Proposed Changes to Existing Measures for HEDIS®[1] MY 2026: Statin Therapy for Patients With Cardiovascular Disease (SPC) Statin Therapy for Patients With Diabetes (SPD)

NCQA seeks comments on proposed modifications to the following two HEDIS measures.

Statin Therapy for Patients With Cardiovascular Disease (SPC). The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

- Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
- Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Statin Therapy for Patients With Diabetes (SPD). The percentage of members 40–75 years of age during the measurement year with diabetes, who do not have clinical ASCVD and who met the following criteria. Two rates are reported:

- Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.
- Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

SPC focuses on the use of moderate or high-intensity statin therapy for secondary prevention in people with established cardiovascular disease.

SPD focuses on prevention for people with diabetes who do not have diagnosed cardiovascular disease and recognizes the use of statin therapy at any intensity. Proposed revisions to each measure are described below.

Changes Proposed to SPC

- **Remove sex-specific age bands.** SPC currently excludes females 21–39 and transgender and nonbinary individuals. Studies show that women are less likely than men to receive statin therapy, despite having diagnosed cardiovascular disease. NCQA proposes removing the sex-specific age bands.
    - ***Note:*** *Pregnancy, IVF, and Clomiphene remain an exclusion for both measures.*

- **Expand the upper age limit to 85.** Expand the upper age limit to 85, to accommodate clinical guideline recommendations such as from the American College of Cardiology and American Heart Association, which state that for patients older than 75 with clinical ASCVD, it is reasonable to initiate or continue moderate or high-intensity statin therapy. Guidelines also state that in older adults, it may be reasonable to discontinue statin use when functional decline, multimorbidity, frailty or reduced life expectancy limits the potential benefits. SPD age bands which capture members 40-75 align with current clinical guidelines and will not be updated.
    - ***Note:*** *Older, frailer populations are already excluded from SPC.*

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Changes Proposed to SPC and SPD

- **Approach to ASCVD identification.** Update the definition of "ASCVD" used to identify the eligible population in the SPC measure and as exclusion criteria in the SPD measure. Currently, plans identify people with ASCVD using two methods:
    1. An event, such as a myocardial infarction or coronary artery bypass graft procedure, in the year prior to the measurement year.
    2. One diagnosis consistent with ASCVD (e.g., coronary heart disease, peripheral arterial disease) during the measurement year *and* one diagnosis during the year prior to the measurement year.

  In keeping with NCQA's goal of modernizing and streamlining measures, NCQA proposes broadening the diagnosis method to read, "*two diagnoses any time during the measurement year or the year prior to the measurement year*," and relaxing the place of service requirements.

  This change aligns with updates to other measures that identify chronic conditions (e.g., hypertension, diabetes). NCQA and clinical expert guidance reviewed and updated the ASCVD value set to ensure that the coding used in the measure accurately identifies clinical ASCVD.
- **Include members in I-SNPs or living long-term in an institution.** Based on recommendations from our Geriatric Measurement Advisory Panel, remove the exclusion for individuals enrolled in an institutional SNP or living long-term in an institution during the measurement year. Exclusion from the measure should be determined by clinical criteria similar to that used in the Advanced Illness and Frailty, ESRD and cirrhosis exclusions, not by plan enrollment or place of residence.
- **Transition to ECDS reporting.** Transition SPC and SPD to ECDS reporting in Measurement Year (MY) 2026.

Testing and Panel Feedback

Proposed changes to SPC were tested in commercial and Medicare populations. We observed a significant increase in the eligible population, as a result of the changes to age range and to the approach to ASCVD identification. Across both product lines, performance decreased by approximately 6–7% for Rate 1 and by approximately 1% for Rate 2. Measurement advisory panels support all proposed changes.

Public Comment Request

NCQA seeks feedback on **the following:**

1. Remove sex-specific age bands to include all members 21–39 years in **SPC.**
2. Expand the upper age limit to include members 76–85 years in **SPC.**
3. Edit the definition of "ASCVD" used in **SPC and SPD.**
4. Include members in I-SNPs or living long-term in an institution in **SPC and SPD.**

Supporting documents include the current measure specifications, evidence workup and performance data.

NCQA acknowledges the contributions of the Cardiovascular, Geriatric, Diabetes and Technical Measurement Advisory Panels.

Measure title	Statin Therapy for Patients With Cardiovascular Disease	**Measure ID**	SPC-E
Description	The percentage of persons 21–85 years of age ~~males 21–75 years of age and females 40–75~~ during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. *Received Statin Therapy.* Persons who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement period. 2. *Statin Adherence 80%.* Persons who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement and rationale	Guidelines from the American Heart Association (AHA) recommend that for men and women 21–75 years of age with a diagnosis of clinical ASCVD, high-intensity statin therapy is recommended. In patients older than 75 years of age the AHA finds it reasonable to initiate or continue moderate or high-intensity statin therapy after evaluation of contraindications. If high-intensity therapy is contraindicated, or when adverse effects are present, moderate-intensity statin therapy should be used. Adherence to both medication and lifestyle regimens are required for ASCVD risk reduction.		
Citations	Grundy, S.M., N.J. Stone, A.L. Bailey, C. Beam, K.K. Birtcher, R.S. Blumenthal, L.T. Braun, S. de Ferranti, J. Faiella-Tommasino, D.E. Forman, R. Goldberg, P.A. Heidenreich, M.A. Hlatky, D.W. Jones, D.M. Lloyd-Jones, N. Lopez-Pajares, C.E. Ndumele, C.E. Orringer, C.A. Peralta, ... J. Yeboah. 2019. "2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol." *Journal of the American College of Cardiology* 73(24).		
Characteristics			
Scoring **Type** **Product lines**	Proportion. Process. • Commercial. • Medicaid. • Medicare.		

