



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Statin Therapy for Patients with Cardiovascular Disease

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C19 – Statin Therapy for Patients with Cardiovascular Disease

CMS Definition: This measure evaluates the percentage of patients with cardiovascular disease who are dispensed an appropriate cholesterol lowering medication.¹ It includes **males aged 21 to 75 and females aged 40 to 75** with clinical atherosclerotic cardiovascular disease who received **at least one high- or moderate-intensity statin** during the measurement year.¹

FIELD	ENTRY
CMS measure name	Statin Therapy for Patients with Cardiovascular Disease, SPC
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Process Measure
Weight	1, standard-weighted
Primary data source	HEDIS; medical and pharmacy claims
Unit of measurement	CMS contract-level measure; individual clinicians and practices do not receive a C19 Star Rating
Trend direction	Higher is better
Case-mix adjusted	No ¹
Measurement period	01/01/2024 – 12/31/2024; two years before reporting year ¹
Star measure credit	One filled pharmacy claim for a high- or moderate-intensity statin during the measurement year, confirmed by the claim. Prescriptions, samples, chart notes, and cash fills do not count, and there is no chart-review pathway. This is a dispensing measure, not an adherence measure ¹
Dispensing rate versus adherence rate	The HEDIS SPC specification reports two rates: dispensing (at least one qualifying statin fill during the year) and adherence (proportion of days covered of at least 80 percent). CMS scores C19 on the dispensing rate only ^{1,2}
Statistical method	Clustering. Cut points are recalculated each year from the distribution of contract scores and are not fixed targets ¹
Not reported for	I-SNP-only contracts, and Prescription Drug Plans ¹
Statin intensity examples	High-intensity: atorvastatin 40–80 mg rosuvastatin 20–40 mg Moderate-intensity: atorvastatin 10–20 mg rosuvastatin 5–10 mg pravastatin 40–80 mg simvastatin 20–40 mg lovastatin 40 mg Low-intensity agents and doses do not satisfy the numerator ²

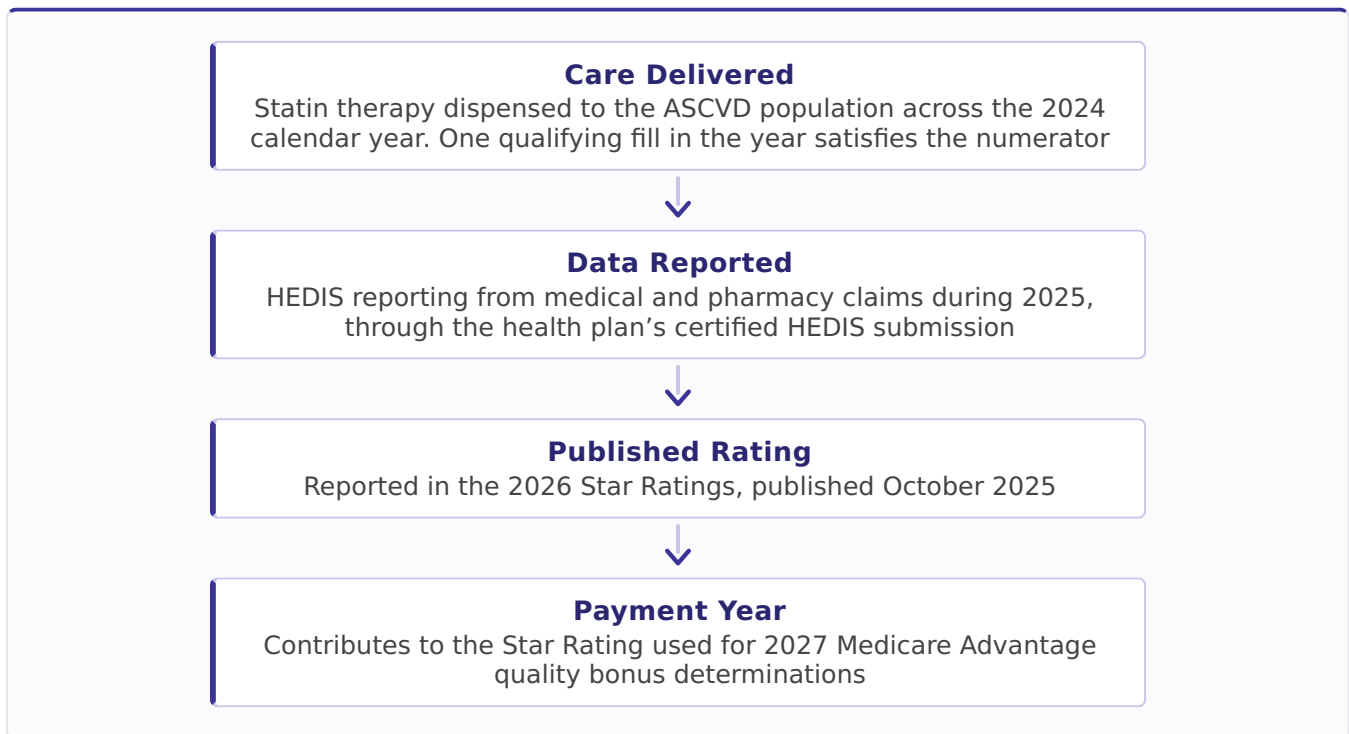
FIELD	ENTRY
ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; EHR = electronic health record; I-SNP = Institutional Special Needs Plan; SPC = Statin Therapy for Patients with Cardiovascular Disease (HEDIS label)	

