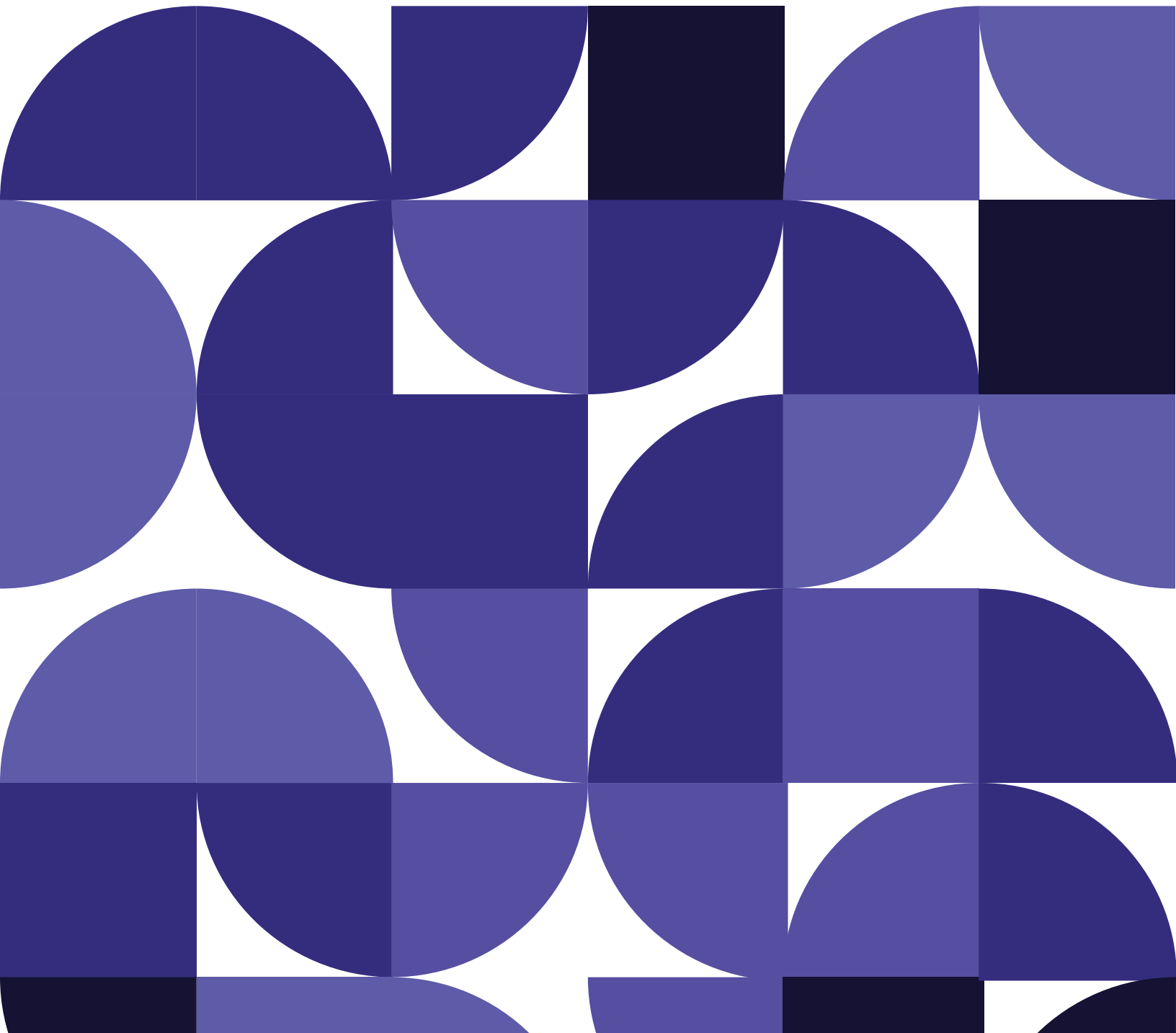


BRAINFUTURES

Expediting Psychedelic-Assisted Therapy Adoption in Clinical Settings



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Prepared by Rockingstone Group, LLC. (Jordanna Davis, MPP, and Jacqueline Lampert, MPP). Edited by BrainFutures Chief Strategy Officer Holly McCormack, in conjunction with CEO Linda Raines, Cofounder Henry Harbin, MD, Director of Program Operations, Jazz Glastra, MS, and CBG Consulting, LLC (Charles Gross, PhD). The recommendations presented in this paper are solely the views of BrainFutures, and participation as a reviewer or contributor does not mean a formal endorsement of this issue brief.

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James Acer

Chief of Staff, MAPS Public Benefit Corporation

Rachel Aidan, PhD, MA

Chief Executive Officer, Synthesis Institute

Mark Bates, PhD

Sunstone Therapist, Sunstone Therapies

John Cammack, MBA

Managing Partner, Kingcedar Holdings, LLC
BrainFutures Advisor

Alexander Cardenas, MD, MA

Psychiatrist
Co-Executive Director and Board Member,
American Psychedelic Practitioners Association

Joy Sun Cooper, MBA

Head of Commercialization and Patient Access,
MAPS Public Benefit Corporation

Michael Cotton

Former President/Chief Operating Officer
Meridian Health Plan

Steve Daviss, MD

Medical Director, Optum

Ingmar Gorman, PhD

Co-founder, Fluence
Clinical Investigator, MAPS
Psychologist

Wesley Hale, MS

Associate Director of Therapy Training,
MAPS Public Benefit Corporation

Henry Harbin, MD

Psychiatrist and Health Care Consultant
BrainFutures Advisor and Board Member
Former CEO, Magellan Health

Lucia Huang, MBA

Co-Founder and Chief Executive Officer, Osmind

Tom Insel, MD

Neuroscientist
Psychiatrist
Former Director, NIMH

Brenda Jackson, MPP

President, Brenda Jackson Consulting, LLC

Rik Kirkland, MA

Journalist and Editor

Emma Knighton, MA, LMHC, CPTR

Trauma Therapist & Psychedelic Integration Therapist,
Unity Within Counseling
Co-Executive Director and Board Member,
American Psychedelic Practitioners Association

Robert Koffman, MD, MPH

Chair of the Board of Psychedelic
Medicine and Therapies

Charles Lief, JD

President, Naropa University

Steven Levine, MD

SVP, Patient Access and Medical Affairs,
COMPASS Pathways

Bill Linton

Executive Director and President of the
Board of Directors, Usona Institute

Carlene MacMillan, MD

VP of Clinical Innovation,
Product and Growth, Osmind

Lia Mix, LMFT, CPTR

Co-Founder, Enthea

Marco Mohwinckel

VP of Clinical Innovation,
COMPASS Pathways

Tura Patterson, MA

Senior Director, Strategic Partnerships, Usona Institute

Janis Phelps, PhD, MA

Professor and Director of Center for
Psychedelic Therapies & Research,
California Institute of Integral Studies

Laura Pustarfi, PhD

Associate Director, Psychedelic-Assisted
Therapies & Research Certificate Program,
California Institute of Integral Studies

Sherry Rais, MSc

Co-Founder and Chief of Staff, Enthea

Brian Richards, PsyD

The Bill Richards Center for Healing
Sunstone Therapies
Aquilino Cancer Center
Johns Hopkins Center for Psychedelic and
Consciousness Research, Bayview Medical Center
Maryland Oncology Hematology P.A.

William Richards, PhD

Psychologist, Johns Hopkins Center for
Psychedelic and Consciousness Research
Director of Therapy, Sunstone Therapies

Dan Rome, MD

Co-Founder and Chief Medical Officer, Enthea

Gretchen Shaub, MPP

Stakeholder Relationship Manager,
COMPASS Pathways

Danielle Schlosser, PhD

SVP, Clinical Innovation, COMPASS Pathways

Scott Shannon, MD

Chief Executive Officer,
Board of Psychedelic Medicine and Therapies
Medical Lead and Core Faculty,
Psychedelic Research and Training Institute (PRATI)

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Executive Summary

The United States is in the midst of a long-standing mental health crisis. One in five U.S. adults experience mental illness each year and 17 percent of individuals experience mental illness before reaching adulthood (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021; Whitney & Peterson, 2019). These estimates predate the Covid-19 pandemic, which has unleashed devastating mental health consequences across the globe. The economic costs of mental illness, though undoubtedly secondary to human costs, are undeniably massive. Healthcare costs for individuals with behavioral health conditions are 2.8 to 6.2 times higher than for individuals without any such conditions (Davenport et al., 2020).

The need for effective, long-term relief is clear, yet there has been limited progress in effective pharmacologic treatment for most behavioral health conditions in the past 30 years and many existing medications fail to help many patients who try them (Insel, 2022; National Institute of Mental Health, 2006). Psychedelics hold promise in part because they work differently than existing medications for mental illness, affecting “neurochemistry, causing shifts in experiential perception and mood, often accompanied by vivid mental imagery and altered auditory processing” (Sky, 2022). Psychedelics act at “specific neurotransmitter receptors in the brain—typically serotonin receptors, as well as other receptors for neurotransmitters such as norepinephrine, dopamine, and glutamate” (Sky, 2022). Now more than ever, it is time to invest in neuroscientific innovation that offers new opportunities for treatment and recovery.

A number of clinical trials testing the use of psychedelic compounds to treat mental health and substance use

disorders are currently underway, and many more compounds are in earlier phases of development (Haichin, 2022). This report addresses how the field moves from the promise of innovation to tangibly better outcomes for patients, identifying consensus principles to lay a solid foundation of cooperation to advance broad access to psychedelic-assisted therapy (PAT).

Three promising candidates are in Phase 2 and Phase 3 FDA-approved clinical trials targeting some of the highest-cost mental illnesses, in terms of both human suffering and economic loss¹: COMPASS Pathways is testing psilocybin for treatment-resistant depression (TRD); the Multidisciplinary Association for Psychedelic Studies Public Benefit Corporation (MAPS PBC) is testing 3,4-methylenedioxy-methamphetamine (MDMA) for post-traumatic stress disorder (PTSD); and Usona Institute is testing psilocybin for major depressive disorder (MDD). All clinical protocols use a “set and setting” approach to support a patient’s experience with the compounds (Hartogsohn, 2017). The clinical protocols typically include an initial assessment, preparatory psychotherapy, the medication/dosing session, and integration support or psychotherapy. Several of the trials have published results with clinically significant responses, including remission in a substantial percentage of participants in the treatment arms of the trials (Davis et al., 2021; COMPASS Pathways plc, 2021b; Mitchell et al., 2021).

The promise of these psychedelic compounds raises great hope for PAT’s potential to relieve pain and suffering for millions of patients. The path from research to clinical adoption, however, is still lengthy and challenging. As the industry prepares for this next critical stage,

BrainFutures seeks to highlight the importance of a shared set of fundamental principles to guide key decision-makers in this process. These principles are:

1. PAT must be **accessible** to all patients who qualify for, and would benefit from, such therapy.
2. PAT must be **affordable** for all patients who qualify for, and would benefit from, such therapy.
3. PAT must meet **high quality** standards to ensure optimal patient outcomes.

Now, a multistakeholder, coordinated effort must be mobilized to minimize regulatory and reimbursement obstacles and solve other policy issues to ensure that accessible, affordable, and high-quality PAT is available to patients who need it. This report focuses on three core policy issues that must be addressed in order to uphold these principles.

POLICY ISSUE 1: ENSURE ACCESSIBILITY IN FDA APPROVAL AND SAFETY REQUIREMENTS

As the FDA evaluates the need for risk evaluation and mitigation strategies (REMS) for psychedelic medicines, the agency must consider its own perspective that REMS “not unduly impede patient access to the drug, and minimize the burden on the healthcare delivery system to the extent practicable (Center for Drug Evaluation and Research & Center for Biologics Evaluation and Research [CDER & CBER], 2019). Further, any REMS contemplated by the FDA must consider the high emotional, social, and economic costs of the conditions targeted for treatment as well as the significant benefits psychedelics demonstrate in

clinical trials. Any REMS should be consistent with or comparable to those in place for existing treatments for the targeted conditions with similar risk and safety profiles to psychedelics. BrainFutures recognizes that each psychedelic compound and each psychotropic class carries their own unique risk and safety profiles.

RECOMMENDATIONS TO ENSURE ACCESSIBILITY IN FDA APPROVAL AND SAFETY REQUIREMENTS

BrainFutures recommends that any REMS required by the FDA for approved psychedelics be:

1. Balanced against the principle of wide access;
2. Contextualized against the high emotional, social, and economic costs of the conditions targeted for treatment;
3. Consistent with or comparable to those in place for existing treatments for the targeted conditions with similar risk and safety profiles to psychedelics;
4. Consistent with generally accepted medical and behavioral healthcare quality assurance standard practices; and
5. Open to the establishment of quality standards and measurement by the field of clinicians, national certification bodies, accrediting agencies, and professional practitioner associations.

POLICY ISSUE 2: ENSURE AFFORDABILITY IN PAYER COVERAGE AND PAYMENT DECISIONS

Public and private health insurance coverage of PAT is a prerequisite for equitable access by all patients who seek such care and for whom it is appropriate. At least three critical issues comprise public and private coverage and payment decisions that ensure PAT is affordable for patients: the **statutory and regulatory framework** for payer coverage decisions, including parity of coverage and reimbursement with physical health benefits; individual payer **coverage determinations**; and a **coding strategy** to ensure adequate, efficient, accurate payments to PAT providers.

RECOMMENDATIONS TO ENSURE AFFORDABILITY IN PAYER COVERAGE AND PAYMENT DECISIONS

BrainFutures recommends that any payer coverage and payment decisions for psychedelics:

1. Follow a path of wider and more comprehensive insurance coverage than has traditionally marked mental health benefits, across all public and private payers;
2. Limit out-of-pocket requirements for patients;
3. Comply with both the financial requirement and treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA), particularly for non-quantitative treatment limitations;
4. Ensure the psychedelic compound and psychotherapy are adequately reimbursed and the coverage is coordinated between behavioral health and pharmaceutical benefits; and
5. Utilize a uniform coding strategy.

POLICY ISSUE 3: PAT MUST MEET HIGH QUALITY STANDARDS TO ENSURE OPTIMAL PATIENT OUTCOMES

PAT stakeholders agree that the field should establish standards to ensure the highest-quality delivery of PAT. While quality standards will ultimately be required in a number of different areas, the two most pressing needs at this time surround provider training requirements and measures to assess PAT care quality.

