Center for Health Care Strategies

Psychedelic-Assisted Therapy and Medicaid: Considerations for Coverage and Access

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Prepared by the Center for Health Care Strategies for the Psychedelic Mental Health Access Alliance

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports organizations across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ABOUT THE PSYCHEDELIC MENTAL HEALTH ACCESS ALLIANCE

The Psychedelic Mental Health Access Alliance (PMHA Alliance) is a national initiative dedicated to supporting the development of the care models, partnerships, and evidence needed to bring psychedelic-assisted therapy (PAT) into Medicaid and other public systems. PMHA Alliance focuses on ensuring that people who depend on publicly funded mental health care can benefit from PAT as they become available. For more information, visit **www.pmhaa.org**.

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Summary of Key Recommendations

Psychedelic-assisted therapy (PAT) combines psychedelic drugs or drugs with psychedelic properties with psychological support or therapy. Emerging research suggests that PAT may benefit people with behavioral health conditions, such as treatment-resistant depression, post-traumatic stress disorder, and substance use disorders. Evidence varies, however, by drug and condition.

Medicaid coverage decisions will strongly influence who can access these treatments. Medicaid is the nation's largest payer for behavioral health services, and more than 40 percent of members have a mental health condition or substance use disorder. Currently, Spravato, or esketamine, is the only psychedelic-like drug approved by the U.S. Food and Drug Administration (FDA).

FDA approval of additional drugs would open potential Medicaid coverage pathways when manufacturers participate in the Medicaid Drug Rebate Program. Coverage alone, however, will not ensure access. States, health plans, and providers will need relevant evidence, clinical guidelines, practical care models, sustainable payment approaches, and a trained workforce. Fiscal pressures and competing implementation demands may further affect state readiness.

Philanthropies, investors, and other interested stakeholders can support four areas of work. Some activities can begin before FDA approval and continue afterward. Others will be most useful once states begin making specific coverage and implementation decisions. Full details are available in the ***Opportunities to Advance Access to PAT*** section of this report.

1. Build the Evidence Base for Medicaid Decision-Making

- **Invest in research that aligns with state Medicaid coverage considerations and the realities of safety-net care delivery.** Future PAT research should reflect populations similar to that of Medicaid. Researchers should also explore and evaluate lower-cost care delivery models that can be scaled in safety-net settings, such as group-based models and the use of peers in PAT delivery. Studies should also collect data and measure outcomes that align with the interests of Medicaid stakeholders.
- **Compile existing research on psychedelic drugs that have received FDA vouchers.** The FDA recently awarded Commissioner's National Priority Vouchers to three drug manufacturers developing psychedelic therapies: Compass Pathways for synthetic psilocybin for treatment-resistant depression, Usona Institute for psilocybin for major depressive disorder, and Otsuka for methylone for post-traumatic stress disorder. If approved, state Medicaid agencies will likely need to review FDA guidance, clinical trial data, and relevant peer-reviewed literature for each drug. A synthesis of public research and studies could help streamline state efforts to review newly approved drugs.

2. Develop Clinical and Care Delivery Frameworks

- **Engage with professional bodies to establish clinical guidelines.** When available, state Medicaid agencies consult clinical guidelines from professional organizations to inform their coverage policies. Engaging professional medical organizations to establish clinical guidelines could help states, managed care organizations (MCOs), and providers understand how to cover and prescribe PAT.

- **Further define PAT care models to inform coverage and integration into safety-net settings.** Medicaid agencies and MCOs will want to understand the care models for PAT to determine coverage guidelines and reimbursement. Providers will need to understand the care model to inform integration into safety-net settings. To support adoption in the safety net, this effort should focus on established delivery settings, such as Certified Community Behavioral Health Clinics, among other settings.
- **Build provider capacity to offer PAT.** Medicaid coverage of a new drug or therapy does not ensure that providers will prescribe it. Many health care providers will require training, education, and ongoing support to effectively deliver PAT and address stigma related to psychedelics.

3. Learn from Existing Coverage and Delivery Models

- **Explore coverage and delivery of Spravato and off-label intravenous (IV) ketamine.** Psychedelics are largely new territory for state Medicaid agencies and safety-net providers. States may look to their experience covering comparable drugs, like Spravato or off-label IV ketamine, when making coverage decisions for other drugs with psychedelic properties. Safety-net providers may also look to their experience adopting new therapies for patients.
- **Explore how other health insurance systems provide and reimburse for PAT.** This report focuses on Medicaid; however, other systems (e.g., Veterans Affairs) could offer useful lessons to help inform research, care and payment model development, clinical guidelines, and approaches to integrating PAT into Medicaid and safety-net settings.

4. Engage Communities and Build Stakeholder Alignment and Implementation Readiness

- **Engage the community to inform psychedelic research and implementation.** Engaging Medicaid members and community-based organizations (CBOs) that serve people with behavioral health conditions who might benefit from PAT — as well as healers from Indigenous communities that use psychedelic medicines — to co-design research and care models can help tailor models to the unique needs of communities. Authentic engagement with patients and CBOs can also help address stigma associated with psychedelics and concerns related to cultural appropriation.
- **Create a multi-state, multi-stakeholder workgroup to inform PAT implementation, and care model and coverage design.** A cross-state workgroup of Medicaid staff, MCO representatives, researchers, health care providers, pharmacists, and other experts could inform PAT research, care models, and coverage design. This type of workgroup could also help identify PAT champions to build a greater understanding among Medicaid stakeholders to support implementation.
- **Establish a cross-state learning forum on psychedelics for Medicaid agencies.** States often look to other states to inform their coverage policies. A multi-state learning forum could facilitate early and ongoing information sharing among Medicaid agencies as they navigate coverage and oversight.
- **Invest in state-specific forums to inform coverage guidelines and implementation.** State-specific, multi-stakeholder workgroups that include Medicaid policymakers and health care providers can be an effective way to inform PAT coverage and its implementation. These forums create opportunities for providers to share real-time insights on implementation challenges and patient needs, while enabling Medicaid officials to communicate operational considerations and policy constraints.

Introduction

KEY TAKEAWAYS

- Psychedelic-assisted therapy (PAT) is emerging as a potential treatment option for conditions such as treatment-resistant depression, post-traumatic stress disorder, and substance use disorders, particularly for individuals who have not responded to existing therapies.
- Federal and state policymakers are increasingly exploring psychedelics and drugs with psychedelic properties through research initiatives, regulatory activities, and pilot programs, signaling growing interest in their role in behavioral health treatment.
- Because Medicaid is the nation's largest payer of behavioral health services and covers a disproportionate share of people with mental health conditions and substance use disorders, Medicaid coverage decisions will play a key role in determining access to PAT.
- This report, developed by the Center for Health Care Strategies for the Psychedelic Mental Health Access Alliance, summarizes emerging evidence on PAT, reviews current federal and state policy and regulatory developments, and highlights key considerations for future investments to inform Medicaid coverage and access.

Psychedelic-assisted therapy* (PAT) refers to the use of psychedelic drugs or drugs with psychedelic properties alongside psychological support or therapy to treat behavioral health conditions. These conditions may include major depressive disorder, treatment-resistant depression, post-traumatic stress disorder (PTSD), and substance use disorders (SUD). Drugs used in PAT may include traditional psychedelics like psilocybin, as well as medications with psychedelic properties, such as 3,4-methylenedioxymethamphetamine (MDMA) and ketamine. As the evidence base for these interventions develops, there is growing interest in PAT as a potential addition to the behavioral health care continuum, particularly for people who have not responded to existing treatment options.

The federal policy and regulatory landscape around psychedelics is evolving. In 2019, the U.S. Food and Drug Administration (FDA) approved Spravato (esketamine), a ketamine derivative, for treatment-resistant depression and depressive symptoms in adults with major depressive disorder and suicidal ideation or behavior. Numerous clinical trials are examining whether psychedelics can help treat various behavioral health conditions. Most recently, President Trump issued an executive order directing federal agencies to accelerate research and review processes for psychedelic drugs.

* The field is still determining the most effective ways to deliver psychedelic treatments and what support is needed during each phase of care, from preparation to integration. There is no consensus on therapeutic guidelines or best practices for psychedelic care.