Qualifying Diagnoses for SPC Denominator

PATHWAY	CRITERIA ^{3,4}	ICD-10-CM/CPT CODES ^{5,6}
Event-based	Patient was discharged from an inpatient setting with a myocardial infarction (MI) on the discharge claim, or received a coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), or any other revascularization in any setting in the measurement year or year prior to the measurement year	MI (inpatient discharge claim): ICD-10 I21.01-I21.B, I22.0-I22.9, I23.0-I23.8, I25.2, I25.6 CABG (any setting): CPT 33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536; HCPCS S2205-S2209 PCI (any setting): CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943; HCPCS C9600, C9602, C9604, C9606, C9607 Other revascularization (any setting): CPT 27220-27231
Diagnosis-based	One diagnosis consistent with ASCVD (for example, coronary heart disease or peripheral arterial disease) during the measurement year, and one diagnosis during the year prior to the measurement year	I20.0, I20.2, I20.8, I20.81, I20.89, I20.9 (angina); I24.0, I24.8, I24.9 (acute ischemic heart disease); I25.xxx (chronic ischemic heart disease); I63.xxx (cerebral infarction); I65.xx, I66.xx (precerebral/cerebral artery occlusion or stenosis); I70.xxx (atherosclerosis); I75.xxx (arterial embolism and thrombosis); T82.855x, T82.856x (cardiac/vascular device complications)

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CABG = coronary artery bypass graft; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; IVD = ischemic vascular disease; MI = myocardial infarction; PCI = percutaneous coronary intervention

How The Years Line Up



The 2026 Star Rating is based on statin fills dispensed during the 2024 measurement year. Any qualifying fill within that calendar year counts toward the numerator, **the measurement period ends on December 31**. A fill dispensed on January 2 of the following year **does not count retroactively**.^{1,2}

In One Sentence

This measure applies to patients (**men aged 21-75 and women aged 40-75**) with established cardiovascular disease. Within that population, it calculates the percentage who filled **at least one moderate- or high-intensity statin** during the year.

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.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<81%	≥81% to <85%	≥85% to <88%	≥88% to <91%	≥91%

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

2026 Industry Performance (2025 → 2026 Trend)

- **National numeric average:** approximately 86% in the 2025 Star Ratings, rising to **87% in 2026**. The average measure rating improved from 3.0 to **3.3 Stars** as the 5-Star threshold eased slightly, from 92% to 91%^{1,7,8}
- **The full scored distribution spans a ten-point range:** 1 Star below 81%, 5 Stars at 91%. On a measure with a narrow scoring range, **the difference between tiers represents a small number of patients per hundred**. As a result, gaps in data documentation, including abandoned fills, cash-pay fills invisible to the plan, and uncoded intolerance, require direct attention¹
- **Broader MA market context:** approximately **64% of MA-PD** enrollees are in health plans rated **four or more Stars for 2026**, and 18 MA-PD health plans earned an overall 5-Star rating⁹

WHAT THE MEASURE IS ASKING



AAVBC PERSPECTIVE — HOW THIS MEASURE WORKS

*This measure's eligibility age is **lower for men (21) than for women (40)**, reflecting the earlier average age of ASCVD onset in men. Men reach comparable cardiovascular disease incidence approximately 7 to 10 years earlier than women.¹⁰ Once a qualifying event has occurred, the clinical standard for statin therapy is the same regardless of sex. **Accurate documentation of these qualifying events is what allows a registry to correctly identify the right patient for the right therapy at the right time.***

In Plain Language

Patients with **established ASCVD**, defined by a qualifying cardiovascular event (myocardial infarction, ICD-10-CM **I21.xx**; or coronary revascularization, **Z95.1/Z95.5**) or a diagnosis of ischemic vascular disease (ICD-10-CM **I20, I24, I25, I63, I65, I66, I70, I75, T82.855x–T82.856x**), should be maintained on a **moderate- or high-intensity statin** unless clinically contraindicated. This measure evaluates whether the statin was **actually dispensed** by the pharmacy at least once during the measurement year. Prescribing, sampling, or documented discussion do not satisfy the numerator, only a dispensing event recorded on a claim does.^{1,2,6}

Why it Exists

Secondary prevention with statins is among the most well established interventions in medicine, yet a substantial gap exists between guideline recommendations and clinical practice. Nearly **half** of eligible adults are not on guideline-directed therapy.¹¹ Among patients who remain on treatment

after a myocardial infarction, full adherence to statin-containing regimens is associated with approximately **25%** fewer major adverse cardiovascular events over two years.⁶ **This measure exists to close that gap:** it sets its threshold at a single qualifying fill because even that minimal requirement is not being met consistently.