RECOMMENDATIONS TO ENSURE PAT MEETS HIGH QUALITY STANDARDS TO ENSURE OPTIMAL PATIENT OUTCOMES

BrainFutures recommends the following steps to ensure optimal patient outcomes:

1. Establishment of a certification authority or authorities for training programs and providers, initial provider certification, and ongoing recertification of provider competencies, including ethical standards and codes of conduct required by each provider's professional license;
2. Harmonization and standardization of core training curricula, with psychedelic compound-specific modules, to be endorsed by professional associations and adopted by all training programs;
3. Establishment of a collaborative group of stakeholders and independent experts within the PAT field to identify a measurement-based approach to PAT;
4. Identification of a set of key quality measures, including both process and outcome measures, to ensure transparency and accountability of providers; and
5. Support of research into emerging and innovative psychedelic treatments and therapies.

NEXT STEPS

In the near-term, the PAT field must align approaches in four key areas:

1. **Standards of Care:** Designation of a specialty association or associations to set standards of care for PAT providers, including standards of quality, medical or clinical practice guidelines, medical review criteria, and performance measures.
2. **Program Accreditation:** Designation of a body to offer independent accreditation of PAT education programs, set standards for effective training, and monitor compliance with those standards.
3. **Provider Certification:** Designation of a certification board to offer independent evaluation and verification of a provider's skills and expertise relative to PAT, to update certification criteria as the specialty evolves, and to provide patients with a trusted credential to help identify qualified providers.
4. **Reimbursement Strategy:** Alignment of stakeholders around a unified coding strategy and implementation plan to facilitate payer coverage determinations, simplify coding and billing processes, and improve access to care; development of parity education materials and briefing documents as free resources to stakeholders to support collective advocacy efforts.

Fortunately, the resources to execute on these goals exist within the PAT community. The key next step is for a trusted entity to identify these capacities within the PAT stakeholder community, and to build consensus around assignment of key responsibilities to identified organizations. 🌐

Introduction

BrainFutures’ work in the field of psychedelics exists in the context of our nation’s long-standing mental health crisis, which creates a desperate need for new and innovative treatments for the most intractable mental health and substance use disorders (MH/SUDs). The Covid-19 pandemic makes this work only more urgent, as its traumas unleash devastating mental health consequences across the globe. Now more than ever, it is time to invest in innovations that offer new opportunities for treatment and recovery.

Fortunately, psychedelics hold great promise for the future of mental health care. A number of clinical trials of psychedelic compounds are currently underway. In addition, many organizations are in the first phases of drug development—discovery and preclinical—working to identify promising compounds that target a variety of MH/SUDs and determine if they are safe for human trials (Haichin, 2022). The exact number of psychedelic medicine trials in process varies at any given moment, and as of September 21, 2021, ClinicalTrials.gov listed more than 350 active or completed studies of psychedelic pharmaceuticals, though not all are indicated for MH/SUDs (National Library of Medicine, n.d.-a).

BrainFutures’ first paper on psychedelic-assisted therapy (PAT), *Psychedelic Medicine: A Review of Clinical Research for a Class of Rapidly Emerging Behavioral Health Interventions*, offered a comprehensive inventory of the evidence for the efficacy of psychedelic compounds. It laid out the significant promise that PAT offers for treating some of our field’s most persistent illnesses, including major depressive disorder (MDD), treatment-resistant depression (TRD), and post-traumatic stress disorder (PTSD). This report, BrainFutures’ second

of three in a series on PAT, addresses how the field converts the promise of innovation detailed in the first PAT report into tangibly better outcomes for patients.

As with any novel therapy, the path from research to broad use presents hurdles and challenges. Within the landscape of PAT, these include questions of coverage, reimbursement, training, quality, and measurement, such as:

- Will the Food and Drug Administration (FDA) approve New Drug Applications for psychedelic compounds? What conditions might these approvals impose on access to the drugs?
- Will PAT be covered by insurance? If so, what will coverage policies be? How will PAT be reimbursed?
- How will the field define “quality” in the context of PAT? How will quality be measured? Who will enforce quality standards?

BrainFutures identifies consensus principles that can help lay a solid foundation of cooperation to advance more equitable and broad access to PAT.

Though this report cannot answer these questions, BrainFutures identifies consensus principles that can help lay a solid foundation of cooperation to advance broad access to PAT. This paper will also identify specific policy problems where consensus is necessary to optimally advance toward a shared

goal of wide PAT access. Relative to these policy challenges, this report provides BrainFutures' related recommendations and suggested next steps.

METHODOLOGY

This paper is informed by a detailed analysis of publicly available information regarding the economic and human costs of mental health conditions; psychedelics and psychedelic-assisted therapy; behavioral health coverage, coding, and reimbursement policies; Food and Drug Administration drug review and approval requirements; psychedelic and hallucinogenic clinical trials targeting MH/SUDs registered with ClinicalTrials.gov as of September 21, 2021; and more. To ensure an up-to-date understanding of this rapidly evolving field, BrainFutures conducted numerous interviews and held many discussions with representatives from emerging professional and national certification associations, manufacturers, independent training providers, an emerging third-party administrator developing a PAT provider network, and clinicians. To better understand payer perspectives on PAT, BrainFutures conducted confidential interviews with the behavioral health medical directors of several national, commercial payers. Collectively, the plans interviewed cover approximately 100 million lives across insurance products, including commercial insurance, Medicaid managed care, and Medicare Advantage, and have a combined revenue of approximately \$400 billion. BrainFutures worked with national reimbursement sustainability experts to identify coding strategies, to develop practitioner unit costs, and to estimate potential revenues for practitioners providing psychedelic-assisted therapy. This includes developing options for practitioners to seek reimbursement from a variety of payer sources.

THE COSTS OF MENTAL ILLNESS

BrainFutures approaches our PAT reports within the context of our nation's extraordinary battle with mental illness. One in five U.S. adults experience mental illness each year, and 17 percent of individuals will experience mental illness even before they reach adulthood (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021; Whitney & Peterson, 2019). One in 20 individuals experience serious mental illness, which results in functional impairment substantially interfering with major life activities (SAMHSA, 2021). Only 45 percent of adults with mental illness will receive treatment in any given year, and the average person will wait 11 years from the onset of symptoms before receiving treatment for the first time (SAMHSA, 2021; Wang et al. 2004).

**As of January 2021,
roughly four in 10 U.S.
adults report symptoms
of anxiety or depression.**

The pandemic has made these statistics even more grave. As of January 2021, roughly four in 10 U.S. adults report symptoms of anxiety or depression, up from just one in 10 in the first half of 2019 (Panchal et al., 2021). U.S. adults also reported increased difficulty sleeping (36 percent), eating (32 percent), increases in alcohol consumption or substance use (12 percent), and worsening chronic conditions due to worry and stress over the pandemic (12 percent) (Panchal et al., 2021).

The situation is particularly severe within certain demographic groups. Emergency department (ED) visits for suspected suicide attempts were 50.6 percent higher among girls aged 12 to 17 in May 2020 than during the same period in 2019 (Yard et al., 2021). Overall, the proportion of mental health-related ED visits among adolescents increased 31 percent compared with May

2019. In addition, throughout 2020 and 2021, the National Center for Health Statistics partnered with the Census Bureau to operate a Household Pulse Survey (Panchal et al., 2021). In the online survey, 56 percent of young adults aged 18 to 24 reported symptoms of anxiety and/or depressive disorder, 25 percent reported substance use, and 26 percent reported suicidal thoughts. Other groups in the survey reporting high levels of anxiety and/or depression include individuals who have been affected by job loss (53 percent), women with children (49 percent), non-Hispanic Black adults (48 percent), Hispanic or Latino adults (46 percent), and essential workers (42 percent) (Panchal et al., 2021).

Healthcare costs for individuals with behavioral health conditions were 2.8 to 6.2 times higher than for individuals with no behavioral health condition.

The economic costs of mental illness, though undoubtedly secondary to human costs, are also undeniably massive. In a 2017 Milliman study of 21 million insured individuals, healthcare costs for individuals with behavioral health conditions were 2.8 to 6.2 times higher than for individuals with no behavioral health condition, depending on their diagnoses (Davenport et al., 2020). Beneficiaries with behavioral health conditions comprised just 27 percent of the total study population, yet accounted for 56.5 percent of total healthcare costs (Davenport et al., 2020). Within the most costly ten percent of this population, 57 percent of beneficiaries had a behavioral health diagnosis. Overall, these high-cost individuals with behavioral health diagnoses accounted for 44 percent of all costs across the 21 million beneficiary population, or an average of \$45,782 per patient per year.

Notably, higher costs for beneficiaries with behavioral health diagnoses are not always attributable to behavioral health treatment alone. In fact, half of the high-cost beneficiaries with behavioral health diagnoses had less than \$95 per year of total spending on behavioral health treatments (Davenport et al., 2020). Across the entire study population, only 4.4 percent of healthcare costs were for behavioral health treatments. While the Davenport, et al., study was not designed to determine causality between behavioral health conditions and high medical/surgical spending, the findings suggest that individuals with behavioral health conditions frequently suffer from physical illness comorbidities that are not well managed. The authors note that consideration and management of behavioral health conditions are “important parts of a comprehensive strategy to manage total healthcare costs and contribute to positive outcomes for patients.”

THE NEED FOR EFFECTIVE, LONG-TERM RELIEF

As former director of the National Institute for Mental Health (NIMH), Dr. Thomas Insel, MD states in *Healing: Our Path from Mental Illness to Mental Health*,

“Today there are about 30 different antidepressants, 20 different antipsychotic drugs, [seven] different mood stabilizers used in bipolar disorder, and [six] different classes of drugs for Attention Deficit Hyperactivity Disorder (ADHD). Almost none of these are more effective than the medications we had [three] decades ago, although newer medications have different and, in some cases, better side-effect profiles.”

While prescription medication and psychosocial treatments are effective for many individuals struggling with these mental illnesses, too many patients have not found effective, consistent, and durable relief (Sky, 2022). As BrainFutures notes in

our previous report, “Too often their conditions are associated with significant patient suffering, especially for those with treatment-resistant disorders, with prevalence rates continuing to rise” (Sky, 2022).

Psychedelics work differently than existing FDA-approved medications for mental illness, affecting “neurochemistry, [and] causing shifts in experiential perception and mood, often accompanied by vivid mental imagery and altered auditory processing” (Sky, 2022). Psychedelics act at “specific neurotransmitter receptors in the brain—typically serotonin receptors, as well as other receptors for neurotransmitters such as norepinephrine, dopamine and glutamate” (Sky, 2022).

PAT is showing efficacy for treating several chronic mental health conditions that are often resistant to existing pharmacological and psychotherapeutic options.

In FDA-approved clinical trials, described in the “Mental Health Diagnoses Addressed by PAT” section below, PAT is showing efficacy for treating several chronic mental health conditions that are often resistant to existing pharmacological and psychotherapeutic options. At the same time, adverse physical effects of psychedelics are for the most part minimal, transient, and/or mitigated by appropriate clinical protocols, with the greatest risk occurring in unsupervised participation (Johnson et al., 2008). These may include dizziness, headache, nausea/vomiting, fatigue, body pain, irritability, heightened blood pressure and pulse, insomnia and/or anxiety, (COMPASS Pathways plc, 2021a; Nichols, 2016). The potential for psychological side-effects, such as depression, anxiety, or even a

psychotic episode, is also cause for concern. Rigorous pre-screening of potential patients and supportive psychotherapy after administration of psychedelic medicines are critical to mitigate these risks.

ABOUT PSYCHEDELIC-ASSISTED THERAPY

Currently, three promising candidates are engaged in Phase 2 and Phase 3 clinical trials of PAT. The drug sponsors, COMPASS Pathways, the Multidisciplinary Association for Psychedelic Studies Public Benefit Corporation (MAPS PBC), and Usona Institute, are pursuing FDA approval for psilocybin for treatment-resistant depression (TRD), 3,4-methylenedioxy-methamphetamine (MDMA) for post-traumatic stress disorder (PTSD), and psilocybin for major depressive disorder (MDD), respectively. Each is testing pharmaceuticals using a “set and setting” approach in their clinical protocols. In psychedelic research, “set and setting” generally refers to the psychological, social, and cultural parameters that may shape an individual’s experience with psychedelic drugs (Hartogsohn, 2017). The set may include things such as the “personality, preparation, expectation, and intention of the person having the experience” and the setting often refers to “the physical, social, and cultural environment in which the experience takes place” (Hartogsohn, 2017). The set and setting for PAT utilized in these clinical trials generally is facilitated by a standard model for therapeutic engagement, which includes an initial patient assessment preparatory psychotherapy, a supervised dosing session lasting several hours, and integrative support or psychotherapy following the dosing session.

Following an initial assessment, preparatory psychotherapy sessions are designed to help the patient build rapport with the facilitators who will be present during the dosing sessions (i.e. develop the therapeutic alliance) and to help the patient identify themes or personal struggles that may affect the dosing experience

(Usona Institute, 2021). Facilitators may also provide psychoeducation regarding the targeted condition and seek to obtain any background information that may become important during the dosing session (e.g., for treatment of PTSD, information about the trauma) (MAPS PBC, 2020). One drug sponsor notes that preparation psychotherapy sessions include demonstrating and practicing “self-directed inquiry and experiential processing” (COMPASS Pathways plc, 2020b). These sessions are intended to prepare the patient for the dosing session, helping them know what to expect. In late-phase clinical trials, the total duration of preparatory therapy is six to eleven hours (COMPASS Pathways plc, 2020a; MAPS PBC, 2020; Usona Institute, 2021).

The medication, or dosing, session is typically conducted by two facilitators (often one male and one female) who are present throughout the session, with the exception of short breaks (i.e. bathroom breaks, etc.) (Usona Institute, 2021). This is in part due to an FDA requirement that dosing sessions include both a licensed mental health care provider and a trained technician or monitor to protect subject safety (Muniz, 2021). Researchers are, however, testing other models of care, particularly surrounding the medication session. For example, an open-label trial involving cancer patients utilizes small-group administration of psilocybin along with one-on-one support from a therapist (Maryland Oncology Hematology, 2021).

