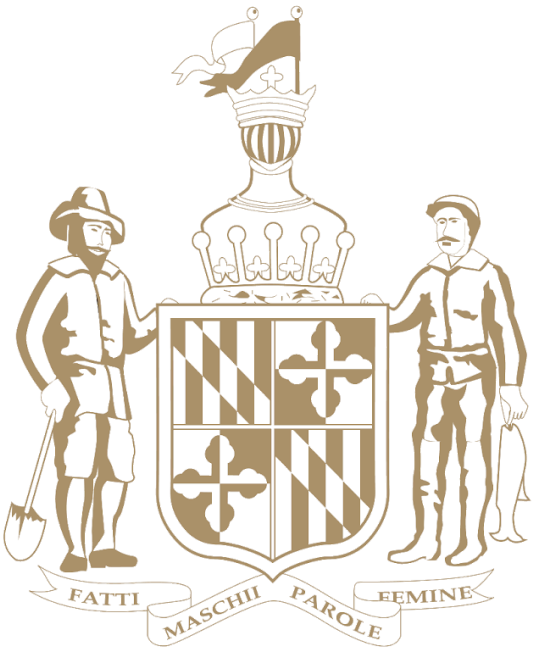

Maryland Buprenorphine Access Workgroup

Fiscal Year 2025

Released: December 31, 2025

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 2024, there were 1,770 fatal drug overdoses in Maryland, according to preliminary data on Maryland's Overdose Data Dashboard.[1] This is a 37-percent decrease from the state's historic high in 2021, when 2,800 people died of 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. Despite this, access and utilization of MOUD is lacking for many who need it. Maryland's Office of Overdose Response 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.[2]

Marylanders currently access buprenorphine through a variety of means. Some of the methods are more traditional, such as access through opioid treatment programs, office-based care, and local health departments. In recent years, more innovative practices have been developed that provide access to buprenorphine through alternative means including in emergency departments, emergency medical services initiation, mobile services, and telehealth services. Some of these options also operate from a low threshold standpoint, meeting people where they are and providing tailored services to their unique needs. 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. The Buprenorphine Access Workgroup requires further data to fully evaluate barriers to care but has identified an initial list of barriers to focus on. These include stigma, racial disparities, pharmacy access issues, limited provider uptake, cost, and rural areas.

The Buprenorphine Access Workgroup will continue meeting in 2026 to further study this issue. The Workgroup intends to gather more data and expand partnerships and collaboration with a variety of stakeholders, including the Maryland Addiction Consult Service and the Maryland Prescription Drug Monitoring Program. The Workgroup will publish a full report with their findings and complete recommendations in 2026.

[1] https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx
[2] https://stopoverdose.maryland.gov/resources/

Introduction

Maryland's Buprenorphine Access Workgroup was established in 2025 to study access to buprenorphine in the state. Pursuant to House Bill 1131 (HB 1131) 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, Maryland's Office of Overdose Response is required to submit a report on the findings and recommendations of the workgroup by December 31, 2025.[3] 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 will continue meeting in 2026 with the ultimate goal of submitting 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;
- summary of access methods for buprenorphine in Maryland; and
- description of barriers to care; and
- next steps for the workgroup

Membership

Members of Maryland's Buprenorphine Access Workgroup include representatives from the following entities:

- Senate of Maryland
- Maryland House of Delegates
- Maryland Institute of Emergency Medical Services Systems (MIEMSS)
- Maryland's Behavioral Health Administration
- Maryland Board of Pharmacy
- Maryland Hospital Association
- Local Behavioral Health Agencies
- The Maryland Association of Counties

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

The members of the workgroup are:

- Senator Arthur Ellis
- Delegate Pamela Guzzone
- Dr. Timothy Chizmar, MD, FACEP, State EMS Medical Director
- Barry Page, MOUD Early Intervention Program Manager, Behavioral Health Administration
- Salima Montes, Program Administrator, Behavioral Health Administration
- Deena Speights-Napata, Executive Director, Maryland Board of Pharmacy
- 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 Rabbit, Policy Director, Behavioral Health System Baltimore
- Matthew Burgan, NRP, CP-C, Frederick County Division of Fire & Rescue Services

Progress in 2025

Maryland's Buprenorphine Access Workgroup held eight meetings in 2025, recordings of which can be found at StopOverdose.maryland.gov/events. Throughout the year, the workgroup engaged speakers to discuss emergent issues, including innovative access methods, racial disparities in access, barriers to care, and stigma and the need for education to reduce stigma.

Goals for the Future

Looking forward, the workgroup intends to continue meeting into 2026 and will develop a full report, complete with thorough recommendations to increase access to care and utilization of buprenorphine services. The workgroup intends to collaborate with partners such as the Maryland Addiction Consultation Services (MACS), supported by Maryland's Behavioral Health Administration, and others in order to develop these comprehensive recommendations.

History of Buprenorphine

What is Buprenorphine?

Buprenorphine is a drug that acts as a partial agonist of opioid receptors, meaning it only partially activates them.[4] 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.

Buprenorphine is available in a variety of formulations for the treatment of opioid use disorder. 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.[5]

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

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). In 2010, the FDA approved a sublingual film version of Suboxone, and in 2017, the FDA approved Sublocade (buprenorphine extended-release subcutaneous injection). 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..[6] NATA 1974 specified that methadone could only be dispensed to treat OUD within specialized opioid treatment programs (OTPs). This system created significant disparities in access to care and set a high bar to treatment access for many patients. 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 the OTP setting. Additional training was required for providers to obtain the X-waiver, a requirement unique to buprenorphine relative to other controlled substances.[7]

Access was still limited under DATA 2000, as physicians could only prescribe buprenorphine for OUD to 30 patients total, and many physicians were not qualified 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 and eliminated 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 means that patients can now access buprenorphine through a variety of different pathways.

Buprenorphine Access in Maryland

Access Overview

In 2024, approximately 36,907 Marylanders filled a prescription for buprenorphine to treat their OUD according to provisional data from Maryland's Prescription Drug Monitoring Program (PDMP).[8] That amounted to approximately 445,000 buprenorphine prescriptions filled for the treatment of OUD from 3,080 providers in Maryland, also according to provisional PDMP data. Buprenorphine is covered by Medicaid in Maryland, and it is also covered by most private insurance plans.

[6] https://www.sciencedirect.com/science/article/pii/S2772724623000033
[7] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821949
[8] PDMP Dashboard, 2020-2025. Prescription Drug Monitoring Program, Maryland Department of Health. Accessed via CRISP Drug-Related Indicators Dashboards, December 2, 2025. Data subject to change.

Marylanders access their buprenorphine through a variety of ways, including by 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 (OBOT)

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, these prescriptions can be filled at a regular pharmacy, rather than being required to attend an OTP in order to receive a dispensed dose.

OBOTs also provides 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 can utilize Maryland's Prescription Drug Monitoring Program.

Opioid Treatment Programs

Opioid Treatment Programs (OTPs) are specialized providers who have met the federal requirements to dispense all types of MOUD including methadone. Methadone is often their focus but most also provide access to buprenorphine as part of their comprehensive substance use disorder treatment services. 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, and ongoing monitoring to support recovery. Opioid treatment programs (OTPs) can be an integral component of a buprenorphine hub and spoke model. The first such model was developed here in Maryland over 15 years ago, at Johns Hopkins. The workgroup will continue to examine how this model can be brought to scale as a critical means of improving buprenorphine access and utilization state-wide. This model uses comprehensive SUD treatment programs 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 of the SUD and related problems. Hubs therefore have a special role at the beginning of a patient's journey. MOUD provision can then be transitioned to spokes (most often primary care clinics/providers) when less comprehensive or intensive SUD treatment will suffice - and can be integrated into a patient's physical health care management. OTP 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

Community Behavioral Health Centers

Community Behavioral Health Centers (CBHCs) such as outpatient mental health clinics, partial hospitalization programs, and substance use disorder residential programs also may 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 clinical settings or the rapid onset of withdrawal symptoms following naloxone administration—symptoms that are often intensely distressing.[9] Buprenorphine offers a powerful tool in these moments because it rapidly relieves withdrawal symptoms while simultaneously blocking other opioids from exerting their effects.

In 2023, 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 County, Frederick, and Wicomico County. Progress is being made towards adoption in other jurisdictions, including Montgomery County and Charles County. Importantly, the success of 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. This funding is being made available from the state discretionary portion of the Opioid Restitution Fund 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. Funding opportunities to support buprenorphine initiation through emergency medical services will be announced annually over the next five fiscal years.

Emergency Department

Patients who present to the emergency department after an opioid overdose or who are assessed and diagnosed with OUD are also important targets for buprenorphine treatment. Providing rapid access to buprenorphine and warm hand-off linkages to care helps ensure that a patient finds and stays in

[9] https://linkinghub.elsevier.com/retrieve/pii/S0196064422005066

treatment. Maryland House Bill 1155 of 2024 requires each hospital to provide patients who present to the ED for an opioid overdose or opioid-related emergency evidence-based care. The law also requires hospitals to have at least one form of each MOUD, to make a referral for the patient, and to include peer support specialists to assist the patient in accessing further care.

Mobile Services

Low-threshold mobile services allow buprenorphine to reach people who otherwise would be 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, woundcare, 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 released from the Baltimore City Detention Center. 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 other reasons routine travel to a brick and mortar location may be difficult. 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.[10]

Barriers to Care

Despite the many access methods that Marylanders have, several barriers exist which limit utilization of these services. Some barriers to care are common across the state, while others are more regional. More data is needed to better understand these barriers, and the Workgroup intends to spend the beginning of 2026 gathering data and then developing a full report which examines these barriers and makes full recommendations on how to address them. Barriers the workgroup has so far identified include:

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, when people apply to Medicaid they do not get benefits right away, and some treatment providers may not give them an appointment until their benefits are active. It is vital that when people are ready to seek care, they can

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

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 during the 90 days prior to their release, including for the coverage of buprenorphine and other MOUD.[11]

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 judgement or distrust towards those struggling with OUD. Because buprenorphine is an opioid agonist, some people believe that using it for treatment is merely replacing one addiction for another. This is a harmful myth that exists among potential prescribers, substance use professionals, people with lived experience of OUD, and the public at large. There is significant evidence that buprenorphine is a highly effective treatment for OUD.[12]

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.[13] Maryland's Racial Disparities in Overdose Taskforce recommends expansion of low-barrier buprenorphine services to help reduce this disparity. 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.[14]

Pharmacy Stock and Dispensing

Workgroup members identified a variety of important issues that create barriers for patients trying to pick up their buprenorphine at pharmacies in Maryland. 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 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.[15]

Limited Provider Uptake

Despite the removal of the requirement of providers to obtain an X-waiver, provider uptake remains limited for buprenorphine treatment. Stigma is once again 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 withdrawals, fear of not being

[11] https://health.maryland.gov/mmcp/pages/1115-healthchoice-waiver-renewal.aspx
[12] https://americanhealth.jhu.edu/news/guiding-principles-addressing-stigma-opioid-addiction
[13] https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00205
[14] CITE TO REPORT WHEN PUBLISHED
[15] https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2024/07/22/the-role-of-pharmacists-in-medications-for-addiction-treatment

able to conduct an adequate assessment, or fear that patients will take up a lot of their time or cause disruptions in the office. Some of these concerns stem from a lack of experience treating people with SUD and some stem from stigmatizing beliefs. 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.

Rural Areas

People living in rural parts of Maryland may lack adequate buprenorphine treatment options in their own communities. Transportation is a frequently cited issue in these areas. The workgroup intends to further study geographic gaps in services and their causes.

Future Considerations

The Workgroup will continue to convene to further investigate several topics, expand and enhance collaboration, and develop a comprehensive report and list of recommendations, including potential legislative amendments. The workgroup intends to collaborate with partners such as MACS, the Maryland Prescription Drug Monitoring Program, and others to ensure robust data accessibility.

The workgroup has identified several topics which will be studied in 2026, including:

- Stigma Reduction, Community Awareness, and Provider Education
- The Hub-and-Spoke Model
- Detention Centers and Correctional Facilities as Critical Touchpoints
- Pharmacy Issues and Pharmacist Drug Therapy Management
- Engaging Insurers to Leverage Existing Care Management and Data Systems
- Low Threshold and Payer-Agnostic Services
- Directory of Providers
- Telehealth and Audio-Only Access
- Case Management
- No Wrong Door Approach