstance.[1] The measure does not require treatment for a condition the evidence does not support.

Commonly Misunderstood

- SUPD is often assumed to require adherence → **one statin fill** during the measurement year satisfies the numerator.[1] The proportion of days covered (PDC) threshold of 80% belongs to a separate measure, Medication Adherence for Cholesterol (Statins). The same patient is typically included in both measures, but each is scored independently[1]
- A diabetes diagnosis is often assumed to define the denominator → **two diabetes-medication fills** define it instead, with no diagnosis required.[1] Registries built on diagnosis codes underestimate the denominator and omit patients identified through off-label fills
- Chart documentation is often assumed to satisfy an exclusion → only a **coded claim** submitted during the measurement year does.[1] Past-medical-history entries, allergy lists, and narrative notes are not visible to this measure, and an exclusion does not carry forward to subsequent years
- A filled statin is often assumed to count regardless of payment method → only the **Part D claim** counts. Cash fills through discount cards, generic discount programs, samples, and VA fills leave an appropriately treated patient scored as untreated[1,2]

HOW PERFORMANCE IS MEASURED

From Fill to Credit

The pathway involves a final-action **PDE record** for a qualifying statin, submitted by the plan and accepted by the reconciliation deadline, with a 2024 date of service.[1] There is no PDC calculation, no treatment-period arithmetic, and no threshold to track across the year. The single dispensing event constitutes the measure. Everything a practice does for **D12** is upstream of that event: the prescription written at the visit, routed through the patient's Part D benefit, filled once, and confirmed.[1]

The denominator operates on its own timeline. The **index prescription start date (IPSD)**, the first diabetes-medication fill of the year, must occur at least 90 days before year end. This ensures the measured population consists of patients on diabetes therapy long enough for statin initiation to be clinically appropriate.[1] CMS assigns star ratings by clustering, includes this measure in the

Part D Improvement Measure **(correlation 0.835)** and the Categorical Adjustment Index, and applies no case-mix adjustment.[1]

CLINICAL PEARL — CASH-PAY FILLS ARE INVISIBLE TO THE MEASURE

Generic statins are inexpensive enough that discount-card and $4-list **cash fills** occur routinely. Cash fills do not count to this measure and to the plan's complete medication record. The correction typically requires no additional patient cost. Many plans place generic statins on a **$0 or minimal-copay tier**, removing the incentive to bypass insurance. In a study of zero-dollar generic programs, moving fills onto the pharmacy benefit measurably improved adherence-measure performance.[8] When a cash fill is identified, the dispensing pharmacy can often reverse and rebill the claim through **Part D**.

Billing Codes Reference — Exclusion Diagnoses

CODE*	DESCRIPTION
G72.0/G72.9/M62.82	Drug-induced myopathy myopathy, unspecified rhabdomyolysis The muscle-injury exclusions, coded when clinically true
N18.6	End-stage renal disease
K74.60/K74.69	Cirrhosis of liver
R73.03	Prediabetes; the correct code for the metformin patient without diabetes
E28.2	Polycystic ovary syndrome; the correct code for the metformin patient without diabetes
Z33.1	Pregnant state, incidental (pregnancy, lactation and fertility exclusions)

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
*Submitted on a claim during the measurement year, and renewed each year the exclusion remains true(1)

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using its **own data and methodology**
Internal proxy	An **organization's internal estimate** based on its own patient population and available records. Useful for improvement work, but not equivalent to the official result

CALL IT THIS	WHICH MEANS
Documentation completeness	How **consistently** the care delivered is documented in structured fields
Patient understanding	Whether patients leave encounters with a **clear understanding** of what care they received, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
**Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

This measure is not case-mix adjusted.[1] A patient panel with greater pharmacy access barriers, copay burden, or medical distrust is scored against the same **unadjusted rate** as any other panel.

HIGH-YIELD INTERVENTIONS

The margin between star tiers represents a small number of patients per hundred. These patients are often identifiable in specific categories: the eligible patient who was never offered a statin, the prescription abandoned at the pharmacy counter, the cash fill the plan cannot detect, or the exclusion documented in narrative text rather than coded on a claim. **Visit-level intervention** should occur within the first week. **Registry review** and **pharmacy partnership** development constitute the thirty-day follow-up work.

