Alaska Task Force for the Regulation of Psychedelic Medicines

Task Force Report | **PUBLIC COMMENT DRAFT**

April 21, 2025

Instructions for Public Comment

- Public comment will be accepted by the Task Force from **Monday, April 21, 2025** through **Monday, May 5, 2025**.
- E-mail written comments to: Rep.Justin.Ruffridge@akleg.gov. Comments received by 5pm on Monday, April 28 will be included in the Task Force's meeting packet. Comments received later will be shared with the Task Force by e-mail.
- Public testimony will be taken in the next Task Force meeting on Tuesday, April 29, 2025, 5:30-7:00 p.m. at the Alaska Capitol, Butrovich Committee Room 205, Juneau, Alaska, and via the Legislative teleconference system. Testifiers have 3 minutes, and are encouraged to send written comments. See www.akleg.gov for meeting information.
- The Task Force will review and consider all comments received in writing or through verbal testimony, to inform revisions to the recommendations and to prepare the final report to the Legislature in May 2025.

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About the Alaska Psychedelic Medicine Task Force

The Psychedelic Medicine Task Force was created through HB 228 (passed 2024) to deliberate and make recommendations regarding potential implementation of therapeutic use of FDA-approved psychedelic medicine to treat certain mental health conditions. The Task Force is time-limited, and charged with producing a recommendations report to the Legislature in 2025.

Origin of the Task Force: Alaska House Bill 228 (2024)

In 2024, the Alaska Legislature passed House Bill 228, sponsored by Rep. Jennie Armstrong, with companion bill SB 166, sponsored by Sen. Dunbar, to establish a task force to identify implementation needs and potential barriers for future authorization by the FDA of prescription drugs containing psychedelic substances. Use of these medications to treat conditions including anxiety, depression, and PTSD has grown in recent years, with initial promise as a treatment modality, and an emerging evidence base with best practices for psychedelic-assisted therapy.

The FDA is currently reviewing data from multiple clinical trials including use of psilocybin and MDMA, and likely to take action in coming years approving one or more of the therapies under consideration. A few states, including Oregon, Colorado, and New Mexico, have already taken steps to create a regulatory framework for medicinal use, and others (such as Minnesota) have created similar task forces to consider what steps would be needed at the state level, following FDA approval of one or more therapies being evaluated, and prepare recommendations for policymakers and regulators.

Scope and Purpose

HB 228 directs that the Psychedelic Medicine Task Force, with defined membership of designated seats from a variety of perspectives and fields, meet at least four times to consider four topic areas identified in the bill. HB 228 directs that by the end of regular Legislative session (May 2025), the Task Force must produce a report of recommendations to deliver to the Legislature and Governor, to inform future policy decisions. Below is an excerpt of the bill, describing the purpose and scope of the Task Force:

> Purpose: To prepare for potential medicalization of psychedelic medicines by U.S. FDA; to make policy recommendations to the Alaska Legislature concerning insurance and licensure, given the unique nature of the administration of psychedelic medicines; and to ensure the state is prepared if psychedelic medicines become available for prescription.
>
> (1) assess potential use of psychedelic medicine in addressing Alaska's mental health crisis;
>
> (2) consider barriers to implementation and equitable access;
>
> (3) consider and recommend licensing and insurance requirements for practitioners in the state if psychedelic medicines are federally reclassified and approved by the FDA; and
>
> (4) consider legal and regulatory changes that could be necessary in the state after federal medical approval of psychedelic medicines.

Task Force Membership

The following people serve on the Task Force. HB 228 directed appointment of two co-chairs, each from the Senate and House; designated seats for state agencies and other organizations named in the bill; and an option for the Task Force to select an at-large member.