In many trials, participants are encouraged to wear eyeshades and listen to carefully selected music, both designed to help focus attention inward (COMPASS Pathways plc, 2020a; MAPS PBC, 2020; Usona Institute, 2021). Dosing sessions are typically held in a quiet room designed to be non-clinical and aesthetically pleasing in appearance. Participants are free to speak with the facilitators at any time during the drug session, and one protocol directs therapists to

check in with the participant if they have not spoken during the first hour of the session (MAPS PBC, 2020). One treatment manual describes a “nondirective approach to therapy based on empathetic rapport and empathetic presence” (Mithoefer, 2017).

The dosing session is followed by a series of integrative support or psychotherapy sessions, in which participants discuss and process their physical and emotional experiences during the dosing session, with facilitator assistance (COMPASS Pathways plc, 2020a; MAPS PBC, 2020; Usona Institute, 2021). One treatment manual directs facilitators to “encourage the transfer of states of acceptance, feelings of intimacy, closeness, and reduced fear experienced in Experimental Sessions to emotionally threatening everyday situations” (MAPS PBC, 2020).

In some trials, patients repeated the dosing session and subsequent integrative psychotherapy sessions for a total of two or three cycles of PAT. After the prescribed number of cycles, treatment is complete, and many patients continue to experience symptom improvement for many months following treatment, sometimes resulting in complete remission.

MENTAL HEALTH DIAGNOSES ADDRESSED BY PAT

The most advanced PAT clinical trials target some of the highest-cost mental illnesses, in terms of both human suffering and economic loss: MDD, TRD, and PTSD.

MAJOR DEPRESSIVE DISORDER

MDD is the leading cause of disability worldwide and in the United States. It affects approximately 17.5 million U.S. adults, just over seven percent of the adult population (2018 estimate) (Greenberg et al., 2021). Nearly 65 percent of those diagnosed with MDD are considered severely impaired (Greenberg et al., 2021).

MDD exerts the greatest burden on individuals and the U.S. economy compared to all other mental and behavioral health conditions, accounting for 2.7 million disability-adjusted life-years in 2016 (Greenberg et al., 2021). The total economic burden of major depressive disorder was \$326.2 billion in 2018 (Greenberg et al., 2021). Of this, 35 percent (\$114.3 billion) was healthcare-related costs, four percent (\$13.4 billion) was suicide-related costs, and the remaining 61 percent (\$198.6 billion) was indirect workplace costs. In the workplace, presenteeism accounted for 70 percent of MDD-related workplace costs, while absenteeism accounted for 30 percent of costs. Interestingly, just 11.2 percent of the total economic burden was attributable to the direct cost of treating major depressive disorder itself (Greenberg et al., 2021). In fact, for every \$1.00 spent on MDD treatment, an additional \$7.91 was spent on MDD-related indirect costs and direct and indirect costs related to comorbidities.

As of March 2022, Usona Institute is engaged in a Phase 2b clinical trial of psilocybin for the treatment of MDD. Usona Institute received Breakthrough Therapy designation from the FDA for this work in November 2019 (Usona Institute, 2019). A separate Phase 2 trial of psilocybin found it was efficacious in treating MDD, with a clinically significant response (defined as a 50 percent or more reduction from their baseline GRID-Hamilton Depression Rating Scale) in 67 percent of participants and remission from depression in 58 percent (Davis et al., 2021).

Additional psychedelic-related clinical trials for the treatment of MDD are testing psilocybin as well as ayahuasca, lysergic acid diethylamide (LSD), and dimethyltryptamine (DMT) (National Library of Medicine, n.d.-a).

TOTAL ECONOMIC BURDEN OF MAJOR DEPRESSIVE ORDER

\$326.2B

TOTAL ECONOMIC BURDEN OF MAJOR DEPRESSIVE DISORDER

\$114.3B

HEALTH-RELATED COSTS

\$13.4B

SUICIDE-RELATED COSTS

\$198.6B

INDIRECT WORKPLACE COSTS

TREATMENT-RESISTANT DEPRESSION

While there is not yet a universally accepted definition of TRD, the diagnosis is typically applied to individuals with MDD who fail to respond, or fail to achieve remission, after two or more trials of medication with adequate dose and duration (Zhdanava et al., 2021). Thus, individuals with TRD may be considered a subpopulation of those with MDD. Patients with TRD “have higher symptom severity, longer episodes of depression, diminished quality of life, and an increased suicide risk, compared to patients with treatment-responsive depression” (Shrestha et al., 2020). Unfortunately, treatment options are limited for individuals with this mental health condition.

Healthcare costs were 29.3 percent higher for individuals with TRD relative to those with treatment-responsive depression.

As may be expected, without a universally accepted definition of TRD, prevalence estimates vary quite widely (12 to 55 percent of individuals with MDD), but there appears to be general agreement that TRD accounts for a disproportionate share of healthcare and economic costs relative to its prevalence (Zhdanava et al., 2021). One prominent study, which defined the condition as failure to respond to one medication trial, estimated that 12 to 20 percent of patients with depression have TRD, accounting for 27 to 41 percent of the total clinical, economic, and societal costs of MDD (Mrazek et al., 2014). Another study found that healthcare costs were 29.3 percent higher for individuals with TRD relative to those with treatment-responsive depression (Olchanski et al., 2013). However, this study used a very high threshold—four

different therapy trials—to identify the TRD population, so may have underestimated these costs.

Zhdanava et al., (2021) estimate that individuals with medication-treated MDD incur additional healthcare, productivity, and unemployment costs of \$92.7 billion per year, relative to individuals without the disorder. They also found that 30.9 percent of the medication-treated MDD population had TRD, using two failed medication trials as the threshold. However, individuals with TRD accounted for an outsized portion of additional costs, relative to their population size: 30.9 percent of the population accounted for 47.2 percent of total costs. Specifically, individuals with TRD accounted for 56.6 percent of healthcare costs, 32.2 percent of productivity costs, and 47.7 percent of unemployment costs.

COMPASS Pathways recently released topline results from its Phase 2b clinical trial of psilocybin for the treatment of TRD. The goal of this trial was to identify the correct dose of COMP360, COMPASS Pathways’ synthetic psilocybin. According to a press release, patients who received a 25 mg dose of COMP360 demonstrated a highly statistically significant reduction in depressive symptom severity after three weeks (COMPASS Pathways plc, 2021b). A separate, smaller open label study also found that patients who took SSRIs concomitant with COMP360 achieved results similar to those in the Phase 2b trial, in which participants were required to “washout” SSRIs due to concerns the drugs could interfere with psilocybin’s therapeutic effects (COMPASS Pathways plc, 2021c). COMP360 was awarded Breakthrough Therapy status by the FDA in 2018.

Additional clinical trials are testing psychedelics in the treatment of TRD, involving additional drug sponsors or collaborator groups (National Library of Medicine, n.d.-a).

POST-TRAUMATIC STRESS DISORDER

PTSD affects approximately 3.5 percent of U.S. adults every year, meaning that one in 11 individuals will be diagnosed with PTSD in their lifetime (American Psychiatric Association, 2020). PTSD can occur in anyone exposed to a traumatic event where symptoms last for more than a month and cause significant distress or problems with an individual's daily functioning (American Psychiatric Association, 2020). Prevalence of PTSD within any given year is 3.5 percent, but substantially higher among women (5.2 percent) than men (1.8 percent) (Harvard Medical School, 2007b). The military health system diagnosed more than 200,000 active-duty service members with PTSD between 2002 and 2017, with the share of service members with a PTSD diagnosis being medically discharged increasing from 16 percent in 2002 to 34 percent in 2015 (Krull et al., 2021).

Women with PTSD symptoms experience significantly higher total healthcare costs, up to 104 percent more than women who do not have PTSD symptoms (Walker et al., 2003). For both men and women with PTSD, higher healthcare costs may be partly explained by a possible association with type 2 diabetes, cardiovascular disease, and metabolic disease (Lukaschek et al., 2013; Dedert et al., 2010). One meta-analysis of studies on PTSD and PTSD symptoms found both were associated with more general health symptoms and general medical conditions, as well as poorer health-related quality of life (Pacella et al., 2013). Compared to patients with MDD, patients with PTSD had higher rates of other mental health disorders and higher mental health care use and costs (Ivanova et al., 2011). These contribute to annual healthcare costs that average 4.2 to 9.3 percent higher for individuals with PTSD than for individuals with MDD (Ivanova et al., 2011).


As of March 2022, MAPS PBC is engaged in a second Phase 3 clinical trial of MDMA-assisted therapy for the

treatment of moderate to severe PTSD (Multidisciplinary Association for Psychedelic Studies [MAPS], 2020). MAPS received Breakthrough Therapy status from the FDA for this potential PTSD treatment in 2017.

67 percent of participants in the MDMA group no longer met the clinical criteria for PTSD.

Results from MAPS' first Phase 3 clinical trial (MAPP1), published in May 2021, found that compared to placebo with therapy, MDMA-assisted therapy significantly reduced the severity of PTSD symptoms (as measured by the Clinician-Administered PTSD Scale for DSM-5) and significantly reduced functional impairment (as measured by the Sheehan Disability Scale) (Mitchell et al., 2021). These results held for patients with comorbidities that are generally associated with treatment resistance, such as history of alcohol or substance use disorder. At the primary study endpoint, 67 percent of participants in the MDMA group no longer met the clinical criteria for PTSD, compared to 32 percent of those in the placebo group; and 33 percent of those in the MDMA group met the criteria for remission, compared to five percent of participants in the control group.

In MAPS' second Phase 3 clinical trial (MAPP2), currently in recruitment, MAPS hopes to build on these results, further demonstrating the safety and efficacy of MDMA-assisted therapy for the treatment of PTSD (MAPS, 2020). MAPS also has completed and ongoing Phase 2 trials testing MDMA in the treatment of eating disorders, anxiety associated with a life-threatening illness, and social anxiety in autistic adults (Haichin, n.d.).

Additional drug sponsors or collaborator groups are engaged in other clinical trials focused on psychedelics for PTSD (National Library of Medicine, n.d.-a). 

Principles to Advance PAT From Clinical Trial to Real World Patients

The promise of these psychedelic compounds for treating MDD, TRD, and PTSD raises great hope for PAT’s potential to relieve pain and suffering for millions of patients. The path from research to clinical adoption, however, is still lengthy and challenging. Upon completion of clinical trials, drug sponsors will submit New Drug Applications to the FDA. The FDA’s approval process will include multiple mechanisms for determining how and when a drug is prescribed and administered to patients. Following a successful approval, payers’ coverage and reimbursement determinations will have additional influence over how patients access PAT. The industry itself—including drug manufacturers, professional associations, a national certification board, and other stakeholders—will also make important decisions about how PAT is accessed and delivered via collective decision-making on provider PAT training and credentialing requirements, a clinical delivery model, and quality definition and measurement. In addition, as with any healthcare innovation, ongoing research will continue to inform the model of care.

As the industry prepares for this next critical stage of implementation, BrainFutures seeks to highlight the importance of a shared set of fundamental principles to guide key decision-makers in this

process. BrainFutures’ work in preparing this report has been aided by PAT stakeholder groups—including manufacturers, providers, and advocates—to coalesce around broad, foundational principles:

1. PAT must be **accessible** to all patients who qualify for, and would benefit from, such therapy.
2. PAT must be **affordable** for all patients who qualify for, and would benefit from, such therapy.
3. PAT must meet **high quality** standards to ensure optimal patient outcomes.

In the sections that follow, this report highlights specific policy problems that influence access, affordability, and quality and underscore the importance of a multistakeholder, coordinated effort to minimize PAT regulatory and reimbursement obstacles. It is imperative that stakeholders develop a collaborative approach to addressing these challenges moving forward. Identifying and articulating this approach will accelerate the adoption of PAT clinical interventions across a wide array of domains.

POLICY ISSUE 1:

Ensure Accessibility in FDA Approval and Safety Requirements

Principle: PAT must be affordable for all patients who qualify for, and would benefit from, such therapy.

The first step toward making PAT available outside of a clinical trial environment is approval by the FDA. The FDA provides an invaluable service to U.S. consumers in their evaluation process: ensuring that drugs are safe and effective for their intended use, that benefits outweigh known risks, and that doctors and patients have the information they need to make informed choices. Should the FDA determine that risk mitigation strategies are required, BrainFutures recommends that such strategies be balanced against the principle of wide access, contextualized against the high costs of the targeted conditions, consistent with protocols established for existing treatments (with similar risk and safety profiles) for the targeted conditions, consistent with quality improvement practices, and open to the establishment of quality standards by psychedelic professional organizations.

The FDA's approval, and any safeguards and quality standards the agency may require, must ensure that PAT is accessible to all patients who qualify for, and would benefit from, such therapy. In practice, this means that the FDA must consider in its risk assessment the high emotional, social, and economic costs of the conditions targeted for treatment and

the significant benefits psychedelics demonstrate in clinical trials. Any risk evaluation and mitigation strategies (REMS) should be consistent with or comparable to REMS in place for existing treatments, with similar risk and safety profiles to psychedelics, for the targeted conditions. BrainFutures recognizes that each psychedelic compound and each psychotropic class carry their own unique risk and safety profiles.

FDA REVIEW REQUIREMENTS

The FDA's review and approval of new drugs and biologics is governed by the Federal Food, Drug, and Cosmetic Act (FFDCA) of 1938, and subsequent amendments, which require that drugs be proven safe before they may be sold in interstate commerce (Federal Food, Drug, and Cosmetic Act, 2022a). A portion of the FDA's Mission states:

"FDA is responsible for advancing the public health by helping to speed innovations that make medical products more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health" (U.S. Food and Drug Administration [FDA], 2018).

There is an inherent tension between “helping to speed innovations,” that is, making drugs available to the American public in a timely manner, and ensuring that those drugs are “more effective, safer, and more affordable.” The FDA’s processes for the approval of new drugs and biologics reflect that tension.

MAPS PBC, COMPASS Pathways, and Usona Institute’s Breakthrough Therapy designations provide an expedited approval process to encourage the development of drugs that treat a serious condition and for which “preliminary clinical data indicates that the drug may demonstrate substantial improvement over available therapy” (FDA, 2019).

