Approach to Medication Relatedness and Coverage: Guidance for Hospice Practice
March 2026

Determining medication coverage is a critical and often challenging component of providing high-quality end-of-life care. Under the Medicare Hospice Benefit (Part A), hospices are expected to cover all medications considered reasonable and necessary for symptom management of the terminal illness, any conditions that contribute to the terminal prognosis, and that are caused or exacerbated by the terminal illness.[1-3] The actions within this framework require careful evaluation, interdisciplinary group collaboration and communication, and strong documentation practices.

Patient Case: Introduction

MG is an 81-year-old female patient referred to hospice care upon return to the nursing home following a hospitalization for aspiration pneumonia. She has a history of HTN, glaucoma, gout, advanced Parkinson's disease, and Alzheimer's dementia (Fast 6D).

Current medications include:

- Allopurinol (Zyloprim®) 100mg; 1 tablet by mouth daily
- Aspirin 81mg; 1 tablet by mouth daily
- Atenolol (Tenormin®) 25mg; 1 tablet by mouth daily
- Carbidopa-levodopa (Sinemet®) 25mg-100mg; 1 tablet by mouth 3 times daily and 2 tablets at bedtime
- Donepezil (Aricept®) 10mg; 1 tablet by mouth at bedtime
- Latanoprost (Xalatan®) 0.005%; Place 1 drop in the affected eye(s) once daily
- Losartan (Cozaar®) 50mg; 1 tablet by mouth daily
- Memantine (Namenda®) 10mg; 1 tablet by mouth twice daily
- Polyethylene glycol (MiraLax®); Dissolve 17grams of powder in 8 ounces of water and drink daily as needed for constipation

What happens next to determine medication relatedness and hospice coverage?

THE HOSPICE BENEFIT AND HOSPICE INTERDISCIPLINARY GROUP/TEAM

Regulatory Foundations

Under Medicare Part A regulations, the Centers for Medicare & Medicaid Services (CMS) has maintained that hospices are responsible for covering all related medications. This expectation has been clearly emphasized in the "Election of hospice care" (CFR § 418.24) for over a decade stating "*that services or medications unrelated to the terminal illness and related conditions [billed outside of Part A] are exceptional and unusual and hospice should be providing virtually all care needed by the individual who has elected hospice*".[4] Hospices must report all diagnoses, related or unrelated, to ensure accurate care planning and prevent inappropriate Medicare Part D billing.

Roles Within the Hospice Interdisciplinary Group/Team (IDG)

Ensuring correct medication coverage is a shared responsibility:[5-7]

- Admission Physician/Prescriber and Nurse: Gathers information on current conditions and therapies (including medications), as well as past medical history, initiates communication with the hospice physician/prescriber, and communicates initial medication coverage determinations to pharmacy and patient/caregiver.
- Hospice Medical Director/Physician: Makes individualized determinations of relatedness and documents the status in the medical record.
- Interdisciplinary Group/Team: Reviews ongoing medication appropriateness, recommends alternatives, coordinates communication between the care team and patient/family to inform decision-making, and updates care plans. This group includes, but is not limited to:[6]
    - Physicians: Focus on illness trajectory, prognosis, and treatments; provide direct patient care or supervision in collaboration with these advanced practice providers:
        - Advanced practice registered nurses and physician assistants: Provide direct patient care and expand the capacity to deliver complex care.
    - Nurses: Provide direct patient care and serve as patient advocates, care coordinators, and educators.
    - Clinical pharmacists: Optimize medication management, resolve or prevent potential drug-related adverse effects and interactions, educate, and recommend therapy adjustments and deprescribing (dose reduction and/or discontinuation).
    - Social workers: Attend to family dynamics, assess and support coping mechanisms and social determinants of health, identify and facilitate access to resources, and mediate conflicts.
    - Chaplains: Assess and address spiritual issues and help to facilitate continuity with the patient's faith community.

