IDAHO OPIOID SETTLEMENT INTRASTATE ALLOCATION AGREEMENT BETWEEN THE STATE OF IDAHO, HEALTH DISTRICTS, AND ELIGIBLE LOCAL GOVERNMENTS

The State, by and through the Attorney General, and the undersigned Participating Local Governments and Participating Health Districts, in consideration of the promises and the mutual covenants set forth herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, enter into this Idaho Opioid Settlement Intrastate Allocation Agreement ("Agreement") and covenant and agree as follows:

General Principles

Capitalized terms not defined below have the meanings set forth in the Definitions section of this Agreement.

- The people of the State of Idaho and Idaho communities have been harmed by the opioid epidemic, which was caused by misconduct committed by certain entities within the Pharmaceutical Supply Chain.

- The State of Idaho, *ex rel.* Lawrence Wasden, Attorney General (the "State"), and certain Participating Local Governments are separately engaged in litigation seeking to hold the Pharmaceutical Supply Chain Participants accountable for the damage they caused.

- The State, Health Districts, and the Participating Local Governments share a common desire to abate and alleviate the impacts of the Pharmaceutical Supply Chain Participants' misconduct throughout the State of Idaho.

- Settlements resulting from the investigations and litigation with Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson have taken the form of National Settlement Agreements.

- This Agreement is intended to facilitate compliance by the State and by the Participating Local Governments with the terms of the National Settlement Agreements and, to the extent appropriate, with other settlements related to the opioid epidemic reached by both the State and Participating Local Governments.

- Idaho's share of settlement funds from the National Settlement Agreements will be maximized only if all Idaho Local Governments of a certain size participate in the settlements.

- The National Settlement Agreements will set a default allocation between each State and its political subdivisions unless they enter into a state-specific agreement regarding the distribution and use of settlement amounts (a "State-Subdivision Agreement"), and this Agreement is intended to serve as such a State-Subdivision Agreement under the National Settlement Agreements.

- The State and certain Participating Local Governments are also involved in ongoing litigation with other Pharmaceutical Supply Chain Participants and the aforementioned investigations and litigation have caused some Pharmaceutical Supply Chain Participants

to declare bankruptcy, and they may cause additional entities to declare bankruptcy in the future.

- This Agreement is also intended to serve as a State-Subdivision Agreement for future resolutions of claims through settlement or in bankruptcy court where both the State and Participating Local Governments have filed suit concerning alleged misconduct in the manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic and the resolution of such claims provide for payments (including payments through a trust) to both the State and Participating Local Governments and allow for the allocation between a state and its political subdivisions to be set through a state-specific agreement ("Future Resolutions"). This includes but is not limited to serving as a Statewide Abatement Agreement under the bankruptcy resolutions in *In re Purdue Pharma L.P., et. al.*, Case No. 19-23649 (RDD) (Bankr. S.D.N.Y.) and *In re Mallinckrodt PLC, et al.*, Case No. 20-12522 (JTD) (Bankr. D. Del.).

- The State is participating in litigation and investigations of certain other Pharmaceutical Supply Chain Participants for which Participating Local Governments are not involved and resolution of such claims are not subject to this Agreement.

A. Definitions

As used in this Agreement

1. The terms "Future Resolutions," "State," and "State-Subdivision Agreement" are defined under General Principles in this Agreement.

2. "Approved Purpose(s)" shall mean those uses identified in the agreed Opioid Abatement Strategies attached as Exhibit A.

3. "Governing Body" means (1) for a county, the board of county commissioners; (2) for a municipality, the city council; and (3) for a health district, the district board of health.

4. "Health Districts" shall mean the seven regional public health districts created pursuant to Title 39, Chapter 4, Idaho Code.

5. "Litigating Participating Local Governments" means the Participating Local Governments that filed an initial complaint in the Opioid Litigation by September 1, 2020.

6. "MDL Litigation" means the matter captioned *In re: National Prescription Opiate Litigation*, MDL 2804 (N.D. Ohio).