Stratifications	None. ~~Age as of the last day of the measurement period and gender.~~ • ~~Males 21–75 years.~~ • ~~Females 40–75 years.~~
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ~~Administrative~~ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Medication lists:** If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service. This rule is not included in the measure calculation logic, and must be programmed manually. **Other guidance:** All persons who are numerator compliant for Rate 1 must be used as the denominator for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). ~~For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 denominator.~~
Definitions	
IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement period.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement period.
PDC	Proportion of days covered. The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator).

	For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply. Sum the days supply, for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement period. Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. Pharmacy during the measurement period. • *Continuous enrollment:* The measurement period and the year prior to the measurement period. • *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period. *Ages:* • 21–85 years as of the last day of the measurement period. • ~~Males 21–75 years as of the last day of the measurement period.~~ • ~~Females 40–75 years as of the last day of the measurement period.~~ ~~*Gender/sex criteria:*~~ Administrative Gender: ~~Female (AdministrativeGender code female).~~ Administrative Gender: ~~Male (AdministrativeGender code male).~~ *Event:* **Persons with clinical atherosclerotic cardiovascular disease.** There are two methods to identify persons with ASCVD: by event and by diagnosis data. The organization must use both methods to identify the initial population, but a person only needs to be identified by one method to be included in the measure. Any of the following during the year prior to the measurement period meet criteria: • Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • CABG (CABG Value Set) in any setting. • PCI (PCI Value Set) in any setting. • Any other revascularization procedures (Other Revascularization Value Set) in any setting.

	Diagnosis. At least two ~~one~~ encounters with a diagnosis of ~~IVD (IVD Value Set~~ ASCVD (ASCVD Value Set~~)~~)* on different dates of service during the measurement period ~~and~~or the year prior to the measurement period. ~~Do not include laboratory claims (claims with POS code 81).~~ ~~The following encounters meet criteria:~~ • ~~An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).~~ • ~~At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:~~ ~~1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).~~ ~~2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).~~ ~~3. Identify the discharge date for the stay.~~
Denominator exclusions	• **Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. • **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. • **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. • ~~**Persons who are 66 years of age and older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).**~~ ~~Persons enrolled in an Institutional SNP (I-SNP) any time during the measurement period.~~ ~~Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.~~ • **Persons age 66 years or older by the last day of the measurement period, with both frailty and advanced illness.** 1. *Frailty.* At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set)* with different dates of service during the measurement period.

<table>
<tr><td></td><td>
2. Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:
– Advanced illness (Advanced Illness Value Set)* on at least two different dates of service.
– Dispensed dementia medication (Dementia Medications List).
• Persons with a diagnosis of pregnancy (Pregnancy Value Set*), in vitro fertilization (IVF Value Set), ESRD (ESRD Diagnosis Value Set*), dialysis (Dialysis Procedure Value Set), cirrhosis (Cirrhosis Value Set*), or dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement period or the year prior to the measurement period.
• Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set*) during the measurement period.
• Myalgia or rhabdomyolysis caused by a statin (Muscular Reactions to Statins Value Set) any time during the person's history through the last day of the measurement period.
Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Denominator</td><td>
Denominator 1—Received Statin Therapy
Initial population minus denominator exclusions.
Denominator 2—Statin Adherence 80%
Persons who meet the numerator criteria for Rate 1.
</td></tr>
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Numerator 1—Received Statin Therapy
At least one dispensing event for a high-intensity or moderate-intensity statin medication (High and Moderate Intensity Statin Medications List) during the measurement period.
High- and Moderate-Intensity Statin Medications
<table>
<tr><th>Description</th><th>Prescription</th><th>Medication Lists</th></tr>
<tr><td>High-intensity statin therapy</td><td>• Atorvastatin 40-80 mg</td><td>Atorvastatin High Intensity Medications List</td></tr>
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</table>
</td></tr>
</table>

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40-60 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List

Numerator 2—Statin Adherence 80%

PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance:

Step 1. Identify the IPSD. Use the *High- and Moderate-Intensity Statin Medications* table to identify statin medication dispensing events.

Step 2. Determine the treatment period. Calculate the number of days beginning on the IPSD through the end of the measurement period.

Step 3. Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. To ensure that days-supply that extends beyond the measurement period is not counted, subtract any days supply that extends beyond December 31 of the measurement period.

Step 4. Calculate the person's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Example: If a person has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

Step 5. Sum the number of persons whose PDC is ≥80% for the treatment period.

Summary of changes

- This is the first year the measure is reported using ECDS.
- Removed sex-specific age bands.
- Expanded the upper age limit to include members up to 85 years of age.
- Removed exclusion for members enrolled in an Institutional SNP (I-SNP) or living long-term in an institution (LTI).