However, even with a Breakthrough Therapy designation, the FDA’s safety standards remain stringent and include at least two well-designed and well-controlled Phase 3 clinical trials. Clinical trials are designed to generate data establishing the safety, efficacy, and effectiveness of a drug in humans (van Norman, 2016). The FDA categorizes clinical trials into Phase 1, 2, and 3. In general, as trials progress, the number of volunteers increases, beginning with a small number of healthy volunteers and progressing to subjects with the targeted medical condition (van Norman, 2016).

Following completion of all clinical trials, a drug sponsor may file a New Drug Application (NDA), the formal step of requesting the FDA to review a drug for marketing in the United States (FDA, 2017). The FDA’s review of an NDA occurs within a framework that considers:

1. The target condition and available treatments, to provide context for weighing the drug’s risks and benefits;
2. Assessment of risks and benefits apparent in the clinical testing data; and
3. Risk management strategies, which may include information on the drug label as well as REMS (FDA, 2019).

FDA’S RISK MANAGEMENT STRATEGIES

As the first psychedelics move toward NDA submission, it is important for stakeholders to understand the risk mitigation tools the FDA is authorized to use once it assesses a drug’s safety profile. After the FDA determines a drug’s risk-benefit ratio, the following harm reduction strategies may be instituted as a required condition of approval.

DRUG LABELS

Drug labels are an essential part of conveying drug safety and effectiveness information to clinicians and patients and are the most basic and most utilized risk mitigation tool at the FDA’s disposal. Federal law defines drug labeling to include “all labels and other written, printed, or graphic matter...accompanying” the drug (Federal Food, Drug, and Cosmetic Act, 2022a). Labeling is the primary source of prescribing information used by clinicians, is published in the widely used Physician’s Desk Reference, and is the basis for patient-focused information produced by manufacturers, pharmacy vendors, and other sources of drug information, such as websites (Dabrowska & Thaul, 2018). FDA regulations dictate the information the labeling must provide as well as required formatting (FDA, 2021).

RISK EVALUATION AND MITIGATION STRATEGY

For some drugs with serious safety concerns, the FDA determines that additional action beyond labeling is necessary “to ensure the benefits of the drug product outweigh its risks” (Center for Drug Evaluation and Research Office of Surveillance and Epidemiology [CDER OSE], 2020). In this case, the FDA is authorized to require a Risk Evaluation and Mitigation Strategy

(REMS). These REMS may be required either as a condition of approval of an NDA or if the FDA becomes aware of new safety information (CDER OSE, 2020). Similarly, the FDA may modify or eliminate REMS upon receipt and review of new safety information.

In general, a REMS may include one or more of the following elements (Center for Drug Evaluation and Research & Center for Biologics Evaluation and Research [CDER & CBER], 2019; CDER OSE, 2020):

1. A Medication Guide or patient package insert;
2. A communication plan to disseminate risk information to providers;
3. Packaging and safe disposal technologies for drugs that pose a serious risk of overdose or abuse;
4. Elements to Assure Safe Use (ETASU), which may include one or more of the following:
 - Special training, experience, or certification for prescribers
 - Certification of pharmacies, practitioners, or healthcare settings that dispense the drug
 - Limitations on the type of healthcare setting that may dispense the drug
 - Evidence of other documentation of safe use conditions, such as laboratory test results, before dispensing
 - Patient monitoring
 - Patient enrollment in a registry;
5. An implementation system through which a drug sponsor can monitor and evaluate implementation of and adherence to ETASU by responsible parties; and
6. A timetable for submission of assessments by the drug sponsor/applicant that monitors whether the REMS is meeting its goals.

Federal law requires the FDA to consider six factors when determining whether a REMS is required (CDER, 2020). The FDA notes that no single factor is determinative and the relative weight of each factor is case specific (CDER & CBER, 2019). The six factors are (CDER & CBER, 2019; CDER OSE, 2020):

1. The estimated size of the population likely to use the drug product;
2. The seriousness of the disease or condition to be treated with the drug;
3. The expected benefit of the drug;
4. The expected or actual duration of treatment with the drug and the impact of treatment length on the likelihood and/or severity of adverse events;
5. The seriousness of any known or potential adverse events and the incidence of such events in the targeted population; and
6. Whether the drug is a new molecular entity, which may have limited information and potentially greater uncertainty about risks that may emerge in post-approval settings.

BrainFutures urges the agency to consider its own perspective that the REMS should “not unduly impede patient access to the drug.”

A proposed-REMS submission may be voluntarily submitted by the sponsoring drug manufacturer or in response to an FDA request and the FDA will consider this proposal before determining final REMS (CDER OSE, 2020). PAT stakeholders largely expect the FDA to require a REMS as a condition of approval for psychedelics, though the exact elements that may be included are unknown at this time. As the

FDA reviews elements to include in any psychedelic REMS, BrainFutures urges the agency to consider its own perspective that the REMS should “not unduly impede patient access to the drug, and minimize the burden on the health care delivery system to the extent practicable” (CDER & CBER, 2019).

As PAT stakeholders try to predict the conditions the FDA may attach to approval of psychedelics, one consideration is that the selection of specific REMS elements “may be influenced by the extent to which they have already been used in the clinical trials to evaluate the drug’s safety and efficacy, and by what is known about the effectiveness of the elements and tools more generally” (CDER & CBER, 2019). According to the FDA (n.d.), there are 62 current REMS in effect. Of these, 90 percent require provider certification, training, patient counseling, and/or patient monitoring; seven percent require only a communication plan; two percent include only a medication guide; and two percent include both a communication plan and a medication guide.

Given current psychedelic clinical trial protocols and the composition of existing REMS for other drugs, it seems likely that the FDA will at least require prescriber certification as well as patient counseling and monitoring, and likely a medication guide and communication plan. These are critical elements to ensure the safe delivery of high-quality PAT, and work is underway to create standards for these elements, both to inform the FDA’s regulatory activity and to disseminate best practices throughout the field. When considering how these safeguards are defined for psychedelic medications, it is helpful to keep in mind additional statutory and regulatory guardrails within which the FDA operates. These include the practice of medicine exemption and the primary mode of therapy specification, detailed below.

FDA MAY NOT REGULATE THE PRACTICE OF MEDICINE

Federal law prohibits the FDA from limiting or interfering with the authority of a healthcare provider to prescribe “a legally marketed device to a patient for any condition or disease within a legitimate healthcare practitioner-patient relationship” (Federal Food, Drug, and Cosmetic Act, 2022b). This is known as the “practice of medicine exemption,” and the FDA has long maintained it does not regulate the practice of medicine. In at least two recent presentations, representatives from the FDA’s Center for Drug Evaluation and Research, Office of New Drugs have reiterated this position (Muniz, 2021; Muniz, 2019). Specific to the development and review of psychedelics, the FDA notes “the FDA does not regulate the practice of psychotherapy” (Muniz, 2019).

THERAPY RECOMMENDATION

Federal regulations do allow the FDA to specify that a drug must be used in conjunction with another “primary mode of therapy, (e.g., diet, surgery, behavior changes, or some other drug)” (Requirements on content and format of labeling for human prescription drug and biological products, 2014). Prescribing information included on the labels of a few FDA-approved drugs, such as naltrexone for opioid use disorders and bupropion for smoking cessation, mentions psychotherapy, but does not require its use in conjunction with the drug. The label for buprenorphine for opioid use dependence includes that all trials used the drug in combination with psychosocial counseling. Beyond these few, however, the development and labeling of most psychiatric medications occurred without regard to concomitant psychotherapy (Muniz, 2019; Feduccia, 2021). The FDA has stated its view that early psychedelic research “found that interpersonal support during psychedelic treatment reduced the risk for psychological adverse reactions,” and that such support

could be considered an element to assure safe use of an approved drug, but “the appropriate extent of support/monitoring needs to be determined” (Muniz, 2021).

RISK MANAGEMENT IN THE CONTEXT OF DISEASE BURDEN AND EXISTING TREATMENTS

As the FDA’s approval framework for determining the need for REMS notes, the context in which psychedelics are reviewed is a critical element of FDA’s risk assessment. Existing treatments for the three conditions currently targeted in late-phase PAT clinical trials—MDD, TRD, and PTSD—are effective for a portion of patients, but many have unpleasant, and in some cases intolerable, side effects. Even the name of some diagnoses, such as “treatment-resistant depression,” clearly signals that existing treatments are failing many patients. The FDA’s designation of psychedelics as a Breakthrough Therapy acknowledges as much. Further, as described earlier in this brief, the impacts of the conditions targeted by these first PAT clinical trials are grave and affect millions of people. These conditions can lead to reduced quality of life, disability, debilitation, suicidal thoughts and attempts, and death, and they effect a growing percentage of the population. FDA must acknowledge that the costs of these conditions are very high, and the potential benefits of effective PAT treatments are also substantial.

COMPARABLE FDA-APPROVED PHARMACEUTICALS

Much of the potential risk surrounding PAT can be mitigated with appropriate clinical safeguards and quality standards for psychedelics. These safeguards and standards should be consistent with or comparable to those in place for existing treatments for the targeted conditions, with similar risk and safety profiles to psychedelics, such as antipsychotics and antidepressants. With these drug classes, the FDA has

been overt with warnings where appropriate, while simultaneously permitting a wide set of providers to prescribe the drugs for patients, presuming they meet any stated REMS criteria, where they exist.

Antidepressant drugs of any class carry a “black box” warning, a label required by the agency for medications with serious safety risks.

The regulatory treatment of antidepressants and antipsychotics offers a useful framework for consideration of risk management tools that the FDA may require. Antidepressant drugs of any class carry a “black box” warning, a label required by the agency for medications with serious safety risks. For antidepressants, this warning concerns the increased risk of suicidal thoughts and behavior among adolescents and young adults who take these drugs. In addition, antidepressant drugs such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are associated with other side effects such as loss of appetite, weight loss, drowsiness, dizziness, fatigue, headaches, nausea/vomiting, sexual dysfunction, and increased risk of cardiovascular and cerebrovascular events (Braund et al., 2021).

FDA utilizes a similar risk management strategy for typical and atypical antipsychotics such as Haldol, Loxitane, Seroquel, Zyprexa, Abilify, and Risperdal. All atypical antipsychotics, for example, have carried a warning label since 2005, noting increased mortality in elderly patients with dementia-related psychosis. In 2008, the FDA added a similar warning to first-generation, or typical, antipsychotics as well. An analysis of 17 placebo-controlled trials showed a “risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated

patients” (Janssen Pharmaceuticals, Inc., 2019). This amounted to a rate of death “in drug-treated patients...[of] about 4.5 percent, compared to a rate of about 2.6 percent in a placebo group.”

Antipsychotics have also been shown to have significant side effects and adverse effects. In a National Institutes of Health-funded study of patients over 40 years of age, researchers from the University of California, San Diego School of Medicine, Stanford University, and the University of Iowa found that within one year of treatment with any of four atypical antipsychotics, one-third of study participants developed metabolic syndrome and one-quarter of patients experienced serious adverse effects within two years (Jin et al., 2012).

Individual antipsychotics carry additional warning labels for a variety of side effects and adverse effects including post-injection delirium/sedation syndrome, severe neutropenia, orthostatic hypotension, bradycardia, syncope, cardiac arrest, seizures, myocarditis, and cardiomyopathy. The severity of some of these conditions requires that certain antipsychotics, such

as Adasuve, Clozapine, and Zyprexa, be administered under specified conditions and distributed by certified providers as part of a REMS (FDA, 2022). REMS requirements involve reviewing training documents created for prescribers. Even given their mixed safety profile, antipsychotics continue to be widely utilized, particularly to manage behavioral and psychological symptoms of dementia (Greenblatt & Greenblatt, 2016).

With both antidepressants and antipsychotics, the FDA does not intend to eliminate risk or overly restrict access to care. Rather, safety concerns are communicated to patients by providers based on REMS that allow for consistent communication within the context of the therapeutic relationship. Psychedelics, like antidepressants and antipsychotics, have unique risk and safety profiles. As the FDA assesses each psychedelic compound to determine whether a REMS is necessary, and if so, what it will require, BrainFutures recommends the FDA follow these precedents of preserving access to care while supporting patient safety. 🌐

RECOMMENDATIONS TO ENSURE ACCESSIBILITY IN FDA APPROVAL AND SAFETY REQUIREMENTS

BrainFutures recommends that any risk mitigation strategies required by the FDA be:

- Balanced against the principle of wide access;
- Contextualized against the high emotional, social, and economic costs of the conditions targeted for treatment;
- Consistent with or comparable to those in place for existing treatments, with similar risk and safety profiles to psychedelics, for the targeted conditions;
- Consistent with generally accepted medical and behavioral healthcare quality assurance standard practices; and
- Open to the establishment of quality standards and measurement by the field of clinicians, national certification bodies, accrediting agencies, and professional practitioner associations.

POLICY ISSUE 2:

Ensure Affordability in Payer Coverage & Payment Decisions

Principle: PAT must be affordable for all patients who qualify for, and would benefit from, such therapy.

Public and private health insurance coverage of PAT is a prerequisite for equitable access by all patients who seek such care and for whom it is appropriate. Driven by inadequate reimbursement, psychotherapy providers often choose not to participate in insurance networks, causing many patients to pay for psychotherapy services out of pocket, severely limiting access for those with lower incomes or inadequate insurance coverage (National Alliance on Mental Illness, 2016). BrainFutures highly recommends that PAT follow a path of wider and more comprehensive insurance coverage than has traditionally marked the field.

BrainFutures estimates that one round of PAT, including patient intake and assessment, preparatory and integration psychotherapy as well as a dosing session, will cost \$5,300–\$7,500 for the psychotherapy alone.

Without public and private insurance coverage, costs will likely make PAT out of reach for many people. Using publicly available information about clinical trial protocols and the 2021 Medicare physician fee schedule, BrainFutures estimates that one round of PAT, including patient intake and assessment, preparatory and integration psychotherapy as well as a dosing session, will cost \$5,300–\$7,500 for the psychotherapy alone. This estimate does not include drug costs, which are unknown at this time, or facility and other fees that may apply. Though these costs may be modest when comparing them to the duration of direct and indirect costs of existing treatments (such as medical costs or worker absenteeism/presenteeism), they still are beyond the reach of a majority of Americans if adequate insurance coverage is not made available (Marseille et al., 2020; Blossom, 2021).