7. "National Settlement Agreements" means the national opioid settlement agreements dated July 21, 2021, with Settling Defendants Johnson & Johnson and Distributors AmerisourceBergen, Cardinal Health and McKesson as well as their subsidiaries, affiliates, officers, and directors named in the National Settlement Agreements, including all amendments thereto.

8. "Non-Litigating Participating Local Governments" means the Participating Local Governments who are not Litigating Participating Local Governments.

9. "Non-Participating Health District" means a Health District who is not a Participating Health District.

10. "Non-Participating Local Government" means a city or county who is not a Participating Local Government.

11. "Opioid Funds" shall mean monetary amounts obtained through the National Settlement Agreements and Future Resolutions as defined in this Agreement. Not included are funds paid to the State to resolve State claims against Pharmaceutical Supply Chain Participants for which Participating Local Governments were not a party or did not otherwise participate. Also not included are funds paid to Participating Local Governments solely to resolve Participating Local Governments' claims against Pharmaceutical Supply Chain Participants, not claims by the State.

12. "Opioid Litigation" means existing or potential legal claims against Pharmaceutical Supply Chain Participants seeking to hold them accountable for the damage caused by their misfeasance, nonfeasance, and malfeasance relating to the unlawful manufacture, marketing, promotion, distribution, or dispensing of prescription opioids.

13. "Participating Local Government" shall mean a county or city within the geographic boundaries of the State who participates in this Agreement and who participates in the National Settlement Agreements and/or Future Resolutions. A Local Government may be a Participating Local Government under the National Settlement Agreements and not for some or all Future Resolutions or vice versa if it does not choose to participate in the National Settlement Agreements or some or all Future Resolutions. Eligible local governments include: (1) all counties within the State of Idaho; and (2) cities within the State of Idaho who are either involved in Opioid Litigation or who have a population of over 10,000.[1] For the avoidance of doubt, a county or city must sign this Agreement to become a "Participating Local Government."

14. "Participating Health District" shall mean a Health District who agrees to participate in this Agreement and in the National Settlement Agreements and/or Future Resolutions. A Health District may be a Participating Health District under the National Settlement Agreements and not for some or all Future Resolutions or vice versa if it does not choose to participate in the National Settlement Agreements or some or all Future Resolutions. For the avoidance of doubt, a Health District must sign this Agreement to become a "Participating Health District."

15. "Parties" shall mean the State, Participating Health Districts, and Participating Local Governments.

16. "Pharmaceutical Supply Chain" shall mean the process and channels through which licit opioids are manufactured, marketed, promoted, distributed, or dispensed.

[1] All references to population in this Agreement shall refer to published U. S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this Agreement. These estimates can currently be found at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html.

17. "Pharmaceutical Supply Chain Participant" shall mean any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution, or dispensing of licit opioids.

18. "Public Health District Fund" means the fund established under Idaho Code § 39-422.

19. "State-Directed Opioid Settlement Fund" means the fund established under Idaho Code § 57-825.

B. Allocation of Settlement Proceeds

1. All Opioid Funds shall be divided with forty percent (40%) to the State ("State Share"); forty percent (40%) to the Participating Local Governments ("LG Share"); and twenty percent (20%) to the Participating Health Districts ("HD Share").[2]

2. All Opioid Funds, regardless of allocation, shall only be utilized for Approved Purposes included in Exhibit A. Compliance with this requirement shall be verified through reporting, as set out in Section D of this Agreement. The parties acknowledge that under the terms of the National Settlement Agreements there are certain allowed non-Opioid Remediation expenditures which require additional reporting under those agreements. Additionally, the parties acknowledge that under the National Settlement Agreements no less than eighty-five percent (85%) of the funds must be used for Opioid Remediation with at least seventy percent (70%) of funds used solely for future Opioid Remediation.