Data element tables

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPC-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease

Metric	Data Element	Reporting Instructions
ReceivedTherapy	Benefit	Meta data
Adherence	InitialPopulation	For each Metric
Total	Exclusions	Only for ReceivedTherapy Metric
	Denominator	For each Metric
	Numerator	For each Metric
	Rate	(Percent)

Measure title	Statin Therapy for Patients With Diabetes	Measure ID	SPD-E
Description	The percentage of persons 40–75 years of age during the measurement period with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported: 1. *Received Statin Therapy.* Persons who were dispensed at least one statin medication of any intensity during the measurement period. 2. *Statin Adherence 80%.* Persons who remained on a statin medication of any intensity for at least 80% of the treatment period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement and rationale	The use of statins for primary prevention of cardiovascular disease in patients with diabetes, based on their age and other risk factors, is recommended by guidelines from the American Diabetes Association and the American College of Cardiology/American Heart Association. Cholesterol-lowering medications, such as statins, are among the most commonly prescribed drugs in America. In the United States, 22% of adults 45 and older take statins. Evidence shows statin use decreases cardiovascular mortality in patients with established cardiovascular disease, and decreases total mortality rates overall. Primary and secondary prevention trial data strongly support starting lipid-lowering therapy with a statin in most patients with type 2 diabetes.		
Citations	Grundy, S.M., N.J. Stone, A.L. Bailey, C. Beam, K.K. Birtcher, R.S. Blumenthal, L.T. Braun, S. de Ferranti, J. Faiella-Tommasino, D.E. Forman, R. Goldberg, P.A. Heidenreich, M.A. Hlatky, D.W. Jones, D.M. Lloyd-Jones, N. Lopez-Pajares, C.E. Ndumele, C.E. Orringer, C.A. Peralta, ... J. Yeboah. 2019. "2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol." *Journal of the American College of Cardiology* 73(24).		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product lines	Commercial. Medicaid. Medicare.		
Stratification	None.		
Risk adjustment	None.		

Improvement notation	Increased score indicates improvement in both rates.
Guidance	**Data collection methodology:** ~~Administrative~~ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Medication lists:** If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service. This rule is not included in the measure calculation logic, and must be programmed manually. **Other guidance:** All persons who are numerator compliant for Rate 1 must be used as the denominator for Rate 2, regardless of the data source used to capture the Rate 1 numerator. *For example,* if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data must be included in identifying the Rate 2 denominator.
Definitions	
IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication, of any intensity, during the measurement period.
Treatment period	The period beginning on the IPSD through the last day of the measurement period.
PDC	Proportion of days covered. The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple prescriptions for different medications dispensed on different days, with overlapping days supply, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same or different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). *For example,* if three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply, sum the days supply, for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement period. Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs.

	For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical during measurement period and the year prior to the measurement period. Pharmacy during the measurement period. • *Continuous enrollment:* The measurement period and the year prior to the measurement period. • *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period. *Ages:* 40–75 years as of last day of the measurement period. *Event:* **Identify persons with a diagnosis of diabetes.** There are two methods to identify persons with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the initial population, but a person only needs to be identified by one method to be included in the measure. • *Claim/encounter data method.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data method.* At least one diagnosis of diabetes (Diabetes Value Set*) and at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medication List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5)* any time during the measurement period.

- ~~**Persons who are 66 years of age and older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).**~~

~~Persons enrolled in an Institutional SNP (I-SNP) any time during the measurement period.~~

~~Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.~~

Persons age 66 years or older by the last day of the measurement period, with both frailty and advanced illness.

1. *Frailty.* At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set)* with different dates of service during the measurement period.
2. *Advanced Illness.* Either of the following during the measurement period or the year prior to the measurement period:
   - Advanced illness (Advanced Illness Value Set)* on at least two different dates of service.
   - Dispensed dementia medication (Dementia Medications List).

Persons with a diagnosis of pregnancy (Pregnancy Value Set)*, in vitro fertilization (IVF Value Set), ESRD (ESRD Diagnosis Value Set)*, dialysis (Dialysis Procedure Value Set), cirrhosis (Cirrhosis Value Set)*, dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement period or the year prior to the measurement period.

Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set)* during the measurement period.

Myalgia or rhabdomyolysis caused by a statin (Muscular Reactions to Statins Value Set) any time during the person's history through the last day of the measurement period.

Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the discharge date for the stay.

Persons who had CABG (CABG Value Set), PCI (CABG Value Set) or other revascularization procedures (Other Revascularization Value Set) in any setting during the year prior to the measurement period.

Persons who had at least two encounters with an ASCVD diagnosis (ASCVD Value Set)* on different dates of service during the measurement period or the year prior to the measurement period.

~~Persons who had an outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).~~

Persons with at least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

<table>
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Coding Guidance
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<tr><td>Moderate-intensity statin therapy</td><td>• Lovastatin 40-60 mg</td><td>Lovastatin Moderate Intensity Medications List</td></tr>
</table></td></tr>
</table>

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	• Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	• Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	• Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	• Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

Numerator 2—Statin Adherence 80%

PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance:

Step 1. Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity, moderate-intensity or low-intensity statin medication during the measurement period. Use the medication list table in Rate 1 to identify dispensing events.

Step 2. To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement period.

Step 3. Count the days covered by at least one prescription for any high-intensity, moderate-intensity or low-intensity statin medication during the treatment period. To ensure the days supply that extends beyond the measurement period is not counted, subtract any days supply that extends beyond December 31 of the measurement period.

Step 4. Calculate the PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

For example, if a person has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

Step 5. Sum the number of persons whose PDC is ≥80% for the treatment period.

