Medications for Assisted Treatment in Opiate Use Disorder

Paige Cady, MD, MPH, FAAFP

Senior Medical Director: KS-1 and MO-1

Oak St. Health

Objectives

Relay experience gained with development of OUD treatment program in Kansas Prisons

Compare the options for medication treatment for OUD and AUD.

Provide strategies to address stigma in leadership and the treatment population.

Why is treatment for substance use disorder (SUD?) important

Ten percent of US Adults experience a substance use disorder (SUD) in their life, but **75% report not receiving any form of treatment**.

SUD is **highly prevalent and undertreated** in most underserved populations including: incarcerated patients, Medicare, and Medicaid recipients.

The most common substances abused are alcohol, prescription drugs (opiates and benzodiazepines), and over-the-counter (OTC) medications.

This increase is believed to be partially driven by the baby boomer generation, born between 1946 to 1964, who had **significant exposure to alcohol and drugs at a younger age**.

Categories of SUD (Abuse or Dependence) Symptoms

Must have **at least 2** symptoms in any of the categories for **abuse** and **at least 4** for **dependence**. **Tolerance and withdrawal are NOT required for ICD-10 dependence.**

Impaired Control	Social Problems	Risky Use	Physical Dependence
Using more of a substance or more often than intended	Neglecting responsibilities and relationships	Using in risky settings	Needing more of the substance to get the same effect (tolerance)
Wanting to cut down or stop using but not being able to	Giving up activities they used to care about because of their substance use	Continued use despite known problems	Having withdrawal symptoms when a substance isn't used
	Inability to complete tasks at home, school or work		

It's the 2/4 Rule!

What is substance use?

“The use of selected substances, including **alcohol, tobacco products, drugs, inhalants, and other substances** that can be consumed, inhaled, injected, or otherwise absorbed into the body with **possible dependence and other detrimental effects**.”

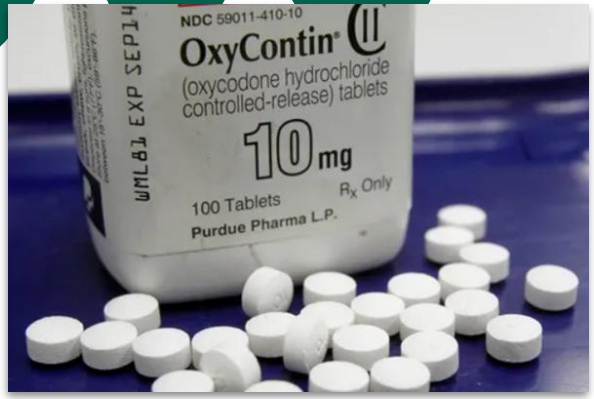
- Per the CDC

Common complications for substance use, abuse, or dependence

Category	Complication	Definition
Psychotic complications	Delusions	Fixed false beliefs
	Hallucinations	Hearing voices/sounds, seeing things, smelling odors, tasting things, and/or feeling tactile sensations with no true sensory stimulus
	Persistent Amnestic disorder	Impairment of anterograde and/or retrograde memory
	Dementia	Clear major neurocognitive impairment associated with IADL functional impairment
	Withdrawal induced delirium	Acute confusional state with disturbances in attention, orientation, and higher order cognition and possible changes in perception and behavior
	Withdrawal with perceptual disturbance	Withdrawal driven hallucinations, illusions, disordered comprehension, inability to recognize words, and objects being dreamlike and unreal
Non-psychotic complications	Sleep disorder	Changes in sleep patterns, duration, and quality, including insomnia, sleep apnea, Restless Legs Syndrome, and narcolepsy
	Mood disorder	Disturbance in mood and affect; Can be depressive, hypomanic/manic, or mixed
	Anxiety disorder	Intense, excessive, and persistent worry/fear
	Intoxication	Actively under the influence of a substance
	Sexual dysfunction	Persistent, recurrent problems with sexual response, desire, orgasm, or pain, including erectile dysfunction