3. **Receipt and Distribution of the State Share**: Funds will be deposited into the State-Directed Opioid Settlement Fund after payment of attorney's fees and costs to the State's outside counsel as provided in Section C.

4. **Receipt and Distribution of the LG Share**: The LG Share shall be paid by check or wire transfer directly to the Participating Local Governments after payment of funds into the Idaho Attorney Fee Back-Stop Fund as provided in Section C.5. Each Participating Local Government will be allocated the percentage of the remaining LG Share as set forth in Exhibit B. Payments will be made directly to each Participating Local Government, and subject to the mechanisms for auditing and reporting set forth below to provide accountability and transparency to the public to verify appropriate use of the funds. Each Participating Local Government may elect to have its share reallocated to the Participating Health District within which it is located. Any funds allocated to a Non-Participating Local Government or to Participating Local Government that cannot be paid under the terms of this Agreement, the National Settlement Agreements, or a Future Resolution shall be allocated to the Participating Health District in which the Local Government is located. A county and some or all of its incorporated cities, in so far as all are Participating Local Governments, may enter into a separate intracounty allocation agreement to modify how the total funds available to said county and cities under Exhibit B are allocated amongst themselves. For the avoidance of doubt, a county or city must agree in writing in order to have its share reallocated under an intracounty allocation agreement. Such an agreement shall not modify any of the other terms or requirements of the National Settlements, Future Resolutions, or this Agreement.

[2] This Agreement assumes that any opioid settlement for Native American Tribes will be dealt with separately.

5. **Receipt and Distribution of the HD Share:** The HD Share shall be paid directly to the Public Health District Fund after payment of attorney's fees and costs to the State's outside counsel as provided in Section C. Funds would be allocated among each Participating Health District based on the aggregate of the percentages allocated to the Local Governments within each such Health District as determined pursuant to paragraph 4 above, and as set forth specifically in Exhibit C. These funds would also be subject to the mechanism for auditing and reporting set forth below to provide accountability and transparency to the public to verify appropriate use of the funds. Any funds allocated under Exhibit C to a Non-Participating Health District shall be allocated to the Participating Health Districts in proportion to the allocation set forth in Exhibit C. If any Participating Health District ceases to exist, the funds shall be allocated between the remaining Participating Health Districts as provided for in this paragraph. If all Participating Health Districts cease to exist, the HD Share will be split equally between the State Share and the LG Share.
6. The State, Participating Health Districts, and Participating Local Governments may coordinate for implementation of opioid remediation strategies. The Parties agree that collaboration promotes the effective use of Opioid Funds and that they will coordinate with trusted partners to collect and share information about successful regional and other high-impact strategies and opioid treatment programs.

C. Payment of Counsel and Opioid Litigation Expenses

1. The Parties recognize that the funds being shared under this agreement were obtained through significant effort by outside counsel retained by the State and Litigating Participating Local Governments in the Opioid Litigation.

2. The National Settlement Agreements provide for the payment of all or a portion of the attorney's fees and legal expenses owed by the State and Litigating Participating Local Governments to outside counsel retained for Opioid Litigation. To effectuate this the court in the MDL Litigation has established a common benefit fund to compensate attorneys for services rendered and expenses incurred that have benefitted plaintiffs generally in the litigation (the "Common Benefit Fund"). The Parties anticipate that Future Resolutions may also provide for the payment of all or a portion of attorney's fees and legal expenses.

3. If funds for attorney's fees and expenses under the National Settlement Agreements, Future Resolutions, and the Common Benefit Fund are insufficient to cover the attorney fee obligations of the State and Litigating Participating Local Governments (as modified by Judge Polster's August 6, 2021 Order in the MDL Litigation), the deficiencies will be covered as set forth in further detail below.

