Tennessee Opioid Settlements
Guide for Local Governments

New Settlements &
Payments for Existing Settlements

March 2023

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I. INTRODUCTION

This document is intended to serve as a guide to opioid settlement matters for Tennessee counties and municipalities (generally referred to as "subdivisions"). The guide addresses the "second wave" of opioid settlements that have recently been submitted for subdivision joinder and the two existing settlement agreements for which settlement payments began last fall.[1] This document is not intended to serve as a comprehensive summary of the settlement agreements. Instead, the focus is on topics that directly concern subdivisions, such as the payments they receive and the request that they join the new settlements.

For both the existing and new settlements, there is a lot of available material providing information about the agreements, the joinder process, payment procedures, FAQs, etc. The key websites are:

- Tennessee Attorney General website. Copies of the settlement agreements and other materials can be found on the Attorney General's Office's website. Link: Opioid Settlements (tn.gov); (https://www.tn.gov/attorneygeneral/working-for-tennessee/filings-of-interest/opioids.html). Any updates or amendments to this guide will be posted to this site.

- National Opioid Settlement website. National counsel for subdivisions maintain this website, which also has copies of the agreements, summaries, and additional information: National Opioids Settlement (nationalopioidsettlement.com).

- Tennessee Opioid Abatement Council website. The Council, which oversees disbursements from the Tennessee Opioid Abatement Fund, has information on the Council and its work: Opioid Abatement Council (tn.gov) (https://www.tn.gov/oac).

While this guide provides a high-level overview of certain provisions in the settlements, it is not in any way intended to be a comprehensive summary of the agreements. Many settlement provisions are not mentioned in this guide and even the matters directly discussed do not address all relevant provisions.

II. BACKGROUND ON BASIC STRUCTURE FOR ALL AGREEMENTS

While there are now seven separate settlement agreements addressing nine companies, the same basic structure and allocation of funds applies to all of them. In 2021, the State anticipated that the first set of settlements would be finalized with the three largest pharmaceutical distributors – AmerisourceBergen Corporation, Cardinal Health, Inc., and McKesson Corporation ("Distributors") – and manufacturer Janssen Pharmaceuticals, Inc., and its parent company, Johnson & Johnson (collectively "J&J/Janssen"). That year, legislation was enacted creating a special trust fund – the Opioid Abatement Fund – and the Opioid Abatement Council, which would disburse the funds. The State also negotiated an agreement with the subdivisions, the Tennessee

[1] This document is subject to correction and being updated. The terms of the settlement agreements and the Tennessee State-Subdivision Opioid Abatement Agreement are controlling and are not amended or in any way affected by this document.

State-Subdivision Opioid Abatement Agreement, addressing some additional details related to the allocation of settlement funds. The settlement agreements, the statutes, and the State-Subdivision Agreement combine to establish the structure used for both the initial settlements and the new ones.

A. The "Three-Bucket" Structure

For both the existing and proposed agreements, settlement funds paid to Tennessee are initially divided into three sub-funds: 15% to the Subdivision Fund, 70% to the Opioid Abatement Fund, and 15% to the State Fund. Counties and qualifying municipalities receive payments from the Subdivision Fund. Counties also receive disbursements from the Opioid Abatement Fund.

1. Subdivision Fund

The Subdivision Fund is paid directly to the counties and qualifying municipalities that participate in the settlements. (Whether a municipality qualifies for direct payments is generally dependent on its size and litigating status. For example, all municipalities with populations of 30,000 or more are qualifying municipalities.) For each settlement, the list of subdivisions eligible for direct payments is set out in the agreement's Exhibit G, which also states the allocable share percentage used to calculate each eligible subdivision's direct payments. The payments are made directly to the subdivisions by the national settlement administrator, BrownGreer. As discussed below, the money is to be used for opioid remediation, as that term is defined in the settlement agreements. The Subdivision Fund does not flow through the State or the Opioid Abatement Council.

