ASAM American Society of Addiction Medicine

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THE MODERNIZING OPIOID TREATMENT ACCESS ACT 2.0 OF 2026 (MOTAA 2.0)

Side-by-Side Responses to Opposition Letter and "Fact" Sheet

Protecting patients and public safety comes first in MOTAA 2.0. The bill would responsibly expand access to methadone, a uniquely effective treatment for opioid use disorder (OUD),[1] through a highly controlled regulated pathway for qualified practitioners working with pharmacists to increase access to lifesaving care. It's designed to reach patients with OUD who have a legitimate medical need for methadone and show up in residential treatment centers, intensive outpatient programs, correctional facilities, skilled nursing facilities, primary care offices, community health centers, emergency rooms, and other healthcare settings, but who have a difficult time accessing the medication they need because it's largely exclusive to opioid treatment programs (OTPs).

MOTAA 2.0 contains strong safety controls at both ends of its pathway: only qualified prescribers can separately register with the Drug Enforcement Administration (DEA) to prescribe methadone for OUD, and pharmacies must comply with all appliable federal and state licensing, registration, and dispensing requirements. **Some opposition materials portray the bill as dismantling oversight and allowing unrestricted methadone prescribing for OUD. That is not the bill before Congress.**

Key MOTAA 2.0 safeguards include:

- practitioner qualification requirements;
- a separate DEA registration for prescribing methadone for OUD;
- state medical licensing controls alongside pharmacy registration and licensing controls;
- federal and state dispensing limits on quantities of methadone for OUD;
- exclusive electronic prescribing;
- expanded prescription drug monitoring program (PDMP) visibility;
- a ban on the pharmacy dispensing of standard methadone pills for OUD;
- observed medication taking when clinically appropriate;
- annual DEA reporting to Congress; and
- a 180-day implementation period to help regulators prepare.

[1] Nosyk B, Min JE, Homayra F, et al. Buprenorphine/Naloxone vs Methadone for the Treatment of Opioid Use Disorder. JAMA. 2024;332(21):1822–1831. doi:10.1001/jama.2024.16954

MOTAA 2.0 critics agree that patients taking methadone for OUD don't require the same intensity of monitoring indefinitely, as reflected by those same critics' support of OTP take-home policies. An earlier version of MOTAA reflected that principle by permitting appropriately selected patients to receive pharmacy-dispensed methadone for unsupervised use. MOTAA 2.0 goes further by adding observed medication taking as an option through pharmacies. Every day clinicians evaluate patients taking methadone for OUD, monitor their progress over time, and adjust their care accordingly. **The debate is not over whether clinical judgment should be allowed in treatment with methadone for OUD. It already is. The debate is whether that judgment can only be exercised in an OTP.**

With roughly 8 in 10 Americans with past-year OUD in 2025 not receiving medication treatment for it,[2] and illicit opioids costing the country an estimated $2.7 trillion annually,[3] Congress can't afford to leave a highly effective medication for OUD out of reach for Americans who need it.

A MOTAA 2.0 Reality Check

OPPOSITION CLAIMS	REALITY
"For more than five decades, federally certified Opioid Treatment Programs (OTPs) have provided methadone through a comprehensive model of care that includes a medical evaluation, carefully individualize dose induction and titration, ongoing patient monitoring, important diversion controls, critical counseling and therapy, and recovery support services."	**OTPs are important. MOTAA 2.0 does not replace them.** The bill adds a controlled, complementary pathway to give qualified practitioners a way to better integrate methadone treatment for OUD with the care setting that best meets their patient's needs, including intensive outpatient care, residential treatment, primary care, correctional health, hospital-based care, skilled nursing facilities, or other addiction treatment programs. **The methadone for OUD access problem is not just about treatment capacity and geography, but whether the medication can be delivered by the care setting where the patient is already engaged.**

[2] Substance Abuse and Mental Health Services Administration. (2026). Key substance use and mental health indicators in the United States: Results from the 2025 National Survey on Drug Use and Health (HHS Publication No. PEP26- 07-010, NSDUH Series H-61). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases

[3] Gilman M. The Staggering Cost of the Illicit Opioid Epidemic in the United States. 2025. Accessed August 2, 2026. https://www.whitehouse.gov/releases/2025/03/the-staggering-cost-of-the-illicit-opioid-epidemic-in-the-united-states/

