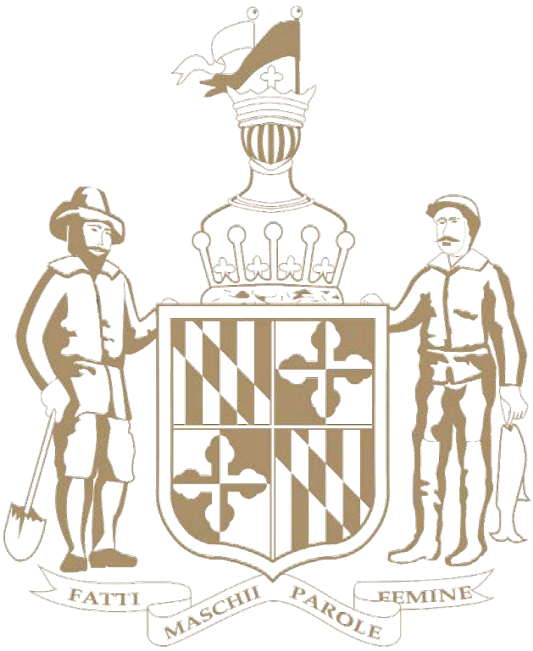


Maryland Buprenorphine Access Workgroup

July 2025 – June 2026

Released: June 17, 2026
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Pursuant to House Bill 1131 (HB1131) Public Health - Buprenorphine - Training Grant Program and Workgroup (Chapter 759 of the Acts of 2025) and in accordance with § 2–1257 of the State Government Article. Copies of this report have been delivered to the Maryland Department of Legislative Services Library pursuant to Maryland State Education Article § 23-301(e).

Executive Summary

In 2025, there were 1,408 fatal drug overdoses in Maryland, according to preliminary data on Maryland's Overdose Data Dashboard.[1] This was a 50% decrease from the state's historic high in 2021, when 2,800 people died from a drug overdose. This decrease is encouraging, and examining all methods to reduce overdose mortality, in particular opioid-overdose mortality, is crucial.

Buprenorphine is one of three medications for opioid use disorder (MOUD) approved by the Food and Drug Administration (FDA). The other FDA-approved MOUD are naltrexone and methadone. MOUD are considered the gold standard for the treatment of opioid use disorder (OUD), and methadone and buprenorphine in particular are considered highly effective.[2] Despite this, access to and utilization of MOUD are lacking for many who need it. Maryland's Office of Overdose Response (MOOR) considers expansion of buprenorphine services a key element of the state's Overdose Response Strategy as a goal of the broader priority of expanding access to treatment for substance use disorders.[3]

Marylanders currently access buprenorphine through a variety of means. Some of the methods are more traditional, such as access through opioid treatment programs (OTPs), office-based care, and local health departments. In recent years, more innovative practices have emerged that provide access to buprenorphine through alternative means, including in emergency departments, emergency medical services initiation, mobile treatment services, and telehealth services. Some of these options also operate from a low threshold standpoint, meeting people where they are in their recovery process, providing tailored services to their unique needs, and reducing barriers to initiating care for difficult-to-reach populations. It is important to expand low-threshold access in particular.

Despite the many ways Marylanders can access buprenorphine, several barriers exist that must be addressed in order to expand access and utilization. These barriers include limited provider capacity, rural access to care, cost, pharmacy access issues, stigma, and the fragmentation of services across the spectrum of care.

This report serves as an update to the interim report published by the workgroup at the end of 2025. This report follows up by making recommendations on how to expand access to and utilization of buprenorphine in Maryland.[4]

[1] https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx
[2] https://library.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
[3] https://stopoverdose.maryland.gov/resources/
[4] https://stopoverdose.maryland.gov/buprenorphine/

Introduction

Maryland's Buprenorphine Access Workgroup was established in 2025 to study access to buprenorphine in the state following the passage of House Bill 1131 (HB 1131). Under this law, Maryland's Office of Overdose Response is required to submit a report on the findings and recommendations of the workgroup by December 31, 2025.[5] Because the workgroup only began meeting in July 2025 and is authorized to meet through the end of June 2026, the workgroup elected to prepare an interim report by the December 31, 2025, deadline and continued meeting throughout the first half of 2026 in order to prepare a thorough final report.

Specifically, HB 1131 requires that the workgroup examine:

i. how buprenorphine services are offered in the state;
ii. the capacity of providers to provide buprenorphine;
iii. any geographic areas where significant gaps in buprenorphine services may exist;
iv. the feasibility of financial support for a long-term expansion of buprenorphine services;
v. a plan for ongoing data collection for the purpose of the monitoring and improvement of buprenorphine services;
vi. how to effectively grow a hub-and-spoke model to ensure access to buprenorphine in the state; and
vii. any other strategies that would improve buprenorphine services in the state.

Maryland's Office of Overdose Response has prepared the report below on behalf of the Buprenorphine Access Workgroup to meet this requirement. Specifically, the report below details the following:

- historical context and background information on buprenorphine;
- a summary of access methods for buprenorphine in Maryland;
- analysis of barriers to care; and
- recommendations to expand access to care.

Membership

The members of the workgroup are:

- Senator Arthur Ellis
- Delegate Pamela Guzzone
- Dr. Timothy Chizmar, MD, FACEP, State EMS Medical Director, Maryland Institute for Emergency Medical Services Systems
- Dr. Nishant Shah, MD, MPH, SUD Consultant, Behavioral Health Administration
- Barry Page, MOUD Early Intervention Program Manager, Behavioral Health Administration
- Salima Montes, Program Administrator, Behavioral Health Administration
- Brian Ricci, PDMP Coordinator, Maryland Prescription Drug Monitoring Program
- Deena Speights-Napata, Executive Director, Maryland Board of Pharmacy
- Malik Burnett, MD, MBA, MPH, Maryland Addiction Consultation Service

[5] https://mgaleg.maryland.gov/2025RS/chapters_noln/Ch_759_hb1131T.pdf

- Melissa Vail, LCPC, Clinical Manager, Sinai Hospital Addictions Recovery Program
- Dr. Kenneth Stoller, MD, DLFAPA, Director, Johns Hopkins Broadway Center for Addictions
- Jason Lassalle, Buprenorphine Expansion Coordinator, Anne Arundel County
- Dan Rabbitt, Policy Director, Behavioral Health System Baltimore
- Matthew Burgan, NRP, CP-C, Frederick County Division of Fire & Rescue Services

Meetings in 2025 and 2026

Maryland's Buprenorphine Access Workgroup held eight meetings in 2025. The workgroup also met eight times in 2026. Recordings of the workgroup's meetings can be made available to the public upon request. If you would like to access recordings of previous meetings, please email StopOverdose@maryland.gov.

Acknowledgements

The workgroup would like to extend thanks to the many partners who joined workgroup meetings and lent their expertise through presentations on special topics. The workgroup would like to thank:

- Sarah Whaley, Executive Director of the Baltimore City Mayor's Office of Overdose Response
- Martha Jurczak, Dr. Eric Weintraub, and others with the University of Maryland School of Medicine and Institute of Health Computing's BCORE initiative
- Susan Bradley and Roopali Kadabha from the Maryland Department of Health's Data Office
- Ana Lazarides, Cathryn Mudrick, and others from Maryland's Prescription Drug Monitoring Program
- Dr. Ayana Jordan from NYU Langone Health
- Dr. Gene Hern, Dre Cantwell-Frank, and Jordan Brandt from The Bridge Center

History of Buprenorphine

What is Buprenorphine?

Buprenorphine is a drug that acts as a partial agonist of opioid receptors, meaning it binds to the same receptors as other opioids but activates them to a much lesser degree.[6] Buprenorphine reduces withdrawal and craving symptoms experienced by a person physically dependent on opioids yet has a ceiling effect for respiratory depression, making it a safe and effective drug for the treatment of OUD. Through a process called cross-tolerance, buprenorphine and other MOUD make fatal overdose less likely by reducing the effects of other opioids in a person's system.

Buprenorphine is available in a variety of formulations for the treatment of OUD. These formulations include: buccal film, sublingual tablet and film, and long-acting subcutaneous injectable. Some buprenorphine formulations are also combined with naloxone, an opioid antagonist and overdose reversal medication. These combined formulations limit the potential for misuse of buprenorphine.[7]

Regulatory Landscape

The FDA first approved buprenorphine for the treatment of OUD in 2002. The initial buprenorphine products approved by the FDA were Subutex (buprenorphine) and Suboxone (buprenorphine/naloxone).

[6] https://www.samhsa.gov/substance-use/treatment/options/buprenorphine
[7] https://www.ncbi.nlm.nih.gov/books/NBK459126/

In 2010, the FDA approved a sublingual film version of Suboxone, and in 2017, the FDA approved Sublocade (buprenorphine extended-release subcutaneous injection), the first buprenorphine long-acting extended-release subcutaneous injection. Since then, a similar product called Brixadi has also entered the market. Other formulations and brands have also been approved by the FDA.