2. Opioid Abatement Fund

The settlement agreements all devote the largest share of money to a fund restricted to future abatement. In the initial agreements, it is called the Abatement Accounts Fund, though the name is slightly different in some of the new agreements.[2] In Tennessee, payments are placed in the Tennessee Opioid Abatement Fund. This is a trust fund, separate from the State's General Fund, and money in the fund must be spent on future opioid abatement and remediation. By statute, funds from the initial settlements that are paid into the Opioid Abatement Fund are allocated as follows:

- 65% of these funds are allocated by the independent Opioid Abatement Council. The Council has announced that these funds will be distributed through a competitive grant application process to be established by the Council.

- 35% of the funds are allocated to counties. These funds are required to be spent on future Opioid Abatement Council-approved abatement programs, but each county will control its share of the funds.

[2] The use of "Abatement" in this fund's name should not suggest that the other funds are not intended for opioid remediation, as that term is defined in the agreements (discussed below). However, there are more restrictions placed on money allocated from the Opioid Abatement Fund.

3. State Fund

The State Fund is paid to the State's General Fund and is allocated pursuant to the regular budgeting process. As with the Subdivision Fund payments, the money is to be used for opioid remediation, as that term is defined in the settlement agreements. It is anticipated that the money will be used to increase funding for future opioid abatement.

B. The Role of Opioid Settlement Statutes

In 2021, the General Assembly passed a package of legislation that put in place the structure for the allocation of settlement funds in Tennessee.[3] The trust fund for abatement, the Tennessee Opioid Abatement Fund, was established along with the Opioid Abatement Council. The statutes require that money placed into the trust fund be spent on future opioid abatement and remediation and require that expenditures be reported. The statutes also require 35% of the amounts paid into the trust fund from certain settlements be directed to the counties.

In addition to addressing the allocation of settlement funds, the 2021 statutes also allow for a statutory release of all public entity opioid claims against the Distributors and J&J/Janssen. This statutory bar, which was implemented for these companies, resulted in the largest payment incentives being met and maximized payments to the State and its subdivisions for these settlements. For the J&J/Janssen agreement, this meant that payments for multiple years were accelerated and paid in 2022. For a statutory bar to become effective, a declaration of release must be issued by the Attorney General with the approval of the Governor and Comptroller.[4]

C. The role of the State-Subdivision Agreement

While the 2021 legislation set out much of the structure for the allocation of settlement funds in Tennessee, additional details were addressed in the **Tennessee State-Subdivision Opioid Abatement Agreement**. This agreement was negotiated by the State and representatives of Tennessee local governments. The agreement sets out the formula for allocating the counties' share of the Opioid Abatement Fund payments. It also applies the 35% county allocation to certain funds paid into the trust fund from companies that have filed for bankruptcy. The State-Subdivision Agreement was submitted to the subdivisions in 2021 and approved by all subdivisions participating in the distributor and J&J/Janssen settlement agreements. A copy of the State-Subdivision Agreement is posted to the Attorney General's website.

III. KEY ADMINISTRATIVE ENTITIES AND CONTACT INFORMATION

There are several entities involved in administering the existing settlements and rolling out the proposed new settlements. The main ones are:

[3] 2021 Public Chapter 491, signed into law by Governor Bill Lee on May 24, 2021.

[4] The Declaration of a Statewide Opioid Settlement Agreement Release for the Distributor and J&J/Janssen settlements is posted to the Attorney General's website.

- **Directing Administrator**: **BrownGreer** is the national settlement administrator for the Distributor and J&J/Janssen settlements. In communications with subdivisions, it refers to itself as the Directing Administrator. The companies deposit payments into a bank, **Wilmington Trust**, and BrownGreer calculates and directs payments to states and subdivisions – including direct payments to the subdivisions from the Subdivision Fund. BrownGreer is also in charge of collecting reports from the subdivisions regarding any non-opioid remediation uses of the direct payments. BrownGreer communicates with each subdivision by email regarding both the direct payments and reporting for these funds and has set up an online portal for each subdivision. (While BrownGreer may also be named the administrator for the new settlements, currently it is only communicating regarding the initial settlements.) BrownGreer's email address is: DirectingAdministrator@NationalOpioidOfficialSettlement.com.