OPPOSITION CLAIMS	REALITY
"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."	**That is not the bill before Congress.** MOTAA 2.0 limits prescribing to physicians who are board certified in addiction medicine or addiction psychiatry and other practitioners who can meet future HHS-established qualification standards for the prescribing of methadone for OUD. Under MOTAA 2.0, prescribing methadone for OUD requires applying for a separate DEA registration, and the bill preserves state scope-of-practice limits; requires electronic prescribing; promotes federal and state dispensing controls on methadone for OUD quantities; imposes a pharmacy ban on standard methadone pills for OUD, and allows observed dosing through pharmacies. **The early-2000s experience is not evidence against a carefully regulated methadone-for-OUD pathway under MOTAA 2.0.** *Note: Methadone for pain remains legally prescribable by any Schedule II prescriber and continues to be dispensed by U.S. pharmacies to this day.*
" . . . 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."	**The criticism assumes that MOTAA 2.0 eliminates controls on quantities dispensed. It does not.** The bill explicitly empowers federal and state authorities with overseeing dispensing quantity controls, and treatment must occur within a regulated framework that includes practitioner qualifications and a separate DEA registration. The bill also prohibits the dispensing of standard methadone pills for OUD and adds supervised dosing when clinically appropriate to MOTAA 2.0's pharmacy pathway. Under federal law, prescriptions must still be issued for a legitimate medical purpose, and pharmacists have a corresponding responsibility.

OPPOSITION CLAIMS	REALITY
"Major law enforcement groups have opposed MOTAA. Several national law enforcement organizations have expressed strong concerns with MOTAA."	**The cited law enforcement concerns were raised before bill sponsors added new safeguards in MOTAA 2.0. ASAM welcomes continued discussions with law enforcement groups regarding the revised bill and believes the current legislation may address concerns previously raised.** The revised bill includes not only separate DEA registration and qualified prescriber limits, but a ban on pharmacy dispensing of standard methadone pills for OUD, promotion of both federal and state quantity controls, observed medication taking through pharmacies when clinically appropriate, annual DEA reporting, and a delayed implementation period to help regulators prepare. Pharmacy dispensing will also expand methadone's visibility in PDMPs.
"Notably, the American Society of Addiction Medicine's own clinical practice guidelines states, 'The administration of methadone should be monitored because unsupervised administration can lead to misuse and diversion. OTP regulations require monitored medication.'"	**The opposition materials quote ASAM incompletely while omitting the very language recognizing that supervised dosing is not required indefinitely for every patient.** The guideline says OTP regulations require monitored administration *"until the patient's clinical response and behavior show that non-monitored doses are appropriate."* That matters. Federal OTP take-home flexibilities already rely on individualized clinical judgment and patient selection, not automatic unsupervised use. MOTAA 2.0 applies that clinical principle outside the OTP setting: supervision remains available and care can be tailored to the patient. **ASAM endorses MOTAA 2.0.**

OPPOSITION CLAIMS	REALITY
"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."	**The early-to-mid 2000s comparison overlooks an important difference: pain prescribing is not OUD treatment under MOTAA 2.0.** Those reports involved methadone for pain prescribed during a time of different regulatory standards, pain prescribing practices, and clinical safeguards than those in place today. As described throughout this document, MOTAA 2.0 is limited to OUD treatment and includes unique safeguards that did not govern the pain-prescribing cases cited from that time.
"SAMHSA's recent reforms are already safely expanding access and improving treatment outcomes and overdose death rates."	**SAMHSA's recent OTP reforms expanded flexibility inside the OTP system, but those reforms are not a substitute for MOTAA 2.0.** MOTAA 2.0 addresses a different gap: it helps patients with OUD whose needs for treatment with methadone may arise in settings outside the OTP system. **There's also an inconsistency in the opposition's argument.** Critics often praise SAMHSA's OTP take-home flexibilities that are based on clinical judgment, yet treat every MOTAA 2.0 pharmacy option, even with observed dosing, as unsafe.

OPPOSITION CLAIMS	REALITY
"87% of the U.S. population already have convenient access (within 40 minutes/30 miles) to MAT with methadone at an OTP."	**A 40-minute/30-mile radius is not convenient access.** Roughly eighty percent of U.S. counties lack an OTP, with nearly half of the counties without an OTP being rural.[4] In a five-state study of high-overdose counties, the average drive to an OTP was nearly 50 minutes in the most rural communities, compared to about 15 minutes to the nearest Federally Qualified Health Center (FQHC) or dialysis center.[5] Research finds that pharmacy-based methadone dispensing could improve access in rural areas where OTPs are often much farther away than other healthcare facilities.[6] Drive-time estimates also miss people who rely on public transit.[7] A patient may live within 30 miles of an OTP and still face many hours of weekly travel. Distance also affects treatment: patients living more than 10 miles from an OTP are 29% more likely to miss a dose than patients within 5 miles,[8] which can introduce diversion risk. **MOTAA 2.0 adds pharmacy dispensing locations while preserving OTP dispensing locations.**