4. Deficiencies for outside counsel for the State shall be paid as follows:

    a. As a means of covering any deficiencies in payment for outside counsel retained by the State specifically for Opioid Litigation, five percent (5%) of the State Share and five percent (5%) of the HD Share from the National Settlements and Future Resolutions not exempt under Section C.7 shall be sent to outside counsel prior to payment to the State-Directed Opioid Settlement Fund and the Public Health

District Fund. No funds from the LG Share shall be used to pay attorney's fees for outside counsel for the State.

b. Outside counsel for the State shall maintain the funds in a separate trust account, not comingled with other funds. Outside counsel for the State shall make application to the Idaho Attorney General's Office for payments out of the trust account for a deficiency, meaning the difference between what their fee agreements would entitle them to (as limited by this Section) minus what they have already collected from attorney fee funds established under the National Settlement Agreements and Future Resolutions and the Common Benefit Fund.

c. Any remaining funds in the account in excess of the amounts needed to cover the deficiency in attorney's fees as provided in this Section shall revert back to the State Share and HD Share and shall be allocated as provided in Section B.

d. Outside counsel for the State shall make a report to the Idaho Attorney General's Office every two (2) years setting forth the balance of the trust account and any outstanding potential deficiencies in order for the Idaho Attorney General's Office to assess whether the trust fund is overfunded and funds should be reverted or underfunded and more funding should be provided.

5. Deficiencies for outside counsel for Litigating Participating Local Governments shall be paid as follows:

    a. As a means of covering any deficiencies in payment for outside counsel retained by Participating Local Governments specifically for the Opioid Litigation, a supplemental Idaho Attorney Fee Back-Stop Fund shall be established.

    b. The Idaho Attorney Fee Back-Stop Fund shall be funded by ten percent (10%) of the LG Share from the National Settlement Agreements and Future Resolutions not exempt under Section C.7. No funds from the State Share and HD Share shall be used to pay attorney's fees to counsel for the Litigating Participating Local Governments. If some or all of the Participating Local Governments believe that ten percent (10%) will not be sufficient to cover a deficiency in attorney's fees those Participating Local Governments can enter into an agreement to hold back an additional amount of up to two and one-half percent (2.5%) of the LG Share allocated to those Participating Local Governments under Exhibit B to be put into the Idaho Attorney Fee Back-Stop Fund. For the avoidance of doubt, no funds above the original ten percent (10%) shall be held back to fund the Idaho Attorney Fee Back-Stop Fund from the share allocated to a Participating Local Government under Exhibit B without their express written agreement, and in no circumstance may the overall amount withheld exceed tweleve and one-half percent (12.5%).

    c. Payments out of the Idaho Attorney Fee Back-Stop Fund shall be determined by majority vote of a committee ("Idaho Attorney Fee Back-Stop Fund Committee") consisting of three members:

        i. One (1) member appointed by the Litigating Participating Local Governments;

ii. One (1) member appointed by the Non-Litigating Participating Local Governments; and

iii. One (1) member jointly appointed by all of the other members listed above.

d. Outside counsel retained by Litigating Participating Local Governments may apply to the Idaho Attorney Fee Back-Stop Fund only for a deficiency, meaning the difference between what their fee agreements would entitle them to (as limited by this Section) minus what they have already collected from attorney fee funds established under the National Settlement Agreements and Future Resolutions and the Common Benefit Fund. For the avoidance of doubt, collectively, outside counsel for Litigating Participating Local Governments are limited to being paid, at most, and assuming adequate funds are available under the National Settlement Agreements, Future Resolutions, the Common Benefit Fund and the Idaho Attorney Fee Back-Stop Fund, attorney's fees totaling fifteen percent (15%) of the LG Share.

e. Any funds remaining in the Idaho Attorney Fee Back-Stop Fund in excess of the amounts needed to cover the deficiency in attorney's fees as provided in this Section shall revert back to the LG Share and shall be allocated as provided in Section B.

f. Applications for funds from the Idaho Attorney Fee Back-Stop Fund must be supported by an affidavit of the attorney setting forth the basis and method of computation for the attorney's fees request. The Idaho Attorney Fee Back-Stop Fund Committee may also request additional documentation to support an application.

g. The Idaho Attorney Fee Back-Stop Fund Committee shall meet at least once annually to review applications and determine whether to release and/or revert funds. Every two (2) years, the Idaho Attorney Fee Back-Stop Fund Committee shall assess the amount remaining in the fund to determine if it is overfunded or underfunded.