Medication coverage determinations hinge on whether a medication supports symptom management, quality of life, and/or goals of care for the terminal illness. Recognizing that in CMS hospice regulations, the familiar term "related to the terminal illness" is used to facilitate coverage determinations, it is important not to default to past misinterpretations of the hospice benefit's intent; managing terminal illness is not as simple as limiting care to a single diagnosis group (e.g., a single condition, such as lung cancer with brain metastases) and then ignoring symptoms of any other chronic condition (e.g., dyspnea from fluid retention caused by a heart failure comorbidity), just because the lungs and heart are separate organs.[8]

Instead, ensure relatedness and subsequent coverage determinations encompass all care that is medically necessary to palliate symptoms for patient comfort; identifying not only the pathophysiology of the terminal illness and the conditions that contribute to that pathophysiology, but also discovering the burden the disease has on all domains of palliative care (physical, psychological, social, spiritual, cultural, financial, legal), regardless.[6,8]

Dragonfly Health © 2026

We will unpack determinations in a stepwise approach in the proceeding sections as follows:

1. A hospice physician (hospice medical director, physician designee, or physician IDG member) determines terminal prognosis and related and unrelated diagnoses.
2. The hospice physician determines medication relatedness and coverage. Collaboration with the interdisciplinary group/team is common at this step for sharing patient details that inform coverage decisions.
3. IDG communicates coverage determinations.

DETERMINE TERMINAL PROGNOSIS AND RELATED & UNRELATED DIAGNOSES

To appropriately determine hospice medication coverage the hospice physician must first identify related and unrelated diagnoses as well as assess indication and need. Determining relatedness is a continuous process which also considers changes in the patient's condition over time.
The hospice physician evaluates available information to:[1,3]

- Identify all related and unrelated diagnoses. A diagnosis is related unless the hospice physician documents in the hospice medical record why that diagnosis is not related.
- Identify the current indication and/or current rationale for each medication.
- Account for the impact of terminal illness on other diagnoses and symptoms.

Note that once a patient elects the hospice benefit, Medicare Part D plans will not cover medications considered the hospice's responsibility, specifically in the four key categories below.[9,10]
1. Analgesics (e.g., acetaminophen, ibuprofen, morphine)
2. Antianxiety medications (e.g., lorazepam)
3. Antiemetics (e.g., ondansetron, prochlorperazine)
4. Laxatives (e.g., senna, bisacodyl)

Patient Case: Determining Terminal Prognosis and Related & Unrelated Diagnoses

The hospice medical director certifies that the patient, MG, is terminally ill, documents the information below, and collaborates with the admission nurse and IDG members to make further determinations:

Related Condition(s):

- Terminal illness: Alzheimer's dementia
- End-of-life symptoms to anticipate: Pain, constipation, nausea and/or vomiting, anxiety
- Contribute to the terminal prognosis (i.e., impact the trajectory of the terminal illness): Parkinson's disease, aspiration pneumonia

Impacted by the terminal illness—hospice to cover symptom management until deemed no longer beneficial:

- Medications for the prevention of pain/discomfort from gout flare-up
- Medications used to lower blood pressure
- Thrombosis prevention

Unrelated Condition(s):

- Glaucoma

DETERMINE MEDICATION RELATEDNESS AND COVERAGE

Medication Relatedness

Medications can be organized in four categories for streamlining decision-making. A medication can be:

1. **Related** to Terminal Illness and/or Contributing Condition(s) **and Beneficial:**

   Hospice covers these (e.g., medication classes Part D plans will not cover such as opioids for pain, lorazepam for anxiety, ondansetron for nausea, and senna for constipation).

2. **Related** to Terminal Illness and/or Contributing Condition(s) **But No Longer Beneficial**:

   Hospice may recommend discontinuation and/or new alternative medication(s) for anticipated symptom management; patients may assume cost if they continue with the non-beneficial medication(s).

   - For example, it may be recommended to begin tapering doses of the dementia medication, memantine, in a patient with a terminal illness of Alzheimer's dementia because it is no longer indicated and may be contributing to nausea; if the family reports worsening agitation/function once memantine is stopped, non-pharmacological and pharmacological therapies can be initiated to manage agitation.