<table>
<tr><td>Summary of changes</td><td>This is the first year the measure is reported using ECDS.
Expanded ASCVD diagnosis criteria to allow diagnosis in the measurement year or the year prior to the measurement year.
Renamed the IVD Value Set to ASCVD Value Set and removed inappropriate codes
Removed denominator exclusion for persons enrolled in an Institutional SNP (I-SNP) or living long-term in an institution (LTI).</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.
Table SPD-1/2/3: Data Elements for Statin Therapy for Patients With Diabetes
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>ReceivedTherapy</td><td>Benefit</td><td>Metadata</td></tr>
<tr><td>Adherence</td><td>InitialPopulation</td><td>For each Metric</td></tr>
<tr><td></td><td>Exclusions</td><td>Only for ReceivedTherapy Metric</td></tr>
<tr><td></td><td>Denominator</td><td>For each Metric</td></tr>
<tr><td></td><td>Numerator</td><td>For each Metric</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD)

Measure Workup

Topic Overview

Cardiovascular disease (CVD), which includes coronary heart disease, heart failure, stroke and hypertension, is the leading cause of death in the United States. Between 2019 and 2022 the death rate due to CVD increased from 200.8 per 100,000 to 210.9 per 100,000 (CDC, n.d.). Diabetes increases the risk of developing CVD by 2–4 times (Johns Hopkins Medicine, 2019). CVD is the current leading cause of death among people with diabetes, accounting for two-thirds of deaths among those with type 2 diabetes (T2D) (ADA, n.d.).

Diabetes often increases risk of other cofactors that lead to an increased risk of heart disease, including high blood pressure, too much low-density lipoprotein cholesterol (LDL-C) and high triglycerides (CDC, 2022). More than 127.9 million (48.6%) American adults have one or more types of CVD (Martin et al., 2024). National initiatives to improve cardiovascular health include the Million Hearts initiative to prevent 1 million heart attacks and strokes by 2027 (CDC, 2024) and the American Heart Association (AHA) goal to increase healthy life expectancy from 66 years to at least 68 years across the United States by 2030 (Angell et al., 2020).

Atherosclerotic cardiovascular disease (ASCVD) occurs when plaque builds up within artery walls. Cholesterol is a primary causal risk factor for development of atherosclerosis and CVD because it can narrow arteries, which reduces the flow of oxygen to organs and throughout the body, resulting in most cardiovascular events like heart attack and stroke (American Heart Association, 2024). LDL-C is most closely associated with CVD risk and is therefore the target of both lifestyle and pharmacological treatment (Martin et al., 2024).

Coronary heart disease (CHD) occurs when plaque builds up in arteries that supply oxygen to the heart (American Heart Association, 2024). An estimated 20.5 million Americans 20 years of age and older have CHD, and the prevalence is higher for males than females (Martin et al., 2024). Plaque buildup can lead to peripheral arterial disease, which results when plaque builds up in arteries that supply oxygen to the legs, arms and pelvis (NHLBI, 2014). About 6.5 million adults 40 years of age and older have peripheral artery disease. The prevalence is higher in older adults and non-Hispanic Black individuals (Martin et al., 2024).

A myocardial infarction (MI) (heart attack) occurs when oxygen rich blood is suddenly blocked from reaching the heart. Approximately 3.2% of U.S adults 20 and older have had an MI; the rate is more than twice as high in men (4.5%) than in women (2.1%) (Martin et al., 2024). Data show that about 14% of people with MI will die from it (Martin et al., 2024).

Relevance

Health importance

Data from the National Health and Nutrition Examination Survey (NHANES) estimate that about 20.5 million American adults 20 and older have CHD. This disease is more prevalent in males than in females (8.7% vs. 5.8 %), and there are slight differences by race/ethnicity. Based on data from the National health Interview Survey (NHIS), the prevalence of CHD is highest in American Indian/ Alaska Native individuals (8.6 %) and lowest in Asian individuals (4.4 %).
CHD prevalence among White people is estimated to be around 5.7%, and around 4.3% among Black people (Martin et al., 2024).
Data from the Framingham Heart Study estimate that the incidence of CHD occurs, on average, 10 years earlier for men than women (Sanchis-Gomar et

al., 2016). In addition, the incidence of cardiovascular events, such as MI and sudden death, occurs, on average, 20 years earlier for men than women (Sanchis-Gomar et al., 2016). In the US, deaths due to CHD account for about 40.3% of total CVD deaths in 2021 (Martin et al., 2024).

Financial importance

In addition to being the leading cause of death in the US, CVD is also among the costliest health conditions. CVD accounted for around $320B in direct health care costs in 2016; this total includes direct costs (e.g., physicians and other health professionals, hospital services, prescribed medications, home health care) (Tajeu et al., 2024). Costs of treating ASCVD specifically are expected to increase 2.5 fold, from $126B in 2015 to $309B in 2035 (Khera et al., 2020). Additionally, the cost of direct expenditures by patients with ASCVD increased by 30% between 2008 and 2019 (Shah et al., 2024). Assuming trends for the cost of treating ASCVD follows those described above, the burden of cost will not only increase for health plans and systems, but also for patients.