- **Implementation Administrator**: For the five new national settlements, **Rubris** is serving as the **National Opioids Settlements Implementation Administrator** for the subdivision joinder process. (Rubris had the same role for the Distributor and J&J/Janssen settlements.) Rubris has sent out emails with the "Participation Package" for the five new settlements. Rubris uses an electronic DocuSign process and has assigned each subdivision a unique Reference Number. Rubris' email address is: opioidsparticpation@rubris.com.

- **Opioid Abatement Council**: The independent council established by statute in 2021 to oversee the State's Opioid Abatement Fund. The Council determines the list of appropriate abatement expenditures for the counties' share of Abatement Funds and allocates the remaining money placed in the trust fund. The chair of the 15-member Council is Dr. Stephen Loyd. The director is Mary Shelton. (While it is an independent entity, for administrative purposes the Council is associated with the Tennessee Department of Mental Health and Substance Abuse Services.) The Council's website is here: Opioid Abatement Council (tn.gov) (https://www.tn.gov/oac). Emails may be sent to: Opioid.Abatement@tn.gov.

- **Tennessee Attorney General's Office**: While the Office does not administer settlement funds, it is a resource for information about the new settlements, the joinder process, and certain state-specific matters, such as the State-Subdivision Agreement. Its website is here: Opioid Settlements (tn.gov) (https://www.tn.gov/attorneygeneral/working-for-tennessee/filings-of-interest/opioids.html). Emails may be sent to Daimon.Duggar@ag.tn.gov.

IV. THE INITIAL SETTLEMENTS

The settlements with the Distributors and J&J/Janssen were finalized last year and initial payments have been made. The national administrator has made direct payments to the counties and eligible municipalities from the Subdivision Fund. The counties are now receiving their allocation from the Opioid Abatement Fund, disbursed by the Opioid Abatement Council. There are different rules for the direct payments from the Subdivision Fund and the payments disbursed from the Opioid Abatement Fund, so the two sources of funds are addressed separately below.

Should the new settlements become effective, the flow of settlement funds from those agreements will work very much like those from the initial agreements.

A. Subdivision Fund Payments

Under the two settlement agreements, 15% of the funds for remediation are directed to the Subdivision Fund. For the Distributor settlement, the maximum amount to be paid into the Subdivision Fund is $74.8 million over 18 years. For the J&J/Janssen settlement, the maximum amount paid into the Subdivision Fund is $17.1 million over 10 years. As stated above, all counties are eligible to receive these direct payments, as are many municipalities. Whether a municipality qualifies to receive money from the Subdivision Fund is generally dependent on the size of its population and whether the municipality sued a Distributor prior to the settlement.

To receive its Subdivision Fund payment, a subdivision must join the settlement and complete a participation form. Litigating subdivisions must also dismiss their lawsuits. All eligible subdivisions joined both settlements and it is understood that all dismissal orders have now been entered.

1. Allocation Among Subdivisions

Subdivision Fund allocation percentages are set out for counties and municipalities in Exhibit G of each settlement agreement. The allocation percentages were developed by the Plaintiff's Executive Committee ("PEC") in the federal multi-district litigation for opioid cases. The PEC is made up of counsel for subdivisions and the states did not participate in determining the formula used for the subdivision allocation percentages. Generally, they reflect metrics measuring the impact of the opioid crisis on a particular community and the level of health-related expenditures by subdivisions.

The allocations for municipalities do not change the share of funds going into particular communities; they just change who controls a portion of the funds. Where a municipality qualifies to receive a direct payment, the municipal allocations are carved out of the share of the county (or counties) where the city or town is located.

