# Operational Analysis for Treatment With Psychedelic-Assisted Psychotherapy

## Operationalizing Medically Appropriate Psychedelic-Assisted Psychotherapy: Delivery-of-Care, Coverage, and Reimbursement Considerations

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### Introduction

Clinicians and payers recognize today's critical importance of access to effective mental healthcare services. The COVID-19–driven demand for these services exposed provider shortages that had been present for years but were largely underappreciated.[1,2] In 2018, for example, more than half of the counties in the United States did not have a practicing psychiatrist.[3] Since then, the share of US adults reporting symptoms of anxiety and/or depression has risen more than threefold over pre-pandemic levels, and drug-overdose death rates are up 58%.[4] Even as these challenges unfold, psychotropic drug development continues to lag behind other pharmaceutical innovation despite the need for more effective medications.[5,6]

To help address the growing societal burden of serious mental and behavioral health disorders, researchers have returned to the study of psychedelic drugs. As of August 2023, more than 150 active or recruiting clinical studies were investigating the utility of classic psychedelics like psilocybin and lysergic acid diethylamide, as well as enactogens like 3,4-methylenedioxymethamphetamine (MDMA) and ketamine, a dissociative anesthetic with hallucinogenic properties. These agents are being studied for the treatment of post-traumatic stress disorder (PTSD), major depressive disorder (MDD), substance use disorder, neurological and cognitive impairments, and other conditions that can be challenging to manage with current standards of care.[7,8] Recognizing that trial sponsors have limited experience in this emerging area of drug development, the US Food and Drug Administration (FDA) issued guidance in June 2023 to support clinical research.

Unlike medications or psychotherapy, either of which may be given independent of one another, most of these therapies in development will involve a combination of modalities. In most protocols under study today, a psychedelic drug is administered as a catalyst for psychotherapy. The drug does not relieve symptoms or correct imbalances in the brain but rather modifies brain function in a way that enables introspection during medication sessions and a window of *neuroplasticity* in the days that follow.[9] During this window, a therapist and patient explore the patient's new insights about previous life events. These *integration sessions* are carefully honed to facilitate meaningful change in the patient's behavior.[10] Together, these modalities form an intervention called *psychedelic-assisted psychotherapy* (PAP).

Given the multimodal aspect of PAP, efforts to assure access, coverage, and reimbursement for all components of this intervention will necessitate a level of cooperation among stakeholders not typically seen today in the provision of behavioral health services. Clinicians and payers alike will need to focus on timely and coordinated care. New benefit designs may be required to facilitate access to a complex treatment regimen. Payers will have to implement adjudication systems that support protocols that span medical, pharmacy, and behavioral health benefits.

This paper is intended to generate awareness of issues that payer decision makers may have to address when preparing for the market entry of these interventions. Many such considerations are novel and fall outside the traditional P&T committee/medical policy-development paradigm. After a short review of medications that are likely to receive regulatory approval by the middle of this decade, we will offer perspectives on delivery of care, coverage, and reimbursement for PAP.

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## The New Wave of Psychedelic Research

Psychedelic drugs have been used in therapeutic settings, largely in indigenous communities, for centuries. In the United States, 2 decades of research ending in the 1970s yielded evidence that certain psychedelics showed promise, as described in one early scientific paper, as "tools for shortening psychotherapy."[11] Following a 25-year hiatus, psychedelic research quietly resumed at selected university research centers, expanding over time. In 2021, Johns Hopkins received the first federal grant for psychedelic treatment research in 50 years.[12] Collectively, these studies have produced an accumulation of evidence suggesting benefits in patients with treatment-resistant depression, a history of opioid and other substance abuse, and PTSD.[13-17]

This renaissance in the study of psychedelic medications has emerged in part because serious behavioral health needs have remained unmet in the United States for decades. In the past quarter century, there has been a steady decline in pharmaceutical advances in mental health care. Between 1996 and 2006, the FDA approved 49 new molecular entities (NMEs) for psychiatric conditions. In the decade that followed, however, only 22 NMEs received FDA approval.[9]

Unmet need is also reflected in response rates to current therapies. Existing treatment options for PTSD, as an example, include behavioral health modalities such as cognitive-behavioral therapy (CBT) and pharmacotherapy such as selective serotonin reuptake inhibitors (SSRIs). Yet many patients with PTSD do not respond effectively to these approaches. One third of the general population with PTSD is believed to be treatment resistant, with nonresponse rates estimated at approximately 50% for CBT[18] and as high as 60% for SSRIs.[19]

Suboptimal outcomes underscore the need for novel treatment approaches,[20] and the modern era of controlled research into agents that are broadly termed in the literature as "psychedelic" medications is now poised to deliver them. A search of "interventions" on ClinicalTrials.gov of "psychedelics" in May 2024 found 11 recruiting, active, or recently completed phase 3 clinical trials studying the utility of psilocybin, MDMA, and ketamine for a variety of behavioral and substance use disorders.[7] Table 1 highlights 3 companies with company-sponsored phase 2b/3 trials.