Having a diagnosis of diabetes while seeking cardiovascular care has been associated with higher medical expenditures. The ADA estimates that $39.3B is associated with cardiovascular-related spending associated with diabetes (ADA, 2023). In a cost-effective analysis of interventions focused on managing diabetes, statin therapy as secondary prevention of CVD was found to be very cost-effective, at $4,627 per quality-adjusted life year (QALY) (Siegel et al., 2020). This is defined as the incremental cost-effectiveness ratio (ICER) greater than zero but less than or equal to $25,000 per QALY or life years gained (LYG). Statin treatment for individuals with type 2 diabetes, compared with no lipid-regulating treatment, was also found to be very cost effective ($3,294/QALY) (Siegel et al., 2020).

Potential for improvement

Statin therapy is a first-line treatment for lowering blood cholesterol. In patients with clinical ASCVD, LDL-C lowering therapy should include maximally tolerated statin therapy. In patients with ASCVD who are judged to be very high risk with LDL-C 70 mg/dL or higher (≥1.8 mmol/L), the addition of a PSK9 inhibitor and/or ezetimibe may be appropriate to meet LDL-C goals (Grundy et al., 2018). Similarly, in patients 40–75 years of age with diabetes, LDL-C lowering therapy should be initiated (Grundy et al., 2018).

Guidelines suggest that when initiating or continuing statin therapy, the goal of treatment should be to lower LDL-C by 30%–50% depending on statin tolerance (Grundy et al., 2018).

Safety considerations and contraindications

Statin therapy is a first-line treatment for lowering blood cholesterol. While statins are considered safe for most patients, there are safety concerns to consider before prescribing and throughout treatment. Previously, statins were contraindicated for people who are pregnant or breastfeeding, and in people of childbearing potential unless they are using effective forms of contraception (Stone et al., 2013). However, studies have shown no increased risk of congenital abnormalities among statin-exposed pregnant individuals (Poornima et al., 2023). As a result, the FDA removed the contraindication for statin use during preconception planning and pregnancy. Despite this change, statins are discouraged for use among pregnant people except in cases of familial hypercholesterolemia, other severe LDL-C increases or established (prior) ASCVD when benefits are judged to outweigh risks (Poornima et al., 2023).

End stage renal disease is an independent risk factor for cardiovascular events; however, evidence does not provide strong consensus for the usefulness of statins in these individuals (Abdelnabi et al., 2021). Guidelines suggest people with renal disease can use statins but should start with a low dose statin (Mach et al., 2020; Grundy et al., 2019).

The most common side effect of statin therapy is statin-associated muscle symptoms (SAMS), which can occur in varying forms of severity. However, the mechanisms behind these side effects due to statin therapy is unclear (Ward et al., 2019). Statin therapy should not be used in patients with rhabdomyolysis, the most severe form of muscle symptoms (Selva-O'Callaghan et al., 2018). Clinicians can discontinue or adjust statin therapy in patients that develop mild to moderate muscle symptoms to assess other muscle related conditions and determine a tolerated statin intensity (Selva-O'Callaghan et al., 2018).

Statins are cleared in the liver and can cause elevated liver biochemistries. This presents a concern for patients with existing liver disease. Research suggests that patients with decompensated cirrhosis and acute liver failure should not receive statin therapy due to the risks associated with elevated liver biochemistries (Vargas et al., 2017).

Statin adherence

ACC/AHA guidelines suggest that adherence to both medication and lifestyle regimens support ASCVD risk reduction (Grundy et al., 2019). This measure uses the proportion of days covered (PDC) to assess adherence. According to the Pharmacy Quality Alliance, a PDC threshold of 80% is supported by clinical evidence for most classes of chronic medications (Pharmacy Quality Alliance, 2022).

The impact of adherence on statin efficacy has been shown to reduce risk of CVD mortality to 1 per 10,000 individuals (Hope et al., 2019). However, research shows that adherence to statin medications is poor in the United States. In real-word clinical registries, more than 50% of patients no longer adhere to statin therapy within 1 year of starting treatment (Rodriguez et al., 2019). NCQA seeks to improve statin adherence in patients with CVD and thereby reduce the risk for cardiovascular related mortality.

Gaps in care

A recent multicenter cohort study analyzed data from Cerner Real-World Data. The study identified 322,153 patients with ASCVD who would benefit from statin therapy, according to the ACC/AHA guidelines, and found that more than 23.9% of patients were not receiving statin therapy. The percentage of patients using non-statin LDL-C lowering therapies was low, with only 4.4% of patients using ezetimibe and 0.7% using a PCSK9 inhibitor (Navar et al., 2023). These results highlight gaps in care for patients with ASCVD and the need for improvement. Alignment with blood cholesterol guidelines will improve quality of care for patients with CVD.

Health care disparities

Systemic racism, inequitable access to general care and specialized services and complexity in navigating the health care system may all contribute to widening disparities in healthy outcomes for people with ASCVD. The challenges to accessing quality care for historically marginalized individuals have contributed to lower statin use among these groups, namely Black, Indigenous and people of color who are uninsured or underinsured, those who identify as female and those who are 65 years and older (Schroff et al., 2017).

Similar challenges are observed amongst patients with diabetes (Mester et al., 2021; Gamboa et al., 2017).

These disparities signal gaps in quality that may contribute to higher cardiovascular mortality rates among some historically marginalized populations.

Scientific Soundness

Clinical importance and evidence

Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by reducing the formation of cholesterol, and help the liver remove cholesterol already in the blood (CDC, 2021). Statins are most effective in lowering LDL-C. The amount of cholesterol lowering effect is based on statin intensity, which is classified as either high, moderate or low intensity.