Most clinical trials have focused on evaluating psychedelic safety and efficacy, rather than standardized psychotherapy. As a result, questions remain about which forms of therapeutic support are necessary, for whom, at what intensity, and over what duration of time to optimize outcomes in routine clinical practice.

At the same time, many clinicians, researchers, and experienced psychedelic practitioners believe ongoing therapeutic support — in a range of forms — is essential to help individuals translate insights gained during psychedelic experiences into lasting psychological and behavioral change. However, the evidence needed to establish best practices for post-treatment care is still emerging.

Throughout this report, CHCS uses the term PAT broadly to encompass care models that combine psychedelic treatment with psychological, therapeutic, or other structured forms of support before, during, and after a psychedelic intervention.

States are also advancing research and regulations related to psychedelics. The following examples, while not exhaustive, highlight several notable state actions. For example, in 2020, Oregon approved the nation's first state-regulated psilocybin program, followed by Colorado in 2022. In 2025, New Mexico established a program for the medical use of psilocybin. In 2026, New Jersey established a state-funded pilot to study psilocybin-assisted therapy in hospital settings. More recently, Louisiana passed legislation that uses opioid settlement funds for clinical trials involving psychedelics, while Massachusetts lawmakers may soon approve a clinical pilot to study psychedelic treatments.

Medicaid is the primary payer for behavioral health care in the United States, covering more than one-quarter of adult treatment costs nationwide. More than 40 percent of Medicaid members have a mental health condition or SUD — a higher rate than among people with private insurance — and Medicaid spending for adults with a mental health diagnosis is twice as high as spending for adults without a mental health diagnosis. Given this prevalence, states have strong incentives to invest in behavioral health care approaches that offer the potential to improve outcomes and lower overall costs. Medicaid coverage decisions will play an important role in determining whether Americans with serious behavioral health conditions can access PAT, if the FDA approves additional drugs.

Coverage alone, however, will not ensure access. It will be important that PAT care models work in safety-net settings that serve Medicaid members' behavioral health needs, and that providers in these settings are willing, knowledgeable, and confident in providing PAT. States, health plans, and health care providers will also require clinical guidelines, sustainable financing models, and training for behavioral health care providers and operations staff. These supports will be important for integrating PAT into care delivery settings in ways that are safe, practical, and responsive to Medicaid members' needs.

The Center for Health Care Strategies (CHCS), with support from the Psychedelic Mental Health Access Alliance (PMHA Alliance), conducted research and interviews with stakeholders and subject matter experts to better understand key considerations for Medicaid coverage of PAT. The research and interviews focused on intravenous (IV) ketamine, MDMA, and psilocybin, and explored opportunities to facilitate their integration into care delivery settings serving Medicaid members.

This report provides an overview of these findings, along with: (1) a summary of current federal and state policy and regulatory activity related to psychedelics, and (2) considerations for future investment to inform Medicaid coverage of psychedelics and access to PAT.

The report also includes an overview of how behavioral health services are financed and delivered for Medicaid members (see Appendix).

About Psychedelic-Assisted Therapy and Evidence

PAT refers to the use of psychedelic drugs or drugs with psychedelic properties — such as MDMA, psilocybin, and ketamine — alongside psychological support or therapy to treat behavioral health conditions, such as PTSD, treatment-resistant depression, and SUD. There are hundreds of psychedelic compounds. Some occur naturally, while others are synthesized in laboratories. The University of California, Berkeley Center for the Study of Psychedelics groups these substances into two categories:

- **Classic psychedelics** primarily affect the brain's serotonin 2A receptors. They can cause visual and auditory distortions; light, sound, and touch sensitivity; altered perceptions of time; synesthesia; and hallucinations. Examples: ayahuasca, DMT, 5-MeO-DMT, LSD, mescaline, and psilocybin.
- **Non-classic psychedelics** are similar to classic psychedelics, but they do not act prominently, or at all, on serotonin 2A receptors. Instead, these drugs may interact with other neurotransmitters. Examples: ibogaine, ketamine, and MDMA.

Researchers continue to study how psychedelic drugs support treatment for behavioral health conditions, with many clinical trials underway. Evidence for psychedelics varies by drug and by the condition treated. PAT has the potential to support better outcomes for people with serious mental health conditions and SUD, including people who have not improved with other treatments, such as selective serotonin reuptake inhibitors and cognitive behavioral therapy. Across studies, there are patterns of key benefits such as: (1) faster symptom improvement; (2) more limited side effects; (3) shorter treatment duration; and (4) enhanced emotional processing that can strengthen psychotherapy and promote lasting changes.

How Does PAT Work?

PAT works alongside psychological support or therapy to treat a behavioral health condition. In general, PAT includes three phases:

- **Preparation**: Patients work with a therapist or other health care providers to explore their reasons for seeking PAT, identify their goals, and build trust with the care team. Providers help prepare patients for what they may experience during medication sessions and how to navigate those experiences.
- **Medication**: Patients take the psychedelic drug under supervision of a therapist or team of trained health care providers. Treatment may involve multiple medication sessions, each lasting several hours and typically occurring over several weeks.
- **Integration**: After medication sessions, patients meet with their therapist without the use of medication. These sessions help patients reflect on their experience and how they relate to their goals.

People working in the psychedelic field often emphasize the importance of "set" and "setting" in shaping a person's psychedelic experience. **Set** is a person's internal state, including thoughts, emotions, experiences, expectations, and mindset. It also includes the person's history and life experience. **Setting** refers to the external environment where PAT occurs (e.g., doctor's office, outdoors, at home), the people present, and broader social atmosphere. Both set and setting can influence a person's psychedelic experience.

Source: https://psychedelics.berkeley.edu/therapy/; https://psychedelics.berkeley.edu/qa/the-role-of-place-and-mindset/

Notable randomized controlled trials (RCTs) of psychedelic drugs include:

- A phase-3 RCT of MDMA for people with moderate to severe PTSD, with reported outcomes of greater reductions in symptoms and related functional impairments (including in work, family, and social life) as compared to individuals who received a placebo; and
- A phase-2B RCT of psilocybin for people with treatment-resistant depression that reported a highly significant reduction in depression for participants receiving a single dose along with structured psychological support.

Systematic reviews of evidence from multiple studies report:

- Statistically significant improvements in depression symptoms and responsiveness to psilocybin treatment for symptoms of depression;
- Limited evidence for lasting reductions in self-reported depression symptoms for ketamine-assisted psychotherapy for people with treatment-resistant depression; and
- Strong positive outcomes for psychedelic-assisted therapy for treatment of alcohol use disorder and smoking cessation.

Current Landscape of Psychedelics and PAT

In recent years, state and federal policymakers have shown growing interest in the potential role of psychedelics and PAT in behavioral health treatment. This activity includes federal efforts to accelerate research and review pathways, Medicaid coverage decisions for certain ketamine-related treatments, and state-regulated access models. While this section outlines recent state and federal activity related to psychedelics, CHCS acknowledges that Indigenous communities have long practiced psychedelic rituals.

This section provides a high-level overview of:

- Federal activity related to bringing psychedelic drugs to market;
- Current Medicaid coverage of psychedelic drugs and therapies; and
- State activities to facilitate access to psychedelics.

Federal Momentum in Bringing Psychedelics to Market

In April 2026, President Trump signed an executive order, Accelerating Medical Treatments for Serious Mental Illness, aimed to accelerate treatments for people with serious mental illness. The executive order includes provisions to further research on and access to psychedelic drugs. Relevant provisions direct:

- The FDA to issue Commissioner's National Priority Vouchers for psychedelic drugs that have received Breakthrough Therapy designations for serious mental illness. These vouchers are being piloted as a pathway to reduce FDA drug application review to 1–2 months;
- The FDA and the U.S. Drug Enforcement Administration (DEA) to establish a pathway for patients to access certain investigational psychedelic drugs, like ibogaine, under the Right to Try Act;

- U.S. Department of Health and Human Services (HHS) to allocate $50 million through the Advanced Research Projects for Health to match investments by state governments in psychedelics research for people with serious mental illness;
- HHS and FDA to collaborate with the U.S. Department of Veterans Affairs and the private sector to increase clinical trial participation and research on experimental psychedelic therapies; and
- The U.S. Attorney General to review relevant products after successful phase-3 clinical trials to support more timely drug rescheduling.