Medications for Alcohol Use Disorders

	Dosing Range	Mechanism	Indication	Monitor
Naltrexone (Revia) Naltrexone ER (Vivitrol)	25-50mg daily 380mg IM q4weeks	opioid antagonist	Alcohol use disorder (↓ cravings, ↓ alcohol euphoria)	**LFTs** (Baseline, 2-4 weeks) **AVOID if AST/ALT >3x normal** **AVOID** if patient on opiate therapy Ok if still drinking
Acamprosate (Campral)	666mg BID-TID	↓ glutamate activity	Alcohol dependence (relapse prevention)	**Begin after detox** Preferred if hepatic disease
Disulfiram (Antabuse)	*250-500mg HS*	*inhibits EtOH metabolism*	*Alcohol dependence (relapse prevention)*	*Must be abstinent >12h* *LFTs (baseline, 2-4 weeks)*



Opioid Use Disorder

Opiate: Alkaloid derivatives of poppy plant (eg. morphine, codeine)

Opioid: Any chemical compound with pharmacologic actions similar to morphine

Heroin: “super pain killer” derived from morphine

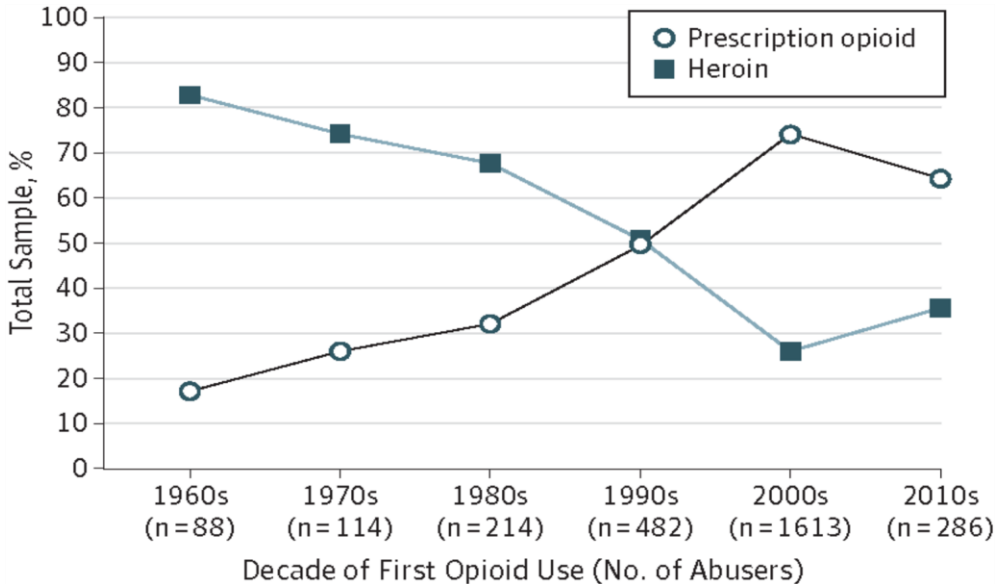
- Estimated ~1 million chronic heroin users

Fentanyl: synthetic opiate 100x more potent than morphine (**Carfentanil** is 10,000x times more potent than morphine)

Prescription Opioids (Oxycontin, Dilaudid, Vicodin)

- **Most often obtained from friends or family members**

The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 years



Percentage of the total heroin-dependent sample that used heroin or a prescription opioid as their first opioid of abuse. Plotted by decade of initial opioid abuse.