According to the most recent blood cholesterol treatment guidelines from the American College of Cardiology and American Heart Association (ACC/AHA), statins of moderate or high intensity are recommended for adults with established clinical ASCVD. Many studies support the use of statins to reduce ASCVD events in primary and secondary prevention.

One systemic review observed large-scale evidence from randomized trials that showed statin therapy reduces the risk of major cardiovascular events like coronary deaths, MI and stroke (Collins et al., 2016). The benefits of statins are shown to increase during each year therapy continues, so larger benefits would accrue with prolonged therapy and persist long term (Collins et al., 2016).

Table 1. Statin Therapy Dosage Intensities

Description	Prescription	
High-intensity statin therapy	• Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-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 • Ezetimibe-atorvastatin 10-20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20-40 mg • Niacin-simvastatin 20-40 mg • Sitagliptin-simvastatin 20-40 mg	• Pravastatin 40–80 mg • Aspirin-pravastatin 40-80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2–4 mg
Low-intensity statin therapy	• Simvastatin 10 mg • Ezetimibe-simvastatin 10 mg • Sitagliptin-simvastatin 10 mg • Pravastatin 10–20 mg • Aspirin-pravastatin 20 mg	• Lovastatin 20 mg • Niacin-lovastatin 20 mg • Fluvastatin 20–40 mg • Pitavastatin 1 mg

Specific Guideline Recommendations

2018 Guidelines on Management of Blood Cholesterol (AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA)

In patients who are 75 years of age or younger with clinical ASCVD, high-intensity statin therapy should be initiated or continued with the aim of achieving 50% or greater reduction in LDL-C levels.
Strength: I; LOE: A

In patients with clinical ASCVD in whom high-intensity statin therapy is contraindicated or who experience statin-associated side effects, moderate-intensity statin therapy should be initiated or continued with the aim of achieving 30% to 49% reduction in LDL-C levels.
Strength: I; LOE: A

In patients with clinical ASCVD who are receiving maximally tolerated statin therapy and whose LDL-C level remains 70 mg/dL or higher (‡1.8 mmol/L) it may be reasonable to add ezetimibe.
Strength IIb; LOE: B-R

In patients with clinical ASCVD who are judged to be very high risk and who are on maximally tolerated LDL-C lowering therapy with LDL-C 70 mg/dL or higher (≥1.8 mmol/L) or a non–HDL-C level of 100 mg/dL or higher (≥2.6 mmol/L) it is reasonable to add a PCSK9 inhibitor following a clinician–patient discussion about the net benefit, safety, and cost.
Strength: IIa LOE: A

In patients with clinical ASCVD who are judged to be very high risk and considered for PCSK9 inhibitor therapy, maximally tolerated LDL-C lowering therapy should include maximally tolerated statin therapy and ezetimibe (I B-NR).
Strength: I; LOE: B-NR

In patients older than 75 years of age with clinical ASCVD, it is reasonable to initiate moderate- or high-intensity statin therapy after evaluation of the potential for ASCVD risk reduction, adverse effects, and drug–drug interactions, as well as patient frailty and patient preferences.
Strength: IIa; LOE: B-R

In patients older than 75 years of age who are tolerating high-intensity statin therapy, it is reasonable to continue high-intensity statin therapy after evaluation of the potential for ASCVD risk reduction, adverse effects, and drug-drug interactions, as well as patient frailty and patient preferences.
Strength: IIa; LOE: C-LD

In adults 40 to 75 years of age with diabetes mellitus, regardless of estimates 10-year ASCVD risk, moderate-intensity statin therapy is indicated.
Strength: I; LOE: A

Grading System Key

American College of Cardiology/American Heart Association: Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatment, or Diagnostic Testing in Patient Care

Class (Strength) of Recommendation:

Class	Suggestion for Practice
I (Strong) Benefit >>> Risk	Suggested phrases for writing recommendations: • Is recommended • Is indicated/useful/effective/beneficial • Should be performance/administered/other • Comparative-Effectiveness Phrases: – Treatment/strategy A is recommended/indicated in preference to treatment B – Treatment A should be chosen over treatment B
Class IIa (Moderate) Benefit >> Risk	Suggested phrases for writing recommendations: • Is reasonable • Can be useful/effective/beneficial • Comparative-Effective Phrases: – Treatment/strategy A is probably recommended/indicated in preference to treatment B – It is reasonable to choose treatment A over treatment B
Class IIb (weak) Benefit ≥ Risk	Suggested phrases for writing recommendations: • May/might be reasonable • May/might be considered • Usefulness/effectiveness is unknown/unclear/uncertain or not well established
Class III: No Benefit (moderate) Benefit = Risk	Suggested phrases for writing recommendations: • Is not recommended • Is not indicated/useful/effective/beneficial • Should not be performed/administered/other
Class III: Harm (strong) Risk > Benefit	Suggested phrases for writing recommendations: • Potentially harmful • Causes harm • Associated with excess morbidity/mortality • Should not be performed/administered other

Level (Quality) of Evidence

Level	Definition
A	• High-quality evidence from more than 1 randomized control trial (RCT) • Meta-analyses of high-quality RCTs • One or more RCTs corroborated by high-quality registry studies
B-R (randomized)	• Moderate-quality evidence from 1 or more RCTs • Meta-analyses of moderate-quality RCTs
B-NR (nonrandomized)	• Moderate-quality evidence from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies • Meta-analyses of such studies