Shortly after the executive order was issued, the FDA awarded three drug manufacturers vouchers for psychedelic compounds being studied for behavioral health conditions. The recipients include:

- Compass Pathways for COMP360, a synthetic psilocybin, for treatment-resistant depression;
- Usona Institute for psilocybin for major depressive disorder; and
- Transcend Therapeutics (recently acquired by Otsuka America) for methylone (TSND-201) for PTSD.

More recently, the FDA issued final guidance on considerations for clinical investigations on psychedelics and scheduled a September 2026 public hearing on potential future therapeutic use of psychedelics. The federal Health Resources and Services Administration, which oversees community health centers, also recently issued a request for information on training and care delivery models to ensure safe and effective administration of future FDA-approved psychedelic therapies. These developments reflect the rapidly evolving nature of the psychedelic policy and research landscape. The examples highlighted are illustrative and do not provide a comprehensive account of all recent federal activities.

Medicaid Coverage of Psychedelics

A common saying among people who work in Medicaid is, "If you've seen one Medicaid program, you've seen one Medicaid program." Federal law sets broad Medicaid requirements, but states have significant flexibility in how they design and operate their programs. While FDA approval can support state coverage of PAT, it does not guarantee access nationwide. For example, Medicaid coverage of current FDA-approved psychedelic-like drugs varies by state.

Access to these treatments is shaped by state policy and Medicaid program decisions, as well as state-contracted Medicaid health plans — often known as managed care organizations (MCOs) — and behavioral health providers. Key policy areas that influence access include: (1) who qualifies as eligible for treatment; (2) which providers can deliver PAT and in what settings; (3) which services are covered; and (4) how these services are paid for. For example, states define medical necessity for each Medicaid benefit, which may be based on factors such as diagnoses, severity of need, and prior treatment failures.

Most Medicaid members (approximately 78 percent in 2024) are enrolled in MCOs. Nearly all states (41 and D.C.) contract with MCOs to administer some or all Medicaid benefits. However, the populations and services covered through managed care vary by state. MCOs would play a key role in managing coverage and provider networks for PAT, if additional psychedelic drugs receive FDA approval and Medicaid coverage becomes available. At the service delivery level, many Medicaid members with serious behavioral health conditions receive care through safety-net behavioral health entities called community mental health centers (CMHCs), including some designated as Certified Community Behavioral Health Clinics (CCBHCs).

To date, Spravato (esketamine), a ketamine derivative, is the only FDA-approved drug with psychedelic properties for adults with treatment-resistant depression or adults with major depressive disorder and suicidal thoughts or actions. Esketamine is the first new type of drug approved by the FDA for the treatment of depression in more than 30 years. Because Medicaid programs generally[†] must cover all FDA-approved drugs from manufacturers participating in the Medicaid Drug Rebate Program (MDRP), all states cover Spravato for its approved indications. However, each state sets its own coverage and medical necessity requirements for the drug. As discussed later in this report, coverage does not necessarily result in access. Even when states cover Spravato, use of the drug among Medicaid members is low. For more information about Medicaid coverage of prescription drugs, see *Prescription Drugs* in the Appendix of this report.

For Medicaid members, there is even less access to IV ketamine. A limited number of Medicaid programs cover off-label use of IV ketamine for the treatment of select depressive disorders, including Massachusetts for treatment-resistant depression and Wisconsin for major depressive disorder with or without suicidality. Other states may allow for very limited access to IV ketamine for medical necessity, and individual MCOs may cover it on a case-by-case basis. There is interest in states to increase coverage to this treatment — including in states such as Arizona and Hawaii that have recently introduced legislation to cover IV ketamine. Because IV ketamine is used off label for select behavioral health conditions, it is difficult to determine how many Medicaid members have received this treatment. Limited state coverage, however, suggests that access is very low.

If the FDA approves additional psychedelic drugs, states will need to determine whether and how to cover PAT-related services (i.e., preparation, medication, and integration). Many of these services are already covered by Medicaid. However, states will need to decide how to package and pay for these services (e.g., number and duration of PAT sessions), whether they should be paid for through a bundled rate, and how payment should vary by provider type and setting.

Some of the infrastructure to support future provider coding and payment for these services has already been developed. Temporary Current Procedural Terminology codes for continuous in-person monitoring and intervention during psychedelic medication therapy were introduced in 2024. These codes are an important first step to standardize documentation, generate evidence, and develop the infrastructure to support future billing.

[†] Federal statute excludes certain drugs and classes of drugs from coverage in the MDRP. Examples include drugs used for anorexia, weight loss, or weight gain; fertility; cosmetic purposes or hair growth; symptom relief of cough and colds; and smoking cessation.

Overview of Medicaid's Process for Reviewing New Drugs After FDA Approval

Federal requirements mandate Medicaid programs to cover newly approved prescription drugs from the time a drug receives FDA approval and enters the market. States may vary in how they approach initial coverage of new drugs, especially when new drugs are standalone, unique therapies without similar comparators. Additionally, because most state Medicaid programs operate in a managed care delivery system with pharmacy carved in, managed care coverage is often dependent on state action. The following provides a high-level overview of the process a Medicaid agency may use to review and implement coverage of a newly FDA-approved drug. For more details on how Medicaid covers prescription drugs, see *Prescription Drugs*.

States monitor the drug development pipeline. Before FDA approval, Medicaid agencies monitor the status of drugs moving through the approval process.

FDA approval triggers Medicaid coverage of most drugs. Once a drug is approved — and in the case of psychedelics, rescheduled at the federal level by the DEA and by states — Medicaid agencies are required to cover them on day one. States must only cover a drug if the manufacturer participates in the MDRP, subject to exclusions.

States and/or MCOs determine coverage criteria and clinical guidelines for use. After approval, Medicaid agencies, and in some cases MCOs, determine a drug's coverage criteria, including preferred drug list (PDL) placement and specific clinical requirements for use.

For novel treatments, prior authorization and/or other utilization management criteria are developed using FDA guidelines, clinical trial data, peer-reviewed literature, and input from the drug utilization review board or pharmacy and therapeutics committee, as well as clinical staff at Medicaid or behavioral health agencies. States may also look to guidelines from medical and professional associations. *Note:* Because Medicaid drug utilization review and pharmacy and therapeutics committees meet on an intermittent basis, the development and publishing of drug-specific prior authorization criteria may be delayed by months after a new drug is approved. To satisfy federal requirements and support patient access, Medicaid programs may have a "new drug" prior authorization form available for providers to submit requests for newly approved products.

States and/or MCOs determine the coverage pathways. At the same time, Medicaid agencies and, in some instances, MCOs determine whether the drug will be covered under the Medicaid pharmacy benefit, medical benefit, or both. Most prescription drugs are covered through the pharmacy benefit and are dispensed at retail pharmacies. Some drugs, such as outpatient drugs, are administered in a physician's office or during a hospital stay and may be covered through Medicaid's medical benefit. States can apply utilization management controls related to accessing the drug, regardless of the coverage pathway.

States issue guidance to providers. When a Medicaid agency establishes new prescription drug coverage, it typically issues provider guidance. This often includes clinical criteria, allowable settings, provider types, billing codes, reimbursement rates, and any utilization management requirements. As an example, see Wisconsin's coverage policy for IV ketamine infusion therapy for major depressive disorder with or without suicidality.

Beyond state guidance, health care providers may also be responsible for following a Risk Evaluation and Mitigation Strategy (REMS) for drugs with safety concerns. REMS are issued by the FDA when a drug is approved. It is highly likely that psychedelic drugs approved by the FDA will include REMS. As an example, see the REMS for Spravato. Of note, REMS criteria may limit timely patient access, as strict distribution, prescribing, and dispensing requirements may create delays and limit provider and pharmacy participation.

States and/or MCOs monitor use, costs, outcomes, and the evidence base. Coverage criteria and utilization management requirements may evolve as states monitor use of the drug among providers and members, clinical outcomes, and the evolving evidence base for the drug and comparable therapies.