**TABLE 1.** Selected Clinical Trials of Psychedelic and Related Drugs*

| Sponsor | Drug and proposed indication | Study<br>• Administration and randomization in phase 3 trial | Timeline |
|---|---|---|---|
| **MAPS**[a] (Lykos Therapeutics)[21] | MDMA for PTSD | MAPP1 (pivotal)/MAPP2<br>• Oral administration with assisted psychotherapy, randomized 1:1 to MDMA or inactive placebo | Phase 3 trials completed; NDA filed 12/12/23, expected FDA decision in 2024[22] |
| **Compass Pathways** | Psilocybin for TRD | COMP005[23] (pivotal) (1 administration):<br>• Oral administration with assisted psychotherapy, randomized in a 2:1 ratio to receive a single 25-mg dose of psilocybin or placebo<br><br>COMP006[24] (2 administrations):<br>• Oral administration with assisted psychotherapy, randomized 2:1:1 ratio to receive 2 doses of psilocybin 25 mg, 10 mg, or 1 mg (control) | COMP005 Phase 3 top-line results expected summer 2024[25]<br><br>COMP006 Phase 3 top-line results expected mid-2025[25] |
| **Awakn** | S-ketamine for severe AUD (UK only) | IV infusion randomized to 1 of the following:<br>• Active: 3 IV ketamine (0.8 mg/kg) infusions + psychosocial support<br>• Placebo: ketamine (0.05 mg/kg) + alcohol education sessions | Phase 2 completed, phase 3 estimated completion 2027[26,27] |

[a]MAPS recently rebranded to Lykos Therapeutics as of January 5, 2024.
*Recruiting, active, or recently completed phase 3 trials. Does not include investigator-led studies.
AUD, alcohol use disorder; IV, intravenous; NDA, new drug application; PTSD, post-traumatic stress disorder; TRD, treatment-resistant depression; UK, United Kingdom.

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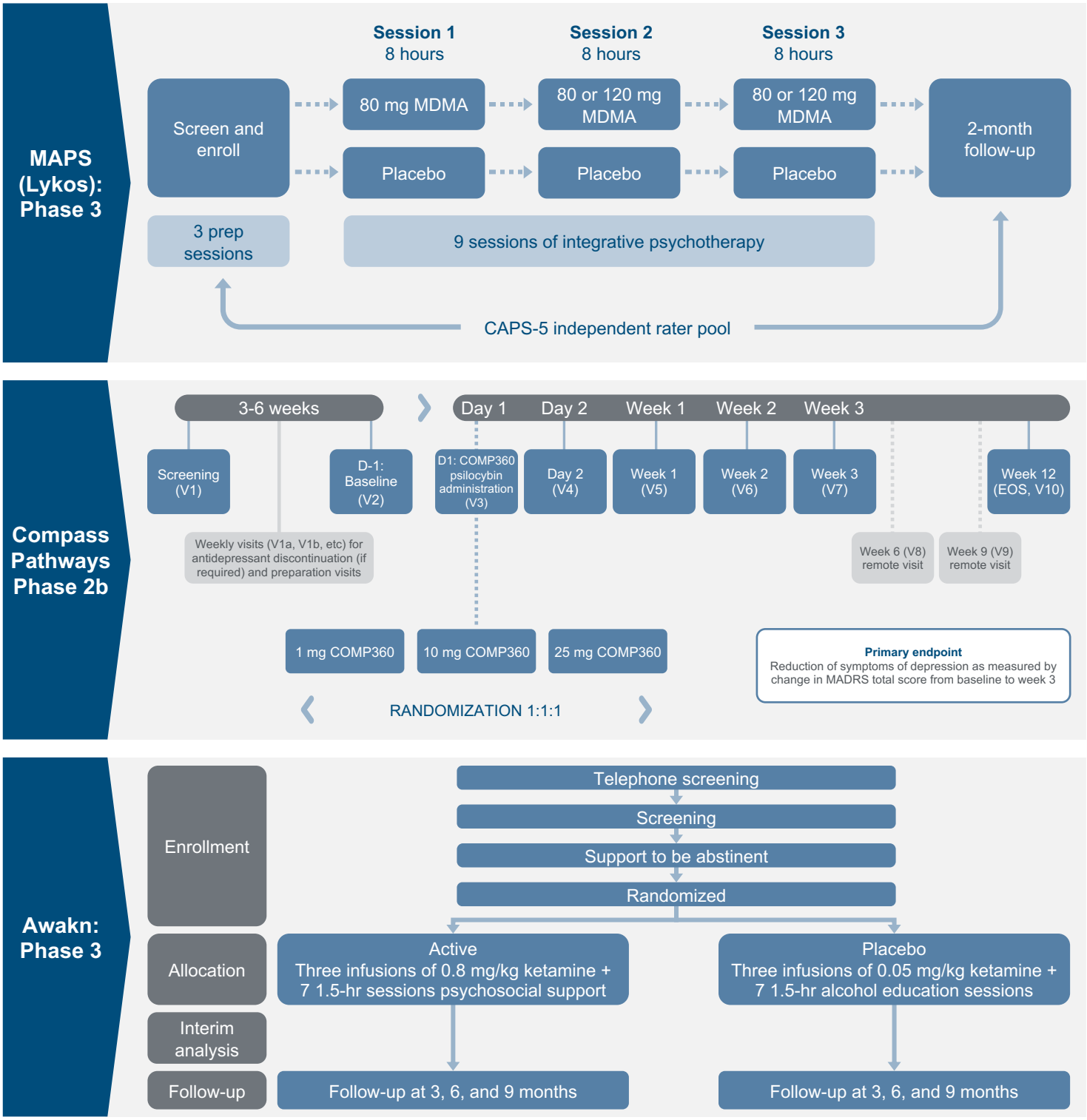
**FIGURE 1.** Treatment and Psychotherapy Sessions