Name	Role	Affiliation
Sen. Forrest Dunbar	Co-chair	Alaska Senate, HB 228 co-sponsor, Attorney
Rep. Justin Ruffridge	Co-chair	Alaska House, Pharmacist
Dr. Robert Lawrence	Designated Seat	Designee, Chief Medical Officer, Dept. Health
Angela Laflamme	Designated Seat	Designee, Dept. Military & Veterans Affairs
Glenn Saviers	Designated Seat	Designee, Dept. Commerce, Community & Economic Development
Justin Heminger	Designated Seat	NAMI Alaska, Board Member
Ann Ringstad	*Alternate*	NAMI Alaska, Executive Director
Dr. Kristen Maves	Designated Seat	Alaska Native Health Board Designee #1, Southcentral Foundation, Pharmacist
Dustin Allen	Designated Seat	Designee, Knik Tribe, Clinical Supervisor
Lauree Morton	Designated Seat	Alaska Network on Domestic Violence and Sexual Assault, Deputy Director
Dr. Paula Colescott	Designated Seat	Alaska State Medical Association
Dr. Lisa Lindquist	Designated Seat	Southcentral Fdn.; AK Psychiatric Assn.
Dr. Michael DeMolina	Designated Seat	Wisdom Traditions Counseling
Dr. Sara Kozup-Evon	Designated Seat	Advanced Practice Registered Nurse Alliance
Dr. Brittany Karns	Designated Seat	Alaska Pharmacy Association
Jennie Armstrong	At-Large Seat	Former Alaska Representative, HB 228 sponsor

The Task Force is supported by legislative staff of the co-chairs, and a contracted facilitator to support the process:

- Arielle Wiggin and Sethan Tigarian, Office of Sen. Dunbar
- James (Bud) Sexton, Office of Rep. Ruffridge
- Tristan Walsh, Office of Rep. Armstrong (through December 2024)
- Anna Brawley, Tiny Birch Consulting (contractor)

Task Force Process

The Task Force was fully constituted in December 2024, with preparatory and logistics work to prepare for official meetings in 2025. The Task Force has scheduled a total of six meetings, with five held as of this draft report's publication, and the last scheduled to hear public comment:

- Meeting 1: Tuesday, February 4, 2025
- Meeting 2: Tuesday, February 26, 2025
- Meeting 3: Wednesday, March 19, 2025

- Meeting 4: Wednesday, April 2, 2025
- Meeting 5: Wednesday, April 16, 2025
- Meeting 6: Tuesday, April 29, 2025 (scheduled, to hear public comment)

Meetings are held in person in Juneau at the Alaska Capitol, Butrovich Committee Room, as well as online, with most members participating by Microsoft Teams; meeting proceedings were livestreamed and are available as recordings at http://www.akleg.gov.

The Task Force adopted Guidelines and Meeting Procedures (*will be attached as appendix in final report*) for conducting meetings, and the process for adoption of recommendations and final approval of the report.

Public Comment Process

Given the time-limited nature and defined scope of the Task Force, the group was required to move swiftly and stay focused on achieving the intent of HB 228. The group also determined that having opportunity for public comment and gathering feedback on a draft product is important. To meet this objective within the timeframe, the group prepared a working draft of the recommendations, and portions of the report still in progress, to publish for public comment over a 14-day period, including an opportunity for testimony at a Task Force meeting. The timeline is as follows:

- Monday, April 21: Draft recommendations and report published, with a notice flyer to share with the general public and interested stakeholders. Written comments to be collected by legislative staff and distributed to the Task Force.
- Monday, April 28: All written comments received by end of day will be packaged and shared with the Task Force with its April 29 agenda packet. (Comments received after this date will also be provided to the Task Force by e-mail, but will be received too late to be included in the packet).
- Tuesday, April 29: Task Force Meeting #6, with public comment period. Public comment will be taken in person in Juneau, via the telephonic legislative testimony system, as well as in writing by e-mail.
- Monday, May 5: Closing date for written public comment.
- May 2025 (date TBD): Task Force considers all public comments, revises recommendations, and takes final vote to approve the report.

About Psychedelic Medicine Therapies

Overview of Psychedelic Medicines

Psychedelics (meaning “mind-manifesting,a term coined by Humphrey Osmond), are a varied group of plant-derived synthetic compounds that have in common the ability to produce sensory, perceptual, and cognitive changes without impairing attention or level of consciousness.