Additional State Activity on Psychedelics

Multiple states and localities have pursued and/or enacted policy changes to regulate and study psychedelic therapies. These policy approaches generally focus on psychedelic research initiatives, development of pilots for designated individuals, state regulation, and decriminalization. The University of California, Berkeley Center for the Science of Psychedelics' Psychedelic Law and Policy Map documents state- and local-level psychedelic policy activity. These approaches vary significantly and do not result in Medicaid coverage. Some examples of recent psychedelic activity include:

- In 2025, **New Mexico** passed the Medical Psilocybin Act, which establishes a program that uses psilocybin to treat medical conditions like treatment-resistant depression, PTSD, SUD, and to support end-of-life care. The same year, **Texas** passed legislation to facilitate higher education institutions, drug developers, and hospitals to conduct clinical trials on ibogaine.
- In 2026, **New Jersey** established a two-year psilocybin pilot to study the clinical use of psilocybin-assisted therapy in hospital settings. **Louisiana** similarly enacted a bill to fund clinical trials for PAT. **Massachusetts** lawmakers may soon approve a clinical pilot overseen by the state's Department of Public Health to study psychedelic treatments.

  Notably, some states have pursued legalization and regulation of certain psychedelics in a non-medical model that does not require a prescription for treatment.

- In 2020, **Oregon** voters approved a ballot measure that authorized the Oregon Health Authority to license and regulate the production of psilocybin and its administration to people without a prescription.
- In 2022, **Colorado** approved a proposition that decriminalized certain natural medicines (e.g., psilocybin, psilocyn, ibogaine, among others) and created a regulatory pathway to license healing centers that can administer certain psychedelics without a prescription.

Stakeholder Insights on Medicaid Coverage of and Access to PAT

To glean additional insights on the potential for Medicaid coverage of PAT, CHCS interviewed state Medicaid officials, state behavioral health officials, health care providers, and other relevant Medicaid and/or PAT subject matter experts. Interviewees described factors that may influence state coverage decisions, care delivery in safety-net settings, and provider participation. Their insights highlight that FDA approval may be a necessary step for broader Medicaid coverage, but it will not be sufficient to ensure access in Medicaid.

Coverage and Benefit Design

This section outlines insights into when and how state Medicaid agencies will review FDA-approved psychedelic drugs and set coverage guidelines.

- **State Medicaid agencies are likely to focus on PAT once a drug is approved by the FDA.** Interviewees widely acknowledged that the most straightforward pathway to Medicaid coverage of a new drug is following FDA approval and subsequently reclassification by the DEA. This is particularly relevant given that several psychedelic drugs under study, including psilocybin, MDMA, and LSD, are all Schedule I drugs. Schedule I substances are classified by the DEA as having a high potential for abuse and no currently acceptable medical use. Many of the state interviewees CHCS spoke to noted that they will begin to explore coverage and medical necessity requirements for psychedelics once they are approved by the FDA and then reclassified to a new schedule by the DEA. Until then, states are more likely to monitor the drug development pipeline at a high level.
- **States consider a variety of factors when making coverage decisions.** State interviewees highlighted several key factors when reviewing new drugs and therapies for Medicaid coverage:
  - **Effectiveness**: States want to understand how effective a new drug or therapy is compared to a placebo, how effective it is compared to existing treatments, and for how long it is effective. These data inform how a state will cover a drug, how it defines medical necessity, and what, if any, coverage limitations it will implement (e.g., step therapy, quantity limits). Medicaid officials will also want to understand for whom a drug is effective. This includes whether studies reflect the populations Medicaid serves (e.g., similar comorbidities and social needs, socioeconomic status, racial and gender diversity). This helps states identify members most likely to benefit from a treatment in real-world settings.
  - **Outcomes**: Interviewees expressed interest in short-, medium-, and long-term outcomes associated with a new drug or therapy. They also noted the importance of understanding how outcomes are measured and whether they differ by populations (e.g., race, gender, socioeconomic status, people with multiple comorbidities). Equity, regardless of how it is framed, is a consideration for states.

Medicaid officials will want to understand for whom a drug is effective, including whether studies reflect the populations Medicaid serves. This helps states identify members most likely to benefit from a treatment in real-world settings.

- **Setting and administration**: Interviewees shared that Medicaid agencies will want to understand where (e.g., at home, in a provider's office) and how (e.g., by the patient, by a licensed provider) a new treatment will be administered, as well as monitoring and specialty pharmacy requirements. States will also want to see standardized clinical practice guidelines that inform coverage criteria and help them understand how the therapy will roll out in real-world settings.
- **Safety**: States will need to understand the safety of new drugs and therapies, including any potential side effects, contraindications, and risks. In general, Medicaid agencies will want to understand if the benefits of the drug/therapy outweigh the risks.
- **Strength of evidence**: Medicaid agencies will consider the strength, quality, and rigor of available research. Medicaid agencies will review clinical trial data, as well as available peer-reviewed research. Some interviewees expressed skepticism about drugs/therapies with an Accelerated Approval from the FDA as they are approved based on a surrogate endpoint (biomarker or physical sign that may correlate with a clinical outcome.) Of note, psychedelic drugs are not being evaluated under Accelerated Approval and are being evaluated under Breakthrough Therapy designations, which do have clinically significant endpoints.
- **Costs and value assessment**: Many Medicaid programs will consider the cost and projected fiscal impacts of a new drug or therapy, including evidence on impacts on use of care. Costs will depend on the components of the recommended care model and coverage policies, such as the types of eligible providers and care settings, and eligible populations. States generally wait until after FDA approval to conduct cost analyses. These analyses, along with evidence on population-specific effectiveness and outcomes, can help states understand value to inform coverage policies.

States will generally wait until after FDA approval to conduct cost analyses. These analyses, along with evidence on effectiveness and outcomes, can help states determine the value of covering a new treatment.

- **Other coverage decisions**: Interviewees noted that Medicaid agencies will look to other coverage decisions and input from other states, Veterans Affairs, and commercial insurers when reviewing new drugs and therapies. One interviewee noted that a commercial insurer's coverage of ketamine-assisted therapy (i.e., off-label use of IV ketamine) for people in the state informed Medicaid's review — in part to ensure that Medicaid members have comparable access to emerging treatments. As mentioned, the FDA will set REMS for select drugs *(see sidebar, page 12)*. These drugs have already undergone a rigorous evaluation with detailed clinical monitoring, evaluation, and safety requirements. As such, REMS is another data source for state Medicaid programs to use to inform their coverage protocol.

- **Coverage and clinical criteria may evolve over time.** Once Medicaid opens coverage for a new drug or therapy, it will establish drug-specific coverage and clinical criteria *(see sidebar on page 12 for more detail)*. Criteria may evolve as the evidence base for the treatment evolves. For example, one interviewee described concerns that Spravato is being administered for longer periods and within more diverse treatment regimens than anticipated. As a result, the state is planning to reduce the length of time of approvals (e.g., six months to three months) to more closely monitor patient participation and outcomes. Given the rapidly evolving landscape for psychedelics, states anticipate closely tracking utilization and outcomes to inform coverage and clinical criteria refinements.

Once Medicaid elects to cover a drug or therapy, it will set coverage and clinical criteria. Criteria may evolve as the evidence base for the treatment evolves.

Care Delivery and Integration into Safety-Net Settings

This section offers insights into integrating PAT within safety-net settings that serve Medicaid members, encouraging provider participation in offering PAT, and potential reimbursement models.

- **Low provider participation with Spravato may offer lessons for future PAT access**. In the two years following FDA approval, Spravato prescribing rates for Medicaid members were low, driven by limited provider participation. Notably, state-level prescribing rates varied significantly, with no Spravato prescribed in 20 percent of states in 2020. One state interviewee reported that only a few providers deliver Spravato at a meaningful volume, and these providers are not mental health providers. Factors that may limit provider participation include the Medicaid payment rates, clinical guidelines and certifications, and limited familiarity with treatment.
- **Community-based behavioral health settings will be key access points**. Community-based behavioral health centers, such as CMHCs and CCBHCs, serve a significant proportion of Medicaid members with behavioral health needs. These clinics typically provide a continuum of services, including therapy, based on a person's needs, and are thus well-positioned to integrate PAT into their service offerings. Existing therapeutic relationships may also support Medicaid members to process their experiences with psychedelics during follow-up integration sessions and ongoing services.
- **Group delivery models may help address staffing and cost challenges**. One challenge for PAT coverage within Medicaid is the staffing needs during preparation and integration phases, as well as support and monitoring during dosing and

Spotlight on Compass Pathways and HealthPort's Partnership

Compass Pathways, a biotechnology company that is investigating the use of synthesized psilocybin (COMP360) for treatment-resistant depression, entered into a strategic collaboration with HealthPort, a multi-site CCBHC in Maryland that offers primary and behavioral health care services.