3. **Impacted** by Terminal Illness and/or Contributing Condition(s) **and *Contingently* Beneficial**:

   Hospice typically covers symptom management until the therapy is no longer deemed beneficial; determinations will change over time, as the terminal illness progresses:

   - At hospice admission:
     - It may not be clear the extent to which each medication manages end-of-life symptoms. Observation and communication with the patient/family over time will inform decisions that include therapeutic alternatives and deprescribing (discontinuation and/or dose reduction) opportunities.
     - Most medications may be considered related, or the symptom/condition impacted, and beneficial; discontinuing medications before trust is established may incite patient confusion and/or anxiety.
   - CMS expects that the hospice will cover these medications while continuing to assess benefit.
   - Deprescribe when medications are no longer beneficial—if these medications are not discontinued when clinically appropriate, the hospice continues to be financially responsible for them, underscoring the importance of continued re-evaluation for deprescribing opportunities. Examples of medications no longer beneficial include:[11-13]
     - Medications for long-term disease management or prevention (time-to-benefit is beyond life expectancy).
       - Lipid-lowering agents (e.g., "statins" such as rosuvastatin (Crestor®)) (See Discontinuation of Statins at the End-of-Life).[14]
     - Medications causing significant adverse effects (harms outweigh benefits within the context of patient's care goals, level of functioning, and life expectancy).
       - Dementia medications (See Dementia Medications & Deprescribing: A Revision).[15]
       - Anticoagulants (See Oral Anticoagulant Conversion Considerations).[16]
       - Antihypertensives used only for blood pressure lowering (See Approach to Blood Pressure Lowering Agents in Hospice Care).[16]
       - Diabetes medications (See Switching or Deprescribing Insulins: When & How).[18]

4. **Unrelated** to Terminal Illness and/or Contributing Condition(s) **and No Longer Beneficial:**

   Discontinuation is recommended.

   - Document unrelated status and coordinate billing.
   - Remove medication burden and reduce risk.
   - Document decision and patient/family education.

Differentiating Hospice Coverage from Hospice Formulary

A hospice formulary represents a list of preferred medications, but it does not replace the need for individualized medication assessments. Hospice formularies encompass most medications commonly used in pain and symptom management; however, they are not intended to include every medication a patient may need.[19] **A medication's formulary status does not determine relatedness.** Maintaining a formulary serves to familiarize clinicians with cost-effective medication therapy but should not be used exclusively to determine hospice coverage.[20]

Patient Case: Determination of Medication Relatedness and Coverage

IDG discovers MG was having more frequent episodes of choking when eating and this is what led to the hospitalization for aspiration pneumonia. Her poor appetite continues to worsen, and she is spending more time in bed due to difficulty ambulating. In the past 6 months, her weight has decreased from 120 to 105 pounds, a decrease of 12.5%. The determining factors that led to hospice election were the family's decision against further blood tests, antibiotics, or other measures to prolong life. Recall her current medications:

- Allopurinol (Zyloprim®) 100mg; 1 tablet by mouth daily
- Aspirin 81mg; 1 tablet by mouth daily
- Atenolol (Tenormin®) 25mg; 1 tablet by mouth daily
- Carbidopa-levodopa (Sinemet®) 25mg-100mg; 1 tablet by mouth 3 times daily and 2 tablets at bedtime
- Donepezil (Aricept®) 10mg; 1 tablet by mouth at bedtime
- Latanoprost (Xalatan®) 0.005%; Place 1 drop in the affected eye(s) once daily
- Losartan (Cozaar®) 50mg; 1 tablet by mouth daily
- Memantine (Namenda®) 10mg; 1 tablet by mouth twice daily
- Polyethylene glycol (MiraLax®); Dissolve 17grams of powder in 8 ounces of water and drink daily as needed for constipation

Assessment of MG's medication list across the four medication relatedness categories support the following IDG determinations:

- **Related** to Terminal Illness and/or Contributing Condition(s) and **Beneficial:**
  - Contributing condition of Parkinson's disease: Carbidopa-levodopa
  - Palliation of related symptom of constipation: Polyethylene glycol
- **Related** to Terminal Illness and/or Contributing Condition(s) **But No Longer Beneficial:**
  - Terminal illness of Alzheimer's disease: Donepezil and memantine
    - Re-evaluate at regular intervals patient/family readiness to deprescribe.
- **Impacted by** Terminal Illness and/or Contributing Condition(s) **and *Contingently* Beneficial:**
  - Engage patient/family on plan to monitor for benefit. Once trust is established, these therapies will need to be reevaluated at regular intervals for deprescribing opportunities:
    - Thrombosis prevention: Aspirin
    - Hypertension: Atenolol, lisinopril
    - Prevention of discomfort from gout flare-ups: Allopurinol
- **Unrelated** to Terminal Illness and/or Contributing Condition(s) **and No Longer Beneficial:**
  - Glaucoma: Latanoprost