They do so by influencing communication networks in the brain that depend on a host of chemicals released by the billions of neurons in the brain. These chemicals are called neurotransmitters; these neurotransmitters affect the neighboring neuron by attaching to a particular receptor on that neuron eliciting its response. This communication between neurons is called neurotransmission.

Mescaline, psilocybin, and LSD belong to a class called *phenyethylamines* which are considered the classic hallucinogens. These compounds influence Serotonergic neurotransmission by binding to the neurons which have the 5HT2 receptor on their surface membrane.

The most prominent subjective effects of the classic Hallucinogens are influenced by set and setting, that is, the expectations and personality of the person who uses hallucinogens, coupled with the environmental and social conditions of use. Mood can vary from euphoria and feelings of spiritual insight to depression, anxiety, and terror. Perception usually is intensified and distorted, and alterations in the sense of time, space and body boundaries. While illusions (visual and auditory distortions of perception) are common, true hallucinations (perceptions that do not have any basis in reality) are not. Synesthesia, a blending of the senses wherein colors are heard, and sounds are seen is a common perceptual distortion. Cognitive function may range from clarity to confusion and disorientation, although reality testing usually remains intact. include alterations in perception, cognition, affect, sense of meaning, and/or sense of self. Psilocybin has been researched for the treatment of Depression.

There is a small group of compounds similar in structure, but whose pharmacology differs from the classic hallucinogens. They have been named ENTACTOGENS with the prototype being MDMA, Entactogen is derived from the roots “en” (Greek, within), “tactus” (Latin, touch), and “gen” (Greek, produce) connoting substances that “produce a touching within.” Entactogens have a mechanism of action and subjective effects distinct from the classic hallucinogens. While these substances affect emotion and promote social interaction, they do not produce the major alterations in sensory perceptions that are typical of the classic hallucinogens (5). MDMA is being proposed for the treatment of PTSD.

Status of Applications for US Food & Drug Administration (FDA) Approval

The goal of phase I studies with the Food and Drug Administration (FDA) is to establish initial safety in humans, which occurs after preclinical laboratory and animal testing have been completed. The drug is given to a small number of healthy volunteers. Side effects and dose ranges are determined. As of April 2025, there are 23 psychedelic compounds undergoing phase I trials registered with the FDA.

In phase II the drug is tested in a small number of volunteers who have the condition the drug is intended to treat. Safety data across a range of doses is collected. Conclusions to efficacy cannot be drawn due to small sample sizes, but the information gathered guides the protocols for phase III studies. There are 31 psychedelic drugs in phase II trials registered with the FDA.

Phase III trials determine a drug's safety and efficacy in a large group of patients with the identified condition or disease. Due to the large number of patients required to complete the study, these typically occur at multiple study sites both within the US and internationally. Typically two phase III studies are needed to provide sufficient evidence of efficacy.

There are six compounds in phase III studies registered with the FDA as of April 2025:

Compass Pathways	Comp360 (Psilocybin)	Treatment Resistant Depression
Usona Institute	Psilocybin	Major Depressive Disorder
Cybin	CYB003 (Deuterated Psilocybin Analog)	Major Depressive Disorder
MindMed	MM120 (LSD D-Tartrate ODT)	Generalized Anxiety Disorder
Awakn	Ketamine	Alcohol Use Disorder
Lykos Therapeutics	MDMA	Post-Traumatic Stress Disorder

Once a drug has completed phase III studies, a drug company will submit a New Drug Application to the FDA. The FDA reviews information from preclinical studies through phase III studies, weighing the risk versus benefit of a given drug for the condition indicated. If approved, a pharmaceutical will be eligible for sale and marketing in the U.S. A typical review time for the FDA to decide on a NDA is 10 months.