Level	Definition
C-LD (limited data)	• Randomized or nonrandomized observational or registry studies with limitations of design or execution • Meta-analyses of such studies • Physiological or mechanistic studies in human subjects
C-EO (Expert Opinion)	Consensus of expert opinion based on clinical experience

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Statin Therapy for Patients With Cardiovascular Disease

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

- *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. (Tables 1–3)
- *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period. (Tables 4–6)

HEDIS Health Plan Performance Rates: Statin Therapy for Patients With Cardiovascular Disease (SPC)

Table 1. HEDIS Received Statin Therapy Indicator Performance—Commercial Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	420	388 (92)	84.0	7.0	78.3	81.7	76.5	80.6	83.7
	F 40-75		335 (80)	75.9	8.0	68.6	72.5	76.5	80.6	83.7
	Total		**393 (94)**	**81.9**	7.0	76.6	79.5	82.9	85.6	87.8
2022	M 21-75	417	389 (93)	84.3	6.3	79.1	82.3	85.1	87.8	89.7
	F 40-75		335 (80)	75.9	7.7	68.6	72.8	76.5	80.3	84.0
	Total		**396 (95)**	**81.9**	7.6	76.2	80.0	83.1	85.7	87.8
2021	M 21-75	419	396 (94)	84.3	6.4	79.1	82.3	85.2	87.6	90.0
	F 40-75		337 (80)	75.8	8.0	67.7	72.6	76.9	80.7	83.3
	Total		**400 (95)**	**82.3**	6.7	76.8	80.3	82.8	85.8	88.5

*For 2023, the average denominator across plans was 440 for females, with a standard deviation of 656, and 1,039 for males, with a standard deviation of 1,651.

Table 2. HEDIS Received Statin Therapy Indicator Performance—Medicaid Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	278	207 (74.5)	80.2	8.2	68.8	79.2	82.6	84.8	86.8
	F 40-75		204 (73.9)	77.4	8.3	64.0	75.0	79.5	82.5	84.8
	Total		213 (76.6)	79.3	8.0	66.6	77.9	81.4	83.9	85.9
2022	M 21-75	272	202 (74.3)	79.8	7.9	71.6	78.6	81.5	84.0	86.1
	F 40-75		194 (71.3)	76.7	8.2	67.0	74.6	78.2	81.8	83.5
	Total		205 (75.4)	78.7	7.7	70.0	77.7	80.4	82.6	85.0
2021	M 21-75	270	199 (73.7)	80.2	8.0	68.4	78.6	82.2	84.7	87.3
	F 40-75		190 (70.4)	76.7	9.1	63.8	74.4	79.1	82.1	85.0
	Total		203 (75.2)	78.5	8.7	65.1	77.6	80.8	83.2	85.9

*For 2023, the average denominator across plans was 641 for females, with a standard deviation of 770, and 873 for males, with a standard deviation of 1,079.

Table 3. HEDIS Received Statin Therapy Indicator Performance—Medicare Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	760	524 (69.0)	87.3	3.9	82.6	85.5	87.6	89.5	91.5
	F 40-75		478 (62.9)	83.3	4.7	77.3	80.7	83.5	86.1	88.6
	Total		560 (73.7)	85.8	4.2	80.7	84.0	86.0	87.9	90.5
2022	M 21-75	750	513 (68.4)	86.4	4.5	81.5	84.6	86.8	88.9	90.9
	F 40-75		471 (62.8)	82.5	4.7	77.0	79.7	82.8	85.3	88.1
	Total		545 (72.7)	85.1	4.4	80.1	82.9	85.1	87.4	90.0
2021	M 21-75	714	481 (67.4)	85.9	4.6	81.1	83.8	86.0	88.6	91.3
	F 40-75		448 (62.8)	82.0	5.1	75.6	79.2	82.3	85.1	88.0
	Total		509 (71.3)	84.5	4.3	79.7	82.3	84.8	87.0	89.5

*For 2023, the average denominator across plans was 1,081 for females, with a standard deviation of 2,724, and 1,568 for males, with a standard deviation of 4,244.

Table 4. HEDIS Statin Adherence 80% Indicator Performance—Commercial Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	420	380 (90)	80.5	6.4	73.1	77.2	80.8	84.2	88.2
	F 40-75		313 (75)	77.6	7.6	67.9	73.5	78.5	82.5	86.2
	Total		388 (92.4)	79.7	6.5	72.2	76.5	80.0	83.9	87.3
2022	M 21-75	417	384 (92)	79.7	6.4	72.0	76.8	80.3	84.0	86.7
	F 40-75		315 (76)	77.5	7.0	68.8	73.8	78.0	82.4	85.4
	Total		391 (94)	79.2	6.4	71.7	76.0	80.0	83.3	86.1
2021	M 21-75	419	389 (93)	80.4	5.9	73.4	77.2	80.9	84.2	86.9
	F 40-75		316 (75)	77.6	7.1	69.0	73.51	77.7	81.9	86.1
	Total		400 (95)	79.6	6.1	72.9	76.6	80.0	83.7	86.4

*For 2023, the average denominator across plans was 352 for females, with a standard deviation of 487, and 887 for males, with a standard deviation of 1,368.