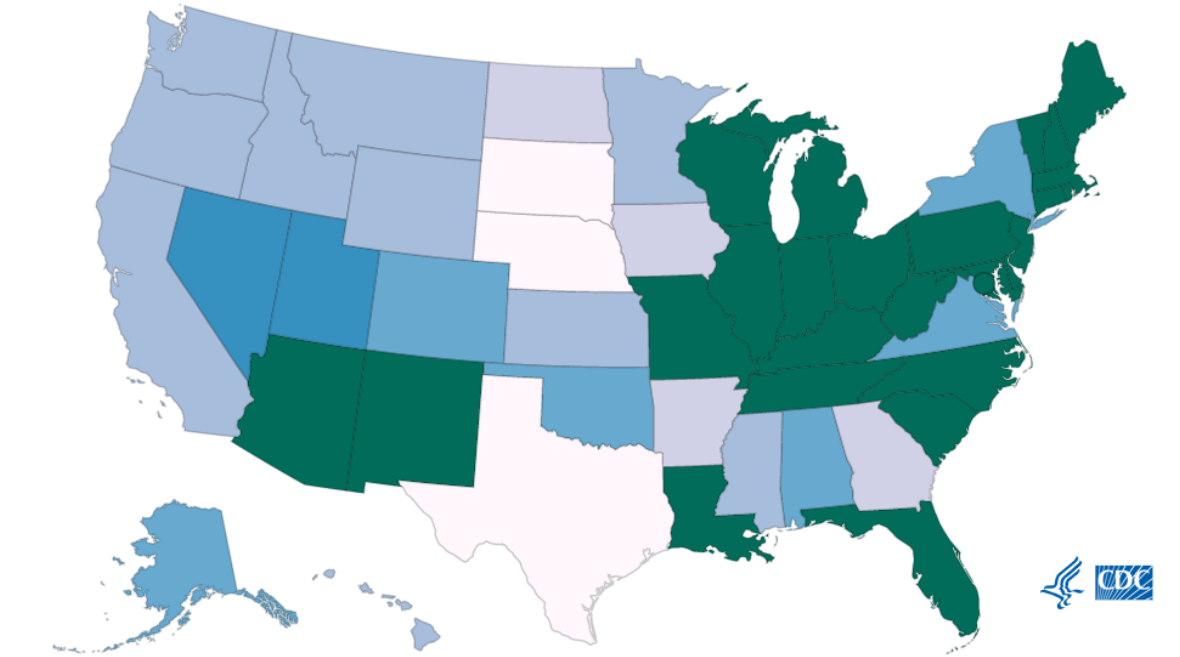
JAMA Psychiatry. 2014

1996 - OxyContin launched by Purdue Pharma as “safe” “non-addictive” and targeted chronic non-cancer pain

Retail Sales of Opioids (1995-2005)

- Methadone ↑ 933%
- Oxycodone ↑ 588%
- Fentanyl ↑ 423%
- Hydromorphone ↑ 244%

Number and Age-adjusted Rates of Drug Overdose Deaths by State, US 2020



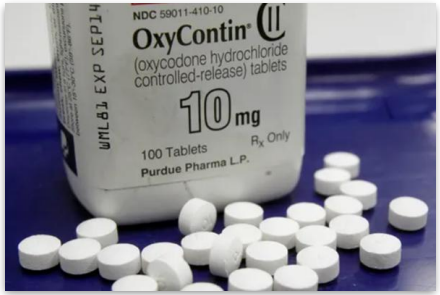
- 932,000 deaths from drug overdose since 1999
- 31% increase from 2019-2020
- 20-50% of opioid deaths due to synthetic opioids like fentanyl or carfentanil
- 48/50 states reporting fentanyl containing xylazine (2022)

Increased risk of overdose when user is attempting to get sober

Opioid Use Disorder

Mechanism of Action:
CNS Depressant

Act at μ (mu), δ (delta) or κ (kappa) receptors to **inhibit neurotransmitter release**



Intoxication:

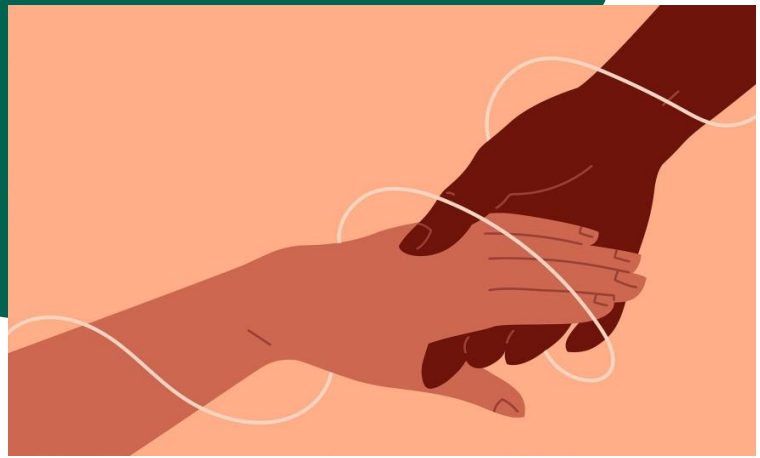
- Analgesia
- Constricted (small) pupils
- Respiratory depression
- Drowsiness
- Slurred speech
- Impaired attention
- Nausea
- Constipation
- Peripheral vasodilation

Withdrawal

- Dysphoric mood
- Nausea or vomiting
- Muscle aches
- Lacrimation or rhinorrhea
- Pupillary dilation
- Piloerection (Goose flesh)
- Sweating
- Diarrhea
- Yawning
- Fever
- Insomnia

Medication for Opioid Use Disorders

	Dosing Range	Mechanism	Monitor	Comments
Methadone	80-120mg daily	**potent μ agonist** t½ = 24-36h	sedation, constipation, sweating, **QTc prolongation** caution with CYP3A4 inhibitors	**Federally regulated clinics** **Dispensed daily** **NOT listed in PDMP data**
Buprenorphine (*Subutex*) **Buprenorphine + naloxone** *(Suboxone)*	Max is 32mg per day 4/1 or 8/2 (tabs or films) Daily -TID	**high-affinity μ partial agonist & κ antagonist** t½ = 48h	**COWS >11 before starting** Headache, vomiting, sweating Less respiratory depression caution with CYP3A4 inhibitors	**Any provider with DEA X** **Dispensed weekly-monthly** **Is listed in PDMP data** AVOID benzodiazepines
Naltrexone (Revia) Naltrexone ER (Vivitrol)	50mg daily 380mg IM q4weeks	**Opioid antagonist**	**LFTs** (Baseline, 2-4 weeks) **AVOID** if AST/ALT >3x normal	**Must be off all opioids (including loperamide) 7-10 days prior to initiating** Data is better for alcohol use disorders



Program Development

Harm reduction: Harm reduction attempts to reduce the adverse consequences of drug use among persons who continue to use drugs. It developed in response to the excesses of a "zero tolerance approach".

Harm reduction acknowledges that drugs are widely available in our society. It encompasses the understanding that traditional law enforcement approaches or those that require complete abstinence do not decrease demand, use, or negative health consequences of substance use.

Resources

1. https://publichealth.jhu.edu/2022/what-is-harm-reduction
2. https://www.samhsa.gov/substance-use
3. https://nida.nih.gov/news-events/news-releases/2024/09/fewer-than-half-of-us-jails-provide-life-saving-medications-for-opioid-use-disorder
4. https://journalofethics.ama-assn.org/article/why-its-inappropriate-not-treat-incarcerated-patients-opioid-agonist-therapy/2017-09
5. https://archive.ada.gov/opioid_guidance.pdf

Kansas Sentencing Commission

SB 123 Medication-Assisted Treatment (MAT)

ELLIOTT D. SMITH, M.A., LAC, PROGRAM DIRECTOR
TRISH BECK, PROGRAM AUDITOR
GWYN HARVEY-BELANGER, B.S., LAC, CERTIFICATION SPECIALIST

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What is MAT?