The designs of current and recent studies of psilocybin, MDMA, and ketamine have typically included a psychotherapy component (Figure 1). Depending on the protocol, one or more preparatory sessions — often for building trust between patient and therapist and to prepare the patient for the psychedelic experience — may precede medication administration. In the period of neuroplasticity that occurs after administration, one or more integration sessions help patients to modify emotional reactions, thought patterns, and cognitive behaviors.[28]

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## Delivery-of-Care Considerations

**DEFINING AN EPISODE OF CARE.** The number of patient encounters in clinical trial protocols has varied. For example, a recent phase 2b trial of psilocybin for treatment-related depression comprised a relatively simple regimen of 6 encounters[14]:

- Three preparatory sessions with a lead therapist
- One administration (dosing) session, attended by the lead therapist and an assisting therapist
- Two integration sessions with the lead therapist within 1 week of administration

By contrast, the protocol for the pivotal phase 3 trial of MDMA-assisted therapy (MAPP1) was more complex, involving 15 patient encounters over a 14-week period[17]:

- Three preparatory sessions with a licensed therapist
- Three cycles of dosing and integration. Each cycle consisted of:
  - One administration session attended by 2 licensed therapists
  - Three integration sessions with a single licensed therapist

Of note, MAPP1 involved 8-hour administration sessions and 42 total hours.[17] Because study protocols generally translate into product labeling, the length and complexity of a treatment episode is an important consideration when developing coverage policy for PAP.

**COORDINATION OF DISCIPLINES.** The integration of modalities within an episode will require a high level of collaboration among stakeholders. Healthcare professionals (HCPs) across disciplines will need to coordinate on prescribing and treatment plans, and payers will have to facilitate rapid access to each stage of a protocol so that patients can take advantage of short windows of neuroplasticity. Various types of medical, pharmacy, and behavioral health professionals may be involved in an episode, depending on an intervention's drug labeling, its mandated risk evaluation and mitigation strategy (REMS) program, and/or a health system or payer's policies.

**PRESCRIBING AND DISTRIBUTION.** Payers may initially be inclined to require that a psychiatrist prescribe a psychedelic medication, but plans experiencing shortages of in-network psychiatrists may need to widen the channel of prescribing to include nurse practitioners (NPs), internists, or even specialists in pain management or physical medicine and rehabilitation.

Answers to questions about how a drug, once prescribed, reaches a patient and is administered are still unknown. Upon FDA approval, a drug on Schedule I of the Controlled Substances Act will be rescheduled but, owing to concerns about diversion, its abuse potential will determine how it is rescheduled.[29] Will federal and state regulations allow a specialty pharmacy to ship the drug directly to a patient? Or would white-bagging, in which the drug is shipped to an authorized HCP for administration, be required? If the latter, who administers the drug? In most cases, scope of license would not allow a PAP-trained therapist who does not have prescribing privileges to administer the drug to a patient at a medication session.

**ATTENDING PERSONNEL.** Requirements about the disciplines of those who accompany a patient during a medication session is likely to depend on the safety of the drug being administered and state licensing requirements. Administration of ketamine, for instance, necessitates continual monitoring of blood pressure, pulse, breathing, and oxygen saturation.[30] In clinical trials of MDMA, no medical monitoring was required.[16,17]

Because psychedelic drugs can cause perceptual disturbances and alterations in consciousness, mental health professionals should be present with a patient for the duration of a medication session. The FDA's 2023 guidance document on the conduct of psychedelic drug trials recommends the presence of two monitors: a graduate-level professional with clinical experience in psychotherapy (a PhD, PsyD, MD, DO, MSW, LCPC, LMFT, or psychiatric NP) as lead monitor, and an assistant monitor with a bachelor's degree and at least 1 year of clinical experience.[29] Scope of licensure in any state may influence whether certain disciplines may be present for medication sessions.

**TRAINING AND NETWORK ADEQUACY.** Payers are likely to require therapists who facilitate integration sessions to have a skill set acquired through specialized training. If such training is not already specified in the drug labeling or mandated by a state, payers should determine the need for it. If a professional organization sets standards for training, payers may be willing to accept sources of training that meet those standards. To ensure that provider supply can meet demand, enough providers will need to be credentialed to facilitate integration.