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Build the denominator from pharmacy fills. Identify patients aged 40 to 75 with two or more diabetes-medication fills and no Part D statin claim this year. Separate true diabetes from off-label metformin use before outreach	**Monthly** · Panel manager or care coordinator	A registry built on diagnosis codes does not reflect this measure's denominator.[1] Splitting the list first routes off-label patients to correct coding **(R73.03, E28.2)**[1]
Flag eligible patients with no statin on the active medication list at point of care, and generate a moderate-intensity generic statin order for physician sign-off during the visit	**Every flagged visit** · MA pends; PCP decides and signs	In a cluster randomized trial, clinician prompts increased statin prescribing by **5.5** percentage points; pairing the clinician prompt with a patient text message increased it by **7.2** points.[9] The order-and-approve workflow requires seconds of visit time

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Present statin therapy in terms of vascular protection at the time it is prescribed	**In the visit** · PCP or embedded clinical pharmacist	Patients often discontinue medications whose purpose they do not understand. Providing a plain-language explanation of the medication's purpose at the time it is prescribed supports sustained adherence
Establish a collaborative practice agreement authorizing the pharmacist to initiate statin therapy for screened, eligible patients without a PCP visit	**Continuous** · Clinical pharmacist under CDTM protocol	Pharmacist-led collaborative care carries the strongest evidence for this measure. A cluster randomized trial of pharmacist-led statin outreach increased optimal statin prescribing from **37.8% to 59.0%** and cholesterol-target attainment from **63.5% to 69.5%** versus usual care[10]
Route every new statinstart explicitly through the Part D benefit. Name the pharmacy, verify the copay, set a 90-day supply with refills, and synchronize with existing diabetes fills	**At every new prescription start** · Pharmacy tech or clinical pharmacist	Explicit benefit routing makes the fill visible to the measure.[1] The 90-day synchronized supply supports performance on **D10**; appointment-based medication synchronization is associated with **3.4 to 6.1** times greater possibility of adherence for new prescription starts[11]
Review diabetic hospital discharges within 72 hours for a missing statin order	**Within 72 hours of discharge** · Care coordinator or pharmacist	Admissions that initiate an **SGLT2 inhibitor or GLP-1 receptor agonist** but discharge without statin therapy are a recurring source of missed cardiovascular protection. Discharge reconciliation identifies these patients months earlier than the next scheduled visit
Run an annual exclusion-recoding review at the visit where the excluding condition is clinically reconfirmed	**Annually, per patient** · PCP with coder or pharmacist support	Every exclusion resets on **January 1**.[1] This review maintains denominator accuracy in both directions: codes renewed where the condition persists, and retired where it does not

ABBREVIATIONS: CDTM = collaborative drug therapy management; CMS = Centers for Medicare & Medicaid Services; GLP-1 = glucagon-like peptide-1; MA = medical assistant; PCP = primary care provider; SGLT2 = sodium-glucose cotransporter-2

Risk Stratification — Who to Reach First

Not every open statin gap carries equal urgency or takes the same time to resolve. Prioritizing outreach by **clinical urgency** and **time-to-resolution** directs limited care team capacity to the

patients who benefit most. The tiers below rank patients from a prescription already in progress to a patient who has not yet started therapy, so outreach follows clinical priority.

