American Association for the Treatment of Opioid Dependence, Inc.

# The Opioid Treatment Access Act (OTAA): Fact-Checking Sheet

## OPPOSE S. 3629

The unabating crisis of opioid overdose deaths in the US has made critically clear the need to assess the federal regulatory framework for Opioid Treatment Programs and identify opportunities to increase access to these essential services. Any proposed changes to this framework must, however, with clear historical vision, retain the spirit and intention of the regulations to provide a care delivery system that is as safe as it is accessible.

The Opioid Treatment Access Act is dangerous. It proposes to eliminate the laws in place for ensuring safe distribution of powerful narcotics and allows private practice physicians to prescribe methadone for opioid use disorder with no controls or oversight. There is significant evidence over the past 20 years that demonstrate that such practices result in increased diversion of powerful narcotics, overdose and death.

Current law allows for the use of methadone to treat opioid use disorders in licensed treatment facilities called opioid treatment programs (OTPs). These programs have robust systems to manage medication, ensure counseling and conduct regular drug testing. These systems have proven over the past five decades to ensure high-quality, evidence-based addiction treatment while simultaneously preventing diversion and abuse of medications that threaten~~s~~ patients and their communities. OTPs are the only provider that can administer methadone for OUD for good reason: methadone is a very effective medication if used appropriately and under the direct supervision of an OTP. It can be lethal if misused.

| Supporters claim… | ✓ FACTS |
|---|---|
| *The bill will increase access to treatment.* | It will result in physicians prescribing a powerful medication with no effort to limit diversion, no counseling, no drug testing and no outcome reporting to evaluate effectiveness - exactly how we got into the current opioid epidemic and record numbers of deaths. |
| *Board Certified Physicians are adequately trained to provide effective treatment.* | Board certified physicians are well trained; however, training alone is necessary but not sufficient to provide safe TREATMENT. TREATMENT is comprised of much more than just prescribing more opioids. |
| *Increased take homes granted by OTPs during the pandemic prove that patients can take medication safely.* | The OTP structure is what makes methadone safe and effective for OUD. Suggesting that methadone is safe and effective for OUD in any other setting is scientific appropriation: it is not evidence-based. |
| *More prescribing without any controls will decrease ODs and deaths.* | Five federal agency reports issued in the 2000s (SAMHSA, 2004; DOJ, 2007; SAMHSA, 2007; GAO, 2009; SAMHSA, 2010) found that the majority of methadone mortality is attributed to physician's prescribing methadone in private practices. |
| *Providers have been prescribing buprenorphine for 20 years.* | Buprenorphine and methadone are very different medications, hence different FDA scheduling. Buprenorphine is unlikely to cause respiratory depression like methadone. Methadone is slow to act and accumulates in the body, making it especially lethal if misused. Moreover, despite exponential increases in buprenorphine prescriptions over the past 20 years, ODs and deaths have notched record levels every year. More opioid prescriptions doesn't stop ODs. Buprenorphine is one of the most diverted medications in the U.S. because it is widely distributed by physicians with no diversion-control effort. Methadone diversion rates have declined significantly over the last 20 years. |

American Association for the Treatment of Opioid Dependence, Inc.

# The Opioid Treatment Access Act (OTAA): Fact-Checking Sheet

| | |
|---|---|
| *Other countries give out methadone at pharmacies.* | Strang study (2010) found that the "Introduction of supervised methadone dosing was followed by substantial declines in deaths related to overdose of methadone in both Scotland and England." Supervised dosing refers to the dispensing and monitoring process required at OTPs, where patients consume treatment medication on-site in presence of medical personnel. Pharmacy-filled prescriptions do not require this consumption monitoring process.<br>Furthermore, a Canadian study found that when methadone is prescribed for OUD and picked up at a pharmacy, patients getting medication from a clinic demonstrated a one-year retention rate of 57.3% compared to 11.9% retention rate at the pharmacy. |

## Proposals for REAL innovation and increased access to evidence-based opioid use disorder treatment:

- Make permanent the provisions of the SUPPORT Act that require Medicare and Medicaid coverage of OTP services;
- Allow OTPs to admit patients to treatment using telehealth;
- Fund pilot programs for OTPs to develop innovative partnerships with hospitals and FQHCs in rural areas.

**OTPs are effective because of all the resources and support provided to each patient.**

**Those resources do not exist in private physician offices and pharmacies.**