Though integration sessions would be led by a licensed professional, plans would also have to decide whether to require specific disciplines or doctoral-level care. Given the current accessibility challenges with access to mental health services, payers may be amenable to integration sessions conducted by psychiatric NPs, social

workers, or other professionals via telehealth as long as the HCP meets any required training requirements.

**SITE OF CARE.** For some types of PAP, the site of care might be relevant, depending on a particular medication's labeling, how it is administered, and whether medical monitoring or proximity to emergency care is required during administration.

For instance, esketamine, which is indicated for treatment-resistant depression and adults with MDD and acute suicidal ideation or behavior, is administered only in a REMS-certified outpatient medical practice. Esketamine labeling requires that a physician monitor a patient's vital signs after administration.[31] By contrast, ketamine — which is off-label for nonsurgical uses — has no established standards for administration or follow-up psychotherapy. Under various models, ketamine has been self-administered as a lozenge at home under supervision of an on-site "chaperone" and a therapist via telehealth; given as an intravenous (IV) infusion in a stand-alone ketamine clinic (some of which do not provide adjunct psychotherapy); or infused at a hospital outpatient department with proximity to an emergency room.[32-34]

In the absence of labeling or state mandates, an integrated delivery network (IDN) may issue its own site-of-care protocols. For instance, though there were no clear safety signals about MDMA-assisted therapy during clinical trials,[16,17] some IDNs familiar only with IV administration of ketamine in specialized clinics may initially require that MDMA administration take place not in a PAP-trained therapist's office but in a facility that can handle emergencies, at least until real-world evidence negates the concern.

Length of a medication session is also a consideration for site of care. Esketamine administration requires a REMS-certified practice to provide a place for patients to be monitored for at least 2 hours. MDMA administration can take up to 8 hours before it is considered safe for the patient to leave — a lengthy period in any space where productivity matters, whether it is in a PAP-trained therapist's office or a university center of excellence.

**Table 2 summarizes some provider-related considerations that may be relevant to the provision of PAP services.**

**TABLE 2.** Selected Delivery-of-Care–Related Considerations for Operationalizing Psychedelic-Assisted Therapies

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| **EPISODES OF CARE**<br>• What components of care make up the integration?<br>• How many patient encounters are required under each component during a course of therapy? |
| **COORDINATION OF DISCIPLINES**<br>• What types of HCPs will be required for an integration?<br>• Are payers' systems set up to facilitate coordination of care across medical, pharmacy, and behavioral health benefits |
| **PRESCRIBING, DISTRIBUTION, AND ADMINISTRATION**<br>• Would the drug be prescribed by a psychiatrist only? To facilitate access, can other relevant specialists prescribe the drug?<br>• How would the drug reach the patient? Who administers it?<br>• Who needs to be present for administration? How many people need to be present? |
| **TRAINING AND NETWORK ADEQUACY**<br>• What kind of provider training is required?<br>• Should preparatory and integration protocols be conducted only by certain mental health disciplines (eg, psychologist, social worker, NP)?<br>• To ease provider shortages, is there a role for supportive personnel or an intern? |
| **SITE OF CARE**<br>• Does a drug require a specialized site of care? Would the treatment need to be adjacent to medical support in the event it is needed?<br>• Can the medication be administered in a patient's home? In a PAP-trained therapist's office?<br>• How long does a drug administration session last? Is space dedicated for it?<br>• Does telehealth have a role in administration or integration sessions? |
| **STATE OR FEDERAL REGULATIONS**<br>• Does the state mandate the use of certain provider specialties?<br>• Does the state limit prescribing of psychedelic drugs to certain provider types?<br>• Does the manufacturer's REMS program require use of a particular specialty? |

HCP, healthcare professional; NP, nurse practitioner, PAP, psychedelic-assisted psychotherapy; REMS, risk evaluation and mitigation strategy.

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## Coverage Considerations

**COVERAGE POLICY.** To make PAP accessible to members, payers will have to work through several operational challenges and practical considerations (Figure 2, Table 3). Perhaps foremost among these will be to establish coverage criteria in the absence of guidelines. Until then, payers may require documentation of clinical improvement for renewed authorization of some services, as currently seen in several payer policies for coverage of esketamine.[35-37]

**BENEFIT DESIGN.** Benefit designs for various interventions may vary significantly. The potential for variation is predictable because the basic process most payers follow when deciding on coverage for a package of services — determine the components and licensure requirements, identify existing codes and site-of-service requirements, and attach a reimbursement rate to it — does not fit neatly into potential PAP protocols. Further, the components of this intervention would likely be paid from two, and possibly three, sources — the pharmacy benefit and either the behavioral health or medical benefit, or both.

Coverage for preparatory and integration sessions may be provided under either the behavioral health or medical benefit, depending on such factors as accessibility considerations, state regulations, and site of service. Providing the full intervention in a center of excellence may trigger the medical benefit — akin to chemotherapy infusions — but if integration sessions were to take place in a PAP-trained therapist's office or at home via telehealth, behavioral health may be the primary source of coverage. In most cases, the pharmacy benefit would cover the drug itself, although the medical benefit benefit could be an option should a psychiatrist or an NP be required to administer the medication to the patient.