Medication-assisted treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. MEDICATION-ASSISTED TREATMENT (MAT) IN THE CRIMINAL JUSTICE SYSTEM: BRIEF GUIDANCE TO THE STATES (samhsa.gov)

MAT combined with behavioral therapy is the generally accepted standard of care for opioid use disorder (OUD). Medication Assisted Treatment for Opioid Use Disorder (bop.gov)

American Society of Addiction Medicine (ASAM), National Council for Behavioral Health, National Institute on Drug Abuse, CDC, WHO and patient advocate groups support increased access to MAT. MAT-IB-Final-51718-1.pdf

Medications approved for treatment of opioid use disorder (OUD)

Methadone

*May be best for clients with pain disorders or other diseases
*Falling out of favor with medical professionals due to difficulty obtaining and side effects such as lethargy
*Can be taken while opioids are still in system
*Must be administered in SAMHSA certified opioid treatment program

Vivitrol

*Injectable form of Naltrexone contributes to better treatment retention and long-term recovery
*Prevents clients from getting desired effects if opioids are used
*Opioids must be completely out of system (can take 7-14 days)or client will experience precipitated withdrawal
*Administered every 30-45 days

Buprenorphine

*Blocks withdrawal symptoms, reduces cravings, prevents desired effects of opioid use
*Preferred formula is Suboxone which combines buprenorphine with naloxone (Narcan) to reduce diversion
*Can be safely initiated sooner after use of illicit opioids (approximately 12-24 hours depending on client and history of use)

Sublocade & Brixadi

*Injectable forms of buprenorphine

Medications approved for treatment of alcohol use disorder (AUD)

Disulfiram

*First drug approved to treat AUD
*Works by increasing toxic byproduct that occurs when alcohol is broken down by the body, creates unpleasant symptoms such as nausea and flushing of the skin
*Can be risky and generally not preferred by physicians

Naltrexone

*Pill taken daily, wears off quickly so clients may choose not to take if they want to drink
*Injectable form (Vivitrol) can also be used for treating AUD
*Blocks pleasant sensations associated with drinking and reduces alcohol craving
*Generally well-tolerated especially in pill form

Acamprosate

*Mechanisms by which it works not fully understood
*Helps modulate and normalize brain activity that is thrown into disarray by cessation of alcohol use
*Reduces symptoms such as insomnia, anxiety, and restlessness
*Likely reduces pleasurable effects of alcohol on brain

Benefits of MAT

- Reduction in overdose events (cuts mortality rate by half or more) MAT-IB-Final-51718-1.pdf
- Significant reduction in craving and withdrawal symptoms leads to reduction in drug use
  - Half as likely to experience recurrence of use MAT-IB-Final-51718-1.pdf
- Promotes recovery by increasing treatment retention and adherence

MEDICATION-ASSISTED TREATMENT (MAT) IN THE CRIMINAL JUSTICE SYSTEM: BRIEF GUIDANCE TO THE STATES

- Improved treatment outcomes MAT-IB-Final-51718-1.pdf, Medication-Assisted Treatment Improves Outcomes for Patients With Opioid Use Disorder | The Pew Charitable Trusts

Additional Benefits of MAT

- Reduces criminal activity, arrests, probation revocations, and re-incarceration MEDICATION-ASSISTED TREATMENT (MAT) IN THE CRIMINAL JUSTICE SYSTEM: BRIEF GUIDANCE TO THE STATES
- Reduces risky activity such as needle sharing and high-risk sexual behavior MAT-IB-Final-51718-1.pdf
- Incredibly cost-effective, $1 spent on SUD treatment leads to between $2 and $10 of savings in health care, criminal justice, and educational costs MAT-IB-Final-51718-1.pdf, could be as much as $100,000 in savings over a client's life span Cost-effectiveness of Treatments for Opioid Use Disorder | Substance Use and Addiction Medicine | JAMA Psychiatry | JAMA Network

SB 123 and MAT

- Reimbursement is for coordinating MAT, not necessarily medication itself. This could mean referring to a clinic or outside prescriber, or a provider could have a prescriber on staff.
  - Intended to cover associated costs incurred by provider such as increased collaboration, transportation, and time making and coordinating referrals.
- Certified providers wishing to receive reimbursement for coordinating MAT should complete an implementation plan addendum.
- Full policy is on website: Providers | Kansas Sentencing Commission
- Recommended educational resource: Community Supervision and Medications for Opioid Use Disorder Toolkit Opioid Response Network