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 ASCVD patient for a qualifying statin and by event history • Prescribing at moderate or high intensity, not low • Routing the fill through insurance to low-cost generics, never cash cards • Establishing efficient e-prescribing and pharmacy communication channels, so dispensing happens without delay • Monitoring the patient population for ASCVD, including early signs and accurate documentation • Verifying the first fill and coding true intolerance precisely	• Hospital discharge regimens surviving the handoff • Pharmacy stock, copays and prior authorizations • The pharmacist callback for the hesitant patient • Caregiver support for complex regimens	• Who carries an ASCVD diagnosis and the qualifying event criteria for the denominator • The intensity classifications and value sets • Cut points, clustering, and the Categorical Adjustment Index

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease



AAVBC PERSPECTIVE — LDL DOES NOT DETERMINE STATIN ELIGIBILITY

The most common performance gap in this measure occurs when **a normal-appearing LDL level is** treated as a reason not to escalate to the required statin intensity. Statin benefit in secondary prevention comes from the ASCVD diagnosis, not the current LDL level. Statins reduce vascular inflammation and stabilize atherosclerotic plaque, **lowering the risk of plaque rupture independent of the LDL value achieved.** High-intensity statin therapy has also produced **measurable regression of coronary plaque volume** on intravascular ultrasound, independent of a specific LDL target.

A patient with a normal LDL level and no qualifying statin has not been successfully managed under this measure.^{11,12,13}

MEASURE SPECIFICATION

HEDIS Clinical Action Measure — Claims Only

ELEMENT	SPECIFICATION
Denominator	Males 21–75 and females 40–75 as of December 31 of the MY, with: -> ASCVD identified via an MI (I21.01–I21.B, I22.0–I22.9, I23.0–I23.8, I25.2, I25.6), CABG, PCI, or other revascularization event in the year prior to the MY, or -> one ASCVD/IVD diagnosis (for example, I20.x angina, I25.x chronic ischemic heart disease, I70.x atherosclerosis) during the MY and one during the year prior (see qualifying diagnoses table for the complete code list). Eligibility resets annually and does not carry forward. Requires continuous medical and pharmacy enrollment in both years
The event	A documented MI, bypass, stent, or ischemic stroke qualifies the patient regardless of whether any note uses the term "ASCVD." This is time-limited to the intake window (July 1 of the year prior through June 30 of the MY). A past event alone does not keep a patient in the denominator indefinitely; continued eligibility requires an ASCVD or IVD diagnosis code in both the MY and the year prior
Numerator	At least one dispensing event for a high- or moderate-intensity statin during the measurement year, from pharmacy claims matched against the specification's medication lists^{1,2}
Statin-intolerance exclusions	G72.0 (drug-induced myopathy); G72.2 (myopathy due to other toxic agents); G72.9 (myopathy, unspecified); M60.9 (myositis, unspecified); M79.10 (myalgia, unspecified site); M79.18 (myalgia, other site); M62.82 (rhabdomyolysis)^{1,2}
Other clinical exclusions	Pregnancy, in-vitro fertilization, or a clomiphene dispensing (measurement year or year prior); ESRD or dialysis (either year); cirrhosis (either year)¹
Standard exclusions	Hospice or hospice services, death, palliative care; for patients 66 and older, I-SNP enrollment or long-term institutional residence, or frailty plus advanced illness, both required. Contract-level small-plan rules apply¹

ELEMENT	SPECIFICATION
Data collection	Administrative claims only. Medical claims for the denominator, pharmacy claims for the numerator. No chart abstraction, no supplemental attestation, no CPT II pathway ^{1,2}
Measurement window	January 1 - December 31, 2024 for the 2026 Star Ratings. Fill-status calculations lock at year end ¹

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CABG = coronary artery bypass graft; ESRD = end-stage renal disease; I-SNP = Institutional Special Needs Plan; MI = myocardial infarction; PCI = percutaneous coronary intervention; MY = Measurement Year



RED FLAG — EVALUATE MUSCLE PAIN BEFORE DISCONTINUING STATIN THERAPY

Confirmed statin-associated muscle injury is not common and affects **roughly one in a hundred patients in randomized trials**, yet up to a third of patients report muscle aches they attribute to the drug. Stopping therapy at the first complaint of muscle pain could harm the patients as **cardiovascular protection ends** as soon as the medication is stopped. Evaluate the symptom first. Try alternate-day dosing, or switch to a different statin (some patients benefit from more hydrophilic statins such as pravastatin or rosuvastatin as they penetrate muscle tissue less readily than lipophilic statins, which may reduce the likelihood of muscle-related side effects), and correct contributing factors such as vitamin D deficiencies. Code confirmed myopathy accurately when it is found.^{2,14,15}