The Narcotic Addict Treatment ACT of 1974 (NATA 1974) created a strict system for the use of methadone, a form of MOUD preceding buprenorphine.[8] NATA 1974 specified that methadone could only be dispensed to treat OUD within specialized OTPs. This system created significant disparities in access to care and set a high bar to treatment access for many patients, such as requiring daily attendance to receive a dispensed dose. The Drug Addiction Treatment Act of 2000 (DATA 2000) created a process whereby physicians could obtain a waiver (popularly referred to as the "X-waiver") from the DEA to treat OUD with buprenorphine outside of OTP settings. Requiring additional training for providers to obtain the X-waiver was unique to buprenorphine relative to other controlled substances.[9]

Access was still limited under DATA 2000, as physicians could only prescribe buprenorphine for OUD to 30 patients total, and many physicians did not qualify or did not initiate the waiver process. The Comprehensive Addiction and Recovery Act of 2016 (CARA) expanded this number to 100 patients and also allowed nurse practitioners and physician assistants to prescribe buprenorphine for OUD to up to 30 patients. This limit was further expanded in 2018 after the passage of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. In 2022, the Mainstreaming Addiction Treatment (MAT) Act was signed, eliminating the federal waiver requirement. Patient limits have also since been lifted.

Buprenorphine can now be prescribed to treat OUD by any clinician who has registered with the DEA and Maryland's Office of Controlled Substances Administration to prescribe controlled substances, without any patient census limits. This allows patients to access buprenorphine through a variety of different pathways, making buprenorphine more accessible today than ever before.

Buprenorphine Access in Maryland

Access Overview

The workgroup received presentations about buprenorphine for OUD access from the Maryland Prescription Drug Monitoring Program (PDMP) and from the Maryland Department of Health (MDH) Data Office, which provided data specific to buprenorphine for OUD access in Maryland's Public Behavioral Health System (PBHS). There are some important limitations to these data sources. The PDMP does not capture data related to direct administration of controlled substances to patients, including within OTPs, or from pharmacies serving hospital inpatients only. For PBHS data, the number of patients who receive buprenorphine may be overcounted due to the fact that CPT Codes H0016/E&M may be counted in more than one treatment type (methadone or buprenorphine). PBHS also has a limited ability to capture data on race, as patient race is not a required field on the Medicaid application. Data for PBHS in fiscal year (FY) 2025 are not final and represent only those services rendered before the state transitioned to a new Administrative Services Organization (ASO) on January 1, 2025. In addition, due to

[8] https://www.sciencedirect.com/science/article/pii/S2772724623000033
[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821949

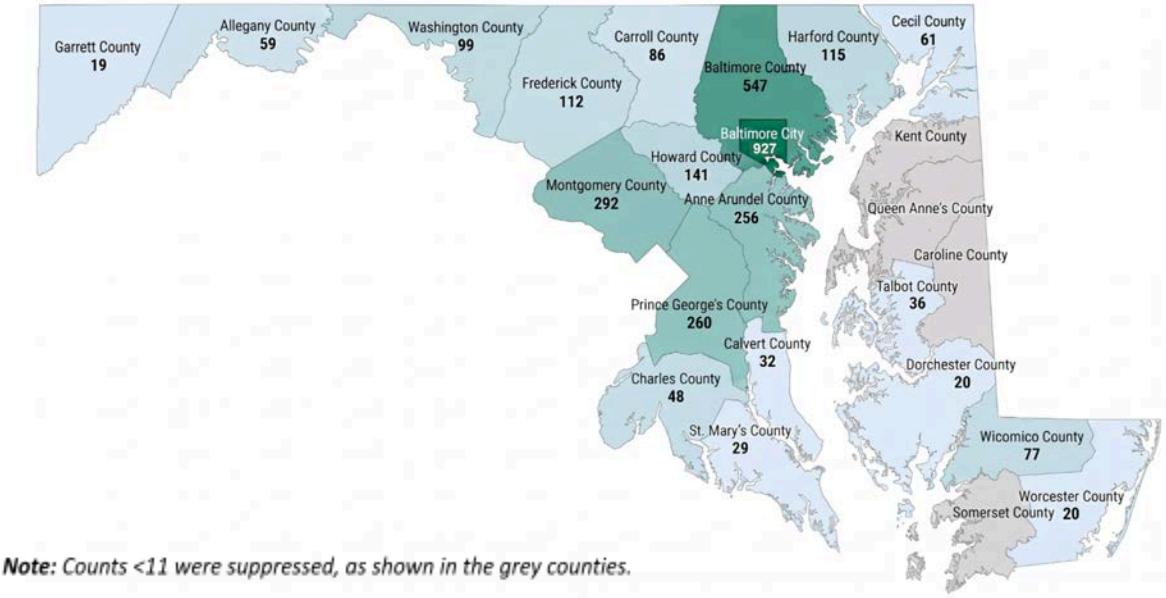
the transition in ASO, data across years are difficult to compare, and historical trends could not be presented to the workgroup.

PDMP Data[10]

In 2025, approximately 36,090 Marylanders filled a prescription for buprenorphine to treat their OUD through a retail pharmacy, according to the Maryland PDMP's annual report for fiscal year 2025.[11] That amounted to approximately 441,000 buprenorphine prescriptions filled for the treatment of OUD from 3,269 prescribers in Maryland. Most providers prescribing buprenorphine for OUD treatment in 2025 were either certified registered nurse practitioners or medical doctors, who accounted for 1,331 and 1,214 providers, respectively.

PDMP data show that prescribers of buprenorphine for OUD are not evenly distributed across the state. As displayed in Figure 1, the jurisdictions with the most prescribers are Baltimore City (927 prescribers), Baltimore County (547 prescribers), Montgomery County (292 prescribers), Prince George's County (260 prescribers), and Anne Arundel County (256 prescribers). Jurisdictions in rural parts of Maryland have comparatively fewer prescribers of buprenorphine for OUD, such as Garrett County in Western Maryland, which has 19 providers, and Dorchester and Worcester Counties in the Eastern Shore, which each have 20 providers. Many factors influence the number of providers that might be present in a local jurisdiction, including population size, overdose mortality rates, and rates of OUD diagnoses.

Figure 1: Buprenorphine Prescribers by Local Jurisdiction, 2025 (Source: PDMP)

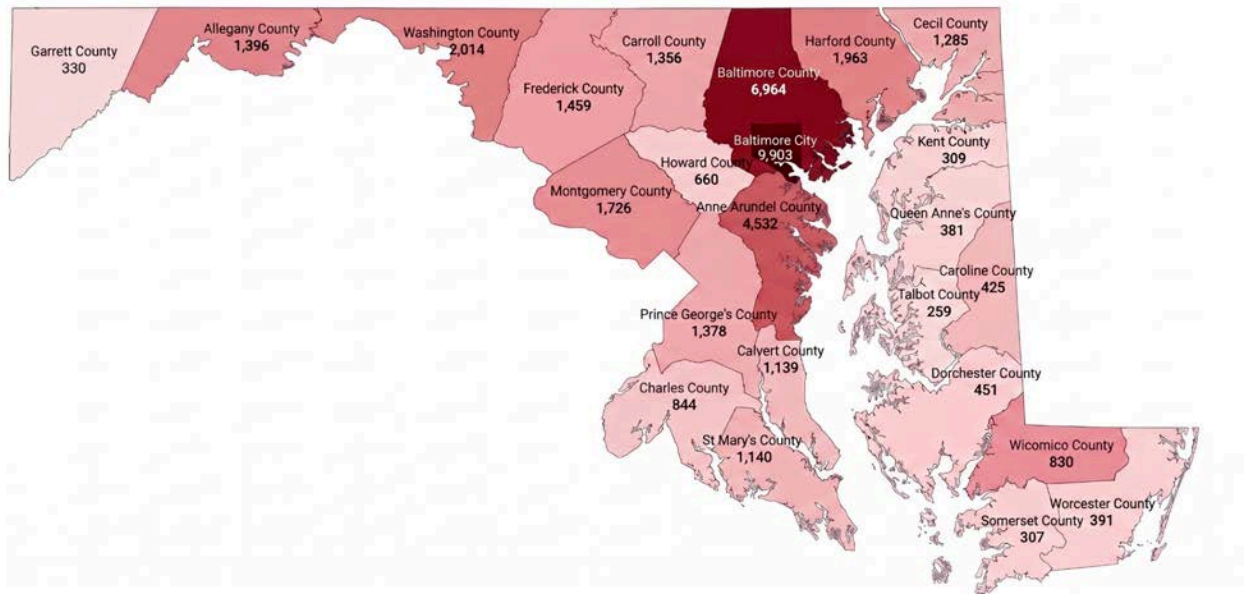


[10] Prescription Drug Monitoring Program, CY2021–CY2025. Maryland Department of Health. Note: PDMP data as of May 2026.