The proposed collaboration will allow the partners to learn how psilocybin treatment could be integrated into outpatient behavioral health care settings, like CCBHCs, and identify any operational, clinical, and reimbursement challenges. The collaboration is pending COMP360's approval by the FDA.

aftercare. Group delivery approaches can create efficiencies for medical providers required to be on site during dosing and aftercare, clinicians, and non-clinical staff such as peer support specialists or community health workers (CHWs). All states responding to a 2022 Kaiser Family Foundation survey on Medicaid behavioral health service coverage reported that group therapy is covered, though some states require copayment or have prior authorization and/or annual service caps.

- **PAT administration in settings with integrated medical and behavioral health care may create efficiencies**. As some PAT models may require a role for medical providers in treatment delivery, it will be especially important to ensure efficient use of these higher-paid providers and to acknowledge workforce limitations. Settings that integrate physical and behavioral health care are limited, in part due to licensing restrictions. Entities that employ both physical and mental health providers, such as some federally qualified health centers and CCBHCs, may be key sites for PAT delivery.
- **Drug safety requirements may affect provider participation and operational feasibility**. The FDA requires a REMS for some medications with serious concerns of severe adverse outcomes. The REMS for Spravato includes requirements for providers (including certification and training) that deliver Spravato, patients who are prescribed Spravato, and pharmacies that dispense Spravato. Patients must be monitored using pulse oximetry for at least two hours, or until sedation, dissociation, and respiratory depression have resolved. A health care provider must also be available on site. If the FDA approves additional psychedelic drugs, accompanying REMS are likely, and states, providers, and pharmacies will need to adhere to all requirements.
- **Health care provider attitudes and education will greatly impact access to PAT.** While Medicaid can define when and how a drug or treatment will be paid for, health care providers strongly influence access. Interviewees underscored that stigma and negative perceptions of psychedelics may impact health care provider adoption of PAT. These factors may also affect patient interest and uptake. Providers will need education and support integrating new clinical models into their practice. This education and support will likely come from provider associations or other organizations that offer training and technical assistance to providers in adopting new care models.
- **Bundled payment models may support PAT delivery**. PAT can require multiple service components, including screening, preparation, medication administration, monitoring, integration, and follow-up. Bundled payment approaches for PAT may offer one way to finance some or all of these components. Both federally qualified health centers and CCBHCs are paid a flat rate per encounter, regardless of what services are delivered. These payment models incentivize coordinated, team-based care and create cost efficiencies important in a resource-constrained Medicaid funding landscape. These payment structures may offer useful lessons for PAT payment design. MCOs, particularly plans with experience testing behavioral health care and payment models, may be valuable partners in developing these bundled payment approaches.
- **Intensive outpatient programs (IOP) may offer another potential reimbursement pathway**. PAT may also align with Medicaid reimbursement through IOP models. IOPs are structured, non-residential programs where patients can receive between nine and 19 hours per week of therapeutic treatment for mental health conditions and/or SUD. This level of care and reimbursement structure may align with the time-intensive nature of some PAT models.

Additional State Medicaid Perspectives on PAT and Covering New Therapies

Following are additional insights about how state Medicaid agencies are likely to approach PAT coverage at present, as well as outstanding questions about PAT implementation.

- **State Medicaid agencies are likely to approach PAT cautiously.** Given that Medicaid is a publicly funded program and administered under a unique federal-state partnership, its staff and leadership are inherently cautious and focused on balancing access, safety, program integrity, fiscal stewardship, and federal compliance. At the same time, they are also innovators and often at the vanguard of efforts to test new approaches to care delivery and reimbursement models. Because psychedelics are still emerging in mainstream medicine and carry longstanding stigma, states are likely to need strong evidence, clear clinical guidance, and operational safeguards before expanding coverage widely.
- **States are under increased federal scrutiny about program integrity.** Program integrity — the effort to prevent fraud, waste, and abuse — is a responsibility for any insurance program. It carries particular significance in Medicaid because the program is publicly financed. The Trump Administration has placed increased emphasis on program integrity, including encouraging states to use new tools and technologies to identify suspicious claims and inappropriate billing practices. To the extent that PAT is delivered in non-traditional settings, or by non-traditional providers, it may be subject to increased state scrutiny to ensure medical appropriateness, proper billing, and consistency with program requirements. Of note, there is less concern about diversion of psychedelics than for other drugs with recreational uses, given that psychedelics will likely be delivered in clinical settings and not dispensed at pharmacies.
- **States have varying levels of familiarity with PAT.** Some state interviewees have been engaged in state-based committees or academic centers on psychedelics, while others had limited knowledge. Across interviewees, states raised questions about implementing PAT, including how to:
  - Address negative provider and public perceptions about PAT;
  - Define staffing models and care settings for delivering PAT;
  - Promote access across diverse populations and geographic areas;
  - Staff and supervise time-intensive care models given workforce shortages;
  - Ensure quality across MCOs;
  - Develop sustainable reimbursement for both the drug and therapy components; and
  - Learn from the use of Spravato.

Opportunities to Advance Access to PAT

Philanthropies, investors, and other stakeholders interested in advancing access to PAT in Medicaid can consider the following actions. These activities can help build the evidence base, clinical guidance, payment models, and provider capacity to support states if additional psychedelics receive FDA approval.

The following actions are organized by timing:

- ✓ **Start before FDA approval:** Activities that may be useful to start before FDA approval and can continue after. Some actions will be most useful and relevant to Medicaid agencies if approval occurs, and at that time. Other actions will require sustained investment and may benefit from early action.
- 🕓 **Begin after FDA approval:** Activities that may be most useful to begin after FDA approval, when states are making specific coverage, payment, and implementation decisions.

Build the Evidence Base for Medicaid Decision-Making

- ✓ **Invest in research that aligns with state Medicaid coverage considerations and the realities of safety-net care delivery.** Future PAT research should reflect populations similar to that of Medicaid (e.g., low socioeconomic status, multiple chronic conditions, people with complex health and social needs). In addition, researchers should explore and evaluate lower-cost care delivery models that can be scaled in safety-net settings. This includes exploring group-based care models and the integration of peers into PAT delivery. Where possible, studies should also collect data and measure outcomes that align with the interests of Medicaid stakeholders (e.g., emergency department use, hospitalization, treatment adherence, member experience). As always, research must also be conducted ethically, with appropriate participant protections.

- ✓ **Compile existing research on psychedelic drugs that have received FDA vouchers.** The FDA recently awarded Commissioner's National Priority Vouchers to three drug manufacturers developing psychedelic therapies: Compass Pathways for synthetic psilocybin (COMP360) for treatment-resistant depression, Usona Institute for psilocybin for major depressive disorder, and Otsuka for methylone (TSND-201) for post-traumatic stress disorder. If these drugs are approved, state Medicaid agencies will need to review FDA guidance, clinical trial data, and relevant peer-reviewed literature for each drug. To support states, a synthesis of existing public research and studies could help streamline their efforts. Whether the drug manufacturer participates in the MDRP at the time of approval, or intends to enter into an agreement with the Centers for Medicare & Medicaid Services (CMS), will determine if Medicaid is likely to cover the drug. As of May 2026, Otsuka America was the only manufacturer among the three voucher recipients that participates in the MDRP.