Benefit complexity raises two obvious concerns. First, coverage policy will likely have to be developed across divisions of a payer. It would be difficult for a P&T committee to issue coverage policy for the drug component of PAP without input from the medical or behavioral health sides of the company. Nor can a behavioral health carve-out decide on benefit design and prior authorization (PA) criteria in a silo. Second, benefits will have to be coordinated in real time or near-real time. Integration sessions may take place the day after administration and, with some treatments, periodically thereafter.

**PRIOR AUTHORIZATION.** Initial payer policies could be expected to limit eligibility for a specific psychedelic drug to populations whose diagnoses are consistent with a specific drug's labeling. PA criteria will likely include proof that conventional therapy was tried but ineffective in a patient. Some payers may also require patients to be evaluated for eligibility for a specific therapy (as is typically done before electroconvulsive therapy).

PA criteria specifying who can prescribe PAP will strongly influence accessibility of care. Patients' difficulty in getting a psychiatric appointment is well documented. In one study published prior to the COVID-19 pandemic, the average wait time in Boston, Houston, and Chicago for an appointment with a psychiatrist was 1 month, if an appointment could be made at all; investigators were able to secure appointments with only 26% of the psychiatrists called.[38] More recently, investigators conducted a "secret shopper" analysis of one major payer in New York City, contacting every psychiatrist in the provider directory. Investigators were given the opportunity to book an appointment with only 3% of the providers listed in the directory.[39]

Simpler PAP protocols may require PA only for the drug, but more complex interventions spanning the pharmacy benefit and either the medical or behavioral health benefit may lend themselves to multiple authorizations. This complexity inherently suggests the need for coordination between the health plan or pharmacy benefit manager and a behavioral health carve-out, if one exists.

Some authorizations may be contingent on completion of a portion of a protocol. In such instances, reauthorizations may have to be granted quickly to meet the recommended timing of patient encounters.

Manufacturers are likely to argue for a single PA for the entire intervention. For complex procedures requiring multiple encounters with the healthcare system before, during, and after an infusion — gene therapy for transfusion-dependent ß-thalassemia or chimeric antigen receptor T-cell (CAR-T) therapy, for instance – payers often do this rather than requiring multiple authorizations or assigning a window of time (eg, 12 months) to the authorization period.[40-42] Similarly, a PAP episode may require a substantial number of patient encounters and therapy hours; this should be reflected in the PA if only a single authorization up front is required.

**COST-SHARING.** Benefit design also has implications for out-of-pocket costs to the patient and adherence to a protocol. High out-of-pocket costs are a well-known barrier to care[43] that cause some patients to skip or delay necessary treatment.[44] Ostensibly, plans investing in coverage for PAP would want members to persist with therapy rather than drop out of it because of recurring copayments and coinsurance. Complex protocols may lend themselves to financial incentives to ensure that patients persist with therapy. A single copayment, for example, may include services by the prescriber, a PAP-trained therapist who leads integration sessions, and the site of care, if necessary, as well as the drug itself.