At least three critical issues comprise public and private coverage and payment decisions that ensure PAT is affordable for patients:

1. The **statutory and regulatory framework** for payer coverage decisions, including parity of coverage with physical health benefits;
2. **Individual payer coverage determinations**; and
3. A **coding strategy** to ensure adequate, efficient, accurate payments to PAT providers.

These issues exist generally across any type of payer, whether it is a fully public plan (Medicare, Medicaid, Children’s Health Insurance Program, Veterans Administration), a publically-funded but privately operated plan (Medicare Advantage, Medicaid Managed Care Organization, TriCARE, state/federal Marketplace) or a private plan (small group plans, large group plans, or self-funded/large employer). Each of these issues is covered in detail in the sections that follow.

STATUTORY AND REGULATORY CONSIDERATIONS FOR PAYER COVERAGE DETERMINATIONS

Payer coverage determinations are not only based on a program or organization’s own policies and procedures, but must also be consistent with state and federal statutory and regulatory requirements. Such requirements are imposed across the spectrum of healthcare services, and could therefore impact coverage or reimbursement policies for PAT.

STATE AND FEDERAL COVERAGE REQUIREMENTS

Some federal and state laws regulate coverage and reimbursement policies for particular items and services, and plans have very little, if any, flexibility in these areas. The Affordable Care Act (ACA), for example, requires that many health plans² cover people with pre-existing conditions without charging these consumers a higher rate, cover preventive care without cost-sharing, and impose no lifetime or annual dollar limits on coverage of “essential health benefits” (U.S. Centers for Medicare & Medicaid Services [CMS], n.d.a). The law defined ten essential health benefits that all plans in the ACA

Marketplaces must offer. Most relevant to PAT are requirements to cover ambulatory patient services, MH/SUD services, and prescription drugs (CMS, n.d.b).

Federal law also regulates coverage and reimbursement decisions for programs such as Medicare Advantage (MA), which offers private Medicare coverage to more than 26 million Americans, or 42 percent of the total Medicare population (Freed et al., 2021). Federal law requires that MA plans cover all Part A and Part B benefits. Among other services and products, these include all emergency and urgent care, and almost all medically necessary services covered by Original Medicare except for clinical trials and hospice services. Federal law similarly requires that state Medicaid programs offer certain mandatory benefits as a condition of receiving federal funds (CMS, n.d.c).

States also impose significant requirements on insurers, in their capacities as the licensing entities that allow insurance-related businesses to sell products or services within their jurisdictions. The National Conference of State Legislatures estimates that more than 1,900 state statutes mandate specific benefits and provider services (National Conference of State Legislatures [NCSL], 2018). Some of these laws simply mandate coverage for a particular service such as substance abuse treatment or contraception; others require coverage by a certain provider such as a chiropractor or social worker; while others require coverage for certain individuals such as adopted children or dependent students (NCSL, 2018). In some cases, state laws are extremely prescriptive, even regulating the number of visits a beneficiary might be allowed for a particular type of provider. State mandates have limited applicability because self-insured employer plans, governed by the Employee Retirement Income Security Act of 1974 (ERISA), are not bound by these requirements. Larger employers tend to utilize ERISA plans more often than smaller businesses, with 64 percent of covered workers participating in such a self-funded plan (Claxton, et al., 2021).

While federal and state laws require payers to offer coverage within categories that may encompass PAT, payers do have some flexibility with regard to the covered services within each category. For example, PAT would likely be included within the ACA's MH/SUD essential health benefit category, and would be considered an outpatient facility or physician service under Medicaid, guaranteeing coverage within plans governed by essential health benefit or Medicaid requirements. But inclusion in such a category does not guarantee universal coverage by commercial payers, which operate under largely different regulatory structures.

MENTAL HEALTH PARITY

While payers may not be required to cover PAT specifically, one particular federal law may help ensure that payer decisions regarding PAT coverage and reimbursement are made using criteria similar to those used for physical health benefits. The 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), also referred to as the federal parity law, is consistent with BrainFutures' principles regarding PAT accessibility and affordability, and it may eventually have the greatest influence over the coverage and reimbursement of PAT.

The MHPAEA prevents health plans that provide MH/SUD benefits from imposing greater limitations on those benefits than on medical/surgical benefits.

The MHPAEA prevents health plans that provide MH/SUD benefits from imposing greater limitations on those benefits than on medical/surgical benefits

(CMS, n.d.d). Health plans subject to federal parity include group health plans for employers with 51 or more employees, most group health plans for employers with 50 or fewer employees, the Federal Employees Health Benefits Program, Medicaid Managed Care Plans, State Children's Health Insurance Programs, some state and local government health plans, any health plans purchased through the ACA Marketplaces, and most individual and group health plans purchased outside the ACA Marketplaces (National Alliance on Mental Illness, n.d.). MHPAEA does not apply to the Medicare program, Medicaid fee-for-service plans, "grandfathered" individual and group health plans created and purchased before the ACA, and plans that have received exemptions.

Over time, MHPAEA regulations have increased in specificity and now require that if a plan includes medical/surgical benefits and MH/SUD benefits, the financial requirements and treatment limitations that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "substantially all/predominant test"). This "substantially all/predominant test" must be applied separately to six classifications of benefits:

1. Inpatient in-network
2. Inpatient out-of-network
3. Outpatient in-network
4. Outpatient out-of-network
5. Emergency
6. Prescription drug

Furthermore, when plans cover MH/SUD benefits, they must provide such benefits in all classifications in which medical/surgical benefits are provided. All cumulative financial requirements in a classification, including deductibles and out-of-pocket limits, must combine both medical/surgical and MH/SUD benefits in the classification.

In addition, plans may not subject MH/SUD benefits to any separate cost-sharing requirements or treatment limitations that only apply to such benefits. For example, plans cannot impose a non-quantitative treatment limitation (NQTL) such as step therapy or pre-authorization for MH/SUD benefits in any classification unless such limits are comparable to, and are applied no more stringently than, limitations for medical surgical/benefits in the classification. NQTLs can even go beyond medical management to include any limitation on benefits: reimbursement, provider network admission standards, and exclusions of levels of care or provider types. Evidence of compliance of an NQTL as applied can vary widely, as detailed by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury in a recent report to Congress:

“For example, a plan or issuer testing the relative stringency of how it applies the NQTL of concurrent care or preauthorization review to MH/SUD benefits versus medical/surgical benefits might test denial rates, reasons for denial, utilization rates, frequency of reviews, lengths of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, or review turnaround times. For an NQTL related to network admission standards, demonstration of comparability as applied might include comparisons of rates for acceptance/denial or withdrawal for MH/SUD and medical/surgical providers, application processing time, network reimbursement rates, latitude granted rate negotiators, or the role of network adequacy metrics” (Walsh et al., 2022).

A plan must follow the same definition of “experimental” across both medical/surgical and MH/SUD benefits.

Most relevant for PAT, this provision also applies to treatment that is experimental or investigative. Subregulatory guidance states, “a medical management standard that limits or excludes benefits based on whether a treatment is experimental or investigative is an NQTL” (U.S. Departments of Labor, Health and Human Services [HHS], and the Treasury, 2019). As such, a plan must ensure that “any processes, strategies, evidentiary standards, and other factors used to impose the exclusion are applied comparably to all medical/surgical and MH/SUD benefits in the relevant classification.” In practice, this means a plan must follow the same definition of “experimental” across both medical/surgical and MH/SUD benefits, and must operationally apply this standard equally across categories (not offering exceptions in one category but not the other, for example).

Finally, if a plan includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits. Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request (CMS, n.d.d).

The DOL, HHS, and Treasury report to Congress also cites hundreds of examples of health plans and health issuers failing to deliver parity for MH/SUD benefits (Walsh et al., 2022). Enforcement actions for such violations of MHPAEA were quite limited until recently, usually including only corrective action and voluntary agreements. However, in August 2021, two

settlement agreements were filed in the case of *Walsh v United Behavioral Health and UnitedHealthcare Insurance Company*, in which the DOL, the New York Attorney General, and private litigants brought claims against United Healthcare Insurance Co., United Behavioral Health, and Oxford Health Insurance, Inc. The complaint alleged that United used an out-of-network reimbursement model that disadvantaged mental health providers by up to 35 percent, and used utilization management techniques for outpatient mental health services that were more stringent than those applied to medical/surgical benefits. Together, the defendants will pay more than \$15.6 million to settle allegations that they violated the law (The Kennedy Forum, 2021). While the settlement is relatively small, this was the first litigation to enforce MHPAEA in the 13 years since the law’s passage, and could indicate much stricter enforcement going forward.

All 50 states and the District of Columbia have passed legislation governing parity for plans within their jurisdictions.

In addition to the federal parity law, all 50 states and the District of Columbia have passed legislation governing parity for plans within their jurisdictions (National Conference of State Legislatures, 2015). Some of these laws more closely mirror the federal law, prohibiting insurers or healthcare service plans from discriminating between coverage for mental health and other medical issues. Others require some minimum level of coverage for mental health benefits, but do not mandate the level of benefit provided, meaning they are not “parity” laws. Still other states have “mandated offering” laws which require an option of coverage for mental health (often for a higher premium) for beneficiaries, but may or may not require that such benefits are equal to other medical benefits.

Comprehensive coverage of PAT by public and private payers will be a prerequisite for full access to such care. Individual payer coverage determinations and coding strategies are major factors in how such coverage policies operate, but the larger statutory and regulatory framework payers face is perhaps even more influential. State and federal requirements are the broadest mechanisms for setting standards for access and equity, and provide great opportunity for wide PAT availability for patients.

PAYER COVERAGE DETERMINATIONS

Upon FDA approval of a psychedelic compound, individual payers, be they public or private, will apply the statutory and regulatory framework described above as well as their own coverage policies to determine if and how they will cover PAT. The sections below offer perspective on how different payer types approach this decision-making process.

MEDICARE

Public programs generally have the most transparent decision-making processes. Medicare, the largest healthcare payer in the U.S., makes national coverage determinations (NCDs) through an evidence-based process led by the Centers for Medicare and Medicaid Services (CMS). NCDs describe the circumstances for nationwide Medicare coverage of a specific service, procedure, or device, and they are binding on all Medicare contractors. In the absence of an NCD, Medicare policy is established at the local level, through Local Coverage Decisions (LCDs), by a Medicare Administrative Contractor (MAC).

An NCD “formal request” can be initiated by CMS or by an individual or entity, but is usually a Medicare beneficiary, a manufacturer, a physician, or a physician professional association. A request may be to establish coverage—in which case it must include elements such as a full and complete description of the item or service,

its proposed use, target population, medical indication, safety and efficacy data, and status of FDA review, with labeling information, if applicable—or to limit or remove coverage. Decisions are usually opened for a 30-day public comment period within six months of opening an NCD review, and a final NCD is issued within 60 days of comment closure. CMS may also “reconsider” an existing NCD at the request of an individual or entity, or it may generate a reconsideration internally.

Medicare coverage is limited to “items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury” (CMS, 2021). A precise definition of “reasonable and necessary,” however, has eluded CMS for over 50 years.

MEDICAID

Unlike Medicare, Medicaid is operated separately by each state, though it is funded as a joint state-federal partnership. Benefits within each state are therefore a combination of broad federal guidelines enforced by CMS and a state’s own design and administration of the program. Under federal law, states’ Medicaid programs are required to cover a set of mandatory benefit categories that include services like inpatient hospital, outpatient hospital, nursing facilities, home health, physician services, and more.

In addition, states may (but are not required to) cover any of a set of optional benefit categories such as prescription drugs, physical or occupational therapy, optometry, dental, eyeglasses, or more.

Given that pharmaceutical coverage is an “optional” benefit under federal law, it is unlikely that all states would ever be subject to a PAT coverage requirement from CMS.

Given that pharmaceutical coverage is an “optional” benefit under federal law, it is unlikely that all states would ever be subject to a PAT coverage requirement from CMS. States would therefore be left to decide on their own whether PAT would be covered as an optional service within each state Medicaid program. All states cover at least some of these optional services through a “state plan”—a policy and operational document approved by CMS outlining eligibility, coverage, and payment parameters, among other program dimensions. In doing so, states must follow three basic rules:

1. Comparability rule: benefits must be equivalent in amount, duration, and scope for all enrollees;
2. Statewideness rule: benefits must be the same throughout the state; and
3. Enrollees must have freedom of choices between providers and managed care plans participating in Medicaid (Medicaid and CHIP Payment and Access Commission, 2021).

The majority of beneficiaries access Medicaid benefits through private Managed Care Organizations. (CMS, n.d.f; Kaiser Family Foundation, 2021). These health plans have contracts with state Medicaid agencies to deliver a prescribed set of services to beneficiaries. States can offer these plans some flexibility in how services are accessed by beneficiaries, but these vary by state.

VETERANS AFFAIRS

Veterans Affairs (VA) health benefits include a comprehensive medical package of preventive care services (immunizations, physician exams, healthcare assessments, screening tests, and health education programs), inpatient and outpatient diagnostic and treatment services (primary and specialty care, medical, surgical, mental health, substance abuse, and prescription drugs), urgent and emergency care services, as well as long-term care services (nursing home, domiciliary care, medical foster home, and state Veterans homes) (U.S. Department of Veterans Affairs [VA], Veterans Health Administration [VHA], 2018).

While all Veterans are eligible for a basic medical package, additional health benefits and cost-sharing levels can differ from beneficiary to beneficiary, based on a veteran's priority group (1 through 8), the advice of his or her primary care provider, and medical standards for treating a condition. Priority groups are assigned to Veterans when they apply for VA healthcare, and are based on military service history, disability rating, income level, and eligibility for other benefits (VA, VHA, 2021a). In addition, a provider may determine that additional ancillary services are needed, and Veterans would then be eligible for services such as additional testing (blood work, x-rays, ultrasounds, etc.), therapy and rehabilitation services, or additional services like prosthetics, audiology, or radiation oncology (VA, VHA 2021b).

Coverage in the VA system is also largely determined by what the VA health system can provide within its facilities, since care is generally delivered on-site. These facilities include hospitals, primary or specialty care clinics, Community Based Outpatient Clinics, Health Care Centers, VA Community Living Centers, and residential care facilities. Recent legislative and regulatory changes have permitted the VA to authorize any eligible care at a non-VA facility if it is necessary to receive treatment (VA, 2019).