Develop Clinical and Care Delivery Frameworks

✓ **Engage with professional bodies to establish clinical guidelines.** When available, state Medicaid agencies consult clinical guidelines from professional organizations (e.g., American Psychiatric Association, American Medical Association, American Society of Addiction Medicine) to inform their coverage policies. Engaging professional medical organizations to establish clinical guidelines could help states, MCOs, and providers understand how to prescribe and administer different types of PAT, and how it fits into treatment for approved indications. Guidelines could also be useful for health care providers looking for information and guidance on providing PAT for select behavioral health conditions. In 2023, BrainFutures and the American Psychedelic Practitioners Association released general professional guidelines for practitioners of PAT.

Piloting Community-Informed PAT Models in Safety-Net Settings

The PMHA Alliance has been investing in PAT research pilots to evaluate group care models with low-income populations. The pilots, under development in **New Jersey** and **New Mexico**, are being co-designed by community members to ensure that the programs align with their needs and are delivered in culturally responsive ways.

In New Mexico, the PMHA Alliance and the University of New Mexico recently launched a psilocybin group therapy program for people with PTSD. The study prioritizes Indigenous community members, women who are survivors of sexual trauma, veterans, and first responders. The program includes wraparound supports to help address participants' health-related social needs.

In New Jersey, similar research opportunities are being explored through a partnership between the PMHA Alliance and the Camden Coalition.

✓ **Further define PAT care models to inform coverage and integration into safety-net settings.** State Medicaid agencies and MCOs will want to understand the care models for PAT to determine both coverage guidelines and reimbursement. Health care providers will need to understand the care model to inform integration into safety-net settings. To support adoption in the safety net, this effort should focus on established delivery settings (e.g., CCBHCs, CMHCs, IOPs). Care model development should clarify staffing for PAT models, particularly given the time and number of staff needed to administer care. Models should also define the staff needed for each phase of care, deploy staff to the top of their license, and explore group treatment options to help lower the cost of care. States, health plans, and providers will also need to consider REMS for approved drugs. Care model development can be informed by implementation science approaches to accelerate adoption while rigorously documenting implementation strategies that impact safety, efficacy, and effectiveness, and should be done in collaboration with community partners who understand the needs of the population served.

🕓 **Build provider capacity to offer PAT.** Medicaid coverage of a new drug or therapy does not ensure that providers will prescribe it. For example, uptake of medications for addiction treatment (e.g., buprenorphine) has required — and continues to require — substantial outreach and capacity building among providers, in addition to coverage among insurers. As PAT would be new to many health care providers, they will need training, education, and ongoing support to effectively deliver PAT and address stigma related to psychedelics.

Learn from Existing Coverage and Delivery Models

- **Explore coverage and delivery of Spravato and off-label IV ketamine.** Psychedelics are largely new territory for state Medicaid agencies and safety-net providers. States may look to their experience covering comparable drugs, like Spravato, when making coverage decisions for other drugs with psychedelic properties. Safety-net providers may also look to their experience adopting new therapies for patients. State interviewees that cover IV ketamine for off-label use noted low uptake, and some interviewees noted similar uptake concerns with Spravato. Further investigation into why utilization remains low could inform broader and future efforts to increase access to PAT. This research could also explore how Medicaid providers have addressed unmet social needs and wraparound supports for those receiving IV ketamine and Spravato. This could inform future PAT care models, including whether unmet health-related social needs impact members' ability to complete treatment.

- **Explore how other health insurance systems provide and reimburse for PAT.** This report focuses on Medicaid; however, other systems (e.g., Veterans Affairs) could offer useful lessons to help inform research, care and payment model development, clinical guidelines, and approaches to integrating PAT into Medicaid and safety-net settings.

Engage Communities and Build Stakeholder Alignment and Implementation Readiness

- **Engage the community to inform psychedelic research and implementation.** Engaging Medicaid members and community-based organizations (CBOs) that serve people with behavioral health conditions who might benefit from PAT — as well as healers from Indigenous communities that use psychedelic medicines — to co-design research and care models can help tailor models to the unique needs of communities. For example, the Camden Coalition and Bernalillo County Health Equity Council are piloting robust community engagement processes designed to ensure that PAT therapy is informed, shaped, and sustained by the communities it aims to serve *(see sidebar, next page)*. Authentic engagement with patients and CBOs can also help address stigma associated with psychedelics and concerns related to cultural appropriation.

- **Create a multi-state, multi-stakeholder workgroup to inform PAT implementation, and care model and coverage design.** A cross-state workgroup of Medicaid professionals, MCO staff, researchers, health care providers, pharmacists, and other subject matter experts could provide feedback on PAT research protocols, care models, and coverage design. This type of workgroup could also help identify champions for PAT and build a greater understanding of PAT among Medicaid stakeholders, which may facilitate implementation. It might also be useful to focus on select states with the capacity and interest to explore PAT. However, participation among Medicaid stakeholders may be linked to likelihood and timing of FDA approval.

Establish a cross-state learning forum on psychedelics for Medicaid agencies. Medicaid agencies often look to other states to inform their coverage policies. States often rely on peer states — those with similar political environments, geographic characteristics, and Medicaid philosophies — to inform their coverage decisions. They may also look to non-peer states to understand how different states are approaching coverage of new treatments. A multi-state learning forum could facilitate early and ongoing information sharing among Medicaid agencies. It could help states learn from experiences with Spravato and off-label IV ketamine and, over time, from one another as they evaluate coverage approaches, establish medical necessity, and develop implementation strategies. This forum could be specific to Medicaid agencies as they navigate coverage and oversight of psychedelic therapies.

Invest in state-specific forums to inform coverage guidelines and implementation. State-specific, multi-stakeholder workgroups that include both Medicaid policymakers and health care providers can be an effective mechanism to inform PAT coverage and its implementation. These forums create opportunities for health care providers to share real-time insights on implementation challenges and patient needs, while enabling Medicaid officials to communicate operational considerations and policy constraints. State selection should be strategic. H.R. 1's impact will vary across states *(see Appendix for more detail)*. States that have not expanded Medicaid may have fewer operational and fiscal pressures. As such, these states may be better positioned to engage around PAT. States with active legislation or that have historically engaged in policy conversations on psychedelics may also be strong candidates.

Research Rooted in Community Engagement

People with low incomes, multiple co-occurring health conditions, and significant health-related social needs are often underrepresented or excluded from clinical trials. CBOs — trusted partners and service providers in many communities — are facilitating listening sessions, designing workshops, and engaging individuals with lived experience, local leaders, and care providers to inform the design and delivery of PAT within a real-world public health context.

The **Camden Coalition** is implementing a community engagement framework over 12 months to develop culturally grounded insights that directly inform pilot study protocols, increasing the feasibility and ethical integrity of PAT. The effort is informed by a model designed in partnership with the PMHA Alliance, the *Equity & Access Support Ecosystem Tool*, based on the Coalition's *Community Ecosystem Alignment Tool*. The model outlines key community factors that support equitable PAT delivery.

The **University of New Mexico**, in partnership with the **Bernalillo County Health Equity Council**, led community engagement and education activities with local stakeholders outside the health system, including people with lived experience who could potentially benefit from PAT and their family members.

Engaging communities in the design of research and care is vital to help ensure that the people most affected can access and trust the treatments being developed.

Looking Ahead

Expanding access to PAT through Medicaid is a long-term endeavor that will require careful groundwork. While FDA approval is the key first step toward Medicaid coverage, states will look to strong and relevant evidence, scalable care models, and vetted clinical guidelines when determining who may be eligible to receive these treatments and under what circumstances. Continued research on the effectiveness of psychedelics and PAT — including studies that reflect the demographics, health needs, and care experiences of Medicaid members — will be especially important.

Further efforts can also support the development of care models that integrate into safety-net settings where many Medicaid members currently receive behavioral health care services. This includes educating behavioral health care providers about PAT and engaging Medicaid policymakers, MCOs, CBOs, and other health care providers to build a shared understanding of psychedelic therapies. These investments can help Medicaid stakeholders assess whether and how PAT could be delivered safely, effectively, and sustainably for people with behavioral health conditions who may benefit from these treatments.