**FIGURE 2.** Coverage Considerations

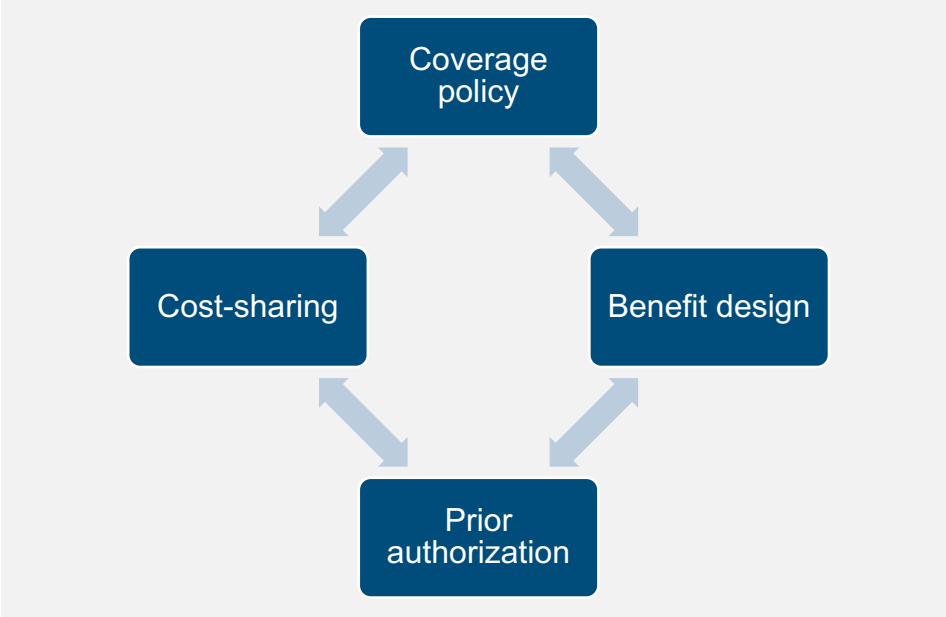


**TABLE 3.** Selected Coverage-Related Considerations for Operationalizing Psychedelic-Assisted Therapies

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| **COVERAGE POLICY** |
| • How are coverage criteria developed, particularly in the absence of clinical practice guidelines? |
| • Will coverage policies require documentation of patient adherence for continued authorization? |
| **BENEFIT DESIGN** |
| • Under which benefit is the intervention covered — medical, pharmacy, behavioral health, or some combination of these? |
| • How are these benefits integrated? What steps would ensure coordination between a payer and a behavioral health carve-out? |
| • What benefit limits may need to change (eg, caps on behavioral health services)? |
| **PRIOR AUTHORIZATION** |
| • What service(s) require(s) prior authorization? |
| • What PA criteria are important? Why? |
| • Would a single PA for the entire intervention, across disciplines, be sufficient? Which entity (health plan, behavioral health carve-out, etc.) authorizes it? |
| • Are multiple authorizations necessary? At what junctures? |
| • What would a scenario with 2 PAs look like? eg: |
| – One PA for administration sessions and a blanket PA for pretreatment and integration sessions |
| – One PA for administration sessions and a separate PA for specific nondrug services chosen from a menu. If additional nondrug services are requested, a provider would have to request another PA |
| • What would a scenario with multiple PAs look like? eg: |
| – Individual PAs for each administration session, with or without verification that nondrug integration sessions have taken place |
| – PA for 3 pretreatment or integration sessions at a time, with reauthorization contingent on patient adherence to the protocol (analogous to the early days of smoking-cessation or weight-loss therapies) |
| **COST-SHARING** |
| • How many copayments/coinsurance are collected from a patient? At what junctures? |
| • Should there be incentives to ensure that patients complete a lengthy protocol? |

PA, prior authorization.

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## Reimbursement Considerations

**PROVIDER COMPENSATION.** The psychedelic drugs under study are not likely to make up a large portion of the cost of a PAP intervention. Rather, most of the cost of PAP will be associated with integration therapy. With behavioral health networks having thinned, in part, by low payment rates that compel therapists to switch to cash-payment practices,[45] adequate provider reimbursement for PAP has access implications for health plans and members.

PAP-trained therapists may have to dedicate a significant amount of time to a single patient. Depending on the intervention, a single episode of care may involve as many as a dozen preparatory and integration sessions with a patient. The same therapist may also be present for one or more medication sessions, each lasting several hours. Rates for time-intensive protocols must account for therapist time at a level that makes their commitment attractive.

The intensity of a medication session also raises quality-of-care considerations that are intertwined with reimbursement. A manufacturer's REMS program is likely to require therapists who facilitate these sessions to undergo specialized training, which can be lengthy and/or costly. The Integrated Psychiatry Institute, for instance, offers a yearlong program that trains therapists for certification in psilocybin, ketamine, and MDMA-assisted therapies and includes an experiential component. Spanning 256 hours, the program carried a tuition of $10,000 as of August 2023.[46] Therapists may expect payment rates that recognize their investment of time and money to become qualified to offer PAP.

**METHODS OF REIMBURSEMENT.** Depending on the protocol under which PAP was studied, an episode of care may involve multiple professional disciplines, sites of service, and sessions over a period of time. In the MAPP1 and MAPP2 phase 3 studies of MDMA, for instance, two PAP-trained therapists guided a patient during each of three 8-hour administration sessions to encourage patients to stay introspective and be aware of feelings and thoughts. The first administration was preceded by three 90-minute preparatory sessions, and each administration session was followed by three weekly, 90-minute integration sessions. In all, the MDMA protocol totaled 66 therapist hours per patient.[17] In the commercial setting, an episode of this nature would also include services by the prescriber, three doses of the drug itself, and potentially, facility charges, depending on where the medication was administered.

The current system of reimbursement is not equipped to account for such complex interventions. Protocols involving combinations of modalities present several claims considerations. Payers may choose to reimburse for individual services, possibly making some payments contingent on record of a claim for a prerequisite service. Reimbursement for the drug, for instance, may or may not depend on completion of preparatory sessions.

Alternately, a payer may choose to establish a case (bundled) rate for an entire protocol. Though they can be complex to administer (see box, Case-Rate Analogs), case rates may be necessary to ensure feasibility of PAP coverage for a broad patient base.

A bundle would not have to include all services. For instance, one payment each time the drug is dispensed and a fixed payment for all therapy services would streamline claims processing across separate payment systems. Alternatively, integration sessions might be bundled, either as a whole or in groups to avoid the risk of paying for sessions in the event of a patient dropout. Selected therapy services might also be carved out and reimbursed separately.

Case rates must consider the totality of therapist time; otherwise, PAP-trained therapists may identify efficiencies, such as group integration sessions. Plans with thin provider networks may need to consider case rates for PAP-trained therapists outside the network.

### Case-Rate Analogs

There are models for dividing case-rate payments among providers. In surgery, for instance, plans have reimbursement guidelines for co-surgeons (in which the skills of both surgeons are needed to perform distinct parts of a procedure), assistant surgeons (physicians who actively assist the operating surgeon), and an assistant-at-surgery, often a physician assistant, an NP, or a nurse midwife acting under physician supervision.[47] These roles may be analogous to prescribers, providers who are present during medication sessions, and PAP-trained therapists who lead the integration work.

