Select Health Quality Provider Program

MEDICATION ADHERENCE: CHOLESTEROL, DIABETES, HYPERTENSION

2026 Quality Measure Reference Guide

What's Inside

Related Quick Links

- Adult/Pediatrics Primary Care Measures Quick Guide
- Report Hub Instructions: Basic User
- Formatting a Gaps List in Excel
- Demographic Allowable Corrections

Select Health

These measures are included in the Primary Care and Endocrinology Quality Provider Programs.

Measure Descriptions

Medication Adherence: Cholesterol

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for a cholesterol medication (statin drug) who fill their prescription often enough to cover 80% or more of the time they are taking the medication*
Denominator	Members ages 18 and older with at least 2 statin medication fills on unique dates of service during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Corrections	As this is a claims-based measure, corrections will **NOT** be accepted.

* Statins and statin combination therapies will enter a member into the Medication Adherence: Cholesterol measure. There is no consideration for an off-label use of a cholesterol medication listed within the methodology of this measure. If a cholesterol medication is filled twice in the measurement year, the member will be included in the measure.

Medication Adherence: Diabetes*

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for non-insulin diabetes medication who fill their prescription often enough to cover 80% or more of the time they are taking the medication**
Denominator	Members ages 18 and older with at least 2 non-insulin diabetes medication fills on unique dates of service during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Corrections	As this is a claims-based measure, corrections will **NOT** be accepted.

* The measure, "Medication Adherence: Diabetes," is the only measure applicable to the Endocrinology Program.

**Non-insulin diabetes and non-insulin diabetes combination therapy will enter a member into the Medication Adherence: Diabetes measure. There is no consideration for an off-label use of a non-insulin diabetes medication within the methodology of this measure. If a non-insulin diabetes medication is filled twice in the measurement year, the member will be included in the measure.

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Measure Descriptions, Continued

Medication Adherence: Hypertension

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are taking the medication***
Denominator	Members ages 18 and older with at least 2 blood pressure medication fills on unique dates of service during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Corrections	As this is a claims-based measure, corrections will **NOT** be accepted.

* Renin angiotensin system (RAS) antagonists (angiotensin converting enzyme inhibitor [ACEI], angiotensin receptor blocker [ARB], and direct renin inhibitor medications) will enter a member into the Medication Adherence: Hypertension measure. There is no consideration for an off-label use of a blood pressure medication within the methodology of this measure. If a RAS antagonist medication is filled twice in the measurement year, the member will be included in the measure.

Allowable Corrections

There are no allowable corrections for the medication adherence measures. The only way for a patient to be compliant in these measures is through a pharmacy claim for a prescription.

Access guidance for general corrections to demographics.

Frequently Asked Questions

Q: Why does this measure matter?

A: Patients are often reluctant to tell their healthcare provider that they do not take their medications. Unless a patient's medication-taking behavior is understood, therapy may needlessly escalate costs to the patient and healthcare system, causing potential harm to the patient. Medication nonadherence can lead to unnecessary hospitalization and emergency room visits.

Medication adherence in chronic conditions impacts measures used to establish the Star ratings for Medicare Advantage (MA) plans like Select Health Medicare. Lower medical expense costs and higher Star ratings affect an insurance plan's ability to offer richer benefits to members and potentially lower premiums.

Addressing medication nonadherence is critical for patient health and safety. Research indicates that those with chronic conditions consistently suffer poor health outcomes and higher rates of hospitalization due to low medication adherence.[1]

Q: What is Select Health doing to help?

A: Outreach to Select Health members includes:

- **New in 2026:** Select Health Medicare members can receive 180-day supplies of Tier 1 medications for a $0 copay from retail pharmacies and Intermountain's Home Delivery Pharmacy.
- Throughout the year, the Select Health Pharmacy team contacts members by phone, email, texts, and mailers who have not adhered to their medication(s). This outreach provides education and pharmacy benefit information as well as addresses barriers to filling prescribed medications.

Q: What are national strategies for improving medication adherence?

A: National strategies include:

- Following these 8 steps to improve medication adherence:
  1. Consider medication nonadherence first as the reason a patient's condition is not under control.
  2. Develop a process for routinely asking about medication adherence. To help identify nonadherence, ask the patient to:
     - Bring their medications to their appointments to help identify if they take them as prescribed
     - Describe "how" they take their medications instead of asking "if" they take them.
  3. Create a blame-free environment to discuss medications with the patient.
  4. Identify why the patient is not taking their medicine.
  5. Respond positively and thank the patient for sharing their behavior.
  6. Tailor the adherence solution to the individual patient.
  7. Involve the patient in developing their treatment plan.
  8. Set patients up for success.
- Using a patient-centered approach to care that stresses:[2]
  - — Multifactorial patient education (e.g., face-to-face education, help with online resource navigation, etc.).
  - — Effective communication using health literacy principles and teach-back strategies.
  - — Active patient involvement in medical decision making.
  - — Cultural sensitivity (**training module available**). For example, if a patient with diabetes has a preference for herbal remedies, explaining that metformin is derived from the French lilac might improve their acceptance of the therapy.
- Simplifying the patient's drug regimen by reducing the number of pills a patient is required to take each day (e.g., switching from metformin immediate release [IR] to metformin extended release [ER]). In a meta-analysis comparing adherence rates for single daily dosing versus additional doses, researchers found that there was a 10% decrease in adherence that occurred with each added daily dose.[3]

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Frequently Asked Questions, Continued

- Writing prescriptions exactly how you intend patients to take them. Pill-splitting may result in under-reporting for adherence measures.
- Educating patients about the advantages of using their pharmacy benefits.