A copy of Exhibit G for the Distributor agreement is in Attachment A. A copy of Exhibit G for the J&J/Janssen settlement is in Attachment B. There are more municipalities listed in the Distributor agreement exhibit because more small cities and towns filed suit against the Distributors prior to the settlement. Thus, the allocation percentages for the counties where these municipalities are located are larger in the J&J/Janssen Exhibit G than in the Distributor Exhibit G.

2. Initial Payments

Initial payments for both settlements were made last fall. BrownGreer has disbursed almost all the Subdivision Fund payments made last year to the counties and municipalities. For a small set of subdivisions that were plaintiffs in one case, there was a delay arising out of difficulties in getting a dismissal order entered because of a change in judges. This has been resolved and those payments either have been made or will be made shortly. Otherwise, all initial payments should have been issued to subdivisions that submitted appropriate payment instructions to BrownGreer.

BrownGreer set up a portal for subdivisions to provide payment instructions. Any questions regarding the payment process should be directed to BrownGreer.

Distributor Payment: Last year was unusual in that two Distributor payments were made in the same calendar year. (Going forward, there is only one scheduled Distributor payment per calendar year.) The Tennessee Subdivision Fund share of the payments in 2022 totaled $6,554,820.52:

Distributor 2022 Subdivision Fund Payments

Payment Number	Payment Year	TN Subdivision Fund Payment Amount
1	2022	$3,195,990.41
2	2022	$3,358,830.11
Total		**$6,554,820.52**

J&J/Janssen Payment: The initial J&J/Janssen payment was also made in 2022. The settlement with J&J allowed for the acceleration of multiple payments if a statutory bar of public entity claims was in place. As Tennessee had such a bar, it received not only its scheduled payment for 2022, but also its payments for 2023-2025. Because payments are frontloaded in this settlement, most of the J&J/Janssen settlement funds have already been paid.

J&J/Janssen 2022 Subdivision Fund Payment

Payment Numbers	Payment Year	TN Subdivision Fund Payment Amount
1-5	2022-2025	$12,794,968.73
Total		**$12,794,968.73**

3. Future Payments

The following information regarding future payments consists of figures showing maximum possible scheduled payments from the settlements. Actual payments could vary for multiple reasons. A company could prepay future scheduled payments, or not make payments as scheduled due to financial distress. Additionally, a small portion of the funds may be needed to pay for administrative expenses. Thus, the maximum payment figures below will almost certainly exceed what is actually disbursed.

Distributor Payments: With two payments having been made, there are scheduled Distributor payments for the next 16 years:

Distributor 2023-2038 Maximum Subdivision Fund Payments

Payment Number	Payment Year	TN Subdivision Fund Payment Amount
3	2023	$3,358,830.11
4	2024	$4,204,051.68
5	2025	$4,204,051.68
6	2026	$4,204,051.68
7	2027	$4,204,051.68
8	2028	$4,944,471.29
9	2029	$4,944,471.29
10	2030	$4,944,471.29
11	2031	$4,156,327.12
12	2032	$4,156,327.12
13	2033	$4,156,327.12
14	2034	$4,156,327.12
15	2035	$4,156,327.12
16	2036	$4,156,327.12
17	2037	$4,156,327.12
18	2038	$4,156,327.12
Total		**$68,259,067.66**

A subdivision can determine its future maximum distributor payment by taking the relevant dollar amount from the third column and multiplying it by the subdivision's allocation percentage from Distributor settlement Exhibit G in Attachment A. For example, Anderson County's allocation percentage is 1.2063249026%, so its maximum distributor payment in 2023 would be 1.2063249026% of $3,358,830.11, which is $40,518.40.

J&J/Janssen Payments: The J&J/Janssen settlement has fewer payment years and, as mentioned, its payments are frontloaded so that almost three-fourths of the payments were made in 2022. There will not be another J&J/Janssen payment until 2026.