6. The Parties agree that should a Future Resolution not provide for any payment of attorney's fees, the parties will confer and in good faith consider an amendment to this Section to provide for additional funds.

7. This Section (Section C) shall not apply to settlements involving McKinsey or the bankruptcy proceedings *In re Purdue Pharma L.P., et. al.*, Case No. 19-23649 (RDD) (Bankr. S.D.N.Y.) and *In re Mallinckrodt PLC, et al.*, Case No. 20-12522 (JTD) (Bankr. D. Del) or other Future Resolutions in so far as the express terms limit the payment of attorney's fees and would not allow for the payment of attorney's fees from the State Share, LG Share, and HD Share.

D. Compliance Reporting and Accountability

1. Participating Health Districts, Participating Local Governments, and the State shall maintain, for a period of at least five (5) years, records of Opioid Fund expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the National Settlement Agreements, Future Resolutions, and this Agreement. During and after the term of this Agreement, the Attorney General shall have access to persons and records related to this Agreement and expenditures of Opioid Funds.

2. Opioid Funds can only be used for an Approved Purpose when the Governing Body of a Participating Local Government or Participating Health District includes in its budget or passes a separate resolution authorizing the expenditure of a stated amount of Opioid Funds for that Approved Purpose during a specified period of time. The budget or resolution should: (1) indicate that it is an authorization for expenditure of Opioid Funds, (2) state the specific Approved Purpose the governing body intends to fund as identified in Exhibit A, and (3) state the amount dedicated to each Approved Purpose for a stated period of time.

3. Opioid Funds are subject to the financial audit requirements for Participating Local Governments and Participating Health Districts as provided under Idaho Law, and shall be separately accounted for in any such audit. If any such audit reveals an expenditure inconsistent with the terms of this Agreement, the Participating Local Government or Participating Health District shall immediately report the finding to the Idaho Attorney General.

4. For every fiscal year in which a Participating Local Government or Participating Health District receives, holds, or spends Opioid Funds, the Local Government or Health District must submit an annual financial report specifying the activities and amounts it has funded. The annual financial report shall be provided to the Idaho Attorney General by emailing the report to opioidsettlement@ag.idaho.gov within ninety (90) days of the last day of the state fiscal year covered by the report. Each annual financial report must include the following information: (1) the amount of Opioid Funds available at the beginning of the fiscal year; (2) the amount of Opioid Funds received during the fiscal year; (3) the amount of Opioid Funds disbursed or applied during the fiscal year, broken down by Approved Purposes set forth in Exhibit A; (4) the amount of Opioid Funds available at the end of the fiscal year. The annual financial reports provided to the Idaho Attorney General will be made publically available by publication on the Idaho Attorney General's website https://www.ag.idaho.gov/consumer-protection/opioid-settlement/ and be maintained on that webpage for a period not less than five (5) years. The Attorney General will also post annual reports of State expenditures of Opioid Funds on the Idaho Attorney General's website and maintain said reports on the webpage for a period not less than five (5) years.

5. If the National Settlement Agreements or any Future Resolutions require that a Participating Local Government or Participating Health District file, post, or provide a report or other document beyond those described in this Agreement, or if any Participating Local Government or Participating Health District communicates in writing

with any national administrator or other entity created or authorized by the National Settlement Agreements or any Future Resolutions regarding compliance with the National Settlement Agreement or Future Resolutions, the Participating Local Government or Participating Health District shall email a copy of any such report, document, or communication to the Idaho Attorney General at opioidsettlement@ag.idaho.gov.