Commonly Misunderstood

- A prescription alone is often assumed to satisfy the measure. **Only the filled pharmacy claim counts.** A prescription abandoned at the counter, a sample, or a discount-card cash fill results in a clinically compliant patient being recorded as non-compliant²
- A patient described as being on a statin is often assumed to qualify. **The intensity of the statin determines eligibility. A low milligram dose of a high-intensity statin can satisfy the measure while a high milligram dose of a low-intensity statin does not** (for example, 5 mg of rosuvastatin outperforms 80 mg of simvastatin). With low-cost, effective high-intensity options now widely available, switching patients to a high-intensity statin is more ideal and accessible²
- Chart documentation is often assumed to influence scoring. **There is no documentation pathway for this measure.** No CPT II code, attestation, or chart review can substitute for a missing fill. The only chart-based action that affects this measure is exclusion coding^{1,2}
- A problem list entry of “statin intolerant” is often assumed to exclude the patient. **Only specific diagnoses, coded within the measurement year, satisfy the exclusion.** The exclusion must be recoded annually^{1,2}

HOW PERFORMANCE IS MEASURED

From Dispensing to Credit

Measurement depends on a pharmacy claim for a qualifying statin and dose during the measurement year that is matched against the specification's medication list. The prescription must be written at a **qualifying intensity**, routed through the patient's insurance, **filled at least once and confirmed on a claim**. **Exclusion coding is the only chart-side option available**, and intolerance diagnoses **must be renewed each measurement year** to remain valid.^{1,2}

CMS assigns measure stars by clustering, includes the measure in the Part C Improvement Measure (**correlation 0.729**) and the Categorical Adjustment Index, and applies no case-mix adjustment.¹

Examples of High- and Moderate-Intensity Statin Medications

DESCRIPTION	PRESCRIPTION* ¹⁶
High-Intensity Statin Therapy	Atorvastatin 40-80 mg
	Amlodipine-atorvastatin 40-80 mg
	Rosuvastatin 20-40 mg
	Simvastatin 80 mg
	Ezetimibe-simvastatin 80 mg
Moderate-Intensity Statin Therapy	Atorvastatin 10-20 mg
	Amlodipine-atorvastatin 10-20 mg
	Rosuvastatin 5-10 mg
	Simvastatin 20-40 mg
	Ezetimibe-simvastatin 20-40 mg

DESCRIPTION	PRESCRIPTION* ¹⁶
Moderate-Intensity Statin Therapy	Pravastatin 40-80 mg
	Lovastatin 40 mg
	Fluvastatin 40-80 mg
	Pitavastatin 1-4 mg

*Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions



CLINICAL PEARL — VA PHARMACY FILLS DO NOT APPLY TO THIS MEASURE

Veterans with Veterans Affairs (VA) insurance often fill prescriptions through VA pharmacy benefits rather than through their Medicare Advantage plan. **VA pharmacy claims are not submitted to CMS and do not count toward this measure.** For a veteran enrolled in Medicare Advantage, **only a fill submitted through the Medicare Advantage plan generates a qualifying claim.** Practices should encourage veteran patients to fill statin prescriptions using their Medicare Advantage insurance card rather than their VA benefit.

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 health plan 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
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 population with greater pharmacy access limitations, copay burden, and medical distrust is scored on the **same unadjusted rate as any other population**. Because the scoring band spans only ten points, these access-related gaps **translate directly into differences in Star tier**.

HIGH-YIELD INTERVENTIONS

The interventions below target the specific points where eligible patients most often **fail to receive or continue** a qualifying statin.

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Run a monthly registry pull of patients with a claims-confirmed cardiovascular event, and check each patient's record for an active, qualifying-intensity statin	Monthly · Panel manager; PCP acts at the visit	Denominator inclusion is determined by claims data for a qualifying cardiovascular event. Patients meeting this criterion must be identified proactively, since the practice may not otherwise be tracking who is eligible
Trigger a point-of-care alert for confirmed ASCVD patients without a qualifying-intensity statin, and prescribe at the visit	Every flagged visit · MA flags; PCP pitches and prescribes	Alerting the clinician and engaging the patient directly together outperformed either approach alone in a cluster-randomized trial ¹⁷
Review cardiovascular discharges and confirm that the hospital-initiated statin is indicated, filled and of qualifying intensity	Within 48 hours of discharge · Care coordinator	Adherence is most commonly lost in the gap between discharge and the first refill
Confirm with the pharmacy that coverage is verified, copay issues are resolved, auto-refill is set, and the first fill is completed	At every new prescription start · Pharmacy tech or clinical pharmacist	Only a dispensed fill counts toward the numerator. Pharmacy-level follow-up on coverage and refill barriers directly determine whether that fill occurs
Contact the patient on day 7 to confirm the prescription was picked up, address expected concerns about muscle aches, and direct any reported symptoms to clinical evaluation	Day 7 after every new prescription start · Care coordinator or nurse	Most self-discontinuation occurs early, when expectation-driven symptoms arise before any perceived benefit ¹⁴

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Transition tolerating patients to 90-day insurance-covered fills	After the first tolerated fill Prescriber standing practice	Fewer refill events reduce the opportunity for a lapse in therapy. This supports both the current and following year's measure performance and contributes to the related Part D adherence measures

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CABG = coronary artery bypass graft; MA = medical assistant; MI = myocardial infarction; PCI = percutaneous coronary intervention; PCP = primary care provider

Risk Stratification — Who to Reach First

Prioritized by absolute risk and conversion speed.