The VA National Formulary lists drugs that must be available at all VA facilities, and includes only those drugs approved by the FDA using a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or biologics license (VA, 2021). The VA's Pharmacy Benefits Management Services coordinates a standardized process to review drugs for inclusion, often initiated in response to an FDA approval (Dicken, 2010). A set of data on safety, efficacy, and cost (a "monograph") is distributed within the VA for comment, and then to its Medical Advisory Panel and the Veterans Integrated Service Network Pharmacist Executive Committee, who review the monograph and vote on formulary inclusion. This process is generally complete within a year of FDA approval. The VA does maintain a non-formulary drug request process, allowing providers to prescribe a non-formulary drug if special needs require it, with a goal of adjudicating such claims within 96 hours.

Coverage and provision of PAT by the VA could substantially improve the quality of life for our nation's military Veterans who suffer from PTSD at rates two to four times higher than the general population (Richardson et al., 2010).

COMMERCIAL PAYERS

Commercial insurance plans are generally thought to follow Medicare's decisions about whether to cover new medical technologies. However, one study of 47 medical devices considered by CMS between February 1999 and August 2013 found that the largest sixteen private payers were "broadly equivalent" to the NCD in only 51 percent of cases (Chambers et al., 2015). NCDs were more restrictive than private payer policies in 23 percent of cases, and NCDs were less restrictive in 22 percent of cases. In other words, commercial payers coverage decisions can differ substantially from Medicare's policies.

Notably, this study also found significant divergence among private payers themselves, with coverage decisions differing across private payers 40 percent of the time (Chambers et al., 2015). Even when all payers covered a device, covered patient populations were not consistent. Inconsistencies between commercial payers are at least partially due to the fact that evidence to make coverage and reimbursement decisions can be limited (American Academy of Actuaries, 2008). This is particularly true given that most medical technologies are tested against a placebo or non-intervention baseline, not against existing treatments. Though commercial payers use expert committees similar to the Medicare program, there is still significant subjectivity in the decision-making process (McQueen et al., 2019).

Commercial payer coverage policies point toward the same goal: covering safe, effective, quality services at the lowest cost.

That said, commercial payer coverage policies point toward the same goal: covering safe, effective, quality services at the lowest cost. BrainFutures' interviews confirmed this will be true as payers consider PAT coverage. Commercial plans generally:

1. Require that covered services have a “proven benefit;”
2. Require that services be “medically necessary;” and
3. Have broad exclusions for certain categories of treatment, or treatments under certain conditions (American Academy of Actuaries, 2008).

This final criteria is particularly relevant to PAT, as insurers regulated by MHPAEA cannot apply a criteria or standard for PAT that is more restrictive than what

is applied to a medical or surgical treatment. Requiring a return on investment (ROI) for PAT means requiring an ROI for all medical or surgical services. Behavioral health medical directors interviewed by BrainFutures generally agreed that insurers look for evidence of an ROI within 18–24 months of treatment. This ROI could be in the form of medical cost decreases, improvement in overall health outcomes, a shift in utilization from more expensive to less expensive settings, reduced absenteeism or presenteeism, or other measures specific to each diagnosis. While commercial insurers may require evidence of cost savings for PAT, they can only do so if they also apply that standard to medical/surgical benefits. It is not clear that this ROI standard is uniformly applied in most coverage decisions for medical/surgical services, and therefore applying such a standard to PAT would appear to be a violation of the MHPAEA.

For the purposes of reimbursement, commercial payers generally base payment on evidence regarding a treatment's efficacy against alternatives, and the overall long-term costs of the intervention. Payers also assess whether the intervention increases safety and reduces recovery times, which are closely tied to lower costs. In addition, commercial payer review, approval, and operationalization (authorization and payment) of a PAT benefit will be greatly expedited by standardized credentialing, accreditation, and billing procedures across the multiple PAT organizations.

Some large employers self-fund their health insurance benefits, meaning they contract with a third party to manage and administer health benefits, paying for covered items and services directly, rather than purchasing health insurance for their workers (Claxton et al., 2021). Self-funding is common among large employers who have enough employees and dependents to create a robust risk pool. In 2021, 64 percent of workers with employer-sponsored health benefits

were in a self-funded plan (Claxton et al., 2021). These self-funded arrangements are exempt from most state insurance laws, such as benefit mandates, giving employers greater autonomy and flexibility in deciding what benefits to offer employees. Given this flexibility, large employers interested in PAT can choose to offer the benefit to their employees when it is legally available.

CODING

Even after public and private payers make coverage determinations to include PAT and PAT services are covered and paid in parity with medical/surgical benefits, there is still the operational challenge of billing and paying for this unique model of care. PAT presents billing challenges, as some aspects of PAT services do not map well onto today's coding system. No existing therapy, for example, exactly models a PAT medication/dosing session, which may include multiple providers/provider types, medication administration, psychotherapy up to a six- to eight-hour period, and subsequent observation.

Medical coding is used to provide healthcare organizations, including providers, systems, and payers, a uniform way to describe and categorize medical items, services, and procedures to increase accuracy and efficiency, and to streamline reporting. The Healthcare Common Procedure Coding System (HCPCS) is a set of codes produced by CMS to categorize and describe medical procedures, supplies, products, and services (National Library of Medicine, n.d.-b). HCPCS codes are divided into two subsystems (CMS, 2022). Level I consists of Current Procedural Terminology (CPT) codes developed and managed by the CPT Editorial Panel, an entity convened by the American Medical Association (AMA) (American Medical Association [AMA], 2019). CPT codes are the national coding set for physicians and other healthcare professional services. These five-digit codes are primarily used to describe medical services and procedures provided by physicians and other healthcare

professionals. HCPCS Level II codes (referred to as HCPCS codes) describe health items and services not included in the CPT codes, such as ambulance services and durable medical equipment, among others. HCPCS codes consist of a letter followed by a four-digit number.

A unified and collaborative approach to PAT coding is needed.

BrainFutures identified that a unified and collaborative approach to PAT coding is needed to:

1. Maximize patient access to treatment;
2. Appropriately reimburse prescribers, practitioners, and manufacturers; and
3. Simplify coding and billing for payers, providers, and patients.

BrainFutures facilitated ongoing conversations with individual drug manufacturers and an emerging third-party administrator developing a PAT provider network, to help identify commercialization considerations relative to coding and the importance of a unified coding strategy for the field. In addition, BrainFutures consulted with several medical coding experts to identify coding, billing, and reimbursement challenges presented by PAT's unique model of care and to outline potential coding options to facilitate coverage and payment of PAT upon FDA approval. As with all medical coding decisions, each provider must determine the factors necessary and present to bill a specific service for each particular patient encounter. This exploration of potentially applicable codes is the first step in crafting a coding strategy that can be used across multiple payers, providers, and manufacturers. Consistency in coding will facilitate coverage determinations, reimbursement processes, and improve access to care.

It is critical to emphasize that BrainFutures does not recommend industry-wide reimbursement negotiation on payment rates. Payment rates should still be negotiated separately by manufacturers, prescribers, and therapists, as required by federal antitrust laws. At the same time, BrainFutures acknowledges the need for equitable reimbursement of mental health services, particularly for psychotherapy, relative to medical/surgical services in compliance with the MHPAEA. Several recent studies, including two reports from the federal government, have confirmed that average in-network reimbursement rates for behavioral health office visits are lower than those for medical/surgical office visits, which contributes to challenges for patients in finding in-network mental healthcare providers and to higher out-of-pocket costs for patients who must utilize out-of-network care (Davenport et al., 2019; U.S. Government Accountability Office, 2022; Walsh et al., 2022). Parity in reimbursement for the psychotherapy services delivered as part of PAT and consensus on a uniform PAT coding methodology will help to facilitate patient access to care and appropriate coverage and reimbursement by payers.

BrainFutures' work has determined that for most, if not all, elements of the PAT protocols utilized in late-phase clinical trials—assessment, preparatory therapy, medication/dosing session(s), and integration therapy—existing codes can be used to capture the care provided to each patient. However, given the number of providers potentially involved in these sessions and the six-to-eight hour length of the medication/dosing session, existing codes must be used in ways that may trigger medically unlikely edits (MUEs) by payers and lead to claims denials. Therefore, to use existing codes, BrainFutures recommends that stakeholders identify a uniform PAT coding methodology, so that any edit overrides or policy exceptions apply to the entire field, rather than negotiated

on a case-by-case basis for individual psychedelic manufacturers, prescribers, therapists, or patients.

Similarly, if leading stakeholders collectively decide that substantial revision to existing codes is not the preferred route toward accurately capturing and billing for the medication/dosing session, then a new code will be required.

BrainFutures recommends that key PAT stakeholders collectively consider these different options and come to consensus on a coding strategy that will serve the entire field.

Both revising an existing code and developing a new code can be lengthy processes, typically involving a minimum of 18 months work for a new code, and often much longer. Regardless of the path chosen, BrainFutures recommends that key PAT stakeholders collectively consider these different options and come to consensus on a coding strategy that will serve the entire field, as this is a matter of some urgency. The case study of Spravato, below, offers a perspective on the importance of coalescing around a unified coding strategy prior to FDA approval, if possible (see “Spravato’s Reimbursement Challenges” section).

OVERVIEW OF PAT CODING OPTIONS AND CONSIDERATIONS

Appendices A–G include a menu of coding and billing options for patient assessment/intake, medication management, preparatory psychotherapy, medication/dosing session, and integration support or psychotherapy. Appendix A offers a full list of codes that could be utilized to bill for different parts of the PAT

model of care. Appendices B–G focus on individual elements of PAT, outlining assumptions BrainFutures used in crafting these options, and stakeholder consensus considerations required to effectively move forward. The following paragraphs overview these findings, aiming to identify accurate and efficient coding strategies for PAT as the field enters its next stage.

Two elements of PAT—patient assessment/intake and medication management—involve coding and billing by a DEA-licensed prescriber. Coding options for these visits are fairly straightforward and can be made at the discretion of, and using the medical and billing judgment of, the prescriber. These potential codes are identified in Appendices B and C.

The remaining three elements of PAT—preparatory psychotherapy, medication/dosing session, and integration support or psychotherapy—present unique coding challenges and would benefit from a unified strategy to ensure accurate, appropriate coding and, thus, wide access to care.

For preparation and integration, BrainFutures’ analysis assumes a total of six (three preparatory and three integration) 90-minute psychotherapy sessions with a practitioner licensed to practice psychotherapy under state laws and trained according to manufacturer or other requirements. The analysis further assumes that two providers (though not necessarily two licensed psychotherapists) will be present for each of these sessions, as has generally been the practice in late-phase Breakthrough Therapy clinical trials. However, billing by two providers for the same services, for the same patient, on the same day, will trigger an MUE, leading to claims denial. Stakeholder consideration of and consensus on the following questions will help facilitate reimbursement:

1. Is it necessary to have a second therapist with the same qualifications in each preparatory and integration psychotherapy session?
 - If necessary and justified, and if payers will not reimburse two therapists, is it practical to have the therapists split the fee?
 - Could another provider type participate in these sessions (i.e. technician, nurse, peer specialist, etc.)?
2. Could the patient have separate preparatory sessions with each therapist who will be present for the medication session; and can the integration psychotherapy sessions be conducted by one licensed therapist?

Potential codes for the preparatory and integration psychotherapy sessions are identified in Appendices D and E.

Finally, late-phase clinical trials generally utilize two providers for the medication/dosing session due to the vulnerable state of the patient and the need for provider breaks given the duration of the session. At least one of these providers must be a licensed behavioral health professional. Credential requirements for the second provider vary. Similar to the situation described above in the preparatory and integration sessions, two providers billing for the same services on the same day will trigger an MUE and claims denial, absent negotiations with payers.

BrainFutures identified four separate potential coding strategy pathways for the extended medication/dosing session for stakeholder consideration and consensus building (outlined in Appendix F):

1. Utilize existing psychotherapy CPT codes for psychotherapy. This would require:

- Payer prior authorization and edit override due to the long duration of the medication session and payer negotiation to pay a second licensed therapist for the same services. Stakeholders should consider:
 - The long duration of the medication session justifies a second practitioner, but what is the justification for having a second licensed therapist with the same qualifications?
 - Could the second practitioner be another type of provider (e.g., technician, nurse, peer specialist, etc.)?

2. Utilize HCPCS codes (H2020, per diem for therapeutic behavioral services) to negotiate a team-based rate with payers. To facilitate payer negotiations, stakeholders should:

- Align on the types of practitioners that will participate in the medication session; and
- Determine whether to negotiate for inclusion of things such as medical oversight, drug storage and handling, training, certification, and enrollment in REMS, if required by the FDA, in the payment.

3. Expand existing CPT code for narcosynthesis (90865).³

- To utilize this existing code for PAT, stakeholders would apply to the CPT Editorial Panel for changes to expand 90865 so that it may be used by non-physician providers and more accurately reflect the services provided in a PAT medication/

dosing session. This multistep process is described by Dotson (2013). Then, stakeholders would work with payers to override the MUE.

4. Create a new code for the medication/dosing session with the flexibility to encompass different psychedelic compounds and varying levels of intensity and/or length.

- This would involve making an application to the CPT Editorial Panel, mentioned above, but for a new code, rather than revision to an existing code.

SPRAVATO'S REIMBURSEMENT CHALLENGES

The need for stakeholder consensus on coding options was reinforced by payer interviews conducted by BrainFutures, which revealed that payers are likely to initially compare PAT to esketamine with regard to reimbursement. Spravato (esketamine) was the first, and currently only, medication with psychedelic effects approved by the FDA to treat a psychiatric disorder. Payers are defaulting to this comparator not because it is the best payment model, but because it is the only psychedelic for which they currently provide coverage. However, a uniform coding strategy across payer types has not emerged for Spravato, causing confusion among providers and payers alike. BrainFutures shares this brief history of Spravato coding as a cautionary tale to emphasize the need for PAT stakeholders to establish and advocate for a unified coding strategy.

Spravato was initially approved in 2019 for TRD, but in 2020 the FDA extended the indication to include adults with MDD with acute suicidal ideation or behavior (Janssen Pharmaceuticals, Inc., 2020). Spravato must be taken under observation by a healthcare provider and patients must be monitored for at least two hours

following administration. This means that, similar to PAT protocols mentioned earlier in this report, there is a drug component and a professional services component (though not psychotherapy) to provision of Spravato.