6. Every Participating Local Government and Participating Health District shall make a good faith effort to comply with all of its reporting obligations under this Agreement. A Participating Local Government or Participating Health District that engages in a good faith effort to comply with its reporting obligations under Section D.7 and D.8 but fails in some way to report information in an accurate, timely, or complete manner shall be given an opportunity to remedy this failure within a reasonable time. A Participating Local Government or Participating Health District that does not engage in a good faith effort to comply with its reporting obligations under this Agreement, or that fails to remedy reporting issues within a reasonable time, may be subject to action for breach of contract. Notwithstanding anything to the contrary herein, a Participating Local Government or Participating Health District that is in substantial compliance with the reporting obligations in this Agreement shall not be considered in breach of this Agreement.

7. If it appears to the State that a Participating Local Government or Participating Health District is using or has used Opioid Funds for non-Approved Purposes, the State may on written request seek and obtain the documentation underlying the report(s) described in this Section (Section D), as applicable. The Participating Local Government or Participating Health District receiving such request shall have fourteen (14) days to provide the requested information. The State and the Participating Local Government or Participating Health District receiving such request may extend the time period for compliance with the request only upon mutual agreement.

8. Following a request made pursuant to D.7, if the State determines that a Participating Local Government or Health District spent any Opioid Funds on an expenditure inconsistent with the terms of this Agreement, the State shall send notice to the Participating Local Government or Participating Health District of such determination and allow sixty (60) days to cure the inconsistent expenditure through budget amendment or repayment. If a Participating Local Government or Participating Health District does not make the cure within sixty (60) days, the State may (i) reduce future Opioid Fund payments to that Participating Local Government or Participating Health District by an amount equal to the inconsistent expenditure; and (ii) to the extent the inconsistent expenditure is greater than the expected future stream of payments, initiate a process up to and including litigation to recover the overage. The State may recover any litigation expenses incurred to recover the funds. Any recovery or redistribution shall be distributed consistent with Section B.4 above.

E. Other Terms

1. This Agreement shall become effective at the time a sufficient number of local governments have joined the Agreement to qualify this Agreement as a State-Subdivision

Agreement under the National Settlement Agreements or any Future Resolutions. If this Agreement does not thereby qualify as a State-Subdivision Agreement, this Agreement will have no effect. Once effective, this Agreement will remain in effect until at least one (1) year after the last date on which any Opioid Funds are spent by Participating Local Governments and Participating Health Districts pursuant to the National Settlement Agreements and any Future Resolutions.

2. The Parties agree to make such amendments as necessary to implement the intent of this agreement. After this Agreement becomes effective, amendments may only be made to this Agreement if approved in writing by the Attorney General and at least two-thirds of the Participating Local Governments and Participating Health Districts.

3. This Agreement shall be governed by and construed under the laws of the State of Idaho using Idaho law. Any action related to the provisions of this Agreement, except as otherwise provided in the National Settlement Agreements or Future Resolutions, must be adjudicated by the Idaho state courts of Ada County in the State of Idaho.

4. This Agreement does not supersede or alter the terms of the National Settlement Agreements or any Future Resolutions except to the extent those terms allow for a State-Subdivision Agreement to do so.

5. If any part of this Agreement is declared invalid or becomes inoperative for any reason, such invalidity or failure shall not affect the validity and enforceability of any other provision.

6. This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which together shall be considered one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this Agreement.

7. Each person signing this Agreement represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this Agreement on behalf of the named governmental entity, and that all necessary approvals and conditions precedent to his or her execution have been satisfied.