 Dragonfly Health © 2026

COMMUNICATE COVERAGE DETERMINATIONS

Clearly communicate all medication coverage determinations (including medications not covered by hospice) to the pharmacist, the patient, and their family to ensure they understand the reasoning. CMS provides a Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" that hospices can use to create an organization specific document to share with patients and families.[21]

When appropriate, offer formulary alternatives and provide the clinical rationale for recommending the discontinuation of medications that are no longer beneficial. Continually update the patient's conditions, level of care, goals of care, and medications in the medical record, especially when changes occur. Discuss changes with hospice physician(s) to ensure proper coverage determinations. An Advance Beneficiary Notice (ABN) must be issued if the patient has not been informed that a medication is non-covered; however, an ABN is not required when there is no change to the established plan of care.[22]

Patient Case: Communicating Coverage Determinations with Patient's Family

When reviewing MG's medications, the hospice team explains to the family how each medication was evaluated for relatedness, clinical benefit, and alignment with comfort-focused goals. Important points shared with MG's family include the following:

- All decisions prioritize comfort and reduce unnecessary medication burden.
- Clearly explained which medications the hospice is covering and not covering and the reason(s) for each determination:
  - Some medications are essential for comfort and will remain covered by hospice. These include the carbidopa-levodopa for Parkinson's and polyethylene glycol for constipation.
  - Some medications may be providing comfort and covered by hospice now but may eventually no longer be helpful—these medications are allopurinol for gout, aspirin for clot prevention, and atenolol and losartan for blood pressure lowering. We will look for opportunities to decrease medication doses or discontinue when they are no longer helping.
  - Medications that are no longer helpful are donepezil and memantine. These are dementia medications and no longer contribute to MG's comfort and may be causing unwanted side effects such as nausea and poor appetite. These medications also increase the burden of taking her pills each day. For these reasons, it is suggested that we slowly decrease the dose of these medications, one at a time, over the next few weeks, while we carefully observe any changes.
  - The glaucoma eye drop, latanoprost, is unrelated to her terminal illness and therefore is not hospice-covered, though they may continue under another payer if desired.

BEST PRACTICE SUMMARY

To ensure compliance and high-quality care:

- Be consistent from the start: Beginning at admission, explain that hospice focuses on comfort, which can mean stopping some chronic medications that are no longer beneficial. Set expectations and reduce distress. Reintroduce the topic of medication adjustment as patient status changes.
- Use the approaches above for each medication at admission and for any plan of care update. Consider embedding in your IDG workflow/checklist.
- Prioritize deprescribing, targeting medications with low end-of-life benefit and high burden.
- Clearly communicate coverage determinations to the patient, their family, and the pharmacy.
- Coordinate benefits. For unrelated medications, ensure the pharmacy bills the correct payer to avoid denials and patient confusion.
- Document in the medical record (envision an auditor's checklist):
  - Related and unrelated rationale.
  - Clinical necessity and goal alignment.
  - Therapeutic/formulary alternative offers and assessment of patient response.
  - Patient notification of hospice non-covered items, services, and medications.
  - ABN issuance, when indicated.
- Reassess continuously. As symptoms and goals shift, so do coverage decisions. Consult with the medical director and IDG to update the plan of care promptly.

ADDITIONAL INFORMATION ON THIS TOPIC

Enclara Pharmacia Palliative Pearls

- Approach to Formulary Alternative Decisions: When to Switch and When not to. https://enclarapharmacia.com/palliative-pearls/approach-to-formulary-alternative-decisions-when-to-switch-and-when-not-to
- Approach to Polypharmacy: A Refresher. https://enclarapharmacia.com/palliative-pearls/approach-to-polypharmacy-a-refresher
- Dementia Medications & Deprescribing: A Revision. https://enclarapharmacia.com/palliative-pearls/dementia-medications-deprescribing-a-revision