TIER	CRITERIA	RESPONSE
Urgent: week 1	Recent MI or PCI (past 3-6 months), unmedicated or below qualifying intensity	Immediate outreach. E-prescribe a guideline-preferred agent. Confirm pharmacy hand-off within the same week. This group represents the highest risk reduction associated with this measure ¹¹
Priority: weeks 2-3	Established ASCVD with an active prescription sitting undisposed	These patients appear resolved in the chart, but claims data confirm the prescription was never filled. Identify and resolve the specific barrier, such as cost, concern about side effects, or logistics, and confirm pickup
Systematic: weeks 2-4	ASCVD by event history, no statin prescription	Queue an EHR flag for the next scheduled visit. For patients with no visit scheduled, initiate direct outreach. This tier requires a provider decision to prescribe
Complex: week 4 and ongoing	Documented intolerance history, prior refusals, repeated lapses	Pharmacist-led management: structured rechallenge, alternative agents or dosing schedules, and accurate exclusion coding where warranted. Non-statin therapy may be clinically appropriate in some cases; this benefits the patient even when it does not affect the measure's numerator ¹⁴

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; EHR = electronic health record; MI = myocardial infarction; PCI = percutaneous coronary intervention



QUALITY OUTCOME — PHARMACIST OUTREACH

In a study at Denver Health, an urban safety-net health system serving low-income and Medicare Advantage patients through Federally Qualified Health Center clinics, clinical pharmacist telephone outreach (mean 27.7 minutes per patient) to ASCVD patients not on statin therapy was associated with a system-wide increase in statin prescribing from 24.7% to 56.6%.¹⁸ **This demonstrates that dedicated pharmacist follow-up produces a measurable increase in the prescribing rate this measure scores, supporting pharmacy-level follow-up as a high-yield use of care-team time.**

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Prescription issued without dispensing confirmation	The prescriber does not receive confirmation that the prescription was filled. This can happen because the pharmacy lacks the patient's contact information, or outreach is attempted but does not reach the patient	Standardized first-fill confirmation, a structured day-7 contact for all new prescriptions ¹⁸
Therapy adherence not reflected in claims data	Cash-discount or VA fills bypass insurance claims, so the patient appears untreated despite taking the medication	Ask about payment method during medication reconciliation, and route generic statin fills through insurance ²
Deferral of therapy based on lipid values	A normal LDL result is treated as a reason to delay starting a statin	Base eligibility on cardiovascular history , not lipid values. Use lipid results only for intensity selection ¹¹
Discontinuity of hospital-initiated statin therapy	A patient started on a statin in the hospital may not have it renewed in time if the discharge summary is delayed or the follow-up visit is missed , and the original supply runs out before a refill occurs	A standardized 48-hour post-discharge medication reconciliation

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Indefinite therapy avoidance based on an undocumented intolerance	A past symptom is treated as a permanent reason to avoid the drug, without meeting criteria for a coded exclusion, leaving the patient neither treated nor formally excluded	Rechallenge as the default clinical response to undocumented intolerance , with precise, measurement-year-specific diagnostic coding applied to confirmed cases ^{2,14}
Low-dose statin dosing misclassified as adequate treatment	A patient started on a low-intensity statin often stays on it indefinitely , with no later check on whether that choice is still appropriate	Reassess long-term low-intensity patients at routine visits , and switch to a high-intensity generic when no clinical reason to remain on low intensity

ABBREVIATIONS: ADT = admission, discharge, transfer; LDL = low-density lipoprotein

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Perceived cure following revascularization	Symptom relief after the procedure is mistaken for a cure, making daily therapy for an asymptomatic condition feel unnecessary to the patient	Reinforce at every post-event visit that the procedure fixed one blockage, while the statin treats the underlying disease ¹¹
Nocebo-driven symptom attribution	Patients attribute ordinary aches to the statin; confirmed muscle injury occurs only in approximately one in a hundred users ⁷	State the actual injury rate at the time of prescribing, and initiate pain management or switching statins rather than stopping therapy if symptoms occur ⁷
Preference for lifestyle modification	Patients who decline therapy often believe diet and exercise can replace medication	Acknowledge the patient's effort and clarify that lifestyle modification is additive to, not a substitute for, statin therapy once ASCVD is established

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease



CLINICAL PEARL — COUNSELING ON RATIONALE IMPROVES ADHERENCE

Adherence is strongest when patients understand the rationale for their treatment. The statin is indicated to reduce the risk of cardiovascular recurrence given the patient's established disease. **Patients are more likely to discontinue medications when they cannot state the reason they are taking them.** Counseling on this rationale at the time of prescribing is a stronger predictor of long-term persistence.¹¹