TIER	CRITERIA	RESPONSE
Tier 1: active but unfilled	An **inactive** or **abandoned** statin prescription already in the pharmacy profile, or a discontinued low-dose trial	Reorder the prescription or switch agents. A pharmacist call should identify the specific **barrier** (cost, fear, or logistics) and **confirm pickup**. This tier resolves fastest
Tier 2: highest clinical stakes	Diabetes with **microvascular complications or high ASCVD risk**, normal liver and muscle baselines, no statin on board	Pend the order for **same-visit sign-off** when a visit exists. Initiate direct outreach when no visit is scheduled. This population carries the largest absolute benefit from therapy[6]
Tier 3: naive or hesitant	**No statin history**, or prior refusals and mild hesitancy	This tier requires sustained engagement through motivational interviewing and repeated reinforcement of the vascular-protection rationale across multiple touchpoints

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Eligible, never offered	A normal lipid panel is mistaken for the absence of an indication **for statin therapy**. This reflects a longstanding clinical habit of prescribing based on lipid values rather than diabetes-associated cardiovascular risk	**Indication-based alerts** triggered by age and diabetes-medication fills, not lipid values, paired with a vascular-protection explanation for the patient[1,7]
Prescribed, never dispensed	An **electronic prescription** is **mistaken for treatment completion**. Copay cost, patient hesitancy, or lack of follow-through can end the process at the point of dispensing, with no signal returning to the practice	Standardized **first-fill confirmation**, a **day-7 follow-up call** for new starts, and copay resolution completed before the patient obtains the prescription[11]

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Treated, but not documented	The patient fills the medication consistently through a **discount card**, **cash payment**, or a low-cost generic list. Because no **PDE claim** exists, the patient is scored as untreated for the full year	Confirm **payment method** at every medication review. Route generics through the **Part D benefit** as standard policy. When a cash fill is identified, request that the pharmacy **reverse and rebill** the claim through Part D[8]
Off-label fills misclassified in the denominator	The registry is built from medication fills, so patients taking metformin for **PCOS** appear alongside patients with true diabetes. An outreach list processed without differentiation treats both groups identically	Separate the list before outreach. Route confirmed diabetes to the statin pathway. Route off-label fills to accurate **exclusion coding (R73.03, E28.2)** on a claim[1]
Statin intolerance documented, never coded	The clinician documents statin intolerance in **narrative text**, which the measure cannot identify. The patient remains in the denominator, and the following year the documentation may no longer be visible in the active record	A **coding step** integrated into the clinical decision. When intolerance is confirmed, the diagnosis is entered on the encounter claim (**T46.6X5A**, or **M62.82/G72.0** for confirmed rhabdomyolysis or myopathy), with an annual renewal flag
Statin discontinued first	Diabetes regimens often include four or five daily medications. Because the statin treats a risk the patient cannot always feel directly, it is frequently the **first medication discontinued** under regimen burden	**Medication synchronization** aligning the statin pickup with diabetes-medication fills,[11] **90-day supplies**, and a patient-articulated understanding of the medication's purpose

ABBREVIATIONS: PCOS = polycystic ovary syndrome; PDE = prescription drug event

Common Pitfalls

Adherence-focused work can shift from patient care to measurement management. The following are not clinical interventions:

- Arranging refills a patient did not request and does not intend to use
- Synchronizing fills solely to preserve a **proportion-of-days-covered** calculation
- Continuing a medication the patient is not tolerating in order to avoid recording a gap
- Recording a filled prescription as taken without confirming with the patient

AAVBC PERSPECTIVE — ADHERENCE BARRIERS ARE OFTEN CLINICAL, NOT BEHAVIORAL

Non-adherence is rarely a matter of patient refusal. Underlying causes typically include **cost**, **side effects**, **regimen complexity**, **transportation barriers**, **health literacy**, **depression**, or an **unaddressed patient belief** about the medication.

For example, a patient who stops refilling because a $40 copay competes with rent or groceries is not refusing treatment; they are facing a cost barrier that a **$0-generic tier** or a **90-day synchronized fill** can resolve directly.