Commercial payers most often cover Spravato as a pharmacy benefit, with providers using the appropriate drug code; the observation is covered as a medical benefit, with providers billing the appropriate Evaluation and Management (E/M) codes for the required observation and monitoring of the patient. The confusion stems from the fact that, in the year following Spravato’s initial approval, Medicare developed new HCPCS codes to incorporate both

the drug and observation/monitoring services, with coverage under Part B (Janssen Pharmaceuticals, Inc., 2021). These new G codes (G2082 and G2083) are required when billing Medicare Part B.

These two coding and reimbursement pathways have caused confusion among providers and payers. Medical coding is intended to provide a universal language for healthcare entities and organizations to clearly communicate about healthcare items and services provided to a patient. When different types of payers require two different code sets for the same services, the system is not operating in an accurate and efficient manner. 🌐

RECOMMENDATIONS TO ENSURE AFFORDABILITY IN PAYER COVERAGE AND PAYMENT DECISIONS

BrainFutures recommends that any payer coverage and payment decisions:

- Follow a path of wider and more comprehensive insurance coverage than has traditionally marked mental health benefits, across all public and private payers;
- Limit out-of-pocket requirements for patients;
- Comply with both the financial requirement and treatment limitation provisions of the MHPAEA, particularly for NQTLs;
- Ensure the psychedelic compound and psychotherapy are adequately reimbursed and the coverage is coordinated between behavioral health and pharmaceutical benefits; and
- Utilize a uniform coding strategy.

POLICY ISSUE 3:

PAT Must Meet High Quality Standards to Ensure Optimal Patient Outcomes

Principle: PAT must meet high quality standards to ensure optimal patient outcomes.

PAT stakeholders agree that the field should establish standards to ensure the highest-quality delivery of PAT. Just as in the rest of physical and behavioral healthcare, in which quality standards and oversight criteria are established by stakeholders and independent experts in each field, so, too, must all those involved in PAT come together to establish standards for the delivery of high-quality care.

While quality standards will ultimately be required in a number of different areas, the two most pressing needs at this time surround provider training requirements and measures to assess PAT care quality. BrainFutures recommends the establishment of a certification authority for training programs and providers and identification of key quality measures to inform a measurement-based approach to PAT.

PAT PROVIDER TRAINING

BrainFutures' conversations with payers revealed that in order to cover PAT, payers need to be assured of the quality of PAT practitioners and the credibility of their training. For payers, this includes the establishment of a certification authority for training programs and providers, initial provider certification, and ongoing assessment of provider competencies. Organizations to fill all of these roles are currently in development and include, among others, the American Psychedelic Practitioners Association (APPA) and the Board of Psychedelic Medicine and Therapies (BPMT). Collectively, these two organizations aim to establish standards of care, core training requirements, national PAT certification (and related exam(s) for providers), continuing education, and accreditation.

There is a pressing need to tackle the important work of harmonizing and standardizing the many training opportunities that currently exist.

There is a pressing need to tackle the important work of harmonizing and standardizing the many training opportunities that currently exist. Today, each psychedelic drug sponsor requires and conducts its own training of PAT therapists, using curricula containing important information for providers. In addition, some entities not affiliated with manufacturers offer training and certificates, though the degree to which these are or will be accepted as substitutes for manufacturer- or FDA-required training, if any, is not clear. These private training programs typically involve a robust curriculum and a minimum of 85 hours of learning encompassing intellectual or didactic learning, personal or experiential learning, and applied learning via clinical experience.

As the field currently stands, providers participating in clinical trials must participate in separate trainings sponsored by each different manufacturer to be eligible to administer PAT using that particular manufacturer's psychedelic compound. This means separate trainings for each pairing of compound and condition, for example, psilocybin for MDD through Usona Institute and psilocybin for TRD through COMPASS Pathways.

BrainFutures found that most training tuition ranges from approximately \$6,000 to \$21,500.

BrainFutures conducted an analysis and assessment of publicly available information to determine comparability across training sponsors, cost of training, and any areas of concern around full implementation of standards utilized in each training. BrainFutures found that most training tuition ranges from approximately \$6,000 to \$21,500 (California Institute of Integral Studies (CIIS), n.d.; MAPS PBC, 2021a; MAPS PBC 2021b; Phelps, 2020; Tai et al. 2021; The Synthesis Institute, n.d.). However, tuition represents only a small part of the total cost of training. This is because providers incur an opportunity cost when taking time away from their practices, forfeiting revenue as a result. BrainFutures research found that training requirements range from 85 to 864 hours. Thus, using the 2021 Medicare fee schedule for one hour of psychotherapy, providers stand to lose \$12,000 to \$122,000 of revenue by spending this time in training rather than working with patients. Together, tuition and lost income result in a total cost of \$18,000 to \$143,000 for a provider to be trained using one compound. (Some programs may have higher tuition than stated here and also require more training hours, making this potential total cost even higher.)

Training prepares providers for quality care delivery by ensuring they have an understanding of the theory, skills, and practice of PAT. For example, according to a review of psychedelic therapist competencies compiled from related literature, six skill sets are noted as important for providers to embody toward maximizing dosing sessions, as well as psychotherapeutic preparation and integration. These include: empathetic abiding presence; trust enhancement; spiritual intelligence; knowledge of

the physical and psychological effects of psychedelics; therapist self-awareness and ethical integrity; and proficiency in complementary techniques (Phelps, 2017). These capacities are intended to help providers navigate the experiential differences—including periods of emotional intensity, perceptual changes, and novel insights—that patients report in PAT treatments (especially dosing sessions) versus other forms of therapy.

PAT stakeholders need to decide whether training protocols should be wholly individualized by compound or whether the training on different therapeutic approaches might be coordinated into a more uniform approach. BrainFutures argues that, if unaddressed, the current approach to training will remain disjointed, time-consuming, and expensive for providers, potentially threatening the supply of clinicians willing to administer PAT and thus patient access. In addition, the creation of multiple training/certification pathways will complicate the process of obtaining payer approval and ongoing payment for PAT interventions. A standardized core curriculum, with add-on modules for specific condition/compound considerations, seems essential to

1. Encourage more providers to become certified,
2. Establish foundational knowledge requirements to inform national certification testing, and
3. Streamline training certification standards for payer coverage considerations.

MEASUREMENT-BASED CARE

M easurement-based care in the treatment of MH/SUD involves “the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient” (Fortney, et al., 2016). Specific billing codes exist for this type of testing evaluation, examples of which are included in Appendix G. Numerous studies have found that

frequent and timely feedback of standardized and quantified patient-reported data (including patient experience of therapy) to the provider during medication management and psychotherapy encounters improves patient outcomes (Alter et al., 2021). One review of 51 relevant articles found that measurement-based care improved patient outcomes 20 to 60 percent, with some studies documenting nearly a 75 percent difference in remission rates when compared to the usual standard of care (Fortney, et al., 2016). Accrediting bodies are putting these results into practice. In 2018, the Joint Commission—an independent, non-profit healthcare accreditation organization that accredits and certifies hospitals, as well as organizations that provide ambulatory and office-based surgery, behavioral health, home healthcare, laboratory, and nursing care center services—implemented a measurement-based care standard for all freestanding behavioral health accredited programs, requiring that they assess the outcomes of care, services and treatment (The Joint Commission, n.d.).

Key stakeholders in the PAT field are well aware of the need for rigorous guidelines and are highly engaged in identifying measurements to assess and assure the quality and safety of care.

Key stakeholders in the PAT field are well aware of the need for rigorous guidelines and are highly engaged in identifying measurements to assess and assure the quality and safety of care. A key challenge for the field now is to coordinate and define commonly agreed upon measures in areas where specific and standardized measurements can improve care, such as: screening measures as part of the patient enrollment process; patient experience measures through the three phases of treatment (preparatory, medication/dosing session(s),

and integration); post-treatment measurement periods (eg. three months, six months, one year); side-effect measures; adverse event tracking; and functional outcomes measures (employment status, housing status, objective measures of global functioning).

OTHER STANDARDS OF CARE

While standards for provider training and quality measures are the most pressing needs, the field must develop additional standards of care. These include requirements regarding the physical environment in which patients undergo

PAT, requirements regarding the number and credential level of providers in the room, whether or not a prescriber/physician is available on-premises, and more. Such standards will professionalize the field across all settings, provide a guide for establishing new practices, offer assurances to payers of a standardized care delivery model, give patients peace of mind, and allow for clear measurement of processes and outcomes across sites. While some of these requirements may be established by the FDA in its approval of psychedelics, the PAT field is exploring and working to establish these best practices. 🌐

RECOMMENDATIONS TO ENSURE PAT MEETS HIGH QUALITY STANDARDS TO ENSURE OPTIMAL PATIENT OUTCOMES

BrainFutures recommends the following steps to ensure optimal patient outcomes:

- Establishment of a certification authority for training programs and providers, initial provider certification, and ongoing recertification of provider competencies, including ethical standards and codes of conduct required by each provider's professional license;
- Harmonization and standardization of a core training curricula, with psychedelic compound-specific modules, to be endorsed by professional associations and adopted by all training programs;
- Establishment of a collaborative group of stakeholders and independent experts within the PAT field to identify a measurement-based approach to PAT;
- Identification of a set of key quality measures, including both process and outcome measures, to ensure transparency and accountability of providers; and
- Support of research into emerging and innovative psychedelic treatments and therapies.

Next Steps

The PAT field continues to grow in complexity as it moves rapidly into its next phase. This growth is necessary and exciting, and moves the field ever closer to a shared goal of wide adoption. But this growth must be structured around a common infrastructure and understanding since no single network or organization can advance the field unilaterally. In fact, unaligned approaches could have a chilling effect on the medical adoption of PAT, leading to poor precedent setting in licensing and training requirements, reimbursement strategies, and regulatory oversight. Coordinated action will help to minimize unintentional barriers and potential delays to patient access.

In the near-term, the PAT field must align approaches in four key areas (see right).

Fortunately, the resources to execute on these goals exist within the PAT community. Organizations including BPMT, APPA, Enthea, MAPS PBC, COMPASS Pathways, Usona Institute, and others are independently and collectively building key pillars to support the emerging field.

Thoughtful and experienced coordination of and collaboration between these four areas is essential.

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FOUR KEY AREAS OF ALIGNMENT


Standards of Care: Designation of a specialty association or associations to set standards of care for PAT providers, including standards of quality, medical or clinical practice guidelines, medical review criteria, and performance measures.

Program Accreditation: Designation of a body to offer independent accreditation of PAT education programs, set standards for effective training, and monitor compliance with those standards.

Provider Certification: Designation of a certification board to offer independent evaluation and verification of a provider's skills and expertise relative to PAT, to update certification criteria as the specialty evolves, and to provide patients with a trusted credential to help identify qualified providers.

Reimbursement Strategy: Alignment of stakeholders around a unified coding strategy and implementation plan to facilitate payer coverage determinations, simplify coding and billing processes, and improve access to care; development of parity education materials and briefing documents as free resources to stakeholders to support collective advocacy efforts.

in identifying these capacities within the PAT stakeholder community, building consensus and strategy around assignment of key responsibilities to identified organizations, and jointly cultivating effective relationships with the regulatory and reimbursement entities described in this brief. Multi-stakeholder input, consensus, and buy-in will help establish a foundational framework of policy and practice for the PAT field, propelling growth through stable, credible, and efficient structures.

BrainFutures aims to continue to offer its behavioral health policy expertise to leading stakeholders as an independent, third-party, public good national nonprofit. Today's work to advance the field will greatly affect future provider interest, treatment affordability, regulatory control, and patient care possibilities. The time for sophisticated core infrastructure coordination is here, and all constituents, most importantly patients, stand to benefit from this coordinated approach in the months and years ahead. 

Conclusion

The emerging consensus around the three broad principles of access, affordability, and quality demonstrates that the psychedelic medicine field is moving in a cooperative direction. This agreement sets the stage for shared engagement moving forward as PAT stakeholders continue to tackle the policy problems that could significantly slow the adoption of these important clinical interventions. The independent work of companies and researchers has propelled psychedelic science into an exciting new phase of development—with the widespread medical adoption of PAT now a real possibility. However, the industry is at a “phase shift” moment, where company-specific efforts must be blended with consortium-style work on the issues that face all stakeholders. These unified efforts will undoubtedly lead to faster and better results than individually addressing the issues cited above.

The field’s next step must therefore be the formation of one or more workgroups to identify very specific solutions to the problems outlined above, as well as detailed implementation plans for reaching those solutions. The work will take time, and is likely to require formal organization, behavioral health content expertise, and coordination across the field, including the many companies, researchers, clinicians, consumers, and other stakeholders that are involved in this important work. This is particularly true as interactions with external players such as government entities, payers, insurers, state and federal judicial systems, professional associations, or even contractors become an increasing part of the effort.

BrainFutures looks forward to being a part of this collective team, as together we accelerate the psychedelic therapy field into accessible, affordable, high quality adoption. 🌐

Appendices

Potential Billing Codes for Psychedelic-Assisted Therapy

(Each provider must decide the factors necessary and present to bill.)