At times the FDA may grant an investigational drug Breakthrough Therapy Designation (BTD), the goal of which is to expedite development and review of treatments for serious or life threatening conditions for which there is an unmet medical need. For drugs that receive BTD designation, the FDA is more involved in the phase III study design, potentially shortening the time to review. Between 2017 and 2025, five psychedelic compounds have received BTD. These include MindMed's MM120 LSD analog for generalized anxiety disorder, Cybin Inc's CYB003 (Psilocybin) for major depressive disorder, Compass Pathway's COMP360 (Psilocybin) for treatment resistant depression, Usona Institute's psilocybin for major depressive disorder, and Lykos therapeutics MDMA for post-traumatic stress disorder.

Given the number of psychedelic compounds in phase III trials with the FDA that have breakthrough therapy designation, it is not unreasonable to imagine an FDA approved psychedelic medicine being available in our community by 2027.

Current and Emerging Best Practices[1] for Use of Psychedelic Medicine-Assisted Therapies

In accordance with HB 228, and informed by the Task Force's review of national protocols, ethics frameworks, and practitioner training models, the following best practices are recommended to guide the safe, effective, and culturally responsive use of psychedelic-assisted therapies in Alaska once federally approved.

Therapeutic Care Model

The preferred model for administering psychedelic medicines in a therapeutic setting follows a structured, tri-phasic process:

1. Preparation sessions focus on screening, consent, safety planning, and rapport-building.
2. Medicine sessions involve supervised administration of the psychedelic compound in a controlled, supportive setting.
3. Integration sessions assist the participant in meaning-making, emotional processing, and translating insights into behavior change.

This model has been consistently supported in practitioner manuals, ethics codes, and training curricula and is expected to reflect protocols outlined by the U.S. Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA) upon scheduling.

Professional Roles and Competency Standards

Best practice treatment delivery for psychedelic-assisted medication requires a multidisciplinary team consisting of licensed prescribers, trained facilitators, integration therapists, and program supervisors. Practitioners should demonstrate proficiency in:

- Trauma-informed, Trauma-Sensitive care
- Navigating states of consciousness
- Cultural and psycho-spiritual responsiveness
- Risk identification and emergency response
- Professional ethics and reflective practice.

Standards established by the State of Colorado are a useful model for consideration for non-licensed facilitators, who still require training and certification to perform this function. Colorado's regulatory structure provides a comprehensive and scalable model for non-licensed individuals, including those without formal degrees in counseling or mental health. Specifically, Colorado requires a minimum of 150 hours of didactic instruction covering ethics, trauma-informed care, safety protocols, and cultural competence; 40 hours of supervised practicum; and 50 hours of consultation. These requirements ensure that facilitators are adequately prepared to support individuals through psychedelic experiences with professionalism and clinical sensitivity.

[1] Current at the time of publication; the evidence base is expected by the Task Force, and clinical community at large, to change over time as additional research and evaluation is conducted.

Ethical and Safety Guidelines

All psychedelic care providers should adhere to a codified set of ethical standards, including:

- Voluntary, informed consent
- Maintenance of ethical and professional boundaries in Pre-, Post-, and during non-ordinary states
- Strict confidentiality and documentation practices
- Harm-reduction strategies for emotional and physical safety.

The Multidisciplinary Association for Psychedelic Studies (MAPS) Code of Ethics[2] and guidance from the American Psychedelic Practitioners Association (APPA), offer foundational frameworks.

Adaptations for Alaska's Geography and Populations

Given Alaska's unique geographic and health access challenges, existing best practices must be adapted to rural and remote communities. These may include:

- Telehealth platforms for preparation and integration
- Hybrid in-home models with safety protocols adapted from anticipated nationally approved standards
- Clinic partnerships for medicine administration
- Respectful collaboration with tribal health entities and Indigenous providers.

DRAFTING NOTE: The final report will include additional information about best practices as currently established at the time of this publication.