Identifying the specific barrier and addressing it is the clinical intervention required, and it can produce substantial improvement for this measure.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Fear of muscle damage	Word of mouth and social media turn a rare adverse event into an expected outcome. Symptoms then occur because they are anticipated, consistent with a **nocebo effect**	Address this at the time of prescribing with supporting data. In the **SAMSON N-of-1 trial**, 90% of the symptom burden reported on statins occurred identically on placebo.[12] Offer dose adjustment as the first response to symptoms, and instruct the patient to contact the practice before discontinuing
"My cholesterol is fine"	A normal lipid panel leads the patient to believe that daily medication is unnecessary	Explain that the medication **protects blood vessels** from the effects of diabetes, independent of the lipid value[5]
Preference for diet and exercise first	A belief that lifestyle change can substitute for medication, often reflecting **strong health motivation**	**Acknowledge the patient's effort** and clarify that lifestyle modification is additive to statin therapy, not a substitute for it, once diabetes is present[5]
Worry that statins raise blood sugar	Patients with borderline glycemic control learn that statins can raise **A1c** slightly and conclude the medication works against their diabetes management	Confirm that the effect is real but small, and present it alongside the **37%** reduction in major cardiovascular events observed in this population.[6] Stating this comparison directly supports patient trust[5]

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Cost and pill burden on fixed incomes	Copay costs compete with essential expenses such as food and utilities. Because the statin treats a risk the patient cannot feel directly, it is often the first medication rationed or discontinued, and discontinuation is frequently reported as forgetfulness rather than cost	Generic-first prescribing, use of a **$0-copay tier** where available,[8] **90-day synchronized fills**,[11] and direct assessment of cost as a clinical variable

ABBREVIATIONS: A1c = hemoglobin A1c

CLINICAL PEARL — LACK OF SYMPTOMS

Statins are prone to discontinuation in part because there is no symptom relief that confirms their effect. Providing the patient with a clear, evidence-led explanation, that the medication protects blood vessels from the effects of diabetes, gives them a reason to continue treatment. **Patients who can articulate a medication's purpose are more likely to remain on it.** Patients who cannot are more likely to discontinue it first when managing multiple medications.

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
No pharmacist authority	Statin initiation is limited to PCP visits, so **unresolved gaps persist** until the next scheduled appointment	A **CDTM collaborative practice agreement** authorizes the pharmacist to conduct screening, contraindication review, and initiation. This is the highest-effect intervention studied for this population[10]
Delayed care-gap reporting	Plan gap reports lag actual fills by **several weeks**. Teams pursue patients who already filled the prescription while missing those who abandoned it recently	**Cross-reference** the plan gap list against current dispensing data before outreach. Treat the plan report as a monthly reconciliation tool

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Exclusions written, not billed	The clinical team documents intolerance thoroughly, but **no role is explicitly assigned** to carry that documentation into the billing pathway CMS requires	A designated owner for the **exclusion-coding** process, a standard code set applied at the point of clinical decision, and an annual renewal review[1]
Discharge regimens without cardiovascular protection	Hospital teams intensify diabetes therapy at discharge and defer statin initiation to outpatient follow-up, which frequently occurs **months later**	A **72-hour discharge medication reconciliation**, with pharmacist authority to initiate therapy under protocol rather than waiting for the next scheduled visit
Late-year starts fall outside the clock	Patients starting diabetes therapy in the fourth quarter do not enter the current year's **denominator**. If the statin is deferred, it frequently misses the following year's denominator as well[1]	Include the statin as a standard component of the **diabetes-medication start bundle**, regardless of the calendar date. The clinical indication is independent of the measurement year[5]

ABBREVIATIONS: CDTM = collaborative drug therapy management; CMS = Centers for Medicare & Medicaid Services; PCP = primary care provider

Equitable Access and Differences in Statin Use

The contract-level rate does not identify which patients are missed, and this measure is **not case-mix adjusted**.[1] Disparities in statin use for primary prevention are among the documented treatment disparities in cardiovascular medicine. Dispensing rates should be examined by **race, ethnicity, language, dual-eligible status, disability, and geography**.[13]

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Black and Hispanic adults	In national survey data, statin use for primary prevention was approximately **fourteen percentage points lower** among Black (23.8%) and Hispanic (23.9%) adults compared with White adults (37.6%). This disparity reflects differences in access, counseling frequency, and trust in the healthcare system[13]	Counseling grounded in the **vascular-protection rationale rather than generic risk messaging**. Pharmacist and community-health-worker touchpoints that do not depend on a single clinician relationship. Dispensing rates reviewed by race and ethnicity[13]