Role of Supervision Officer

- Collaborate with treatment providers regarding the successes and ongoing needs of SB 123 clients receiving MAT.
- Be aware that medication may cause a false positive on a drug screen.
- If a SB 123 client on MAT is required to serve a jail sanction, collaborate with the MAT provider and local jail to make every possible effort to ensure that receipt of MAT is not negatively impacted by the jail sanction.
- If a SB 123 client on MAT is facing the revocation of their probation, officers should communicate this to the MAT provider as soon as they are aware that a motion to revoke has been filed.

Role of Treatment Provider

- Identify clients who may benefit from MAT and offer when clinically appropriate. The decision to receive MAT shall be voluntary and made by the client.
- Ensure that clients receiving MAT are also engaged in either social detox, residential, reintegration, IOP, OP, or relapse prevention(RP) services. They may also participate in peer mentoring when in OP or RP.
- Use of medication shall be incorporated into client's treatment plan.
- A dually-signed CPA must be completed prior to initiating MAT.
- Collaboration with supervision officers is critical. Providers may also need to coordinate care with local jails.

Role of Treatment Provider (cont'd)

- Provide minimum once monthly urine drug screen to ensure compliance and prevent diversion.
- Work with client to ensure continuity of care upon expiration of SB 123 funding or taper client in a manner consistent with best practices to reduce possibility of adverse outcomes.
- Cooperate with KSSC auditing efforts outlined in policy.
- Send requested data to KSSC by July 15 of each year.

MAT Billing

- Billing codes are active in Carelon and are the same as SOR billing codes.
- Brixadi may be prescribed and billed as Sublocade.
- CPA will serve as auth.
- For clients without insurance, providers only need to submit a dually-signed CPA with MAT checked to bill.
- To request reimbursement for a UA lab confirmation, submit an invoice from the lab or other documentation demonstrating that the client's UA was sent to a lab. If the client has insurance, see next slide. No CPA is needed to receive reimbursement for this service.

Modality	Cost Cap	Required Service Components
Medication Assisted Treatment (MAT)	**Oral Naltrexone** $37/day **Vivitrol injection** $65/day **Buprenorphine** $37/day **Sublocade injection** $90/day **Methadone** $30/day **Acamprosate** $40/day **Disulfiram** $35/day **UA lab confirmation** $200/test	Maximum paid units: • 548 days per court case Components: • Use of FDA-approved medications in combination with counseling and behavioral therapies • Must be billed concurrently with another level of care (i.e. social detox, intermediate/residential, reintegration, therapeutic community, intensive outpatient, outpatient, or relapse prevention) • May be short term (e.g., to manage withdrawal) or part of client's long-term recovery • Approved providers may bill for each day client benefits from medication

MAT Billing (clients w/insurance)

- For clients with insurance:
  - If payment is received from primary insurance related to coordinating MAT, submit EOB(s) within 45 days of issuance. Reimbursement will be the difference between KSSC's daily rate and what was paid by primary insurance.
  - If no payment is received from the primary insurance related to coordinating MAT because client was referred out for services, reimbursement will be the daily rate indicated on the cost caps. If an invoice is received related to the client's MAT, this should be submitted as part of the client's chart as additional documentation.
  - Specific situations may need to be worked out on a case-by-case basis in collaboration with approved provider, KSSC, and Carelon.

All are encouraged to take advantage of DCCCA's Naloxone Program providing free naloxone to community organizations.

Thank you!

- Elliott D. Smith, M.A., LAC, Program Director
  - Elliott.Smith@ks.gov
  - 785-296-8930
- Trish Beck, Program Auditor
  - sb123payments@ks.gov
  - 785-296-1546
- Gwyn Harvey-Belanger, B.S., LAC, Certification Specialist
  - Gwyn.S.Harvey@ks.gov
  - 785-296-3443