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Handoff gap following cardiac events	Cardiology initiates statin therapy, and primary care assumes cardiology handles renewal; neither party renews it	Assign renewal responsibility explicitly at discharge: primary care is responsible for renewal unless cardiology documents otherwise. Verification should be based on confirmed fills, not assumed ownership
Limited pharmacy access	Patients traveling long distances for monthly refills predictably experience lapses in therapy. This pattern reflects access limitations, not nonadherence	Default to 90-day fills or mail-order pharmacy for stable patients, and establish local pharmacy partnerships in areas with limited retail access
Unprocessed refill requests	Approved renewals remain unprocessed in the practice's workflow, creating an administrative delay	Clear the refill queue daily before attributing any gap to patient nonadherence
Unrenewed exclusion coding	An intolerance diagnosis coded once expires unnoticed , since the measurement-year look-back resets annually ^{1,2}	Review the documented-intolerance list annually, timed to the visit where intolerance is clinically reconfirmed ²

Equitable Access and Differences in Statin Treatment

This measure is **not case-mix adjusted**, and the aggregate rate does not identify which patient subgroups are underperforming.¹ Disparities in statin treatment are **among the most well-documented treatment gaps in cardiology.** Dispensing rates should be **tracked by race, ethnicity, sex, income, and geography.**

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Black and Hispanic adults	In national survey data, statin use for primary prevention was roughly fourteen points lower among Black (23.8 percent) and Hispanic (23.9 percent) adults than White adults (37.6 percent) . The access and trust patterns behind this gap affect secondary prevention outcomes as well ¹⁹	Community health worker and pharmacist outreach built on trust. Use 90-day and mail-order fills where pharmacy access is limited. Review prescribing and dispensing rates by race and ethnicity ¹⁹
Women with established ASCVD	Cardiovascular disease is the leading cause of death in women. However, women are prescribed qualifying-intensity statins less often than men and discontinue therapy at higher rates. Cardiovascular risk in women is frequently underestimated at prescribing, and muscle-related symptoms more often lead to discontinuation	Apply risk-based thresholds identically by sex. For muscle symptoms, pursue statin adjustment, schedule change, or a hydrophilic statin before discontinuation, using the same rechallenge standard applied to men ¹⁴
Low-income and dual-eligible patients	Financial instability interrupts fills, and these interruptions are recorded by the measure as treatment failure rather than as a financial barrier	Prioritize generic prescribing, apply copay assistance before dispensing, and route fills through insurance. Ask about cost as a standard clinical variable at every renewal
Rural patients	Distance interferes with refill opportunities	Use mail-order and 90-day supplies as the standard pathway for rural patients, and use a day-7 call to replace the in-person follow-up that distance prevents
ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease		



DOCUMENTATION REMINDER

On a claims-only measure, **documentation does not generate numerator credit**, its only function is determining **denominator exclusion**. Intolerance exclusions **require specific diagnosis codes entered within the current measurement year**, for example: drug-induced myopathy paired with the corresponding adverse-effect code, and dialysis or cirrhosis codes where applicable. A note reading "stopped statin, side effects," without a corresponding diagnosis code, **does not satisfy the exclusion and does not carry forward to the next measurement year**.^{1,2}

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
The first six months after MI or PCI	Treatment benefit and nonadherence risk are both highest in this window , so hospital-initiated therapy must be actively sustained by primary care	A 48-hour post-discharge medication reconciliation, a day-7 follow-up call , and reinforcing that the procedure alone was not sufficient treatment
Ischemic stroke and PAD	Non-cardiac ASCVD qualifies identically for this measure but is missed more often , since specialty clinics may assume primary care is already managing it ²	Feed stroke and PAD histories into the same registry and alert logic used for cardiac ASCVD
Diabetes with ASCVD	This population overlaps with glycemic and renal quality measures , and statin benefit is greatest here	Statin status can be reviewed in the same visit as A1c and renal panel review . A single pharmacist outreach call can address this measure alongside related diabetes measures
Frail patients near end of life	This population is where continuing therapy may no longer be clinically appropriate , and the measure specification permits exclusion accordingly	Code frailty-with-advanced-illness or hospice exclusions when deprescribing is clinically appropriate

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; MI = myocardial infarction; PAD = peripheral arterial disease; PCI = percutaneous coronary intervention

Patient Journey

BEAT	CONTENT
Presents as	A man in his late sixties, eight months past a drug-eluting stent , arrives for a routine visit. The registry flags him: ASCVD by event, no statin claim in eleven months. His chart says atorvastatin 40 mg , prescribed at discharge, filled twice, however nothing charted after that. He claims he feels well
What happens	The PCP asks what happened to the medication. The answer is layered: his legs ached for a week (a neighbor reported that statins damage muscles), the copay was an irritant, and he believed the stent had resolved the problem. Three barriers, three responses: the protection reframe, the real number on muscle risk with a promise of adjustment over abandonment, and a switch to a 90-day generic fill through his benefit at a fraction of the copay
Outcome	He accepts the restart at the same intensity . The e-prescription goes out during the visit, the pharmacy tech confirms the fill on day 5 , and the day-7 call finds no symptoms and a reassured patient. The claim posts, credit for the measurement year, and protection extending well beyond it
Follow-up	The patient transitions to maintenance-tier management: 90-day fills, symptom-related concerns routed to clinical adjustment rather than discontinuation, and an annual claims-based verification . Because the qualifying cardiovascular event remains part of the denominator indefinitely , this verification should be built into standard workflow