[2] Link to MAPS Code of Ethics, adopted 2021 and revised 2022: https://maps.org/wp-content/uploads/2022/06/MAPS_Psychedelic_Assisted_Psychotherapy_Code_of_Ethics_V4_22_June_2022_Final.pdf

Recommendations

The Task Force is directed to consider the four following topics, with recommendations about how to address these topics:

1. *Potential Therapeutic Use*
2. *Implementation and Access*
3. *Licensing and Insurance Requirements*
4. *Potential Legal and Regulatory Changes*

The Task Force has prepared the following draft findings and recommendations for feedback. Recommendations are not categorized into the four topics, but have been formed as the group considers each topic and how they are interrelated questions.

Draft Findings for Public Comment

1. **Finding**: The Task Force has reviewed the available literature on psychedelic medicine therapies, as well as their status in FDA review, and determined that the available evidence suggests there are potential therapeutic uses.

2. **Finding**: The current evidence base and best practices indicate that effective use of psychedelic medicines for treatment of certain mental health conditions, such as treatment-resistant PTSD, means medicines are used in a treatment setting as part of an overall psychotherapeutic approach, and not simply self-administered. Furthermore, this requires a team approach, with potentially multiple provider types playing roles in the treatment process, from medical evaluation and psychological assessment, to prescribing medications, to ongoing monitoring during patient sessions.

3. **Finding**: Alongside FDA approval, the DEA would be expected to re-schedule certain psychedelic substances with medical uses. If the DEA re-scheduled psychedelic medicines as a Schedule II, III, and IV controlled substances, the medications would be subject to the requirements (and exemptions) of the Alaska Prescription Drug Monitoring Program (PDMP).[3]

4. **Finding**: The current clinical evidence and experience with other behavioral health therapies indicates that a team approach to care is important, including a team of providers who may be playing distinct roles in the treatment, with differing types of licensing and credentials. For example, a medical doctor may be authorized to prescribe the medications, while a registered nurse may administer the medication, and a health aide may be responsible for monitoring the patient during a medication session.

5. **Finding**: Consent is especially important with psychedelic therapy, and requires meaningful work to inform and educate the patient about the process, establish clear boundaries and informed consent before treatment begins, with decisions about how

[3] See Alaska Board of Pharmacy statutes and regulations, pp. 56-58. Link: https://www.commerce.alaska.gov/web/Portals/5/pub/PharmacyStatutes.pdf

treatment will be provided, what type(s) of facilitator or other providers the patient will work with, determining consent for interaction before, during, and after treatment sessions (for example, what types of touch the patient consents to, or does not consent to), and generally establishing the patient has provided informed consent.

6. **Finding**: The Task Force discussed at length, but did not make a definitive recommendation, about whether a non-licensed facilitator model (such as one modeled on the regulatory structure in place in the state of Oregon) would be appropriate for use in Alaska. The group considered role(s) for non-licensed providers, and made recommendations for certification, but did not take a position on whether or not to consider an equivalent model to that of Oregon.

Draft Recommendations for Public Comment

1. **Recommendation**: If and when psychedelic medicine therapies are FDA approved, the state should take action to allow for their use in Alaska, rather than prohibiting use.

2. **Recommendation**: Identify clinical working group(s) whose function is to regularly review updated studies and the evidence base to make recommendations, and rely on these entities to provide ongoing guidance on use of these therapies.

3. **Recommendation**: To the extent possible, reserve use of state statute for broad enabling language and key components of a regulatory structure, and leave most regulatory decisions to the relevant boards and agencies. Regulations still require robust public process in order to be adopted, but can be updated or modified more predictably and easily than statute changes, which require an act of the Legislature. It is likely that appropriate parameters for use of these therapies will change over time, as the evidence base matures and FDA approval may be granted for multiple therapies.

4. **Recommendation**: If and when psychedelic medicine therapies are FDA approved, the Alaska State Medical Board should update the Guidelines for Prescribing Controlled Substances to include appropriate use of psychedelic medication for approved indications.

5. **Recommendation**: If and when psychedelic medicine therapies are FDA approved, the Alaska Board of Nursing should develop and adopt an advisory opinion on the use of FDA approved psychedelic medications in non-acute settings.