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Women	Women show **lower statin initiation** and **higher discontinuation rates**, associated with higher reported muscle symptoms and less aggressive primary-prevention prescribing by clinicians	Application of the **same indication-based threshold regardless of sex**.[5] For reported muscle symptoms, dose adjustment before discontinuation, with the nocebo evidence discussed directly with the patient[12]
Adults 40–50	The **youngest eligible patients** tend to view diabetes as a **metabolic condition rather than a vascular one**, and clinicians prescribe statins to this group least often. This is the decade in which prevention yields the greatest gain in years of protection, yet it is the most frequently skipped	Establish eligibility at the time of diabetes diagnosis.[5] Configure the point-of-care flag to trigger at **age 40**
Low-income and dual-eligible patients	Primary non-adherence is concentrated in this population. The first fill often does not occur due to **copay cost, transportation, or pharmacy access**. Cash discount cards can then obscure the fills that do occur	Use of a **$0-generic tier** and copay resolution completed before the point of dispensing,[8] same-visit pharmacist initiation where authorized,[10] and benefit-routed 90-day fills as the default

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
New type 2 diagnosis, age 40–75	The statin indication is established at the **time of diagnosis**, concurrent with the metformin decision. Introducing it **early** as a standard component of diabetes care reduces later resistance to adding the medication[5]	Present glucose control, blood pressure management, and vascular protection as a **single standard of care**

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Diabetes with established ASCVD	This population is included in both **D12** and **C19**. The C19 numerator applies a stricter standard, requiring a moderate- or high-intensity statin	Prescribe to the stricter standard. A moderate- or high-intensity agent satisfies both measures and aligns with secondary-prevention evidence.[5] **A single fill can satisfy both measures simultaneously**
The metformin patient without diabetes	Metformin fills for prediabetes or PCOS place patients in the denominator despite the absence of a statin indication under this measure's logic[1]	These encounters require coding. Document **R73.03 or E28.2** on the claim, renewed annually. Any statin decision should be based on the patient's **individual risk profile**[1]
Hospital discharge with intensified diabetes therapy	**SGLT2 inhibitors** and **GLP-1** receptor agonists are often initiated **during hospitalization**, while statin initiation is deferred to outpatient follow-up, which frequently does not occur as scheduled.	The **72-hour medication reconciliation** should treat a missing statin as a discharge gap requiring immediate correction, under pharmacist protocol where available
Older and frail patients	SUPD is based on **chronological age** and does not include a frailty or advanced-illness exclusion. A 74-year-old with advanced dementia is scored identically to a healthy 58year-old[1]	**Clinical judgment takes priority.** When limited life expectancy makes primary-prevention benefit unattainable, document the individualized decision and accept the resulting open measure.[5] The hospice exclusion applies only where clinically appropriate; no other adjustment to this measure's logic is available[1]

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; GLP-1 = glucagon-like peptide-1; PCOS = polycystic ovary syndrome; SGLT2 = sodium-glucose cotransporter-2; SUPD = Statin Use in Persons with Diabetes

Patient Journey

BEAT	CONTENT
Presents as	A woman in her **early sixties** with **type 2 diabetes**, well controlled on **metformin** and an **SGLT2 inhibitor**, arrives for a routine visit. Her **LDL has never been flagged**. The pre-visit review identifies two diabetes-medication fills this year and no statin claim. She meets **denominator** criteria with an open numerator, and the indication for statin therapy has not previously been discussed with her
What happens	During the intake visit, the medical assistant asks "I see you're due for a heart-protective medication. Have you ever had a reaction to a cholesterol medication?" The patient reports no personal history, though her sister discontinued a statin due to muscle symptoms. The PCP signs the pended atorvastatin order and briefly reviews the **rationale**: the medication protects blood vessels from the effects of diabetes independent of the LDL value, the documented rate of muscle-symptom attribution, and an agreement that she will contact the practice before discontinuing. The prescription is routed to her regular pharmacy as a **90-day supply** through her **Part D** plan, synchronized with her diabetes medication refills
Outcome	The claim posts within the week, satisfying **numerator credit** for the measurement year. The patient can now articulate the medication's purpose. Because the fill is already synchronized, she enters **D10** adherence tracking with the infrastructure in place
Follow-up	The panel manager's monthly registry pull confirms the fill and transfers her to the maintenance list. The same pull identifies another patient on metformin for prediabetes without a diabetes diagnosis and routes that patient to coding rather than outreach. **R73.03** is documented on the next claim, **removing the patient from the denominator accurately**

