Protect Patient and Public Safety:
OPPOSE MOTAA S.4941

ADVOCATES
FOR OPIOID ADDICTION TREATMENT

What is MOTAA?

The *Modernizing Opioid Treatment Access Act (MOTAA S.4941)* has been introduced, and this revised version is even more dangerous than previous versions. This bill would eliminate longstanding opioid use disorder (OUD) treatment safeguards by opening the door to allow any provider, even those with no training or experience in addiction medicine, to prescribe a Schedule II controlled substance with a high risk of overdose (methadone) for unsupervised pick-up in a pharmacy. Such a move would recreate the "pill mill" prescribing environment that fueled the opioid crisis and put patients and public safety at risk – just like it did in the early 2000s when physicians were prescribing methadone for pain.

Why is MOTAA dangerous?

Methadone is a powerful Schedule II narcotic with a high risk of overdose and death if misused, improperly prescribed, or diverted. For this reason, the government created the highly regulated Opioid Treatment Program (OTP) model, which requires robust diversion controls, careful intake and methadone titration procedures, comprehensive staffing requirements, patient monitoring, and extensive clinical oversight. MOTAA would dangerously dismantle the critical safeguards, comprehensive oversight, and accountability standards that have protected patients and communities by governing medication-assisted treatment (MAT) with methadone for decades.

Under MOTAA S.4941, new patients could pick up potentially unlimited quantities of methadone for unsupervised use on day one – enough methadone to cause dozens of fatal overdoses if diverted, misused, or accidentally ingested.

This Dangerous Experiment Has Been Tried and it Failed

Five federal reports found that the vast majority of methadone overdoses in the early-to-mid 2000s were attributable to physicians prescribing methadone for unsupervised pharmacy pick-up and use– putting patients and communities at risk as death, overdose, and diversion increased dramatically.[1-5]

> **"The administration of methadone should be monitored because unsupervised administration can lead to misuse and diversion. OTP regulations require monitored medication".[6]**
>
> **AMERICAN SOCIETY OF ADDICTION MEDICINE**

The United Kingdom, Canada, Sweden, and Denmark tried relaxing methadone prescribing safeguards and saw higher methadone-related overdose deaths, increased diversion, and lower patient treatment retention. When countries reinstated supervised and controlled dosing, they saw substantial declines in methadone-related overdose deaths.[7-11]

[1] Center for Substance Abuse Treatment. (2004). Methadone-associated mortality: Report of a national assessment (SAMHSA Publication No. 04-3904). Substance Abuse and Mental Health Services Administration. https://atforum.com/documents/CSAT-MAM_Final_rept.pdf

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[5] Center for Substance Abuse Treatment. (2010). Methadone mortality: A reassessment. Substance Abuse and Mental Health Services Administration. https://cdn.vox-cdn.com/uploads/chorus_asset/file/19541909/Methadone_Mortality_A_2010_Reassessment 0.pdf

[6] American Society of Addiction Medicine. (2020). The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. Journal of Addiction Medicine, 14(2S Suppl 1), 1–91. https://doi.org/10.1097/ADM.0000000000000633

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[10] Sweden Anna Fugelstad. "What Lessons from Sweden's Experience Could be Applied in the United States in Response to the Addiction and Overdose Crisis. Addiction 117, no. 5 (2022): 1189-1191. https://doi.org/10.1111/add.15847

[11] D G Gauthier, J Eibl, D Marsh. "Improved treatment-retention for patients receiving methadone dosing within the clinic providing physician and other health services (onsite) versus dosing at community (offsite) pharmacies." Northern Ontario School of Medicine. 2018. https://pubmed.ncbi.nlm.nih.gov/30064001/

Strong Opposition to MOTAA

There is strong opposition to liberalizing methadone. A recent study of health care professionals who prescribe medication to help treat opioid use disorder found that 78% did not support prescribing methadone via pharmacies.[12]

Law Enforcement

- Major County Sheriffs of America
- National Alliance of State Drug Enforcement Agencies
- National Police Association
- National Sheriffs' Association
- Sergeants Benevolent Association NYPD

Providers

- Addiction Policy Forum
- Advocates for Opioid Addiction Treatment
- American Association for the Treatment of Opioid Dependence
- National Association for Behavioral Healthcare

MOTAA Will Not Meaningfully Expand Access

MOTAA would only deregulate prescribing a Schedule II narcotic in communities where critical protections are already in place and working. 87% of the U.S. population already have convenient access (within 40 minutes/30 miles) to MAT with methadone at an OTP, and the would-be MOTAA prescribers overwhelmingly practice in these same communities.[13] Additionally, most addiction providers don't accept Medicaid: 74% of low-income non-elderly OUD patients are uninsured or on Medicaid,[14] but only 38% of addiction medicine specialists accept Medicaid patients. [15]

> **"If providers are unable or unwilling to treat Medicare and Medicaid enrollees, these actions [policy changes] will have limited success in expanding access to treatment."**
>
> **OFFICE OF THE INSPECTOR GENERAL, CMS[15]**

SAMHSA's Recent Reforms are Already Safely Expanding Access and Improving Treatment Outcomes.

Between November 2022 and November 2025, the U.S. saw a 37% reduction in opioid overdose deaths.[16] This decrease is partly attributed to the regulatory flexibilities the Substance Abuse and Mental Health Services Administration (SAMHSA) granted OTPs in 2020 during the COVID pandemic, including take-home doses, telehealth initiation, and the start of mobile medication units. Beyond overdose reduction, OTPs are also expanding access and improving outcomes since the flexibilities became permanent in April of 2024. For example, a recent SAMHSA report found that 71% of OTPs have implemented at least half of the changes and 93% of OTPs have implemented at least a quarter of the changes.[17]

PROTECT PATIENTS AND PUBLIC SAFETY

REJECT MOTAA

While improving access to treatment is an important priority, MOTAA fails to improve access while exponentially increasing risk of diversion and overdose. Congress should continue to reject MOTAA and instead support evidence-based policies that actually expand access to treatment without compromising patient safety, accountability, and public safety.

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[15] Office of Inspector General, U.S. Department of Health and Human Services. (2024). Medicare and Medicaid enrollees in many high-need areas may lack access to medications for opioid use disorder (OEI-BL-23-00160). https://oig.hhs.gov/documents/evaluation/9999/OEI-BL-23-00160.pdf

[16] NCHS, National Vital Statistics System. Estimates for 2025 are based on provisional data. Estimates for 2015-2024 are based on final data (available from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[17] Substance Abuse and Mental Health Services Administration. Revised Regulations for Opioid Treatment Programs (Publication No. PEP25-02-025). U.S. Department of Health and Human Services, 2025. Available from: https://library.samhsa.gov/sites/default/files/revised-regulations-otp-pep25-02-025.pdf