6. **Recommendation:** If and when psychedelic medicine therapies are FDA approved, and if pending legislation to expand Pharmacist prescriptive authority (SB 147 introduced in 2025, or a future bill) is passed, the Alaska Board of Pharmacy should develop and adopt an advisory opinion on the use of FDA approved psychedelic medications in non-acute settings by pharmacists working under collaborative agreements.

7. **Recommendation**: Regulate uses of these products according to evidence-based treatment protocols. Depending on the therapies and substances approved for clinical

use, there may be multiple approved ways to administer these medications, such as micro-dosing (taking small amounts) or conducting a session via telehealth.

8. **Recommendation**: The State should consult with the existing Controlled Substances Advisory Committee, established in AS 11.71.100, who should:
    - Recommend regulations to the Board of Pharmacy regarding the prevention of excessive prescribing and the diversion of newly approved drugs.
    - Evaluate the effectiveness of treatment resources for persons with existing substance use disorders stemming from use of the psychedelic class of drugs.
    - Evaluate the enforcement policies and practices regarding crimes involving controlled substances.
    - Review budget requests and recommend appropriations regarding the building out of regulations around handling of FDA approved psychotropic medications.
9. **Recommendation**: Align licensing and credentialing requirements for providers with treatment models in evidence-based therapies, with attention to what each provider is authorized to do.
10. **Recommendation**: Upon FDA approval and DEA scheduling, the State should fully mirror federal scheduling and Risk Evaluation and Mitigation Strategies (REMS) without adding duplicative or conflicting state rules, and whether DEA licensure is required for prescribers. This approach respects federal science and streamlines access for patients and providers.
11. **Recommendation:** To ensure safety and prevent diversion, the Task Force recommends integrating psychedelic medicines into the Alaska Prescription Drug Monitoring Program (PDMP) upon federal scheduling. This would allow for real-time monitoring of prescribing and dispensing, with no major new cost to the State.
12. **Recommendation**: Develop a pathway for a non-licensed psychedelic facilitator role, with a State-issued certification requirement that includes any necessary required training for monitoring patients during treatment. Benefits of this pathway include increased access to psychedelic care that is a cultural fit to the preferences and needs of the patient as well potentially increasing access to psychedelic care by decreasing costs. Potential models for this role include the Community Health Aide Program (CHAP), as well as the Traditional Healers track of the Alaska Commission for Behavioral Health Certification process.Topics may include training in heart rate and oxygen level monitoring, emergency and first aid response if the patient experiences an emergency during treatment. State certification of non-licensed providers also provides regulatory and enforcement oversight by the State, which increases patient protection.
13. **Recommendation**: The State should determine what training(s) and continuing education are necessary to maintain a license, endorsement on a license, certification, and/or demonstrating competency in their scope of practice, such as prescribing authority. The State should also consider how providers can access appropriate trainings and certification based on FDA guidance and other clinical sources. If there is current federal

guidance or requirements for training, the State should follow these; if this does not exist at the time of FDA approval, it may require the State to establish training requirements or guidelines in the interim to address this need.

14. **Recommendation:** In developing Alaska's training and certification framework for psychedelic-assisted therapy facilitators, the Task Force recommends modeling the standards established by the State of Colorado. Adopting a similar model in Alaska will support public safety, uphold ethical standards, and ensure statewide consistency while maintaining accessibility for rural and Indigenous communities.

15. **Recommendation**: Allow prescription and/or administration authority for any provider with existing authorizations for controlled substances, if the treatment is within their scope of practice and consistent with their training.
Includes: Physicians, physician assistants (PAs) with dispensing authority, advanced practice registered nurses (APRNs) with dispensing authority.
Pending/Potential: Pharmacists with dispensing authority (Alaska SB 147).
Excludes: Dentists, veterinarians, and optometrists.

16. **Recommendation**: Treatment and access to prescriptions should not occur through use of standing orders of medication, but regardless of setting and provider, the patient should first undergo both medical and clinical evaluations to determine the treatment is appropriate.