APPENDIX A. POTENTIAL BILLING CODES FOR ALL COMPONENTS OF PAT

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

+90785	Add-on code: interactive complexity; may be added to the diagnostic psychiatric evaluation (90791, 90792), to psychotherapy services (90833-90838), and to group psychotherapy (90853) when communication factors are present during the visit
90792	Psychiatric diagnostic evaluation with medical services
90837	Psychotherapy, 60 minutes with patient and/or family member; Services represent insight oriented, behavior modifying, supportive, and/or interactive psychotherapy
90865	Narcosynthesis; physician only (MUE = 1)
99204	Office of other outpatient visit for the evaluation and management of a new patient, moderate level of medical decision making (45-59 minutes)
99205	Office or other outpatient visit for the evaluation and management of a new patient, high level of medical decision making (60-74 minutes)
99211	Office of other outpatient visit for the evaluation and management of an established patient, may not require the presence of a physician or other qualified healthcare professional
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making (30-39 minutes)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making (40-54 minutes)
+99354	Add-on code: prolonged services in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (list in addition to code for psychotherapy service) (MUE = 1)
+99355	Add-on code: prolonged services in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (list in addition to codes for psychotherapy and prolonged services first hour) (MUE = 4)
+99415	Add-on code: Prolonged clinical staff services with physician or other qualified healthcare professional supervision (non-facility only) (MUE = 1)
+99416	Add-on code: Prolonged clinical staff services with physician or other qualified healthcare professional supervision; each additional 30 minutes (non-facility only) (MUE = 3)
+99417	Add-on code: Prolonged evaluation and management services in the outpatient setting for services beyond the minimum required time of the primary procedure code; each 15 minutes of total time (55 minutes or more)
XP	Modifier code; separate practitioner, a service that is distinct because it was performed by a different practitioner

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES

+G2212	Prolonged office or other outpatient visit; 15 minutes (MUE=4)
H2010	Comprehensive medication services, per 15 minutes, face-to-face only
H2020	Therapeutic behavioral services, per diem
T1002	Registered nurse (Rn) services, up to 15 minutes
T1003	Licensed practical nurse (LPN)/licensed vocational nurse (LVN) services, up to 15 minutes

APPENDIX B. PATIENT ASSESSMENT/INTAKE CODING OPTIONS

Assumptions: DEA-licensed, REMS-enrolled prescriber, office or other outpatient setting with telehealth as a viable option

Stakeholder consensus required: Each prescriber can make the appropriate billing code choices here; consensus on this billing element is not required.

OPTION 1: PRESCRIBER

99204 Office of other outpatient visit for the evaluation and management of a new patient, 99204 = moderate level of medical decision making (45-59 minutes); 99205 = high level of medical decision making (60-74 minutes)
or 99205

+99415 Prolonged services (MUE = 1)

+99416 Prolonged services; each additional 30 minutes (non-facility only) (MUE = 3)

OPTION 2: PRESCRIBER

90792 Psychiatric diagnostic evaluation with medical services

APPENDIX C. MEDICATION MANAGEMENT CODING OPTIONS

Assumptions: Follow-up sessions with the prescriber may be necessary for medication management purposes. These sessions could take place in an office or other outpatient setting, or via telehealth.

Stakeholder consensus required: Each prescriber can make the appropriate billing code choices here; consensus on this billing element is not required

PRESCRIBER

99214 Office or other outpatient visit for the evaluation and management of an established patient, moderate level of medical decision making (30-39 minutes)

99215 Office or other outpatient visit for the evaluation and management of an established patient, high level of medical decision making (40-54 minutes)

+99417 Add-on code: Prolonged evaluation and management services in the outpatient setting; each 15 minutes of total time (55 minutes or more)

APPENDIX D. PREPARATORY PSYCHOTHERAPY CODING OPTIONS

Assumptions: Three 90-minute psychotherapy sessions with a practitioner licensed to practice psychotherapy under state laws and trained according to manufacturer and/or REMS requirements.

Stakeholder consensus required: Clinical trials have utilized two licensed therapists in each of the preparatory sessions. If two practitioners bill for the same services for the same patient on the same day, this will trigger a MUE, which payers are unlikely to override.

- What is the justification for having a second therapist with the same qualifications in each preparatory session?
 - If justified, and if payers will not reimburse two therapists, is it practical to have the therapists split the fee?
 - Could another provider type, who will participate in the medication session, also participate in the preparatory sessions (i.e. technician, nurse, peer specialist, etc.)?
- Could the preparatory sessions be conducted by one licensed therapist, with the patient having separate sessions with each therapist who will be present for the medication session?

INDEPENDENTLY LICENSED THERAPIST

90837	Psychotherapy, 60 minutes
+99354	Prolonged services; first hour (MUE = 1)
+99355	Prolonged services; each additional 30 minutes (MUE = 4)

APPENDIX E. INTEGRATION PSYCHOTHERAPY CODING OPTIONS

Assumptions: Three 90-minute psychotherapy sessions with a practitioner licensed to practice psychotherapy under state laws and trained according to manufacturer and/or REMS requirements.

Stakeholder consensus required: Clinical trials have utilized two licensed therapists in each of the integration sessions. Billing for two practitioners will require payer negotiation.

- What is the justification for having a second therapist with the same qualifications in each integration session?
- If justified, and if payers will not reimburse two therapists, is it practical to have the therapists split the fee?
- Could another provider type, who will participate in the medication session, also participate in the preparatory sessions (i.e. technician, nurse, peer specialist, etc.)?
- Could the integration sessions be conducted by one licensed therapist, with the patient having separate sessions with each therapist who was present for the medication session?

INDEPENDENTLY LICENSED THERAPIST

90837 Psychotherapy, 60 minutes

+99354 Prolonged services; first hour (MUE = 1)

+99355 Prolonged services; each additional 30 minutes (MUE = 4)

APPENDIX F. MEDICATION SESSION CODING OPTIONS

Assumptions: A six- to eight-hour medication session, during which the patient self-administers the psychedelic compound and psychotherapy and other therapeutic interventions (such as skill-building, peer support, and psycho-education) are provided by at least one licensed therapist and another provider. Medical oversight is provided by a physician, mid-level practitioner, registered nurse, or licensed practical nurse.

Stakeholder consensus required: Two practitioners are present during the medication session due to the vulnerable state of the patient. Clinical trials have generally utilized two licensed therapists, however, as described above, two therapists billing for the same services on the same day will trigger an MUE, absent negotiations with payers.

Stakeholders may consider three separate coding strategy pathways, each of which raise additional issues for consideration:

- Use existing psychotherapy CPT codes for psychotherapy. This would require:
 - Prior authorization and edit override due to the long duration of the medication session.
 - Payer negotiation to utilize Modifier XP (separate practitioner, a service that is distinct because it was performed by a different practitioner) to pay a second licensed therapist for the same services.
 - The long duration of the medication session justifies a second practitioner, but what is the justification for having a second licensed therapist with the same qualifications?
 - Could the second practitioner be another type of provider (i.e. technician, nurse, peer specialist, etc.)?
 - Some codes could apply to these provider types, but Medicare rates are either low or do not exist; negotiation with private payers would be required.
- Utilize HCPCS code H2020 (and possibly H2010) to negotiate a team-based rate with payers:
 - H2020 describes a per diem payment for therapeutic behavioral services.
 - H2010 describes comprehensive medication services, per 15 minutes, face-to-face only.
 - To facilitate payer negotiations, it would be helpful if the field could align on the types of practitioners that will participate in the medication session.
 - The negotiation could also include things such as medical oversight, drug storage and handling, training, certification, and enrollment in REMS.
- Expand existing CPT code for narcosynthesis (90865)³.

- 90865 describes a procedure in which the provider administers a narcotic drug to induce a hypnotic state that facilitates psychiatric diagnosis and treatment.
- Currently, 90865 may only be billed by physicians. It is paid as an hourly rate and carries an MUE of 1 (as the code is currently constructed, billing for more than one unit of narcosynthesis on the same day will trigger claims review/denial).
- To utilize this existing code for PAT, stakeholders would apply to the CPT Editorial Panel for changes to expand 90865 so that it may be used by non-physician providers and more accurately reflect the services provided in a PAT medication/dosing session. This multistep process is described by Dotson (2013). Then, stakeholders would work with payers to override the MUE.
- Create a new code for the medication/dosing session.
 - This would involve making an application to the CPT Editorial Panel, mentioned above, but for a new code, rather than revision to an existing code.

OPTION 1: UTILIZE EXISTING CPT CODES FOR PSYCHOTHERAPY

90837	Psychotherapy, 60 minutes
+99354	Prolonged services; first hour (MUE = 1)
+99355	Prolonged services; each additional 30 minutes (MUE = 4) would require edit override
+90785	Interactive complexity; may be added to psychotherapy services when communication factors are present during the visit

All codes would require payer negotiation to bill for a second practitioner (Modifier XP) or sharing the rate between the two providers

OPTION 2: USE EXISTING HCPCS CODE AND NEGOTIATE A TEAM-BASED RATE

H2020	Therapeutic behavioral services, per diem. Would require negotiation with payer regarding services included and rate
H2010	Comprehensive medication services, per 15 minutes, face-to-face only

OPTION 3: WORK TO EXPAND EXISTING CPT CODE FOR NARCOSYNTHESIS

90865	Narcosynthesis; provider administers a narcotic drug to induce a hypnotic state that facilitates psychiatric diagnosis and treatment. Would require expansion to include non-physicians and edit override to permit billing of 6-8 units per dosing session
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OPTION 4: WORK TO CREATE A NEW CODE FOR THE MEDICATION/DOSING SESSION

APPENDIX G. EXAMPLES OF MEASUREMENT-BASED CARE CPT CODES

96130	Psychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Each additional hour (List separately in addition to code for primary procedure). At least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified healthcare professional, two or more tests, any method, first 30 minutes
96137	Each additional 30-minute increment needed to complete the service is billed with code 96137
96146	The patient is administered a single, standardized psychological or neuropsychological test using an electronic platform such as a computer, which scores the test on completion

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Endnotes

1. For a more complete review of the clinical research please see Sky (2022).
2. The ACA imposes these requirements on non-grandfathered plans in the individual and small group markets.
3. 90865 describes the administration of a narcotic drug to induce a hypnotic state that facilitates psychiatric diagnosis and treatment. Currently, 90865 may only be billed by physicians, is paid as an hourly rate, and carries an MUE of 1. As the code is currently constructed, billing for more than one unit of 90865 on the same day will trigger claims review/denial.

BRAINFUTURES

BrainFutures was launched in 2015 by the nation's second oldest mental health advocacy organization, the Mental Health Association of Maryland (MHAMD). For more than 100 years, MHAMD has addressed the mental health needs of Marylanders of all ages through programs that educate the public, advance public policy, and monitor the quality of mental healthcare services. Building on this success, and bolstered by a cross-disciplinary advisory board of leading experts, BrainFutures brings together diverse stakeholders, policymakers, funders, and influencers to accelerate and scaffold national adoption of effective practices targeting four main areas: youth, workforce, mental health treatment, and older adults. Breakthroughs in our understanding of the brain have the potential to improve learning outcomes for children, optimize functioning at work, enhance treatment for mental health or substance use problems, and maintain sharp thinking as we age.

BrainFutures writes evidence-based issue briefs and releases recommendations that fill knowledge gaps related to brain-focused applications targeting the above segments of society. These educational resources highlight the latest advances in brain plasticity and how their application is transforming quality of life for people of all ages. Through this process, we not only gain insight from experts and innovators, we also foster support for change, building coalitions and cross-disciplinary collaborations to advance both adoption and access to new breakthrough applications. Ultimately, by informing the public, cultivating influential relationships, and connecting communities of diverse advocates we help propel the change that is needed to make meaningful progress.

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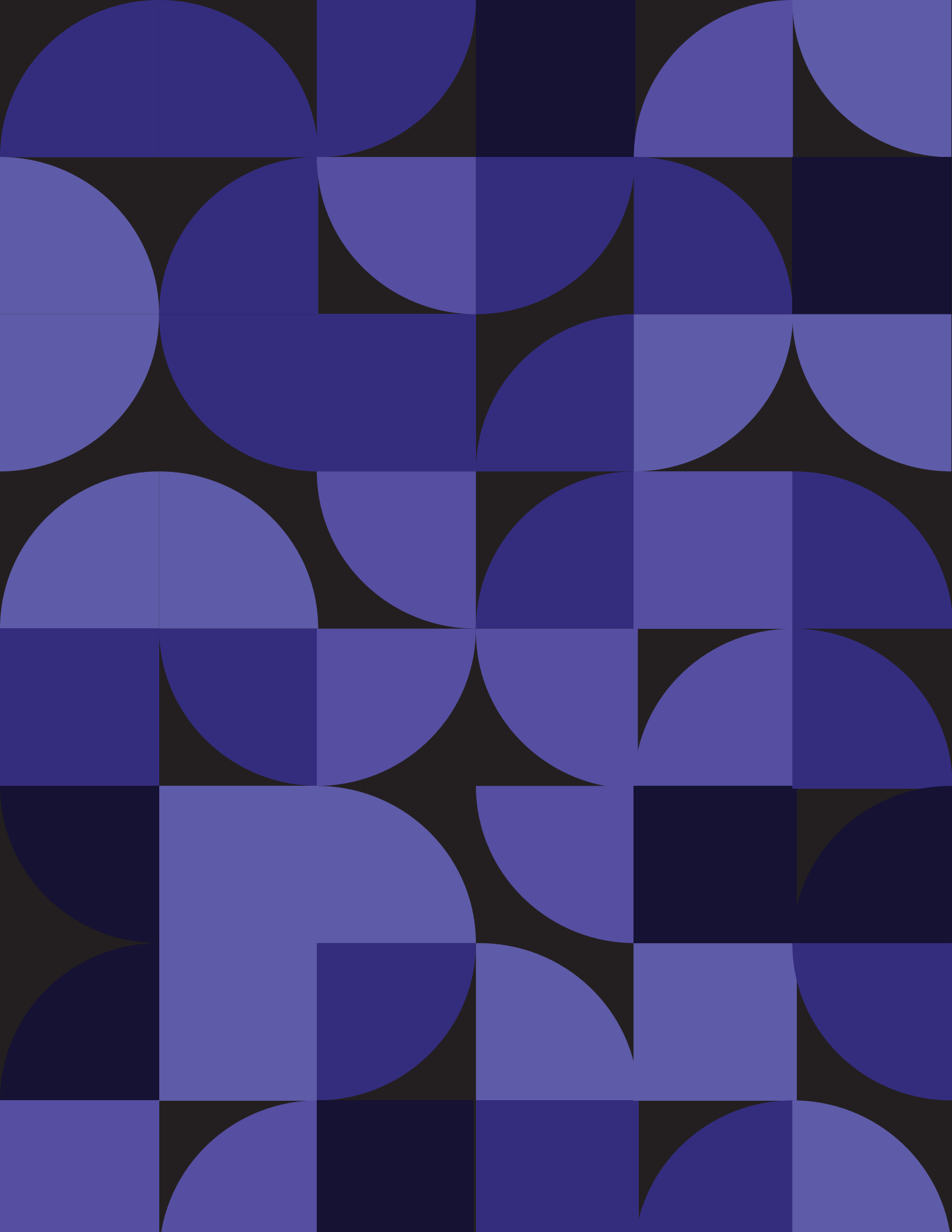
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