FOR THE STATE OF IDAHO

LAWRENCE G WASDEN
ATTORNEY GENERAL
STATE OF DAHO

DATE: October 25, 2021

[Other Signature Pages to Follow]

Exhibit A
Approved Opioid Abatement Strategies

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following[1]:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[1] As used in this Exhibit A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Public Creditor Trust Distribution Procedures.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. <u>CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)</u>

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

Exhibit A
Approved Opioid Abatement Strategies

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    2. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school

employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid-

or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT B

ALLOCATION OF LOCAL GOVERNMENT SHARE

Local Government	Percentage of Local Government Share
Ada County, Idaho	13.2776278333%
Adams County, Idaho	0.1446831902%
Ammon City, Idaho	0.0812916024%
Bannock County, Idaho	3.0595589832%
Bear Lake County, Idaho	0.6082712041%
Benewah County, Idaho	0.6526829809%
Bingham County, Idaho	1.6421270812%
Blackfoot City, Idaho	0.6283857401%
Blaine County, Idaho	0.9137717551%
Boise City, Idaho	12.7586409110%
Boise County, Idaho	0.3309644652%
Bonner County, Idaho	2.5987361786%
Bonneville County, Idaho	3.7761253875%
Boundary County, Idaho	0.8788284447%
Burley City, Idaho	0.4485975363%
Butte County, Idaho	0.1839745518%
Caldwell City, Idaho	1.1958553249%
Camas County, Idaho	0.0422073443%
Canyon County, Idaho	5.0120113688%
Caribou County, Idaho	0.4396183832%
Cassia County, Idaho	0.7270235866%
Chubbuck City, Idaho	0.4841935447%
Clark County, Idaho	0.0420924425%
Clearwater County, Idaho	0.4890418390%
Coeur D'Alene City, Idaho	2.7593778237%
Custer County, Idaho	0.2133243878%
Eagle City, Idaho	0.1711876661%
Elmore County, Idaho	0.8899512165%
Franklin County, Idaho	0.5753624958%
Fremont County, Idaho	0.5716071696%
Garden City, Idaho	0.5582782838%
Gem County, Idaho	1.3784025725%
Gooding County, Idaho	0.6966472013%
Hayden City, Idaho	0.0047132146%
Idaho County, Idaho	0.8474305547%
Idaho Falls City, Idaho	3.8875027578%
Jefferson County, Idaho	0.9842670749%
Jerome City, Idaho	0.4169017424%
Jerome County, Idaho	0.6223444291%
Kootenai County, Idaho	5.6394798565%
Kuna City, Idaho	0.1849461724%

Local Government	Percentage of Local Government Share
Latah County, Idaho	1.2943861166%
Lemhi County, Idaho	0.4880814284%
Lewis County, Idaho	0.2882543555%
Lewiston City, Idaho	2.0176549375%
Lincoln County, Idaho	0.1930184422%
Madison County, Idaho	1.2748404845%
Meridian City, Idaho	2.4045650754%
Minidoka County, Idaho	0.9140620922%
Moscow City, Idaho	0.6590552650%
Mountain Home City, Idaho	0.5706694591%
Nampa City, Idaho	3.3274647954%
Nez Perce County, Idaho	1.2765833482%
Oneida County, Idaho	0.2371656647%
Owyhee County, Idaho	0.5554298409%
Payette County, Idaho	1.2750728102%
Pocatello City, Idaho	2.9494898116%
Post Falls City, Idaho	0.6781328826%
Power County, Idaho	0.3505171035%
Preston City, Idaho	0.1496220047%
Rexburg City, Idaho	0.1336231941%
Shoshone County, Idaho	1.2841091340%
Star City, Idaho	0.0001322772%
Teton County, Idaho	0.4258195211%
Twin Falls City, Idaho	1.8245765222%
Twin Falls County, Idaho	3.3104301873%
Valley County, Idaho	0.8074710814%
Washington County, Idaho	0.4917358652%

EXHIBIT C
ALLOCATION OF HEALTH DISTRICT SHARE

Health District	Percentage of Health District Share
District 1 (Panhandle)	14.50%
District 2 (North Central)	6.87%
District 3 (Southwest)	13.38%
District 4 (Central)	31.95%
District 5 (South Central)	10.11%
District 6 (Southeastern)	11.31%
District 7 (Eastern)	11.88%