ABBREVIATIONS: LDL = low-density lipoprotein; MA = medical assistant; PCP = primary care provider; SGLT2 = sodium-glucose cotransporter-2
Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Medication Adherence for Cholesterol QRG (D10)	Applies after the first fill. **D12** measures initiation; **D10** measures the proportion of days covered over the full year. A single 90-day synchronized fill supports performance on both measures
Statin Therapy for Patients with Cardiovascular Disease QRG (C19)	Applies to **secondary prevention**. Patients with diabetes and established ASCVD are included in both measures. **C19**'s moderate- or high-intensity requirement is the standard to prescribe to for both

GUIDE	WHEN TO REACH FOR IT
Diabetes Care Measures (C11, C12, C13)	Applies at the **same pre-visit review point**. The statin check can be addressed alongside A1c monitoring, the eye exam, and the kidney panel in a single pharmacist touchpoint
Medication Adherence for Diabetes Medications QRG (D08)	Applies to the **same denominator population**. The diabetes-medication fills that trigger D12 are the same claims **D08** scores for adherence, so medication-synchronization infrastructure supports both measures

ABBREVIATIONS: A1c = hemoglobin A1c; ASCVD = atherosclerotic cardiovascular disease; QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- This measure does not read the chart note. **The claim record determines the score.**[1] Chart documentation therefore serves three functions: establishing accurate denominator status, recording exceptions, and providing the routing information that makes the fill visible to the measure. This includes confirmed or corrected diabetes status, a recorded indication discussion, the exclusion code on the claim, and the Part D routing instructions attached to the prescription
- **Confirm diabetes status explicitly for every patient on the fills-based gap list**, for example, "type 2 diabetes, on metformin and empagliflozin" or "metformin for prediabetes, no diabetes." The denominator logic cannot distinguish between these cases; the chart must
- **Document the specific barrier behind every non-fill:** cost, fear, side effects, or logistics. The barrier determines the appropriate intervention and whether an exclusion applies or a gap remains
- Document refusals as **shared decisions**: what was discussed, what was offered, and when the conversation will resume. This documentation establishes the decision as informed and prepares the following year's visit

What Belongs in the Record

ELEMENT	WHAT TO RECORD
Diabetes status, verified	The **actual condition** underlying the qualifying fills: confirmed type 1 or type 2 diabetes, or the off-label indication (prediabetes, PCOS) that should be coded instead[1]

ELEMENT	WHAT TO RECORD
The therapy, with routing	**Agent, dose, 90-day supply and refills, the named pharmacy, and an explicit benefit instruction**: "Must bill through Medicare Part D benefit. Do not use cash discount cards"
The education delivered	The **vascular-protection rationale discussed**, the guideline basis noted (statin recommended regardless of baseline LDL),[5] side-effect misconceptions addressed, and the patient's agreement or concerns recorded in their own words
The exclusion, coded and current	The specific diagnosis coded on this measurement year's claim, including muscle injury, cirrhosis, ESRD, pregnancy, lactation, fertility treatment, prediabetes, or PCOS, with the annual renewal flagged[1]
The symptom workup	**For muscle complaints**: symptom pattern, severity, CK level where indicated, the rechallenge or agent switch attempted, and the outcome. This record distinguishes true myopathy from expected-symptom discontinuation[12]
Non-prescription decision	The **shared-decision record of a refusal, or a deliberate decision not to prescribe** due to frailty or limited life expectancy. Documented clinical judgment allows continuity of care to honor that decision

ABBREVIATIONS: CK = creatine kinase; ESRD = end-stage renal disease; LDL = low-density lipoprotein; PCOS = polycystic ovary syndrome

Clinical Documentation Optimization - SOAP Example

A worked note for the routine-visit patient in Section 8.