[11] Prescription Drug Monitoring Program Annual Report, Fiscal Year 2025. Prescription Drug Monitoring Program, Maryland Department of Health. https://dlslibrary.state.md.us/publications/Exec/MDH /HG21-2A-05%28f%29%283%29 _2025.pdf

As displayed in Figure 2, below, Baltimore City has the most patients filling prescriptions for buprenorphine to treat OUD, with 9,903 patients, followed by Baltimore County, with 6,964 patients, Anne Arundel County, with 4,532 patients, Washington County, with 2014 patients, and Harford County, with 1,963 patients. Despite the lower number of prescribers in Western Maryland and the Eastern Shore compared to Central Maryland, jurisdictions in these regions have relatively high rates of patients filling prescriptions of buprenorphine for OUD. For example, Allegany County has the highest rate with 21 prescriptions per 1,000 patients, followed by Baltimore City with 17, Kent County with 16, Dorchester County with 14, and Washington County with 13. This indicates that not all jurisdictions have achieved a level of treatment access commensurate with local rates of OUD diagnoses.

Figure 2: Patients Receiving Buprenorphine by Local Jurisdiction, 2025 (Source: PDMP)



Note: *Patients can appear in more than one jurisdiction if they moved within the calendar year.*

Patients received buprenorphine for OUD via different routes of administration, with sublingual buprenorphine formulated with naloxone prescribed and dispensed in the highest amount by far, with 327,815 prescriptions filled for this formulation in 2025. The next highest prescription count was for sublingual tablet buprenorphine combined with naloxone, with 56,415 prescription fills for this formulation in 2025. Monthly extended-release injectable buprenorphine had 16,416 fills. The least commonly prescribed and dispensed form of buprenorphine was weekly injectable buprenorphine without naloxone, with 229 prescription fills in 2025.

Several payment types were used by Marylanders receiving prescriptions of buprenorphine for OUD. The most commonly used payment type was Maryland Medicaid, which accounted for 231,315 prescription fills of buprenorphine for OUD in 2025, followed by commercial insurance, which accounted for 133,704 prescription fills. Medicare accounted for 33,408 prescriptions, and private pay/other payer types accounted for 29,472 prescriptions in 2025.

PBHS Data

The majority of individuals, 91%, receiving buprenorphine treatment services through PBHS received medication at an OTP rather than at an acute care hospital or an outpatient SUD treatment program. In FY 2024, 20,543 Medicaid recipients in Maryland received buprenorphine treatment, equivalent to approximately 12 buprenorphine recipients per 1,000 Medicaid-eligible Marylanders.[12] PBHS data also revealed significant disparities in geographic access to buprenorphine, with several counties showing no providers who billed PBHS for buprenorphine in FY 2024, including Garrett, Kent, Caroline, and Somerset Counties. Lastly, PBHS data revealed that PBHS Medicaid expenditures for individuals receiving MOUD compared to individuals not receiving MOUD are very similar. The average cost per person on MOUD, as opposed to someone with OUD not on MOUD, is slightly higher, in part because they are also receiving support services, such as counseling along with their MOUD. Additionally, the slightly increased cost of PBHS Medicaid utilization does not account for the significant long-term toll of a patient cycling in and out of treatment, developing costly skin and soft tissue infections related to injection drug use, or non-fatal overdoses.

Where do Marylanders receive buprenorphine for OUD?

Marylanders access their buprenorphine through a variety of ways, including in-person, telehealth, and mobile-outreach methods. Each access point has its own benefits and drawbacks, and there is no one-size-fits-all approach. Some of the ways people in Maryland access buprenorphine include:

Office-Based Opioid Treatment

Federal regulations now allow physicians, physician assistants, and nurse practitioners to prescribe buprenorphine for the treatment of OUD as long as they have registered with the DEA and Maryland's Office of Controlled Substances Administration to prescribe controlled substances. Obtaining a buprenorphine prescription directly from a prescriber who is not associated with a formal substance use disorder program is generally called office-based opioid treatment (OBOT). These settings provide patients with the convenience of more flexible scheduling and the ability to receive a prescription for buprenorphine from their primary care provider. Additionally, patients can fill these prescriptions at an outpatient pharmacy, rather than being required to attend an OTP in order to receive a dispensed dose.

Some OBOTs may also provide the opportunity for patients to receive holistic primary and preventative care in addition to OUD treatment. This could include screening for a variety of other physical health conditions and providing mental health services such as counseling. OBOT clinicians can also offer telehealth services, and the prescriptions written in these clinics are captured in Maryland's Prescription Drug Monitoring Program.

Opioid Treatment Programs

Opioid treatment programs are specialized providers who have met the federal requirements to dispense all types of MOUD, including methadone. Methadone is often their focus, but most OTPs in Maryland also provide access to buprenorphine as part of their comprehensive substance use disorder treatment services. Buprenorphine is dispensed at OTPs, which typically includes multiple take-home doses per

[12] ASO Optum's claims paid through 12/31/2024. *Data for FY 2025 are not final and represent only those services rendered and paid before the ASO transition on 1/1/2025. Percentages tally over 100% accounting for those individuals who received and were billed for services at multiple facility types.

week or month. OTPs are permitted to provide up to a month of take-homes from the time of admission, which is more liberal than the rules for methadone take-home doses.

Individuals can contact a local clinic to complete an intake assessment, after which a qualified medical provider can evaluate them for buprenorphine treatment. These clinics are required to offer a suite of psychosocial supports, such as counseling, case coordination, recovery support services, peer support services, provision of or referral to physical or mental health services, vocational and housing services, harm reduction services, and ongoing monitoring to support recovery.

Community Behavioral Health Centers

Community Behavioral Health Centers (CBHCs), such as outpatient mental health clinics, partial hospitalization programs, and substance use disorder residential programs, may also provide buprenorphine induction and maintenance, although it is less common than with OTPs. Many CBHCs also provide low-barrier and rapid appointments, making buprenorphine more accessible to those seeking help.

Local Health Departments

Local health departments in Maryland play a key role in helping individuals access buprenorphine treatment for opioid use disorder. Many counties offer services where clients can complete an assessment and be connected to a qualified prescriber for buprenorphine initiation. Health departments often provide or coordinate related services such as counseling, peer support, harm-reduction supplies, and referrals to ongoing community treatment programs.

Emergency Medical Services Field Induction

The period immediately following an opioid overdose represents a critical opportunity for intervention. However, many individuals revived by emergency medical services (EMS) with naloxone and rescue breathing decline transport to hospitals or further medical care. This refusal may stem from previous negative experiences in emergency clinical settings or the rapid onset of withdrawal symptoms following naloxone administration—symptoms that are often intensely distressing.[13] Buprenorphine offers a powerful tool in these moments because it rapidly relieves withdrawal symptoms while simultaneously blocking other opioids from exerting their dangerous effects, and EMS in Maryland are empowered to initiate patients on buprenorphine after an overdose. A 2023 study of the impact of EMS-administered buprenorphine on overdose survivors in New Jersey found that patients had a 12-fold increase in being engaged in treatment at 30 days if they were initiated on buprenorphine by EMS after an overdose, and they also had significant decreases on the Clinical Opioid Withdrawal Scale (COWS).[14]

In 2023, Maryland Institute for Emergency Medical Services System (MIEMSS) created an EMS-initiated buprenorphine protocol known as the Medications for Opioid Use Disorder by EMS and Linkage to Treatment (MODEL-T) protocol. This is an optional supplemental protocol that Maryland jurisdictions may opt into, provided they have the necessary training and partnerships. Jurisdictions wishing to adopt the protocol must receive a letter of approval from MIEMSS. Some jurisdictions have adopted the MODEL-T protocol, including Baltimore City, Baltimore County, Charles County, Frederick County, Montgomery County, Wicomico County, and the Salisbury Fire Department. Importantly, the success of

[13] https://linkinghub.elsevier.com/retrieve/pii/S0196064422005066
[14] https://pubmed.ncbi.nlm.nih.gov/36192278/

an EMS-initiated buprenorphine program largely depends upon linking patients to ongoing care with treatment providers. Expeditious low-barrier, follow-up care remains a rate-limiting step in many communities across the state.

In September 2025, MOOR published a request for proposal for a new Buprenorphine Training Grant Program with money dedicated to train paramedics in the practice of buprenorphine field induction. This funding is being made available from the state discretionary portion of the Opioid Restitution Fund (ORF)[15] in accordance with Maryland House Bill 1131 of 2025, which established the Buprenorphine Training Workgroup and the Buprenorphine Training Grant Program. Buprenorphine training may be available through local prescribers, and training typically lasts one to two days. Applicant governments may request up to $10,000 per county for funds to be completely utilized by June 30, 2026. A total of $50,000 is available through this grant program for the remainder of the 2026 fiscal year. To date, no jurisdictions have applied for this funding opportunity. Funding opportunities to support buprenorphine initiation through emergency medical services will be announced annually over the next five fiscal years.

Emergency Department

Hospital emergency departments (EDs)represent an important opportunity to initiate buprenorphine treatment for patients following an opioid overdose or who are assessed and diagnosed with OUD. Research has demonstrated that patients who present to an ED after an opioid overdose are much more likely to return to the ED and are also at a significantly increased risk of fatal overdose.[16] Providing rapid access to buprenorphine and warm hand-off linkages to care helps ensure that patients find and stay in treatment. Maryland House Bill 1155 of 2024 requires each hospital to provide patients who present to an ED for an opioid overdose or opioid-related emergency with evidence-based care. The law also requires hospitals to have at least one form of each MOUD, to make a referral to substance use treatment, and to include peer support specialists to assist patients with accessing further care. However, the legislation did not include any funding or an evaluation component, and specific state-level data on the number of patients accessing buprenorphine through hospital EDs does not currently exist.

Historically, the Behavioral Health Administration has provided funding to support emergency departments in implementing workflows for screening, brief intervention, and referral to treatment (SBIRT), peer recovery specialist integration, and buprenorphine prescribing. Current efforts have focused on educating EDs and providers about their obligation to treat, supported by the Maryland Addiction Consultation Service (MACS).[17]

Low-Threshold and Mobile Services

Low-threshold mobile services allow buprenorphine services to reach people who otherwise would be unlikely or unable to receive treatment. Anne Arundel County Department of Health operates the Maryland Mobile Wellness Program, or Wellmobile, which offers mobile low-barrier access to buprenorphine, care coordination, peer support services, wound care, sterile supplies, and more to people in need. The Wellmobile delivers services throughout the county and also offers telehealth and audio-only buprenorphine services to people across the state. Another good example is the Project Connections at Re-Entry (PCARE) initiative that provides mobile buprenorphine access to individuals

[15] https://stopoverdose.maryland.gov/orf/
[16] https://pubmed.ncbi.nlm.nih.gov/31229387/
[17] https://www.marylandmacs.org/

released from the Baltimore City Detention Center.[18] The PCARE Van parks directly outside the detention center and provides immediate buprenorphine induction to returning citizens at release. Mobile services like these play a critical role in initiating care for patients and bridging their treatment until linkage to a community provider is possible.

Telehealth Services

Telehealth services offer an opportunity to expand services to a variety of individuals who are unable to receive in-person care. These services are helpful for people who live far from a provider, lack transportation or childcare, have employment that creates scheduling barriers, or when routine travel to a brick-and-mortar location may be difficult for other reasons. Federal regulations allow telehealth prescribing of buprenorphine, and a final rule published in the Federal Register in January 2025 also allows audio-only telemedicine for the treatment of substance use disorders, including initiation on buprenorphine for OUD.[19]

The Baltimore City Mayor's Office of Overdose Response (BCMOOR) provides funding to the Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE) initiative, which is led by the University of Maryland School of Medicine and Institute for Health Computing. BCORE is a multi-disciplinary collaborative that engages people with OUD at critical moments in their care journey to connect them with MOUD and long-term care.[20] A key component of BCORE is a telehealth line, which is staffed by addiction medicine clinicians to prescribe buprenorphine for OUD and connect patients with follow-up care in their community after initiating them on buprenorphine. These clinicians can also refer patients to methadone providers when appropriate. The BCORE telemedicine line demonstrates the great potential for telemedicine to increase access to care.

Barriers to Care

Despite the many access methods that Marylanders have, several barriers exist that limit utilization of these services. Some barriers to care are common across the state, while others are more regional.

Limited Provider Uptake and Provider Capacity

Despite the removal of the requirement for providers to obtain an X-waiver, provider uptake remains limited for buprenorphine treatment. Stigma is a major contributing factor to this barrier. Primary care providers are not necessarily used to treating OUD and thus may be afraid to treat patients with SUD for a variety of reasons, including fear of causing precipitated withdrawal, inadequate training, insufficient time to provide necessary care, or fear that treating patients with OUD will take an exorbitant amount of time or cause disruptions in the office. Addressing provider fears and concerns is crucial, as is education and outreach to reduce stigma. Supporting prescribers through mentoring programs like MACS and by connecting them with highly specialized OUD treatment providers, as in a hub-and-spoke model, can alleviate fears and reduce stigma.

There are also challenges related to accurately tracking the capacity of buprenorphine providers in the state. The Substance Abuse Mental Health Services Association (SAMHSA) formerly hosted a

[18] http://www.bhli.org/the-pcare-van.html
[19] https://www.federalregister.gov/documents/2025/01/17/2025-01049/expansion-of-buprenorphine-treatment-via-telemedicine-encounter
[20] https://ihc.umd.edu/university-of-maryland-led-bcore-initiative-gets-major-boost-from-opioid-restitution-funds/

Buprenorphine Practitioner Locator tool, but the resource has recently been taken offline. The state also lacks a Maryland-specific list of providers who offer buprenorphine for OUD.

Geographic Gaps

Maryland is a diverse state, with its counties spread across rural and urban areas. Needs differ based on the realities of life in different geographic areas. People living in rural parts of the state may lack adequate buprenorphine treatment options in their own communities due to a smaller number of local prescribers, and a lack of transportation infrastructure may contribute to gaps in access to care in these areas as well.

In 2025, MACS published a Health Disparities Needs Assessment Planning Report that analyzed overdose patterns combined with buprenorphine prescribing indicators to identify jurisdictions with potential treatment gaps and to help prioritize outreach.[21] Based on their analysis, MACS stratified jurisdictions into four categories corresponding to different need and capacity categories. These categories were Higher Need/Lower Capacity, Higher Need/Higher Capacity, Lower Need/Lower Capacity, and Lower Need/Higher Capacity. MACS created the table below to show into which category each jurisdiction falls.

Table 1: Buprenorphine Capacity and Need Categorization

	Higher Need	**Lower Need**
Lower Capacity	Baltimore County, Charles, Frederick, Harford, Howard, Montgomery, Prince George's	Dorchester, Talbot
Higher Capacity	Allegany, Anne Arundel, Baltimore City, Carroll, Cecil, St. Mary's, Washington, Wicomico, Worcester	Calvert, Caroline, Garrett, Kent, Queen Anne's, Somerset

Congress established the Rural Health Transformation Program (RHTP) in 2025 to provide $50 billion to address health disparities in rural communities. In December 2025, Maryland was awarded $168 million in federal funding to modernize health care in rural areas.[22] The RHTP Plan describes the state's commitment to increasing access to behavioral health care, including SUD treatment and expansion of MOUD access.[23]

[21] Prepared by Burnett, M., MBA, MPH, MD, Vasquez, A., MHS, Hess-Mutinda, R., LMSW, BS, Zavelsky, L., BA, Shrock, H., MBS, Coble, K., LCSW-C, & Kleykamp, A., PhD, MA. (2025, December). MACS health disparities needs assessment planning report. University of Maryland School of Medicine, Maryland Addiction Consultation Service. Data Sources and Data Collaborators include the Maryland Prescription Drug Monitoring Program (PDMP), and the Health Services Cost Review Commission (HSCRC). Supported by the Maryland Department of Health Behavioral Health Administration.

[22] https://health.maryland.gov/pophealth/Pages/Rural-Health-Transformation-Program.aspx

[23] https://health.maryland.gov/pophealth/Documents/Rural%20Health/RHTP/MD-RHTP-Plan-CMS-Approved-12

Insurance and Cost

Many people who need buprenorphine services are unable to pay for treatment. Office visits and the medication itself can be expensive for people without insurance. Buprenorphine is covered by Maryland Medicaid and many private insurance plans, but not everyone has Medicaid or private insurance. Private insurance plans also have variable copays and coverage options. Additionally, while PBHS has a program that covers initial treatment for people who are uninsured for up to 90 days, allowing people to get treatment while still signing up for Medicaid or other insurance if eligible, some providers may not be aware of this, which could be a barrier to care. It is vital that when people are ready to seek care, they can do so at that moment.

People who are leaving incarceration are especially vulnerable to this barrier. In 2024, the Maryland Department of Health received approval from the Centers for Medicare and Medicaid Services to extend Medicaid coverage to incarcerated individuals in Maryland state facilities during the 90 days prior to their release, including for the coverage of buprenorphine and other MOUD.[24] However, the 1115 waiver has not been rolled out for use by local correctional facilities, meaning people leaving jail will not have active Medicaid benefits and may struggle to access care.

Finally, due to the implementation of work requirements and six-month redeterminations for Medicaid eligibility as a result of the implementation of Public Law 119-21, also known as the "One Big Beautiful Bill," starting on January 1st, 2027, there will be an increased administrative burden on Medicaid-eligible individuals, resulting in disruptions in care or loss of coverage.

Data Limitations

One of the biggest barriers to making specific recommendations that would increase access to buprenorphine is the challenge of integrating data from multiple systems. Maryland has made significant progress with regard to data sharing, launching public-facing dashboards that capture the scale of the overdose crisis across the state and how jurisdictions are spending local prescription opioid settlement funds. However, capturing the scale of treatment access with buprenorphine is a larger challenge because data on treatment is dispersed across multiple systems. The workgroup is grateful for the generous support from both the state PDMP and BHA. Each provided data to help capture the prevalence of buprenorphine prescribing and dispensing across the state. We are also grateful to the work done by MACS and PDMP in their Health Disparities Needs Assessment Planning Report, which captures variations in buprenorphine prescribing across the state.

As such, the workgroup is unable to provide a comprehensive snapshot of treatment that would provide meaningful data on how to best direct resources, evaluate compliance with legislative mandates, and give local jurisdictions the tools to identify the most at-risk populations in their community.

PDMP data provides a comprehensive total of prescriptions that are dispensed by pharmacies; however, pharmacies do not receive sufficient detailed information on race or provider type to accurately understand disparities in prescribing patterns. Prescriptions from providers working across systems cannot be differentiated, so treatment access through EDs, hospital inpatient units, outpatient behavioral health clinics, or primary care provider offices cannot be differentiated and accurately monitored.

-29-2025.pdf

[24] https://health.maryland.gov/mmcp/pages/1115-healthchoice-waiver-renewal.aspx

Due to 42 CFR Part 2, the federal regulations that govern special privacy and confidentiality protections for SUD treatment records, there is a historic and current exclusion of data regarding MOUD dispensed directly to patients by OTPs, which creates a blind spot in Maryland's public health data. This data gap obscures the true volume of buprenorphine dispensed for OUD and methadone services, making it impossible to fully evaluate local treatment networks. Recent updates to 42 CFR Part 2 allow OTPs to report data to state prescription drug monitoring programs as long as patient consent is obtained.[25] Although OTPs can now legally report this data under federal law, critical challenges persist, including necessary statutory amendments, technical infrastructure upgrades, and secured funding.

In 2025, the PDMP convened an OTP Reporting Workgroup to assess the feasibility of collecting and reporting data from OTPs.[26] The workgroup recommended three steps to help with integrating this data, including an OTP enrollment designation to alert providers that an individual is currently enrolled in an OTP, a unified consent form that would standardize the consent process to sharing information with the state health information exchange (HIE), and funding procurement to assist in comprehensive real-time data integration between OTPs and the state HIE.

Pharmacy Stock and Dispensing

Pharmacies face issues related to their stock of buprenorphine, in part due to limitations set by wholesalers. Pharmacists also cite fear of DEA scrutiny as a concern, as well as a lack of clarity from the DEA as to what "red flags" could trigger enforcement actions. These two issues are often described as being fueled by recent litigation related to opioid prescriptions, as many pharmacies and distributors were found liable for the prescription opioid crisis due to excessive prescriptions. Pharmacies also experience supply chain issues that affect buprenorphine access. All of these issues can lead to patients being unable to get a valid prescription filled, leading to people having to travel to multiple pharmacies to get their medication or going without the medication they need.[27]

Providers also struggle to help patients identify pharmacies in their community that stock buprenorphine for OUD. Some pharmacies may not stock buprenorphine for OUD at all, and some pharmacies may not stock all formulations of buprenorphine for OUD. There is currently no method for providers to monitor pharmacy stock, which makes it challenging to know which medication to prescribe and where to send a patient to fill their prescription.

Stigma and Equity

Pervasive negative attitudes towards people with OUD make it challenging for many to seek treatment. Some of these negative attitudes are born out of a belief that people with OUD do not get better, and others result from judgment or distrust towards those struggling with OUD. Because buprenorphine is an opioid agonist, some people believe that using it for treatment merely replaces one addiction with another. This is a harmful myth that exists among potential prescribers, substance use professionals,

[25] https://www.federalregister.gov/documents/2024/02/16/2024-02544/confidentiality-of-substance-use-disorder-sud-patient-records

[26] https://health.maryland.gov/pdmp/Documents/[UPDATED%20+%20LINKED]%20Meeting%20Minutes%20Archive/OTP%20Workgroup/Final%20Report%20-%20OTP%20Reporting%20Workgroup.pdf

[27] https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2024/07/22/the-role-of-pharmacists-in-medications-for-addiction-treatment

people with lived experience of OUD, and the public at large. There is significant evidence that buprenorphine is a highly effective treatment for OUD.[28]

Residential SUD programs, intensive outpatient programs, and partial hospitalization programs are often visible and familiar types of SUD treatment. Many individuals in the community struggling with OUD are likely to seek treatment at these traditional SUD programs and may be unaware of specialized OTPs and OBOT. Many of these inpatient and outpatient SUD programs, however, do not offer MOUD and may actively discourage MOUD or require that doses be tapered or minimized due to stigmatized beliefs about the use of medication in seeking treatment and recovery. One recent national study showed that fewer than a third of residential SUD programs offered buprenorphine or methadone treatment with the option to continue maintenance MOUD treatment.[29]

Racial disparities in access to buprenorphine are also significant and must be addressed. Several studies show that Black people receive buprenorphine treatment for OUD less frequently than white people in Maryland.[30] In 2022, Maryland's Racial Disparities in Overdose Taskforce recommended expansion of low-barrier buprenorphine services to help reduce this disparity.[31] The 2025 Maryland Overdose Response Advisory Council report shows that white people receive MOUD through Maryland's Public Behavioral Health System at much higher rates than Black people.[32] The 2025 MACS needs assessment and planning report also noted disparities in access to buprenorphine, with over 100,000 more prescriptions of buprenorphine filled by white, non-Hispanic Marylanders.[33] The MACS report also found that males were more likely to be prescribed buprenorphine than females and that buprenorphine for OUD prescribing was higher for males in all counties.

[28] https://americanhealth.jhu.edu/news/guiding-principles-addressing-stigma-opioid-addiction
[29] https://jamanetwork.com/journals/jama/fullarticle/2769709
[30] https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00205
[31] https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2023/04/Racial-Disparities-in-Overdose-Task-Force-Policy-and-Programmatic-Recommendations.pdf
[32] https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2026/01/2025-Maryland-Overdose-Response-Advisory-Council-Annual-Report.pdf
[33] Prepared by Burnett, M., MBA, MPH, MD, Vasquez, A., MHS, Hess-Mutinda, R., LMSW, BS, Zavelsky, L., BA, Shrock, H., MBS, Coble, K., LCSW-C, & Kleykamp, A., PhD, MA. (2025, December). *MACS health disparities needs assessment planning report*. University of Maryland School of Medicine, Maryland Addiction Consultation Service (MACS}. Data Sources and Data Collaborators include the Maryland Prescription Drug Monitoring Program (PDMP), and the Health Services Cost Review Commission (HSCRC).Supported by the Maryland Department of Health Behavioral Health Administration

Recommendations

On May 26th, 2026, the workgroup voted to accept the following list of final recommendations. The workgroup's recommendations fall into several distinct categories:

- Provider Capacity
- Geographic Gaps
- Feasibility of Financial Support for Long-Term Expansion of Services
- Data
- The Hub-and-Spoke Model
- Statewide Telehealth Line
- Low-Threshold Services
- EMS Induction and Referral
- Hospital and Emergency Department Access
- Pharmacy Issues and Pharmacy Access
- No Wrong Door Approach
- Anti-Stigma and Education
- Culturally-Sensitive and Evidence-Based Approaches to Reach Vulnerable and Marginalized Groups
- Ensure and Expand Buprenorphine Services in Carceral Settings
- Long-Acting Injectable Buprenorphine

Provider Capacity

As discussed above, there is no regularly updated list of providers offering buprenorphine for OUD services in Maryland. The workgroup believes that better tracking of buprenorphine services in the state is necessary to better understand capacity.

Recommendations:

1. Implement a survey to track the availability of buprenorphine providers across jurisdictions. Survey methods should be explored, including the possibility of incorporating the survey into licensure renewal for clinicians.
2. Create a list of buprenorphine for OUD providers that is regularly updated according to survey data and host this list on state websites. For each provider, the list should describe:
    a. hours of operation of a clinic or medical provider office;
    b. whether a clinic is accepting new patients; and
    c. location and contact information.
3. Expand the number of OTPs in certain jurisdictions within Central Maryland with higher need/lower capacity, as described in the 2025 MACS report.
4. Encourage OTPs to provide buprenorphine treatment, utilizing all formulations of buprenorphine.
5. Task Overdose Prevention Teams (OPTs) with defining a treatment capacity framework for their jurisdiction to assist with the tracking process.[34]
6. Align monitoring of buprenorphine services and capacity building efforts with legally mandated services, such as buprenorphine in local correctional facilities and hospital emergency departments.

[34] https://stopoverdose.maryland.gov/overdose-prevention-teams/

Geographic Gaps

The 2025 MACS disparities report, referenced above, provides a helpful framework for understanding treatment capacity in different jurisdictions across the state. PBHS data also revealed several treatment deserts in the state. Despite the capacity limitations in some jurisdictions, there are promising methods on the horizon to increase access to care, such as through telemedicine or expansion of services with federal Rural Health Transformation Program grant dollars.

Recommendations:

1. Ensure that all people who need buprenorphine can receive it in a way that is most convenient for them.
2. BHA and MACS should continue to work together to establish ongoing criteria for need/capacity in rural areas and report annually on how jurisdictions fit within this framework.
3. BHA, MACS, and MOOR should develop a toolkit to prioritize spending of grant funds and local prescription opioid settlement funds based on the capacity/need framework.
4. Leverage telehealth care models to fill gaps in rural care, such as by initiating buprenorphine with audio-only telemedicine as authorized by the January 2025 rule change jointly issued by the DEA and HHS.
5. Use federal Rural Health Transformation grant funds to improve access to buprenorphine for rural Marylanders.

Feasibility of Financial Support for Long-Term Expansion of Services

According to a 2022 research article published in *Drug and Alcohol Dependence*, buprenorphine treatment for OUD operates at a significant cost savings as compared to untreated OUD.[35] A 2025 study published in *JAMA Pediatrics* suggests that buprenorphine treatment for pregnant and post-partum individuals accounts for significant cost savings and improved health outcomes for parent and child.[36] The potential boon in significant long-term cost savings of buprenorphine treatment, coupled with Maryland PBHS data reflecting similar Medicaid expenditures in the short term for patients receiving MOUD compared to patients not receiving MOUD, suggests that investing in buprenorphine treatment is a worthy endeavor. A 2021 systematic review found that MOUD, including buprenorphine, plays a significant role in medication adherence for HIV patients receiving antiretroviral therapy, leading to increased viral suppression.[37] A 2020 study found that patients who were hospitalized for a drug use-related skin or soft tissue infection (SSTI) and received MOUD after hospitalization had lower rates of SSTI recurrence and lower rates of reshospitalization at one year.[38] Many more studies contribute to the growing body of evidence suggesting that MOUD access improves health outcomes and reduces healthcare costs in the long run.

Despite the cost-benefit to treating patients with buprenorphine, funding for buprenorphine and other MOUD remains a barrier to care, especially for certain vulnerable Marylanders. MOUD access for people incarcerated in local correctional facilities is required by Maryland law, but not all facilities have fully implemented MOUD programs. Implementing these programs is vital, and improving coordination of state funding for local correctional facilities is critical. Uninsured Marylanders may also struggle to access

[35] https://pmc.ncbi.nlm.nih.gov/articles/PMC9852082/
[36] https://jamanetwork.com/journals/jamapediatrics/article-abstract/2838297#google_vignette
[37] https://pmc.ncbi.nlm.nih.gov/articles/PMC8378589/#s16
[38] https://pmc.ncbi.nlm.nih.gov/articles/PMC7502512/#S17

buprenorphine. Lastly, impending changes to Medicaid eligibility threaten to disrupt care and support for those who need it most.

Recommendations:

1. Improve coordination of funding for local correctional facilities regarding implementation of MOUD programs, ensuring that people who are incarcerated have a reasonable means of receiving care.
2. Consider supplemental funding for buprenorphine treatment for uninsured Marylanders.
3. Require BHA and Maryland Medicaid to report on the impact of coverage changes with the implementation of Public Law 119-21, also known as the "One Big Beautiful Bill," with regard to SUD coverage and buprenorphine prescribing.

Data

Directing resources to make treatment data more transparent is an important step to targeting treatment and support where needs are greatest. Developing integrated data capacity at the state level that can be used to monitor, support, and evaluate statewide and local buprenorphine initiatives is critical. Working to integrate PBHS, Maryland Medicaid, PDMP, and HSCRC data can help build the infrastructure to ensure people with OUD can access treatment across the continuum of care and transition smoothly between systems. This is a first step towards a broader integrated data set that could potentially include all payers.

Recommendations:

1. Improve statewide data alignment and reporting on buprenorphine and SUD treatment and referral data by integrating HSCRC and PDMP to allow for monitoring and evaluation of hospital emergency department buprenorphine treatment versus community-based prescribing.
2. Develop a unified data system that integrates the following data sources: PBHS, Maryland Medicaid, PDMP, CRISP HIE, and HSCRC.
3. Create unified outcomes, process measures, and performance metrics for the state to track.
4. Develop a data dashboard that can provide jurisdictional and statewide monitoring of MOUD access, utilization, and treatment capacity, with an initial focus of creating an internal dashboard for state employees with data from PBHS and PDMP to provide a comprehensive view of MOUD treatment across outpatient providers in Maryland.
5. Develop a data dashboard that utilizes data systems to generate data on the number of people who presented to hospital emergency departments with OUD-related conditions and the percent treated within seven days or released from care.
6. Improve data capture related to age, sex, race, and geographic access to further illuminate disparities and barriers to buprenorphine care.
7. Monitor the distribution of pharmacies and OTPs providing buprenorphine to ensure adequate access across the state.
8. Develop a means to capture and share pharmacy-level data so that providers can know which pharmacies are stocking which formulations of buprenorphine.

The Hub-and-Spoke Model

Integrating SUD services in primary care settings is essential for expanding buprenorphine utilization and improving patient outcomes. The hub-and-spoke model seeks to address this by leveraging specialized

SUD treatment providers experienced in using MOUD (such as OTPs) as a hub where the most difficult and complex stages of treatment can be accomplished, such as the initial assessment, early medication induction, and stabilization. MOUD provision can then be transitioned to spokes (most often primary care clinics or providers) when less comprehensive or intensive SUD treatment will suffice and can be integrated into a patient's physical health care management. Hubs can support the spoke providers in the care of patients, whether by doing the "heavy lifting" of more complex treatment elements as above, or providing as-needed consultation on shared cases, and/or being a source of referral back to the spoke should the patient demonstrate a need for more comprehensive care. The first such model was developed here in Maryland over 15 years ago, at Johns Hopkins University.[39]

OTPs provide comprehensive treatment for OUD and co-occurring disorders. This includes the use of MOUD and medications for other SUDs, such as alcohol use disorder and medications for nicotine use disorder. OTPs also provide non-medication therapies for these disorders, including counseling (group and individual), psychotherapy, case management, and peer recovery support. Co-occurring medical and mental health conditions can be monitored and addressed - whether through direct services within the OTP or through coordinated care.

In order to facilitate this process, the OTP needs to 1) be licensed in such a way as to permit such services to be provided, and 2) have a reimbursement structure available for integrative models of care. For example, in a buprenorphine hub-and-spoke model that has an OTP as a hub of expertise and resources for treatment of OUD, there are times in the patients' treatment when the medication dispensing will be through an external office-based provider prescribing to pharmacies, which will dispense the buprenorphine to the patient. The OTP, during such times, may continue to treat the patient, addressing remaining treatment care plan goals, delivering counseling and care management services, monitoring drug use via toxicology testing, etc. The prescriber and OTP coordinate care. During these times, the OTP effectively acts as a Level I SUD provider, as opposed to a traditional OTP delivering and billing for medication services. In fact, there may be times when office-based prescribing continues even during times of relative instability, while the OTP escalates its level of non-medication treatment to intensive outpatient (level 2.1). Given the existing expertise, competencies, and documentation/logistics that OTPs and their staff must possess to meet numerous levels of oversight (SAMHSA, CMS, state Medicaid, COMAR, accreditation), they effectively already meet the requirements for OP/IOP level of care, and should be licensed, automatically, as such. That is, OTP care should be considered a service that is provided from the base of an OP/IOP program, which has its own set of additional requirements for licensure and accreditation. Some such programs already exist, but require additional effort, cost, and surveys to maintain, due in part to the need for separate licenses. Therefore, by making this process easier or automatic, more programs could operate with this level of nimbleness and implement innovative models such as a hub-and-spoke model with greater ease.

Addressing OTP reimbursement concerns is also important to maximize the impact of a hub-and-spoke model. Currently, there are limits to the number and type of visits that a patient can have in any given day, meaning that patients sometimes must return to the OTP on subsequent days for components of their treatment, just for the sake of billing. For example, an OTP patient should be able to visit the program on a single day and receive SUD services (dosing, counseling), go to a health suite to see a medical provider for hepatitis C treatment, and then finish their visit by seeing the program psychiatrist or other medical provider for medication monitoring of their major depressive disorder. That is not

[39] https://pmc.ncbi.nlm.nih.gov/articles/PMC4347582/

currently possible, as both state and federal rules prevent billing Medicaid for different services on the same day.

Despite the barriers described above, the state has two programs currently in place that can be used to expand access to this type of care:

- The Health Home program allows OTPs to invest in care coordination services to help behavioral health patients link to mental health and medical services. Ensuring that more OTPs implement the Health Home Program will ensure that patients receiving care in OTPs are able to better navigate to medical services.
- The Collaborative Care Model for Behavioral Health Services allows primary care providers to integrate SUD care by consulting SUD specialists. There has been limited use of the Collaborative Care Model for SUD across the state, as it has mostly been used for mental health treatment in primary care. OTPs are supervised by board-certified addiction medicine specialists and, since 2020, have been able to provide telehealth services. OTPs are uniquely positioned to provide specialized SUD care through the collaborative care model to advise community providers on the initiation of buprenorphine and more complex SUD care.

Widespread adoption of the hub-and-spoke model can also be facilitated by creating trainings given by presenters with expertise in running such models, establishing learning collaboratives, and by instituting technical assistance and financial support to encourage participation and early adoption.

Recommendations:

1. Utilize OTPs or other specialized SUD treatment providers as hubs to take the heavy lifting off of OBOTs, provide mentorship around patient issues, and provide a safety net for when patients need a higher level of care or observation during times of instability.
2. In higher need / lower capacity jurisdictions, the hub-and-spoke model should be adapted based on the Bridge Program, using ED-based treatment along with a 24/7 telehealth line for bridge services.
3. Ensure that it is easy for OTPs to provide treatment that doesn't include medication dispensing by approving OTPs as Level I providers, encouraging the utilization of the Collaborative Care Model for SUD treatment across care systems, encouraging utilization of the Health Home Program, and providing education to potential spoke providers on their ability to prescribe buprenorphine. The state should also explore innovative billing structures with stakeholder input.

Statewide Telehealth Line

Telehealth services offer an opportunity to expand services to a variety of individuals who are unable to receive in-person care. Federal regulations allow telehealth prescribing of buprenorphine, and a final rule published in the Federal Register in January 2025 also allows audio-only telemedicine for the treatment of substance use disorders, including initiation on buprenorphine for OUD.[40] The BCORE initiative is piloting a telehealth line for MOUD treatment and referral that can serve as a model for the state when considering how to extend these services to more Marylanders.

[40] https://www.federalregister.gov/documents/2025/01/17/2025-01049/expansion-of-buprenorphine-treatment-via-telemedicine-encounter

Recommendations:

1. Develop a 24/7 state-wide hotline for treatment and referrals.
2. Support the BCORE model in order to scale up services across the state.
3. Encourage access to MOUD for people in recovery residences via the telehealth line.

Low-Threshold Services

Low-threshold services allow patients to access care in a variety of settings at low or no cost and without many requirements for participation. They are a critical component of expanding access to care to all Marylanders, including Marylanders who are unhoused, uninsured, or struggle to access traditional healthcare settings for any reason.

Recommendations:

1. Require programs receiving ORF that offer MOUD to focus on low-barrier access to care, including same-day initiation and walk-up appointments.
2. Expand low-threshold mobile services to more communities, looking towards the Anne Arundel County Wellmobile or the PCARE Van as models.

EMS Induction and Referral

EMS clinicians are frontline professionals in the overdose field who have the opportunity to initiate buprenorphine treatment and link patients to ongoing care. EMS must be supported by community providers, hospitals, and a telehealth line in order to ensure that patients receiving buprenorphine can connect to same- or next-day follow-up care. The availability of low-barrier, next-day resources is vital and must increase in order to sustain positive long-term patient outcomes. Evaluation is also important to understand what percentage of individuals with OUD treated by EMS remain engaged in treatment at 30 days.

The EMS Bridge Model, developed by the Bridge Program, engages EMS in the treatment of OUD. The model uses EMS initiation of buprenorphine and engages patients with motivational interviewing, helping connect them to follow-up care with a warm hand-off to EDs. Patient navigators work with patients to assist them with ongoing treatment and support. Paramedics also leave naloxone with patients and their peers. A review of the Bridge Program's EMS pilot program found that 25% of patients were retained in treatment at 30 days.[41]

Notably, all of Maryland's EMS jurisdictions provide "leave behind" naloxone to patients, friends, and family members after overdose responses. In addition, there are currently six Maryland jurisdictions that provide EMS-initiated buprenorphine, similar to the Bridge program and "Bupe FIRST" team in Camden, New Jersey. With appropriate resources and support, these programs can grow, and new jurisdictions may join the effort.

Recommendations:

1. Identify barriers to implementation of buprenorphine initiation within EMS programs across the state.

[41] https://pubmed.ncbi.nlm.nih.gov/35420925/

2. Continue to fund buprenorphine training for EMS clinicians, supporting this endeavor with a 24/7 telehealth line.
3. Identify best practices for post-overdose and SUD care to share with EMS providers.

Hospital and Emergency Department Access

Post-overdose care in the ED is a critical opportunity to intervene with individuals struggling with OUD. EDs provide 24/7 access and high-level medical wraparound care. In 2024, HB 1155 passed, requiring hospitals to establish and maintain protocols for MOUD screening, induction, and referral. Additional effort is needed to ensure that all hospitals are using best practices with regard to buprenorphine access, beyond the minimum requirements of HB 1155. The Bridge Program is a highly successful model for expanded MOUD access in the ED. It relies on low-barrier, immediate access to MOUD, navigation to ongoing care in the community, and the development of a culture of overdose prevention and stigma reduction. The Bridge Program showed significant promise with regard to increased buprenorphine access in EDs after initial implementation in California, where the model was developed.[42] The Bridge Program offers training and technical assistance to EDs, along with consultation to providers, hospital administrators, and state employees.

Ensuring that Maryland has a sustainable model for the Bridge program is key to its successful implementation. An article from Johns Hopkins University Bloomberg School of Public Health describes how leveraging federal funding and changes to state Medicaid policy is ideal for sustainability.[43] The National Academy for State Health Policy (NASHP) further describes the need to create Medicaid reimbursement codes for patient navigators in the ED as a vital component of sustainability.[44] Data collection and analysis are also needed so that a return on investment calculation can be made to demonstrate efficacy of the model.

Recommendations:

1. Ensure that all acute care hospitals offer buprenorphine induction with appropriate referrals, and encourage utilization of addiction consultation services, including peer support services, to facilitate this.
2. Explore policy changes needed to provide sustainable funding and reduce authorization barriers for immediate MOUD access and patient navigation in EDs.
3. Utilize the Bridge Program model for expanded MOUD access in EDs.
4. Implement the 72-hour rule for methadone continuation on discharge.

Pharmacy Access

A primary concern for pharmacy owners and pharmacists regarding buprenorphine for OUD is the misconception that stocking it will lead to heightened risk for their investigation by state or federal authorities. State officials from PDMP, Maryland's Office of Controlled Substances Administration (OCSA), the Maryland Board of Pharmacy, and MOOR can work together to reassure pharmacists that proactively managing OUD is a public health priority that aligns with, rather than contradicts, their responsibility to prevent diversion.

[42] https://ajph.aphapublications.org/doi/10.2105/AJPH.2024.307710
[43] https://opioidprinciples.jhsph.edu/how-federal-grants-built-the-california-bridge/
[44] https://nashp.org/california-bridge-considerations-for-state-financing-of-oud-treatment-in-emergency-departments/

The disparate stock of buprenorphine at pharmacies remains an issue for patients and prescribers. Prescribers do not know where to send their patients to fill their prescriptions for buprenorphine. Without a method for providers to monitor pharmacy stock, it is challenging for prescribers to feel confident in knowing which formulation of buprenorphine to prescribe and to which pharmacy they should send a patient.

Recommendations:

1. PDMP, OCSA, the Board of Pharmacy, and MOOR should collaborate on a unified message to pharmacy owners and pharmacists to reassure them that increasing access to buprenorphine for OUD does not inherently elevate a pharmacy's risk profile for state or federal investigation.
2. Leverage existing relationships with the DEA's Diversion Control Office to alleviate pharmacy concerns.
3. Investigate methods to address pharmacy supply and stock issues.
4. Create a mapping tool that overlays pharmacy locations with jurisdictions with high rates of OUD and PDMP data.

No Wrong Door Approach

Buprenorphine or other medications for OUD are often the best treatment option for individuals diagnosed with OUD. It is essential that all SUD programs screen program participants for the appropriateness of MOUD, educate participants on the effectiveness of MOUD, and facilitate access to MOUD, either directly or through established referral agreements. MOUD access or referral to a provider that can offer MOUD is not currently a requirement for licensure for residential SUD programs, intensive outpatient programs, or partial hospitalization programs. Establishing this expectation as a requirement for licensure could help create a "no wrong door" approach to MOUD access.

Recommendations:

1. Adopt regulations in COMAR to require screening for, education on, and access to MOUD as a requirement for licensure for SUD programs, including residential, intensive outpatient, and partial hospitalization programs.
2. Create a network of linked services with the goal of normalizing OUD treatment.

Anti-Stigma and Education

Stigma against buprenorphine is widespread, with many people uninformed about or doubting the efficacy of buprenorphine and other MOUD. Negative attitudes and beliefs towards people who use drugs, people with SUD, and MOUD are pervasive and are a barrier to care. Sometimes, even people with SUD and people in recovery hold internalized stigma towards MOUD. A targeted anti-stigma and awareness campaign is necessary to educate providers, patients, and the general public about the effectiveness of MOUD and their validity as a recovery pathway. Anti-stigma and education campaigns should also be targeted toward government entities such as social services, housing, criminal justice, employment services, and other support agencies.

Recommendations:

1. Fund a comprehensive public education campaign to address stigmatizing beliefs that are limiting MOUD usage.

   a. Tailor messaging for relevant stakeholders, including medical professionals, frontline addiction treatment providers, peers, people who use drugs, and the general public.
   b. Include people with lived and living experience in the development of the product, allowing them to share their stories.
   c. Pay special attention to the reduction of stigma regarding the use of methadone, which can exist in providers who are already comfortable utilizing buprenorphine.
2. Expand interdisciplinary education and training on SUD and OUD, such as at graduate programs for medical or behavioral-health specific education and training.

Culturally-Sensitive and Evidence-Based Approaches to Reach Vulnerable and Marginalized Groups

As described in the Stigma and Equity section of this report, racial disparities in access to buprenorphine are significant, with Black Marylanders receiving buprenorphine for OUD less frequently than white Marylanders. At the same time, despite overdose deaths in Maryland reaching a 10-year low, overdose mortality among non-Hispanic Black men over the age of 55 remains disproportionately high, with the overdose mortality rate for this group three times higher than for white men in the same age bracket.[45]

Engaging people who use drugs with cultural humility is vital in order to help connect vulnerable and marginalized groups to evidence-based practices, such as buprenorphine treatment. Imani Breakthrough is a program developed and implemented by Dr. Ayana Jordan that engages individuals to access SUD care by centering eight "dimensions of wellness" (emotional, occupational, intellectual, environmental, financial, social, physical, and spiritual) and the five "Rs of citizenship" (rights, responsibilities, roles, resources, and relationships). Imani was co-developed by people in recovery and people of color and uses evidence-based practices for community engagement. The program involves group support sessions and classes to teach community members about recovery.[46] Maryland can look into bringing Imani Breakthrough to its communities or seek a similar method of community engagement.

Skilled nursing facilities (SNFs) are a component of the healthcare system that encounter many vulnerable people who may have OUD. Hospitals often are in need of placing patients in short-term SNFs to improve clinical outcomes due to complications associated with substance use. Maryland instituted a novel program, called OUD MEETS, to make MOUD treatment initiation and referral to SNFs easier for patients in hospitals. Coordination with community OTPs for discharge planning is also a component of OUD MEETS. A study of the program showed high rates of initiation of MOUD in the hospital and continuation through the entire SNF stay.[47] As we see older adults disproportionately impacted by the overdose crisis, SNFs and other long-term care facilities are important partners in ensuring access to evidence-based treatment. Expanding the OUD MEETS program and engaging SNFs and long-term care facilities in stigma reduction and education is important for improved MOUD access and comprehensive care for people with OUD.

Recommendations:

1. Address historical mistrust of the medical establishment due to past misconduct by healthcare providers.

[45] https://governor.maryland.gov/news/press-releases/governor-moore-announces-maryland-overdose-deaths-falling-fourth-straight-year-reaching-10-year-low
[46] https://pubmed.ncbi.nlm.nih.gov/37207836/
[47] https://www.jsatjournal.com/article/S0740-5472(22)00177-5/abstract

2. Train skilled nursing facilities to accept and continue MOUD treatment after OUD-related hospitalizations.
3. Explore bringing the Imani Breakthrough Program to Maryland, or develop a similar model to build trust and engage marginalized groups.

Ensure and Expand Buprenorphine Services in Carceral Settings

People who are incarcerated are disproportionately affected by substance use disorders, with data from the Bureau of Justice Statistics showing that nearly two-thirds of incarcerated people meet the criteria for substance use disorders.[48] Local correctional facilities are required by the Annotated Code of Maryland Article – Correctional Services § 9–603 to implement MOUD programs, offering at least one formulation of each FDA-approved MOUD to patients for whom MOUD is appropriate. The state provides significant funding through various grant opportunities for local correctional facilities to host MOUD programs, yet problems persist with regard to implementation.

Reentry from incarceration is also a critical period. Multiple studies have indicated that drug overdose is the leading cause of death after release from incarceration.[49,50,51] The first two weeks post-release from incarceration is the time of highest risk, with a study from North Carolina showing a 40-fold increased odds of an opioid overdose in that period of time.[52] Maryland recently was approved for a Medicaid 1115 demonstration waiver to enroll people who are incarcerated in state facilities in Medicaid starting 90 days prior to release, including for SUD care. It also allows Medicaid to pay for a 30-day supply of medication upon release.[53] While the 1115 HealthChoice demonstration waiver currently only applies to individuals in state facilities, it could be expanded to people in local correctional facilities in the future.

Recommendations:

1. Improve coordination of funding for local correctional services to implement MOUD programs.
2. Improve reporting and transparency on services in local correctional facilities. Data should reflect whether facilities are limiting or restricting the number of people treated or capping dosages or discharge bridge prescriptions.
3. Utilize the Medicaid 1115 waiver to enroll people in local correctional facilities in Medicaid 90 days prior to release, once it is possible for local correctional facilities to participate in the waiver.

Long-Acting Injectable Buprenorphine[54]

The use of long-acting injectable buprenorphine (LAI-B) has been shown to be safe and effective in multiple clinical settings; however, there are several barriers to its use, including:

- DEA-compliant storage requirements;
- prior authorizations;
- FDA-mandated Risk Evaluation and Mitigation Strategy (REMS) certification for pharmacies.
- inability to receive the medication by mail.

[48] https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf
[49] 10.1056/NEJMsa064115
[50] 10.1111/j.1360-0443.2010.02990.x
[51] 10.2105/AJPH.2018.304514
[52] Ibid.
[53] https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/
[54] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2840048#google_vignette

- LAI-B must be administered by a licensed provider, rather than self-administered.
- high upfront cost of LAI-B for a buy-and-bill program; and
- requirement that patients have been on sublingual buprenorphine for 7 days.

Recent innovations allow community pharmacies to become REMS-certified. This allows FQHCs, CCBHCs, or other clinics co-located with a pharmacy to keep the medication on site and readily available for patients to initiate. Pharmacies are also able to directly administer the injection with a valid prescription from a DEA-licensed provider. This has only been done at a few pharmacies around the state, but can serve more patients, especially in rural areas, and could also help individuals transitioning from institutional to community settings (i.e., jails, long-term care facilities, etc).

Removing the prior authorization requirement for LAI-B can speed up the time from when a provider orders the medication to when patients can receive it. Due to the current process, after a provider receives prior authorization and orders the LAI-B to their practice from a specialty pharmacy, the dose has already been paid for by Medicaid. If a patient fails to return for their injection, the dose must be disposed of after 45 days; however, pharmacies can keep the medication stocked until the patient arrives to be seen and only charge Medicaid when the medication is dispensed, preventing wasted doses.

LAI-B is a useful tool for initiating buprenorphine in patients who are otherwise hard to treat. Traditional treatment protocols require patients to avoid using any illicit opioids for 12–24 hours prior to taking their first sublingual dose. The dose can trigger painful acute withdrawal if taken too soon after their last use. This can discourage patients from future treatment attempts. New protocols, called direct-to-inject, allow patients to directly receive LAI-B even when they have used illicit opioids recently or have had prior difficulty initiating buprenorphine.[55] This is because LAI-B has a slower onset of action. This has been studied in low-barrier community settings and in hospital emergency departments as a safe and effective way to initiate buprenorphine in difficult-to-reach populations. The biggest barrier to implementing direct-to-inject protocols is the upfront cost of LAI-B and the current need for prior authorization to administer it from a pharmacy.

Exploring options for bulk purchasing and contracting with the manufacturers of LAI-B products may allow providers to better access these medications. The current buy-and-bill funding model for providers requires a large upfront cost. Modifying the buy-and-bill program to allow providers to use state grant funds to purchase their first few doses, which could be reimbursed by Medicaid after the injection is given, can help expand access to LAI-B. It is also worth exploring the option of allowing emergency departments to bill separately for the cost of LAI-B to lower the barrier to its utilization.

Recommendations:

1. Encourage the use of LAI buprenorphine through pharmacist-dispensed injections and direct to inject same-day initiation protocols.
2. Expand financial options to initiate and treat with long-acting injectable buprenorphine.

[55] https://bridgetotreatment.org/wp-content/uploads/Bridge_National_DTI-protocol_Updated_May_2026.pdf

Appendix A: PDMP Buprenorphine Provider and Dispensing Data Tables

Table 2: Buprenorphine for OUD Treatment Providers by Jurisdiction

Jurisdiction	Provider Count
Baltimore City	927
Baltimore County	547
Montgomery County	292
Prince George's County	260
Anne Arundel County	256
Howard County	141
Harford County	115
Frederick County	112
Washington County	99
Carroll County	86
Wicomico County	77
Cecil County	61
Allegany County	59
Charles County	48
Talbot County	36
Calvert County	32
St Mary's County	29
Dorchester County	20
Worcester County	20
Garrett County	19
Queen Anne's County	Suppressed
Caroline County	Suppressed
Kent County	Suppressed
Somerset County	Suppressed

Table 3: Buprenorphine for OUD Treatment Patient Totals by Jurisdiction

Jurisdiction	Patient Count
Baltimore City	9,903
Baltimore County	6,964
Anne Arundel County	4,532
Washington County	2,014
Harford County	1,963
Montgomery County	1,726
Frederick County	1,459
Allegany County	1,396
Prince George's County	1,378
Carroll County	1,356
Cecil County	1,285
St Mary's County	1,140
Calvert County	1,139
Charles County	844
Wicomico County	830
Howard County	660
Dorchester County	451
Caroline County	425
Worcester County	391
Queen Anne's County	381
Garrett County	330
Kent County	309
Somerset County	307
Talbot County	259