Case rates for neuropsychological testing and transcranial magnetic stimulation (TMS) may also serve as models for reimbursement of some PAP interventions. In neuropsychological testing, a full evaluation may take as long as 8 hours. TMS typically involves multiple treatments over a period of 4 to 6 weeks.

Esketamine- and ketamine-assisted psychotherapy do not provide comparable analogs. Esketamine does not require an integration component, and claims for the drug, administration, and medical monitoring are usually filed separately. Ketamine is not FDA approved for the treatment of behavioral health disorders and, as such, payers generally do not consider its use in this context medically necessary, although integration therapy (when offered) may be covered as any other session under behavioral health benefits.

Companies that offer ancillary benefits packages (like dental and vision care) to employers are beginning to focus on PAP. Enthea, for instance, offers coverage for ketamine-assisted psychotherapy and is building a network of providers in anticipation of MDMA and psilocybin approval.[48]

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**COST-EFFECTIVENESS.** Depending on the full cost of an intervention, a payer may wish to see rigorous estimates of total-cost-of-care offsets for certain populations, particularly if the primary expense is not for the drug itself. Some health systems have solid analytics capabilities and can work with payers to identify total costs for each patient as a baseline. Coverage for some members may depend on the degree to which clinical- and cost-outcome models can be population-stratified or certain outcomes demonstrated on a population basis.

**CODING.** The American Medical Association established new Current Procedural Terminology (CPT®) codes that account for the time and overall complexity of some treatment protocols. In January 2024, codes take effect for continuous in-person monitoring and intervention during PAP medication sessions.[49] One code is used to report total duration of in-person time with a patient. Another set of codes account for concurrent in-person participation of a second clinician (eg, a therapist or nurse who provides medical monitoring), precluding payer systems from rejecting same-day claims when more than one therapist is present.

If payers choose to bundle services for an intervention, new codes may be necessary for use with case rates.

**Table 4 summarizes some reimbursement-related considerations for the provision of PAP services.**

**TABLE 4.** Selected Reimbursement-Related Considerations for Operationalizing Psychedelic-Assisted Therapies

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| **PROVIDER COMPENSATION**<br>• Is provider reimbursement adequate to support accessibility to an intervention?<br>• Does compensation account for therapist hours or specialized training? |
| **METHODS OF REIMBURSEMENT**<br>• What payment models may be most appropriate (eg, individual claims, case rate with or without drug)?<br>• How would payment for bundled claims be divided among providers? |
| **COST-EFFECTIVENESS**<br>• Can cost offsets be estimated? What variables should be considered?<br>• Which patients (eg, multiple hospitalizations or substantial comorbidities) would show the greatest cost benefit? |
| **CODING**<br>• Are systems updated with codes to enable payment for lengthy sessions, multiple sessions, multiple providers billing for the same services on the same day, or case rates?<br>• What claims rules or modifications would be required so that systems can process complex claims? |

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## Discussion and Conclusion

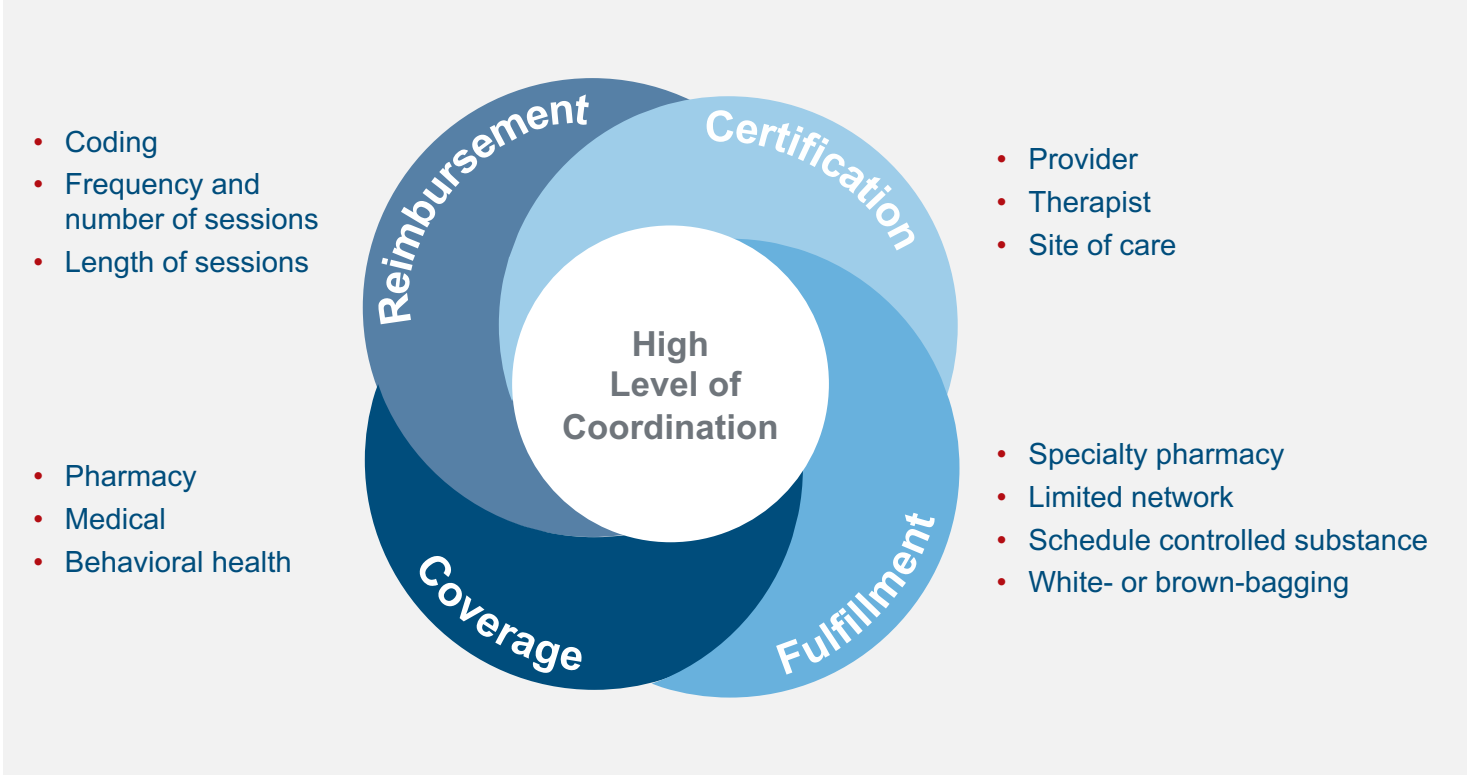
The re-emergence of PAP research places mental health care on the threshold of a new era. The timing of this development is critical. A 2-decades-long decline in NME approval rates for psychiatric conditions, strong growth in demand for mental health services in recent years, and the persistence of treatment-resistant conditions has created a perfect storm of unmet needs.