S — Subjective

Routine diabetes follow-up. **Type 2 diabetes**, stable on metformin and an SGLT2 inhibitor; **A1c 6.8%** last month. No chest pain, no claudication. On direct inquiry: never started a statin and never offered one; family history of a sibling stopping one over leg aches. No personal history of muscle symptoms, liver disease, or statin exposure.

O — Objective

Age 62. Pharmacy record: **two diabetes-medication fills this year, no statin claim**. LDL 92 mg/dL on last panel. Liver enzymes normal within the year. Blood pressure at goal.

A — Assessment

Type 2 diabetes mellitus, age 40–75, without statin therapy; guideline indication for moderate-intensity statin for primary cardiovascular prevention regardless of baseline LDL.[5] No exclusion applies: no muscle-injury history, no cirrhosis, no ESRD, not pregnant.

P — Plan

Vascular-protection rationale discussed (statin recommended for diabetes independent of cholesterol values); patient restates purpose in her own words. Muscle-symptom concern addressed with the placebo-comparison evidence and an explicit agreement to call before stopping.[12] **Started atorvastatin 20 mg daily**, **e-prescribed** as a 90-day supply with three refills, synchronized with

existing diabetes fills. Pharmacy note: "Must bill through Medicare Part D benefit. Do not use cash discount cards." First-fill confirmation assigned to pharmacy tech; nurse call at day 7 for tolerance.[5]

Documentation Examples

Complete — initiation with the loop closed

"*Type 2 diabetes (age 62): statin indicated for primary prevention regardless of baseline LDL; rationale discussed, teach-back completed. Atorvastatin 20 mg daily, 90-day supply, 3 refills, synchronized with diabetes fills at [pharmacy]. Pharmacy note: must bill through Medicare Part D benefit — do not use cash discount cards. First-fill confirmation due [date].*"

Complete — true intolerance, coded on the claim

"*Documented statin-induced myopathy: proximal muscle weakness with CK elevation on two agents at reduced doses, including alternate-day rechallenge. Diagnosis coded to today's encounter claim (drug-induced myopathy, G72.0); non-statin lipid therapy initiated on clinical grounds. Exclusion recoding flagged for annual renewal.*"

Incomplete

"*Patient refuses statin due to fear of muscle aches.*" "*Statin held due to elevated LFTs; will recheck in 6 months.*" "*Patient uses GoodRx for atorvastatin 20 mg.*" — the first documents a recoverable conversation as a dead end, the second describes an exclusion it never codes, and the third describes a treated patient the measure will score as untreated all year.[1]

DOCUMENTATION REMINDER — MAINTAIN TWO ACCURATE LISTS

This measure depends on two lists the practice must maintain accurately: the **denominator** (every fills-qualified patient, with misclassified entries recoded correctly and exclusions coded and current on claims) and the **fill list** (every statin confirmed reaching the patient through the benefit, never assumed from the prescription alone). All other activity, including patient education, pharmacist outreach, and copay resolution, serves to move patients from the first list to the second.

One Status, Clearly Stated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Eligible; no statin, never offered	The **largest group** of patients affected by this measure.[7] Flag for the next scheduled visit with a pended order. Initiate direct outreach when no visit is scheduled
Prescribed; fill pending	Prescription routed through the benefit, with day 3 to 7 verification assigned to a **named team member**. This status offers the greatest opportunity for intervention
Filled; credit posted	**PDE claim confirmed.** Subsequent work shifts to persistence: medication synchronization, 90-day refills, and **D10** performance