Q: What are some other best practices for this measure?

A: To help close gaps in care:

- Set a weekly reminder on your calendar to pull an updated medication adherence list and provide outreach to those needing a refill.
- Consider changing prescriptions from 30-day supplies to 90- or 180-day supplies for maintenance medications.
- Contact Intermountain Home Delivery Pharmacy.
- Use post-discharge visits to discuss continuing medication for chronic conditions and reinforce medication adherence.
- Provide verbal and written education to patients about the importance of taking prescribed medication.
- For patients not taking their medication as prescribed, discuss and address any barriers they may be experiencing. Refer to the Common Barriers to Adherence at right.
- Contact your Select Health Quality Provider Program representative to discuss resources and support available.
- Encourage the patient to use these strategies to help with adherence:
  - — Use a weekly pillbox.
  - — Ask the pharmacy to sync prescriptions.
  - — Set up auto-refill reminders with their pharmacy.
  - — Get medications packaged at the pharmacy.
  - — Utilize reminder notes and alarms.
  - — Match medication schedules with daily routines.
  - — Use a calendar and write down the day, time, and dose of each medication.

COMMON BARRIERS TO ADHERENCE

Discuss and make recommendations regarding:

- Conflicting information received from a second provider
- Health literacy
- Conflicting information received through self-research
- Unrealistic expectations
- Financial burden and transportation
- Lack of motivation
- Remembering to take medications
- Not using pharmacy benefit provided or not filling using the insurance benefit

References:

1 New England Healthcare Institute. *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease: A NEHI Research Brief.* August 2009. https://www.akleg.gov/basis/get_documents.asp?session=28&docid=3370. Accessed February 16, 2026.

2 Brown MT, Bussell JK. Medication adherence: WHO cares? *Mayo Clin Proc.* 2011;86(4):304-314.

3 Claxton AJ, Cramer J, Pierce C. A systematic review of the associations between dose regimens and medication compliance. *Clin Ther.* 2001;23(8):1296-1310.

Select Health

Working Your Open Gaps List

STEP 1
Create a current gaps-in-care list: 1. Open your Gaps-in-Care-for-Download report: **QPP Report Hub** 2. Apply these filters: — **Super clinic:** Choose your clinic. — **Measure:** Click on "Medication Adherence: Cholesterol (STATINS)," "Medication Adherence: Diabetes (DIABETES)," and "Medication Adherence: Hypertension (RASA)." — **Status:** Leave all boxes checked. Include "Compliant," "Achievable," and "Past Due." 3. In the drop-down menu on the top right side of the page, change the view from **"Member"** to **"Download."** 4. Follow the instructions on the screen to export the data to Excel. Refer to **Report Hub Instructions: Basic User**.
STEP 2
Format your Excel export. (Refer to **Formatting a Gaps List in Excel**.)
STEP 3
Review tips for working your gaps-in-care list (below).

Measure Information

Medication adherence improves health outcomes by using pharmaceutical therapy for effectiveness and stability of patients diagnosed with diabetes, high cholesterol, and hypertension. By reducing the risk factors of disease progression through medication adherence, the patient's quality and length of life as well as overall well-being can improve.[1]

Tips for Working Your Gaps-in-Care List

1. **Pull the Medication Adherence Measures separately from the other clinical measures.**
   Medication adherence requires work with compliant patients, whereas the other clinical measures would have those patients filtered out.
2. **Pull a new Medication Adherence patient list weekly.**
   Work the list on a weekly or biweekly basis. This will provide you the most updated claim information and allow you to stay on top of the outreach/reminder calls for those coming due or overdue for their refill.
3. **Review and understand data in list columns (**see **Figure 1a** and **Figure 1b** on page 8); note that dates may not reflect the current measurement year.
4. **Work the patient list to determine needed outreach.**
   Once you have your exported patient list, be sure to expand all columns, wrap text, and add a filter to the top row as shown in **Formatting a Gaps List in Excel**, which allows you to easily sort the list as indicated below:
   - Sort the entire list by the "Achievable Date" column, which is the due date for the next refill. Sort "Oldest to Newest" to bring the past due and upcoming dates to the top. **Do NOT work the list based on the "Status" column.**
   - Scroll down to find those with an achievable date of today's date, and prioritize outreach to all patients due for a refill between today and the next 2 weeks.
   - Next, looking at the "Achievable Date" column, scroll up to focus outreach to the patients who are overdue for a refill (having surpassed the Achievable Date).
   - **Optional**: If you have a large list of patients overdue for a refill, consider prioritizing your outreach to those with a PDC of 70-99%.
   - For the patients who are overdue for a refill, there may be an opportunity to ask them about any barriers with taking their medication as prescribed (cost, transportation to the pharmacy, remembering to take their medications, pill splitting, etc.). This could be a good time to provide the patient with some additional education and resources.