Payers will likely have to work through multiple challenges with providers to operationalize PAP. In the area of care delivery, there are unanswered questions about who should necessarily be part of a treatment protocol, site-of-service considerations, and how state or federal regulations may facilitate or hinder distribution of a medication or the delivery of services. Of primary concern is the shortage of psychiatrists, inadequate therapist networks, and reimbursement models that have contributed to both over time. Furthermore, the FDA committee's concerns regarding MDMA trial design due to functional unblinding, along with an insufficient ("I") rating from the Institute for Clinical and Economic Review (ICER), underscore the complexities and potential hurdles in gaining coverage and reimbursement, even if the drug is approved later this year.[50,51]

Payers will also want to determine whether current benefit designs support the delivery of treatments involving a combination of modalities. Some organizations will find there is work to be done across medical, pharmacy, and behavioral health benefits to create coordinated and seamless access to each stage of the intervention. Such efforts must occur in tandem with third parties that create regulations and other pathways that enable access.

The considerations described in this paper for operationalizing PAP weave a web of complexity that will require innovative thinking and stakeholder collaboration and coordination (Figure 3). No single entity involved in facilitating access to PAP can address all these considerations alone.

**FIGURE 3.** Coordination of Efforts Needed to Operationalize Access to Psychedelic-Assisted Therapies



This level of collaboration is achievable, providing tremendous opportunity for addressing long-neglected clinical needs in a sizeable population. As an example, once payers have identified needs, it may be useful to partner with an institution or health system to pilot a plan for access, address operational challenges, and collect outcomes data.

Manufacturers of the drugs used to facilitate PAP may also play a similar role. Manufacturers, for instance, can provide guidance to health systems interested in creating a delivery-infrastructure model. Working through third-party training organizations, a manufacturer can help to educate psychiatrists, therapists, and other clinicians on how a medication can facilitate meaningful therapy — which also can help to eliminate clinician barriers to acceptance. Such a project could be piloted with a regional IDN or community health center to identify efficiencies and solicit participation of trained HCPs in a network (brick-and-mortar, telehealth, or a combination of both). The IDN could then approach payers, having removed obstacles of credentialing and access that payers would otherwise have to solve.

**SUMMARY.** Psychedelic-assisted psychotherapy represents the vanguard of new approaches to intractable mental health conditions. Their imminent arrival — the first psychedelic drug is expected to enter the market in 2024[20] — necessitates coverage and payment models as unique as the interventions themselves. In preparation, payers will need to engage in cooperative discussions with providers and behavioral health carve-outs about coordination of services, reexamine benefit design to enable appropriate access, and develop adjudication systems to support required treatment protocols. With the expected commercialization of these therapies by mid-decade, the time is now to begin creating an infrastructure for delivery, coverage and access, and reimbursement.

## Takeaway Points

- Psychedelic-assisted psychotherapy (PAP) introduces delivery-of-care, coverage, and reimbursement considerations that the current system of healthcare financing in the US is not fully configured to accommodate
- A PAP intervention may involve complex combinations of modalities and multiple provider types, requiring a new level of coordination across medical, pharmacy, and behavioral health benefits

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