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Abandoned at the counter	**Prescription active, no claim submitted.** A pharmacist call should identify the specific barrier (cost, fear, or logistics) and address it directly
Filled outside the benefit	**Cash or discount-card fill identified.** The patient is treated but scored as untreated. Offer benefit routing, explained through its role in medication-safety monitoring, and request that the pharmacy reverse and rebill the claim[8]
Symptom under workup	Muscle complaint under evaluation, including rechallenge, agent switch, or CK-confirmed myopathy. **The patient remains in the denominator until the workup is complete and an exclusion is coded**[12]
Excluded; coded this year	True intolerance, cirrhosis, ESRD, pregnancy, lactation, fertility treatment, prediabetes, or PCOS coded on a current-year claim, with **annual renewal** flagged[1]
Declined; informed	**Shared decision documented**, with the specific concern identified and a scheduled date to revisit the conversation. This status is not permanent

ABBREVIATIONS: CK = creatine kinase; ESRD = end-stage renal disease; PCOS = polycystic ovary syndrome; PDE = prescription drug event

SEVEN KEY TAKEAWAYS

1 Diabetes is the indication

For patients aged 40 to 75 with diabetes, guidelines recommend statin therapy regardless of the lipid panel result. Deferring treatment until a lipid value crosses a threshold is this measure's most common gap.[7]

2 One Part D claim is the entire numerator

Any statin, filled once through the benefit, satisfies the requirement.[1] Cash fills, discount cards, samples, and VA fills do not count.

3 The denominator is defined by fills

Two diabetes-medication fills place a patient in the denominator, including metformin prescribed for prediabetes or PCOS.[1] These patients require accurate coding, not automatic statin prescribing.

4 Exclusions must be coded on claims and renewed annually

Recognized exclusions include muscle injury, cirrhosis, ESRD, pregnancy, lactation, fertility treatment, prediabetes, and PCOS.[1] Narrative chart documentation alone does not exclude a patient.

5 A reported muscle symptom requires workup, not discontinuation

Most reported statin symptoms occur at the same rate on placebo, and dose adjustment or rechallenge resolves symptoms in most patients. True intolerance should be coded precisely.[12]

6 Patients need to understand the medication's purpose

A patient who can explain why the medication is prescribed is more likely to remain on it than one who cannot.

7 The fill is the minimum, not the goal

Clinical benefit depends on the adherent year that follows the first fill. Synchronized 90-day supplies initiated now support **D10** performance later, and sustained persistence is the actual clinical objective.[6,11]

Changes to Monitor

Current as of 2026-09-08.

KIND OF CHANGE	GOOD PRACTICE
Measure status and specification	D12 remains an active, standard-weighted Part D process measure, adapted from the PQA measure concept; it is not among the eleven measures the CY2027 final rule removes.[1,14] The PQA-maintained NDC and exclusion-diagnosis lists are updated and posted with each year's Technical Notes. **Refresh registry logic against them before each measurement year**[1,2]
Rating-year methodology	Cut points reset annually through clustering; revalidate cut points, Categorical Adjustment Index treatment, and Improvement Measure inclusion **(correlation 0.835 for 2026)** each cycle.[1] Both plan-type rows move independently — check the row that matches the contract[1]

KIND OF CHANGE	GOOD PRACTICE
Rating-year policy	The **CY2027** final rule did not implement the planned health-equity-based reward; the historical reward factor continues. Confirm reward-factor treatment each Advance Notice cycle[14]
Companion-measure landscape	C19 (Statin Therapy for Patients with Cardiovascular Disease) is scheduled for removal beginning with the 2028 Star Ratings, and the Part D adherence measures (including D10) are scheduled to **drop from weight 3 to 1 in 2028 and return to 3 in 2029**.[14] The clinical work is unchanged; the scoreboards around this measure are not. Reconfirm cross-references each cycle
Clinical guidance	The **ADA Standards of Care revised annually**. Statin intensity selection, age-band guidance and older-adult individualization all carry revision risk. Refresh the clinical rows of this guide against the current Standards[5]
Internal tools and patient materials	Review the fills-based registry logic, the ghost-denominator coding pass, the exclusion-renewal pass, the Part D routing note text, and the CDTM protocol annually; **do not** label any retained prior-year cut points as current

ABBREVIATIONS: ADA = American Diabetes Association; CDTM = collaborative drug therapy management; NDC = National Drug Code; PQA = Pharmacy Quality Alliance

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