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; PCP = primary care provider

Note: Case is illustrative and is not a reported individual case

Companion Guides - Making Connections

GUIDE	WHEN TO REACH FOR IT
<u>Medication Adherence for Cholesterol QRG (D10)</u>	Addresses sustained adherence: this measure counts the first qualifying fill, while D10 measures the proportion of days covered over the full year that follows
Diabetes Care Measures (C11, C12, C13)	Addresses the overlap population. Patients managed through the diabetes pre-visit workflow represent the highest-benefit group for this measure's statin check
<u>Transitions of Care QRG (C20)</u>	Covers the post-discharge medication reconciliation process used in this measure's week-one intervention tier

ABBREVIATIONS: QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- This measure is claims-based and **does not review clinical notes directly**; documentation **determines the accuracy of the denominator and the validity of any exclusions**. The ASCVD-qualifying event **should be recorded in the chart with a date**; statin intensity **should be documented alongside the drug name**; and intolerance **should be recorded using diagnosis codes**^{1,2}
- **Document intensity explicitly**: "atorvastatin 40 mg, high-intensity". "On a statin" is not sufficient and it is how low-intensity misses occur²
- **Document the barrier behind every non-fill clearly**: cost, fear, side effect, logistics. The reason determines both the correct intervention and whether an exclusion applies
- **Document refusals as shared decisions**: what was discussed, what was offered, what comes next

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The qualifying event	Note which pathway qualifies the patient: an event (MI, CABG, PCI, or other revascularization) confirmed by ICD-10/CPT code and date within the measurement year's intake window, or an ongoing diagnosis (ASCVD/ IVD, including ischemic stroke or PAD) confirmed by diagnosis code. Event-based qualification is time-limited to that window and must be reinforced by continued diagnosis coding
The therapy and intensity	Statin, dose, and intensity classification. Pharmacy to which the prescription was routed. Fill status: confirmed, pending, or abandoned ²
Muscle symptom evaluation	For reported muscle symptoms: symptom pattern, severity, rechallenge or statin switch attempted, and outcome ¹⁴
Exclusion coding	Specific diagnosis codes for confirmed intolerance or applicable systemic exclusions , entered within the current measurement year. Exclusion coding must be renewed annually ^{1,2}
Barrier and resolution	The specific barrier identified, the corresponding intervention applied (copay program, 90-day fill transition, pharmacist follow-up), the responsible party, and the date

ELEMENT	WHAT TO RECORD
Clinical decision to withhold or discontinue therapy	The clinical rationale for a patient refusal or a clinically indicated deprescribing decision. Documented rationale supports the clinical decision on review
ABBREVIATIONS: CABG = coronary artery bypass graft; MI = myocardial infarction; PAD = peripheral arterial disease; PCI = percutaneous coronary intervention	

Clinical Documentation Optimization - SOAP Example

A worked note for the patient in Section 8.

S — Subjective

Routine follow-up, **eight months post drug-eluting stent** to the LAD ([date]). Feels well; no chest pain, dyspnea, or exertional symptoms. On direct inquiry, stopped atorvastatin after two fills: one week of bilateral leg aching, neighbor-sourced alarm about muscle damage, copay friction, and a belief that the stent resolved the underlying problem.

O — Objective

Pharmacy claims: last statin fill ten months ago; no dispensing since. No documented CK elevation or myopathy workup associated with the prior symptoms. Blood pressure and remaining regimen reviewed and current.

A — Assessment

Clinical ASCVD (CAD, post-PCI) without guideline-directed statin therapy for ten months. Prior symptoms consistent with expectation-driven myalgia rather than statin myopathy; brief, bilateral, self-limited, never evaluated. No exclusion applies.

P — Plan

Protection rationale reviewed; **therapy targets the disease**, not the lab value; patient able to restate it. Muscle-risk numbers discussed honestly with an explicit adjustment-not-abandonment agreement. Restarted **atorvastatin 40 mg (high-intensity)**, e-prescribed through his **Part D benefit as a 90-day fill**; copay verified acceptable. Pharmacy tech to confirm the first **fill within 7 days**; a nurse call at **day 7 for symptoms**. If muscle symptoms recur: CK, then dose or agent adjustment per protocol, not discontinuation. Annual claims check flagged; ASCVD event history confirmed and dated in the problem list.^{2,6,7}

Documentation caution

Documentation serves three functions relevant to this measure: **establishing the qualifying denominator event, supporting dispensing through insurance routing and fill verification, and directing the intolerance pathway toward clinical adjustment rather than discontinuation.**

Documentation Examples

Complete: initiation with the loop closed

"Clinical ASCVD (ischemic stroke, [date]). Initiated rosuvastatin 20 mg daily (high-intensity), e-prescribed to [pharmacy] via the patient's benefit; 90-day supply. Protection rationale discussed,

teach-back completed. First-fill confirmation received [date]; day-7 call: tolerating well, no symptoms."