NOTE: Examples used in this document are for instructional purposes only; the dates that appear are only representative of what a user might see.

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Working Open Gaps List, Continued

Figure 1a. Understanding Date Columns

Qualified Date: The date of the first qualifying medication fill.

Compliance Date: The date of the most recent refill.

Achievable Date: The date the next refill is due based off the last refill date and quantity of pills.

Measure Name	Qualified Date	Compliance Date	Status	Status Detail	Achievable Date	Measure Instructions
Med Adherence: Diabetes (DIABETES)	MM/DD/YYYY		Past Due	PDC 76.60%METFORMIN 1000 MG TABLET Prescribing provider HUDDLESTON, JASON Qualifying fills on Dates (days supply): (MM/DD/YYYY(90); MM/DD/YYYY(90)) Phar: WALMART PHARMACY 10-4438 ph: 8017660732 fax: 8017660882 RXN: 7472284 RR: 2)	MM/DD/YYYY	Member did not complete prescription refill by MM/DD/YYYY.
Med Adherence: Cholesterol (STATINS)	MM/DD/YYYY		Achievable	PDC 66.05% ATORVASTATIN 40 MG TABLET Prescribing provider HANCOCK, BRYCE Qualifying fills on Dates (days supply): (MM/DD/YYYY(90); MM/DD/YYYY(90); MM/DD/YYYY(90)) Phar: SMITH'S PHARMACY #271 ph: 3856857005 fax: 3856857015 RXN: 6508257 RR: 2)	MM/DD/YYYY	Member needs prescription refill by MM/DD/YYYY.
Med Adherence: Hypertension (RASA)	MM/DD/YYYY	MM/DD/YYYY	Compliant	PDC 100.00% VALSART/HCTZ TAB 320-25MG Prescribing provider HAMMER, JARRETT Qualifying fills on Dates (days supply): (MM/DD/YYYY(90); MM/DD/YYYY(90); MM/DD/YYYY(90); MM/DD/YYYY(90)) Phar: INMTN HD PHARMACY DBA INTERMOUNTAIN SPECI ph: 8012841114 fax: 8012841115 RXN: 40055451 RR: 1)	MM/DD/YYYY	Member needs prescription refill by MM/DD/YYYY.

Figure 1b. Understanding List Columns: Status and Status Detail

Status Notes:

- **Compliant:** The patient is at or above 80% PDC.
- **Past Due:** The patient has dropped below 80% PDC, and they are late picking up their refill (the "Achievable Date" has passed).
- **Achievable:** The patient has dropped below 80% PDC but has some time before the next refill is due (not having surpassed the "Achievable Date").

Qualified Da	Compliance	Status	Status Detail
1/9/2024	1/14/2024	Compliant	PDC 100% GLIMEPIRIDE 2 MG TABLET Prescribing provider Qualifying fills on Dates (days supply): (01/09/24(90); 01/14/24(90)) Phar: WALMART PHARMACY 10-2050 ph: 7025645776 fax:)
1/9/2024	1/15/2024	Compliant	PDC 100% LOSARTAN/HCT TAB 100-12.5 Prescribing provider Qualifying fills on Dates (days supply): (01/09/24(90); 01/15/24(90) Phar: DICKS PHARMACY ph: 8016770171 fax: 8016770173)
1/3/2024	1/16/2024	Compliant	PDC 100% SIMVASTATIN 40 MG TABLET Prescribing provider Qualifying fills on Dates (days supply): (01/03/24(90); 01/16/24(90)) Phar: R PHARMACY ph: 8017320202 fax: 8017321315)

Status Detail Notes:

- **Proportion of Days Covered (PDC)** is calculated by dividing the number of covered days by the number of days in the treatment period. This PDC percentage continuously changes as patients fill/don't fill their medications. The patient's PDC must be **at or above 80%** at the end of the measurement year to be compliant for the measure.
- **Medication Name and Prescribing Provider:** The most recently filled medication and prescriber.
- **Qualifying Fills on Dates (days supply):** Dates medication(s) were filled and quantity of pills.
- **RXN:** Prescription number.
- **RR:** Remaining refills.

Reference

1. Neiman AB, Ruppar T, Ho M, et al. CDC grand rounds: Improving medication adherence for chronic disease management—innovations and opportunities. November 17, 2017. *MMWR Morb Mortal Wkly Rep.* 2017;66(45). https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm. Accessed February 16, 2026.

Questions about the Quality Provider Program? Contact us at QualityProvider@selecthealth.org.

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