17. **Recommendation**: The State must consider Alaska's unique geographic and health access challenges, particularly for rural and remote communities. Creating regulatory systems for provider licensing and credentialing, defining methods of accessing and delivering treatment, and considerations for culturally appropriate practices, should take into account the challenges and limited capacity of rural health systems. This includes methods for patient access, such as whether preparation and integration sessions (non-medication sessions) could be conducted through telehealth; it also includes considerations for what provider types and pathways for certification exist, such as the proposed equivalent to the Traditional Healer track (*see Recommendation 12*).

18. **Recommendation**: A code of ethics should be created, or adopted by reference, for all providers engaged in psychedelic-assisted therapy, and integrate this code of ethics into any required licenses, certifications, or other roles who work with patients. This is important not only for upholding high standards of care, but also provides codified expectations on providers, given the nature of the therapy and potential for patient harms if violations of boundaries, consent, or other ethical issues occur.

19. **Recommendation**: The State should establish requirements for informing patients of their rights, as well as a venue and process for addressing grievances. For example, requiring postings or notices about patients' rights and what to expect; requiring a consent form signed by the provider and patient before treatment begins; publishing where and how to report grievances; and (likely through a certification or endorsement system for providers), establishing which entity(ies) have authority to take action in the case of grievances.

20. **Recommendation**: Health care payors (insurers) should uniformly and equally apply reimbursement rates for the same type of health care service or supply and for health care providers who are practicing within their scope of their license and who are authorized to bill for health care services or supplies under the current CPT codes adopted by the AMA or other industry standard method of coding.

21. **Recommendation**: Regarding determining the amounts to be billed: Medicaid Pharmacy and Therapeutics committee will need to consider the availability of this drug and determine the structure for prior authorization as well as what can be billed for.

22. **Recommendation**: Medicaid Pharmacy and Therapeutics committee shall consider the pricing of the medications that fall within the category of Psychedelic medication to be part of the Medicaid pharmacy benefits, rather than part of a “buy and bill” model which hinders access.

23. **Recommendation**: Advocacy is needed to ensure active efforts by the American Medical Association, (AMA) and Centers for Medicare & Medicaid Services, (CMS) on developing billing codes that will promote sufficient reimbursement for psychedelic therapy delivery are vital to ensuring patient access post-FDA approval.

DRAFT EXAMPLE: *Alaska Psychedelic Practitioner Credentialing Matrix*

This table is an illustrative example of defined provider roles that could be recognized for delivering psychedelic-assisted therapies, as well as required experience, training, competencies, and applicable certification(s). This example is provided for consideration, and is not a specific recommendation of the Task Force.

Role	Experience Required	Practicum Hours	Training Hours	Required Competencies	Reference Requirements	Certification or Endorsement
Psychedelic Facilitator (Entry-Level)	None (Entry-level support role under supervision)	# hours direct observation Internship # hours Consultation	# contact hours in ethics, somatics, safety, documentation, cultural awareness	Basic understanding of psychedelic care, Ethics, boundaries, Trauma- Informed Care, Cultural Considerations, Support techniques	# personal or professional references	Completion of approved training program and supervisor sign-off
Certified Psychedelic-Assisted Therapy Practitioner (Licensed)	# years (# hours) clinical experience	# hours supervised Trauma-Informed / Trauma Sensitive practicum	# contact hours including pharmacology, trauma care, ethics, integration therapy	Trauma- informed care, altered states navigation, cultural humility	# references, # from a licensed supervisor	State-recognized certification or license in mental health field
Traditional Healing Practitioner (THP)	Community-recognized experience in traditional healing practices	Community-verified training or mentorship under recognized traditional practitioners	Flexible; documentation of oral/traditional transmission or cultural training accepted	Ability to guide healing practices using cultural and spiritual knowledge	# community-based references (tribal, spiritual, elder-based)	Endorsed by tribal council, spiritual authority, or cultural review board