Appendix: Behavioral Health Care in Medicaid

Medicaid Eligibility

Medicaid covers many people with serious mental illness, including individuals with treatment-resistant depression and post-traumatic stress disorder who may be candidates for PAT. Medicaid is a means-tested entitlement program for people who meet federal eligibility requirements. Mandatory covered populations, subject to federally established income thresholds, include: (1) parents; (2) children; (3) pregnant people; and (4) older adults and people with disabilities receiving Supplemental Security Income (SSI). States may cover these groups at higher income levels, additional older adults and people with disabilities who do not receive SSI, and "medically needy" individuals. Among nonelderly adults who qualify for Medicaid through SSI, about one-third qualify based on a mental health disability, such as psychotic or mood disorders.

States may also choose to cover the Medicaid expansion population, including non-disabled, childless adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level. As of 2026, 40 states and D.C. have expanded Medicaid. Nearly 30 percent of this population have a behavioral health condition.

Public Law 119-21, commonly known as the 2025 Budget Reconciliation Bill (H.R. 1), requires states to implement "community engagement" requirements (commonly known as work requirements) for Medicaid expansion populations. Beginning January 1, 2027, eligible members must document 80 hours per month of work or an equivalent qualifying activity, such as community service or education, to maintain eligibility. The law includes exemptions for several groups, including caretakers of children or disabled individuals, American Indians, and people designated to be "medically frail."

The medical frailty exemption is especially relevant for people with serious behavioral health conditions. CMS' June 2026 interim final rule defines a medically frail individual as having a condition that impairs their ability to work. States will need to determine how to identify and verify the conditions and level of impairment. These choices may affect whether people with serious behavioral health needs can maintain Medicaid-covered behavioral health treatment.

Information and Resources on H.R. 1

H.R. 1/Public Law 119-21 significantly impacts Medicaid. It includes restrictions on eligibility and financing that are estimated to reduce enrollment by 10 million and cut nearly $1 trillion in resources from the program over 10 years. States are focused on implementing these changes while managing budget pressures.

The following resources provide detail on the law's changes and impacts to Medicaid:

- **OBBBA Medicaid Policy Timeline -** Details key policy changes and their deadlines. *(National Association of Medicaid Directors)*
- **Health Provisions in the 2025 Federal Budget Reconciliation Law** - Outlines key changes to Medicaid and includes a timeline. *(Kaiser Family Foundation)*
- **A Summary of Federal Medicaid Work Requirements** – Outlines key points about Medicaid work requirements. *(CHCS)*

In addition to work requirements, H.R. 1 includes several other eligibility provisions for the expansion population, including more frequent eligibility checks and new co-pays, as well as new limitations on

coverage for legal immigrants. See the sidebar on the previous page for more details on the implications of the new federal law on Medicaid programs.

Medicaid Mandatory and Optional Benefits

States can design their Medicaid benefit packages within federal requirements. Examples of mandatory benefits include inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, home health, and nursing facility services. Examples of optional benefits include many diagnostic, screening, preventive, and rehabilitative behavioral health services, and prescription drugs.

Beyond benefits, Medicaid coverage is further tied to eligible providers and covered settings. In practice, this means that access depends not only on whether a service or drug is covered, but also on who can provide it and where it can be delivered.

Behavioral Health Services

All state Medicaid programs cover mental health screening and assessment services, some forms of outpatient mental health treatment, and inpatient psychiatric care. Many states also cover residential services, partial hospitalization or day treatment, crisis services, and supportive services.

Because many behavioral health services are optional, state coverage varies. All states cover mental health therapy and inpatient psychiatric hospitalization for adults, while many states cover crisis services and day treatment. States typically cover individual, family, and group therapy.

States may cover behavioral health care services through several Medicaid authorities *(see the Medicaid Policy Change section of this appendix)*, which can result in coverage varying within a state based on factors such as behavioral health diagnosis and member age.

Notably, federal law — specifically, the Mental Health Parity and Addiction Equity Act — requires that health plans and insurers, including Medicaid MCOs, refrain from placing harsher limits or higher costs on mental health and substance use care than on medical or surgical care.

Prescription Drugs

Prescription drugs are an optional benefit, though all states and D.C. cover them. States that elect to cover prescription drugs must generally cover all drugs (excluding those in exempt classes such as drugs for weight loss and fertility treatments, among others) approved by the FDA when the manufacturer participates in the MDRP.

Under the MDRP, drug manufacturers enter into a discount agreement with HHS in exchange for Medicaid coverage of most of a manufacturer's drugs. This agreement requires drug manufacturers to notify CMS, and by extension Medicaid agencies, of newly approved outpatient drugs. Manufacturers pay quarterly rebates to states, and those rebates are shared between states and the federal government. Nearly all drug manufacturers participate in the MDRP. Beyond the MDRP, participating manufacturers must also enter agreements with the federal government for other programs, including the 340B Drug Pricing Program, which provides more favorable pricing to certain safety-net settings, as well as the U.S. Department of Veterans Affairs Federal Supply Schedule Service.

States develop preferred drug lists (PDL), which identify preferred and non-preferred drugs. Non-preferred drugs can still be prescribed, but states may employ utilization management strategies, like prior authorization, to control access. States with managed care are increasingly adopting a uniform PDL that requires all Medicaid MCOs to cover the same drugs using the same prior authorization criteria.

States are also required to develop drug utilization review programs to help reduce misuse and abuse of outpatient prescription drugs. Drug utilization review programs cover both prospective and retrospective drug review and provider education. States also maintain drug utilization review boards that create standards for appropriate drug use and retrospectively review drug utilization patterns. Pharmacy and therapeutics committees help to inform the PDL, drug reviews, and coverage decisions.[‡]

As with all Medicaid benefits, prescription drug coverage is tied to medical necessity. Each state can define medical necessity for a particular benefit. State Medicaid agencies and MCOs use a range of strategies to ensure medical necessity, control costs, and prevent diversion and misuse — subject to compliance with federal parity law under the Mental Health Parity and Addiction Equity Act. Examples include:

- **Prior authorization**, which requires prescribers to seek approval from a Medicaid agency or MCO before a drug is dispensed;
- **Step therapy**, which requires a person to try a preferred therapy before accessing a non-preferred option; and
- **Quantity limits**, which restrict the amount of a drug that Medicaid will cover.

Some states limit utilization management to ensure access to care. For example, as of 2023, 10 states reported prohibiting utilization controls for mental health drugs.

States may use external reviews to inform prescription drug coverage. Most states report using comparative effectiveness studies from the Institute for Clinical and Economic Review or the Drug Effectiveness Review Project (DERP), which is run by the Center for Evidence-Based Policy at Oregon Health & Science University. DERP reports synthesize published evidence, along with policy and data analysis, and can help inform coverage decisions, utilization management, practice guidelines, and provider education for off-label use. These reports are proprietary for the states that participate in DERP.

Health-Related Social Needs Services

Medicaid programs may cover services that address health-related social needs, including needs related to housing, food, transportation, and other factors that may affect health. These services could be important for PAT care models. Many Medicaid members face significant social and economic barriers to care, including unstable housing and food insecurity. People with unmet social needs are also more likely to have behavioral health conditions, including depression and SUD — conditions that PAT seeks to address.

Medicaid programs have several ways to cover health-related social needs services that help members stay connected to coverage and access care. Examples include housing supports (e.g., housing deposits, tenancy sustaining supports), nutrition assistance (e.g., medically tailored meals), and non-medical

[‡] This report details how each state has handled drug review responsibilities as of 2023, including the entity responsible for the drug PDL in each state.

transportation. Federal flexibilities for these services expanded in recent years, but flexibilities have narrowed under recent federal policy changes. That said, managed care has long covered expanded services and is likely to continue.

Non-Emergency Medical Transportation

Patients may be unable to drive after receiving PAT, and may need supervised transportation home after treatment. Non-emergency medical transportation (NEMT) could help address this need.

NEMT is a required Medicaid benefit that supports access to medically necessary care, including behavioral health care. It covers travel to and from medical appointments, and states vary in how they manage the benefit. Most states contract with a transportation broker or require MCOs to manage and deliver NEMT. Some states administer the benefit directly by covering costs on a per-ride basis.

States generally determine NEMT coverage based on whether the person has no other means to get to a medically necessary health care service. State policies may consider whether a member has a car or license, has a disability that limits their ability to provide or arrange travel, or is unable to travel or wait for services alone. States can also limit services based on medical necessity or utilization management approaches.