[4] Duff JH, Carter JA. *Location of Medication-Assisted Treatment for Opioid Addiction : In Brief Location of Medication-Assisted Treatment for Opioid Addiction : In Brief.* 2019

[5] Joudrey PJ, Edelman EJ, Wang EA. Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. JAMA. 2019;322(13):1310–1312. doi:10.1001/jama.2019.12562

[6] Joudrey PJ, Chadi N, Roy P, et al. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: a cross-sectional study. *Drug Alcohol Depend.* 2020;211:107968. doi:10.1016/j.drugalcdep.2020.107968.

[7] Howell BA, Kim J, Thornhill TA, et al. Travel Time to Methadone Treatment Via Personal Vehicle vs Public Transit. JAMA Netw Open. 2026;9(2):e2557361. doi:10.1001/jamanetworkopen.2025.57361

[8] Amiri S, Lutz R, Socías ME, McDonell MG, Roll JM, Amram O. Increased distance was associated with lower daily attendance to an opioid treatment program in Spokane County Washington. J Subst Abuse Treat. Oct 2018;93:26-30. doi:10.1016/j.jsat.2018.07.006

OPPOSITION CLAIMS	REALITY
"The United Kingdom, Canada, Sweden, and Denmark tried relaxing methadone safeguards by allowing for unsupervised pharmacy pick-up and saw higher methadone-related overdose deaths, increased diversion, and lower patient treatment retention. When countries reinstated supervised dosing, like we currently have in the U.S., they saw substantial declines in methadone-related overdose deaths."	**The international evidence is more nuanced than this claim suggests, and its lesson is the need for safeguards, not a ban on pharmacy dispensing. Pharmacy dispensing of methadone for OUD continues to be used in countries outside the U.S today.** MOTAA 2.0 reflects lessons learned through the bill's qualified, separately registered prescribers, ongoing federal and state controls over quantities dispensed, exclusive electronic prescribing, supervised dosing through pharmacies when clinically appropriate, expanded PDMP visibility, and now restrictions on eligible formulations for OUD.
" . . . only 38% of addiction medicine specialists accept Medicaid patients."	**Critics often cite this 38% figure to suggest that Medicaid patients wouldn't have meaningful access under MOTAA 2.0. That number does not support that claim.** The 38% figure came from an analysis that looked at office-based buprenorphine providers nationwide, excluding Florida, and identified those matched to 2022 Medicaid claims for prescribing or administering buprenorphine to at least one Medicaid enrollee. The cited report also doesn't explain whether Medicaid services billed through facilities where MOTAA-qualified prescribers may practice, such as hospitals, community health centers, or other licensed treatment programs were fully captured by the analysis' buprenorphine provider-to-claims matching method. **The cited report is simply not a measure of Medicaid participation among MOTAA 2.0–qualified practitioners.**

OPPOSITION CLAIMS	REALITY
"When health care professionals who prescribe a different medication to help treat OUD were asked if they support office-based methadone prescribing with pharmacy pickup, 78% were opposed."	**The cited 2020 survey did not ask clinicians whether they opposed office-based methadone prescribing with pharmacy pickup.** It asked 728 X-waivered outpatient OUD clinicians which policy changes they would like continued or adopted after the COVID-19 pandemic, and 28% selected "the opportunity for patients to receive office-based methadone." The survey did not ask an opposition question. The authors also noted that "office-based methadone" was not defined, which may have affected how respondents understood the option.

Everyone agrees that methadone treatment for OUD requires safeguards. MOTAA 2.0 embraces that principle in a controlled, complementary pathway, limited to qualified and specially registered prescribers, while OTPs continue to serve an important role in OUD treatment.

WHO SUPPORTS MOTAA 2.0?

MOTAA 2.0 is supported by a diverse coalition of more than 100 organizations. The growing coalition includes physicians, pharmacists, psychologists, addiction counselors, hospitals, addiction treatment programs, FQHCs, OTP providers, correctional health professionals, law enforcement officials, civil rights attorneys, public safety partners, cities, recovery advocates, patients, and families.

Find the full list of endorsing organizations at ASAM.org/MOTAA.