Table 5. HEDIS Statin Adherence 80% Indicator Performance—Medicaid Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	278	202 (72.7)	71.0	9.3	60.0	65.4	71.0	76.6	82.4
	F 40-75		198 (71.2)	71.0	9.6	59.0	65.3	72.2	76.8	81.5
	Total		212 (76.3)	70.7	9.2	60.0	65.2	70.5	76.5	81.8
2022	M 21-75	272	196 (72.1)	70.3	9.8	57.1	64.1	70.8	76.6	81.6
	F 40-75		188 (69.1)	70.1	10.2	58.3	65.0	70.7	76.5	81.9
	Total		204 (75.0)	69.9	9.8	56.7	64.6	71.1	76.2	81.0
2021	M 21-75	270	191 (70.8)	70.0	9.0	58.3	64.2	69.8	76.1	81.2
	F 40-75		181 (67.0)	70.7	9.7	59.0	65.5	71.4	77.1	82.8
	Total		199 (73.7)	70.2	9.0	59.2	65.3	70.0	76.2	81.3

*For 2023, the average denominator across plans was 512 for females, with a standard deviation of 602, and 725 for males, with a standard deviation of 887.

Table 6. HEDIS Statin Adherence 80% Indicator Performance—Medicare Plans

Measurement Year	Stratification	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
				Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	M 21-75	760	508 (66.8)	86.9	5.0	81.2	84.1	87.2	89.8	93.2
	F 40-75		467 (61.5)	85.8	5.4	80.0	83.1	85.7	88.8	92.3
	Total		546 (71.8)	86.4	5.1	80.5	83.5	86.5	89.4	92.4
2022	M 21-75	750	498 (66.4)	86.2	5.0	80.1	83.2	86.6	89.5	92.1
	F 40-75		448 (59.7)	84.6	5.6	77.1	81.6	84.9	88.5	91.2
	Total		538 (71.7)	85.3	6.5	79.2	82.2	85.7	88.9	91.5
2021	M 21-75	714	470 (65.8)	85.5	5.1	78.3	82.6	85.8	88.8	91.9
	F 40-75		431 (60.4)	84.1	5.4	77.5	81.2	84.2	87.5	90.6
	Total		503 (70.5)	84.9	5.3	78.2	82.1	85.2	88.4	91.1

*For 2023, the average denominator across plans was 927 for females, with a standard deviation of 2,279, and 1,420 for males, with a standard deviation of 3,766.

Statin Therapy for Patients With Diabetes

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

- *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year. (Tables 1–3)
- *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period. (Tables 4–6)

HEDIS Health Plan Performance Rates: Statin Therapy for Patients with Diabetes (SPD)

Table 1. HEDIS Received Statin Therapy Indicator Performance—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	401 (95.5)	63.6	6.3	57.4	61.2	64.1	67.1	69.5
2022	417	404 (96.9)	64.5	6.0	58.6	62.5	64.9	67.7	70.2
2021	419	405 (96.7)	65.4	5.7	60.6	62.9	65.9	68.7	71.2

*For 2023, the average denominator across plans was 6,276 individuals, with a standard deviation of 13,264.

Table 2. HEDIS Received Statin Therapy Indicator Performance—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	225 (81.0)	63.8	7.4	52.0	60.8	65.3	68.1	71.4
2022	272	214 (78.9)	63.8	7.9	54.2	60.4	65.1	68.4	72.1
2021	270	214 (79.3)	64.7	8.3	53.2	62.0	66.2	69.5	72.9

*For 2023, the average denominator across plans was 6,324 individuals, with a standard deviation of 9,275.

Table 3. HEDIS Received Statin Therapy Indicator Performance—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	605 (79.6)	78.5	6.2	72.5	76.1	78.8	81.8	84.7
2022	750	589 (78.5)	78.6	5.2	72.9	75.9	78.6	81.7	84.7
2021	714	553 (77.5)	78.3	5.0	72.8	75.5	78.3	81.5	84.1

*For 2023, the average denominator across plans was 4,335 individuals, with a standard deviation of 11,979.

Table 4. HEDIS Statin Adherence 80% Indicator Performance—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	420	395 (94.1)	74.7	7.4	65.9	70.3	74.7	80.0	83.6
2022	417	397 (95.2)	74.0	7.0	65.7	70.0	74.5	79.0	82.0
2021	419	402 (95.9)	73.9	6.4	65.6	70.3	74.4	78.6	81.3

*For 2023 the average denominator across plans was 4,094 individuals, with a standard deviation of 8,954.

Table 5. HEDIS Statin Adherence 80% Indicator Performance—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	278	224 (80.6)	67.4	9.8	53.2	61.4	68.1	73.4	79.7
2022	272	213 (78.3)	66.1	10.0	52.7	60.2	66.3	72.3	78.0
2021	270	213 (78.9)	66.2	9.5	54.6	60.8	66.4	71.9	77.4

*For 2023, the average denominator across plans was 4,201 individuals, with a standard deviation of 6,267.

Table 6. HEDIS Statin Adherence 80% Indicator Performance—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2023*	760	594 (78.2)	84.9	5.1	78.7	82.2	85.0	87.9	91.6
2022	750	577 (76.9)	83.9	5.7	77.1	80.4	84.2	87.6	90.3
2021	714	544 (76.2)	83.0	5.7	76.2	79.7	83.3	86.8	89.7

*For 2023, the average denominator across plans was 3,547.4 individuals, with a standard deviation of 9,697.6.