Behavioral Health Service Delivery

Many Medicaid members with serious behavioral health conditions receive care in safety-net settings that use team-based care models and offer a continuum of services based on need. These settings may play a key role in supporting access to PAT if additional psychedelic drugs receive FDA approval for medical use and Medicaid coverage pathways become available.

Medicaid enrollees are much more likely than privately insured individuals to receive care in inpatient treatment settings, outpatient mental health centers, and day treatment programs. They are also less likely to receive treatment in a private therapist's office. CMHCs are a primary access point for Medicaid members seeking outpatient services, including therapy. CMHCs were developed after the 1963 Community Mental Health Act, which aimed to shift care away from institutions and into community-based settings. Some CMHCs operate as standalone facilities, while others may also be designated as federally qualified health centers or rural health centers. MCOs often prefer to contract with these large anchor entities that primarily serve Medicaid patients and that offer a more robust continuum of care and stronger infrastructure than small-group or independent providers can deliver.

Some CMHCs are designated as CCBHCs, established in 2021 under the Excellence in Mental Health Act. More than 500 CCBHCs operate across nearly every state and provide a comprehensive array of mental health and SUD services, including medications for addiction treatment. CCBHCs must meet strict requirements related to timely access, quality reporting, staffing, and coordination with social services, criminal justice, and education systems. Many CCBHCs receive an enhanced, cost-based reimbursement rate in the form of a site-specific daily or monthly prospective payment per encounter, regardless of the nature of the visit. Given their unique role in meeting the needs of vulnerable populations and payment structure that incentivizes comprehensive, team-based care, CCBHCs may be well-positioned as PAT providers.

Behavioral Health Care Workforce

PAT requires a trained behavioral health care workforce to deliver and support multiple treatment components, which may occur in individual or group settings. Behavioral health care workforce shortages have been well-documented nationwide and are particularly challenging in Medicaid. Many behavioral health care providers — including but not limited to psychiatrists — are less likely to accept Medicaid than private insurance. Common reasons include Medicaid's lower reimbursement rates relative to other payers, reimbursement delays, and administrative burden.

The community-based workforce, such as CHWs and peer support specialists, may play a supportive role in PAT care teams. CHWs and peers often share lived experience with the people they serve and can help build trust, support care navigation, and connect people to services that address health-related social needs.

More than half of all states reimburse for CHW services under Medicaid, including for health education, care navigation, and socioemotional support. Nearly all states provide Medicaid coverage for peer support services, which support recovery for people with mental health and SUD conditions. Evidence on the impacts of CHWs and peer support specialists on improving patient outcomes has led to growing interest in these roles. However, many provider organizations face challenges sustainably financing these positions and integrating them into care teams.

Medicaid Financing

States administer Medicaid under federal oversight, and the program is financed through a federal-state partnership. The federal government provides open-ended matching funds to states for allowable spending. The federal share varies by state, eligibility group, and type of expenditure.

The amount of federal matching to each state is determined by the federal medical assistance percentage (FMAP). States with lower per capita incomes receive a larger FMAP, which means the federal government pays a larger share of their Medicaid costs. Costs for certain populations and activities are reimbursed at a flat federal rate across all states.

States must use state and local public funds to cover the non-federal share of Medicaid costs. At least 40 percent of this non-federal share must come from state revenue. The remainder can be from other public sources, such as county funding and health care-related taxes.

Of note, Medicaid is the second-largest category of state general fund spending. Because most states are required to balance their budgets, fiscal pressures can affect whether and how states adopt new Medicaid benefits, payment models, or delivery system innovations. Recent federal policy changes under H.R. 1 are expected to increase budget pressures for many states. These pressures may shape state decisions about whether and how to cover emerging treatments, including psychedelics.

Medicaid Managed Care

In managed care arrangements, states contract with MCOs to administer Medicaid benefits to eligible members. In exchange for a fixed per member per month payment, MCOs maintain a provider network, review and pay claims, and provide care management services. Notably, when determining whether a service is covered for a member, MCOs cannot use more restrictive criteria than authorized by the state.

Because MCOs operate under financial risk, they have an incentive to promote cost-effective services and have the flexibility to cover additional services. States that do not use managed care administer Medicaid benefits through fee-for-service (FFS), a payment model in which providers are reimbursed for each covered service they deliver to members.

The benefits of operating Medicaid through managed care include greater cost predictability, flexibility in service offerings, reduced administrative responsibilities for states, and improved coordination of health care and social supports. While there are nearly 300 Medicaid MCOs in operation, five large, publicly traded firms account for approximately half of national enrollment. Other key players include local, nonprofit MCOs that, while smaller, may have closer relationships with safety-net providers and more flexibility to innovate.

States operating managed care programs can also "carve out" some benefits. In carve out arrangements, states either administered those services directly through FFS or contact with separate entities to manage the services. Carve out policies for behavioral health care and pharmacy benefits will shape how PAT components are covered, authorized, and coordinated.

Historically, behavioral health services were managed in many states by public entities at the regional or state level through carve out arrangements. In recent years many states have moved to "carve in" behavioral health services into comprehensive managed care arrangements that include both physical and behavioral health care coverage, with 32 states and D.C. pursuing this arrangement. Nine states carve out behavioral health care to separate behavioral health organizations or FFS. Some states use tailored models for managing behavioral health care for select populations based on need, such as specialty plans that oversee comprehensive services for people with serious mental illness.

States administer the pharmacy benefit through FFS, managed care carve ins or carve outs, or through a single state pharmacy benefit manager. Most states carve in the pharmacy benefit to their MCO contracts. This means that states are likely to include in MCO contracts the administrative and clinical requirements for managing the pharmacy benefit. How a state administers its pharmacy benefit may affect how states review and cover psychedelic drugs, apply utilization management, and coordinate coverage with therapy or monitoring.

Medicaid Policy Change

Changes to Medicaid policy occur at both the federal and state levels. At the federal level, Congress can pass legislation that expands or limits Medicaid coverage, financing, or program requirements. CMS issues rules and regulations that further define the conditions under which states can operate their Medicaid programs and draw down federal resources.

At the state level, governors can direct Medicaid agency priorities, and state legislatures approve Medicaid budgets and may pass legislation directing specific Medicaid activities (e.g., pilots, requirements to seek federal authority for new benefits). Other Medicaid stakeholders, such as providers, MCOs, and advocacy organizations, may also seek policy changes. Other influences can also prompt Medicaid policy changes, such as new drug or therapy approvals from the FDA, legislation, advocacy, and requests from a governor or an MCO.

States need federal authority or approval to make changes to their Medicaid programs. Under federal statute, state Medicaid programs must meet several core requirements:

- **Comparability**: Members must have access to the same amount, duration, and scope of benefits;
- **Statewideness**: Benefits must be available throughout the state and cannot exclude members or providers because of where they live or work; and
- **Freedom of choice**: Members must be permitted to choose a health care provider from among those participating in Medicaid.

Within these parameters, states can use several pathways to change Medicaid coverage or delivery:

- **State plan amendments**: States can use these plans to add optional services and describe state-specific standards for their Medicaid program;
- **Waivers**: States can seek federal approval to forgo certain requirements — commonly to support managed care implementation or to pilot new services; and
- **Managed care policy requirements**: States can use managed care contracts to allow or encourage MCOs to cover additional services. For example, states can authorize in lieu of services that allow MCOs to cover medically appropriate and cost-effective substitutes for services comparable to Medicaid services.

Several factors can affect the feasibility of Medicaid policy change, as summarized by the National Association of Medicaid Directors, including state budget limitations, Medicaid agency administrative capacity, statutory and regulatory restrictions, provider availability, and political feasibility.

Recent federal Medicaid changes under H.R. 1 impose new and significant budget constraints on states. To address federal funding reductions, Medicaid agencies may need to reduce optional eligibility categories, cut certain optional benefits, and/or reduce provider payment rates. In addition, because Medicaid agencies will be focused on implementing H.R. 1 requirements, their capacity to invest in expanded benefits may be limited. Medicaid expansion states may face more significant implementation demands, because several new requirements apply to the Medicaid expansion population.