 Dragonfly Health © 2026

References

1. Determination of Hospice Medication Coverage. Alliance for Care at Home, formerly National Hospice & Palliative Care Organization (NHPCO). Updated June 2022. https://allianceforcareathome.org/wp-content/uploads/NHPCO-Medication-Flow-Chart.pdf
2. Centers for Medicare & Medicaid Services. Hospice Center. Accessed Mar 16, 2026. https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center
3. Code of Federal Regulations. Title 42, Chapter IV, Subchapter B, Part 418: Hospice Care. Accessed Mar 16, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#se42.3.418_156&node=pt42.3.418&rgn=div5#se42.3.418_156
4. § 418.24 Election of hospice care. In: Code of Federal Regulations. Title 42, Chapter IV, Subchapter B, Part 418: Hospice Care. Accessed Mar 16, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#se42.3.418_156&node=pt42.3.418&rgn=div5#se42.3.418_156
5. § 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services. In: Code of Federal Regulations. Title 42, Chapter IV, Subchapter B, Part 418: Hospice Care. Accessed Mar 16, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418#se42.3.418_156&node=pt42.3.418&rgn=div5#se42.3.418_156
6. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: NationalCoalition for Hospice and Palliative Care; 2018. https://nationalcoalitionhpc.org/wp-content/uploads/2024/03/NCHPC67840.html
7. Determining Relatedness to the Terminal Prognosis Process Flow. Alliance for Care at Home, formerly National Hospice & Palliative Care Organization (NHPCO). Updated April 2020. https://allianceforcareathome.org/wp-content/uploads/NHPCO-Relatedness-Process-Flow_Revised-Version-2.0-2020vFINAL.pdf
8. Parker J. The Complex Quandary Over Hospice Relatedness. In: Hospice News. Dec 5, 2025. https://hospicenews.com/2025/12/05/the-complex-quandary-over-hospice-relatedness/
9. Centers for Medicare & Medicaid Services. Memo: Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice. Jul 18, 2014. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf
10. Centers for Medicare & Medicaid Services. Memo: Update on Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice. Nov 15, 2016. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf
11. Pruskowski J. Deprescribing. In: Palliative Care Network of Wisconsin Fast Facts. Apr 17, 2024. https://www.mypcnow.org/fast-fact/deprescribing/
12. Holmes HM. Rational prescribing for patients with a reduced life expectancy. *Clin Pharmacol Ther*. 2009 Jan;85(1):103-7.
13. Holmes HM, Min LC, Yee M, Varadhan R, Basran J, Dale W, Boyd CM. Rationalizing prescribing for older patients with multimorbidity: considering time to benefit. *Drugs Aging*. 2013 Sep;30(9):655-66.
14. Tran NN, DiScala SL, Mandi D, et al. Discontinuation of Statins at the End-of-Life. In: Palliative Care Network of Wisconsin Fast Facts. https://www.mypcnow.org/fast-fact/discontinuation-of-statins-at-the-end-of-life/
15. Enclara Pharmacia. Dementia Medications & Deprescribing: A Revision. In: Palliative Pearls. Feb 27, 2023. https://enclarapharmacia.com/palliative-pearls/dementia-medications-deprescribing-a-revision
16. Enclara Pharmacia. Oral Anticoagulant Conversion Considerations. In: Palliative Pearls. Oct 12, 2021. https://enclarapharmacia.com/palliative-pearls/oral-anticoagulant-conversion-considerations
17. Enclara Pharmacia. Approach to Blood Pressure Lowering Agents in Hospice Care. In: Palliative Pearls. Jun 18, 2025. https://enclarapharmacia.com/palliative-pearls/approach-to-blood-pressure-lowering-agents-in-hospice-care
18. Enclara Pharmacia. Switching or Deprescribing Insulins: When & How. In: Palliative Pearls. Jun 23, 2022. https://enclarapharmacia.com/palliative-pearls/switching-or-deprescribing-insulins-when-how
19. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. *Am J Health-Syst Pharm*. 2021;78:907-918.
20. Enclara Pharmacia. Approach to Formulary Alternative Decisions: When To Switch and When Not to. In: Palliative Pearls. Feb 23, 2026. https://enclarapharmacia.com/palliative-pearls/approach-to-formulary-alternative-decisions-when-to-switch-and-when-not-to
21. Centers for Medicare & Medicaid Services. Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs." In: Hospice Center > Hospice Coverage > Downloads. Accessed Mar 16, 2026. https://www.cms.gov/files/document/model-hospice-election-statement-addendum-march-2024.pdf
22. Centers for Medicare & Medicaid Services. Advance Beneficiary Notice of Non-Coverage Form. In: Hospice Center > Hospice Coverage > Related Links. Accessed Mar 16, 2026. https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice