Medication-Assisted Treatment:
Policy Recommendations for Maryland

Medication-assisted treatment is a method used to treat substance use disorders including opioid dependency. The most common medications used in the United States for opioid treatment include buprenorphine, methadone, and naltrexone. Naloxone is also used for overdose prevention. Poly-morphone assisted treatment refers to a type of medication-assisted treatment that involves administering or dispensing pharmaceutical grade heroin or hydromorphone, a derivative of morphine.

Summary of current Maryland state law
In Maryland, methadone and buprenorphine treatment fall under “Opioid Maintenance Therapy,” which is the use of “pharmacological interventions, including full and partial opiate agonist treatment medications, to provide treatment, support, and recovery to opioid-addicted patients.” A prescription for a “controlled dangerous substance” must be “for a legitimate medical purpose by an individual practitioner acting in the usual course of the individual practitioner’s professional practice.” Federal law dictates the framework of physician qualification and certification for treating opioid addiction, including the prescribing of methadone and buprenorphine.

Authorized providers of methadone must be associated with a controlled drug therapy program unless it is an emergency medical situation. Methadone must be administered on site where the controlled drug therapy program is located unless the medical director of the program deems otherwise. Methadone can also be used for chronic pain management, in which case it can be prescribed by a physician like any other drug.

The Baltimore City Health Department participates in a partnership to enroll City residents who are in active buprenorphine treatment in health insurance and to find a primary care doctor who will help them with their ongoing treatment.

In the summer of 2015 the Governor’s Office of Crime Control & Prevention began awarding $500,000 grants to detention centers for monthly administration of naltrexone before inmates are released to help them transition back to community life. Unlike methadone and buprenorphine, naltrexone does not need to be administered daily to achieve desired effects and is given once-a-month by injection. Naltrexone blocks opioids from binding to receptors in the brain. The main drawback of this drug is cost and susceptibility to fatal overdose for people who terminate treatment.

As of December 2015, the Maryland’s Behavioral Health Administration has proposed revisions to Medicaid reimbursement for drug treatment centers that would reduce payments for methadone treatment by nearly half in order to increase payments for counseling services.

Research evidence
- Research suggests that patients who receive medication assisted treatment have better treatment retention rates than patients who receive a placebo or no medication. Among medication types, patients who received methadone had better retention rates than those who received buprenorphine with naloxone, a combination intended to deter intravenous use of the drug. Methadone maintenance has a superior safety profile compared with buprenorphine and is a better match for many patients with heroin use, whereas buprenorphine may be suitable for patients with pain reliever addiction and offers greater convenience and privacy. For patients that do not respond well to methadone maintenance therapy, heroin-assisted treatment was associated with better retention.

- Studies show that opioid detoxification in which the goal of the treatment is sustained abstinence is ineffective and potentially unsafe.

- Research suggests that medication assisted treatment with naltrexone is associated with an increased number of opioid-free days, improved adherence rates in drug use disorder treatment programs, and reduced cravings and drug-seeking behaviors.

- A systematic review and meta-analysis of six randomized trials of heroin-assisted treatment found positive effects on illicit heroin use, treatment retention, and mortality.

- In Baltimore City, one research study showed violent crime associated drug treatment centers is less frequent than violent crime associated with convenience or corner stores.

Policy recommendations
1) While increasing payments for counseling services is important, reducing reimbursements for methadone treatment to do so as proposed by Maryland’s Behavioral Health Association would be counterproductive. Furthermore, reimbursements for counseling services should only be increased for patients receiving medication-assisted treatment.
2) Enact law requiring local jurisdictions to comply with the Americans with Disabilities Act in terms of zoning substance use treatment facilities.

3) Behavioral Health System Baltimore or another similar entity should release a request for proposals to use the Substance Abuse Prevention and Treatment (SAP&T) block grant funding to develop, test and implement innovative programs to integrate substance use disorder treatment into primary care settings or to promote co-location and/or better coordination of care. Some of this funding may be used to assist opioid treatment programs in early implementation of the state’s Medicaid health home program.

4) Require county and city jails to ensure individuals have access to needed medication assisted treatment.

5) Implement a poly-morphone assisted treatment pilot program housed in a university setting with wraparound services to research the effectiveness of pharmaceutical grade heroin and/or hydromorphone targeting individuals for which other medication assisted treatment is not effective. Consider utilizing grant funding available from the Centers for Medicare and Medicaid Services’ innovator program or through 1115 waivers.

Implementation considerations

- Some critics oppose medication assisted treatment for various reasons, including: misplaced concerns about potential negative effects of opioid treatment programs’ presence in local communities (despite research showing that such programs do not increase crime rates) and a misunderstanding of medication assisted treatment as distinct from other medical interventions, like insulin for people with diabetes. If a poly-morphone assisted treatment pilot program is established, implementers will need to work with the Drug Enforcement Agency to obtain limited amounts of pharmaceutical grade heroin if that is determined to be the best drug for the pilot program.

- Expansion of current medication assisted treatment programs and implementation of new programs will require additional providers trained in recognizing and treating substance use disorders.

- Diversion of pharmaceutical grade heroin to illegal markets remains a concern, though studies to date suggest that no diversion has occurred in countries with established heroin assisted treatment programs.