Complete: genuine intolerance, coded

"Recurrent proximal muscle pain with CK elevation on two statins at reduced doses, including alternate-day rechallenge. Diagnosis: drug-induced myopathy (G72.0) with adverse effect of antihyperlipidemic agent (**T46.6X5A**), coded this measurement year. Non-statin lipid therapy initiated on clinical grounds; exclusion recoding flagged for annual renewal."

Incomplete

"On statin therapy." "Statin discussed, patient hesitant." "Stopped statin due to side effects." — no intensity, no fill status, no workup, no code. The first hides a low-intensity miss, the second buries a recoverable conversation, and the third fails to exclude the one patient who may deserve it.²



DOCUMENTATION REMINDER — DENOMINATOR AND DISPENSING ACCURACY

This measure depends on the accuracy of the following: **the denominator**, meaning every ASCVD-qualifying event identified in claims with exclusions coded and current, and **dispensing records**, meaning every qualifying fill confirmed. All practice-level interventions, including patient outreach, follow-up calls, and copay assistance, function to move eligible patients from the denominator into confirmed dispensing.

One Status, Clearly Stated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Qualified, no therapy	ASCVD confirmed by event history, with no statin prescription on file. This status requires a provider decision: flag for the next scheduled visit, or route to direct outreach
Prescribed, fill pending	Prescription routed through the insurance benefit. Verification owned within 3 to 7 days
Dispensed, credit posted	Qualifying claim confirmed. Transition to persistence management: 90-day fills, symptom routing to clinical evaluation, and annual recheck
Prescription abandoned at the pharmacy	Prescription is active, but no claim is posted. A pharmacist should identify the specific barrier, such as cost, concern about side effects, or logistics, and resolve it directly
Symptom under evaluation	For example, a reported muscle complaint under clinical evaluation: rechallenge, agent switch, or CK-confirmed myopathy. This status remains open until the evaluation is complete
Excluded, coded for the current year	Specific diagnosis codes entered within the current measurement year. Requires annual renewal

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Declined, informed	Shared decision-making documented, with lifestyle modification acknowledged and a follow-up conversation scheduled. This status is not permanent
Cash-pay conversion candidate	Patient identified as filling through a discount-card program. Insurance-based routing should be offered, with an explanation of the associated safety monitoring benefits. This patient is receiving therapy but is not yet reflected in the measure

ABBREVIATIONS: ASCVD = atherosclerotic cardiovascular disease; CK = creatine kinase

KEY TAKEAWAYS

1 One filled pharmacy claim for a moderate- or high-intensity statin constitutes the entire measure

No clinical note, diagnosis code, medication sample, or documented intention satisfies this requirement, and no cash-pay fill counts.^{1,2}

2 Dose and drug must be verified against the intensity classification

Intensity is determined by the specific agent-and-dose combination, not the milligram amount. Low-intensity statins do not satisfy the numerator.²

3 A risk of nonadherence occurs between prescribing and dispensing

First-fill confirmation, a day-7 follow-up call, copay assistance applied before dispensing, and a transition to 90-day fills once tolerated address this gap.

4 Reported muscle pain requires clinical evaluation

Confirmed myopathy is rare, structured rechallenge returns most labeled-intolerant patients to therapy, and confirmed cases should be coded precisely, with exclusion coding renewed each measurement year.^{1,2,14}

5 Counseling should emphasize cardiovascular protection rather than cholesterol reduction

A patient who understands the reason for treatment is more likely to remain on it. The belief that a procedure alone resolved the underlying disease should be addressed directly following any revascularization.¹¹

6 This measure requires only a single qualifying fill, but the clinical benefit depends on sustained therapy across the full measurement year

Persistence-focused work also supports the **D10** adherence measure and represents the actual clinical objective.^{2,11}

Changes to Monitor

Current as of 2026-09-02.

KIND OF CHANGE	GOOD PRACTICE
Measure status and specification	C19 remains an active Part C process measure using HEDIS MY2024 SPC Rate 1. NCQA specification updates are reported to include changes to the age and sex bands in later measurement years. Confirm the denominator definition against the licensed specification before each cycle rather than carrying this guide's bands forward ^{1,2}
Rating-year methodology	Cut points reset annually through clustering. Revalidate cut points, Categorical Adjustment Index treatment, and Improvement Measure inclusion (correlation 0.729 for 2026) each cycle; the 2025 comparison figures in Section 1 trace to the 2025 Technical Notes and plan-published summaries ^{1,3,4}
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 ¹¹
Medication lists and intensity classes	The qualifying agents, doses and intensity classifications are in the licensed NCQA medication lists, and change with them. Refresh registry logic and the intensity requirements in this guide before each measurement year ²
Clinical guidance	Lipid-management guidance (intensity selection, non-statin escalation, older-adult individualization) carries its own revision cycle; refresh the clinical rows against current cardiology guidance ⁶

KIND OF CHANGE	GOOD PRACTICE
Internal tools	Review the event-history registry logic, the intolerance-recoding annual pass, the no-cash-fill policy, and the day-7 call scripts annually ; do not label retained prior-year cut points as current
ABBREVIATIONS: NCQA = National Committee for Quality Assurance	

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