J&J/Janssen 2023-2031 Maximum Subdivision Fund Payments

Payment Number	Payment Year	TN Subdivision Fund Payment Amount
3	2023	Paid in 2022
4	2024	Paid in 2022
5	2025	Paid in 2022
6	2026	$645,338.82
7	2027	$645,338.82
8	2028	$645,338.81
9	2029	$821,629.19
10	2030	$821,629.20
11	2031	$821,629.20
Total		**$4,400,904.03**

A subdivision can determine its future maximum J&J/Janssen payment by taking the relevant dollar amount from the third column and multiplying it by the subdivision's allocation percentage from J&J/Janssen settlement Exhibit G in Attachment B. (Remember, the allocation percentages for some subdivisions will be different for the two agreements.[5])

4. Use of Direct Payments from Subdivision Fund

The rules concerning how settlement funds may be used are different for the direct payments from the Subdivision Fund and the county disbursements through the Opioid Abatement Council from the Opioid Abatement Fund. The restrictions on the direct payments from the Subdivision Fund are set out in the settlement agreements. (For the disbursements flowing through the Opioid Abatement Fund, state statutes and other restrictions apply.)

Both the Distributor and J&J/Janssen settlement agreements state that the parties to the agreement intend for "Settlement Fund" payments to be used for "Opioid Remediation" and there are a number of provisions in the agreements related to the use of funds. (The term "Settlement Fund" in the agreements includes the Subdivision Fund, which is the source of the direct payments to municipalities and counties.) Though there is other relevant language in the agreements, the central language regarding the use of funds can be found in Section V.B of the Distributor agreement and Section VI.B of the J&J/Janssen agreement.

The definition of "Opioid Remediation" is substantially the same in both agreements. "Opioid Remediation" means care, treatment and other programs and expenditures (including reimbursement for past such programs) designed to: (1) address the misuse and abuse of opioid products; (2) treat or mitigate opioid use or related disorders; or (3) mitigate other alleged effects of the opioid abuse crisis, including on those injured as a result of the opioid abuse crisis. Exhibit E (which is the same in both settlement agreements) provides a non-exhaustive list of expenditures that qualify as being paid for Opioid Remediation.[6] Qualifying expenditures may include reasonable related administrative expenditures.

The allowance for Subdivision Fund payments to be used as "reimbursement" for past remediation expenditures potentially provides flexibility in the use of those funds for subdivisions that have had such past expenditures. As discussed in the next section, it may also limit what needs to be reported regarding the use of payments from the Subdivision Fund.

It should be noted that the flagging of this language regarding the use of settlement funds, should not be viewed as encouraging the use of settlement payments for non-opioid abatement purposes. Given the resources needed to address the opioid crisis in the state, the Attorney General's Office encourages subdivisions to use all funds to expand and add to remediation and abatement efforts.

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[5] For example, Bedford County has a lower allocation percentage in the Distributor Exhibit G than in the J&J/Janssen exhibit because Shelbyville and Wartrace have allocations for the Distributor settlement but not for J&J/Janssen.

[6] As discussed below, the Opioid Abatement Council largely adopted the list of remediation expenditures used in Exhibit E of the settlement agreements as approved expenditures for Abatement Fund disbursements to counties. (There are a few tweaks.) The Council's list is attached as Attachment C.

Under the settlement agreements, it is also possible to pay attorneys' fees and litigation expenses from the Subdivision Fund payments, though the settlements include separate fee and costs funds so this should not be necessary. (See the section on "Attorneys' Fees and Cost Funds" below.)

5. Reporting Requirements for Direct Subdivision Fund Payments

There is a limited reporting requirement for Subdivision Fund payments, which is being administered by the national Directing Administrator, BrownGreer. Reporting is set up to occur every six months, but for these direct payments subdivisions only have to submit a report when there has been an expenditure that does not qualify as opioid remediation. Consequently, reporting is only required if there has been a use of the funds for something that is neither opioid remediation nor qualifying reimbursement for a prior remediation expenditure. There is no need for a subdivision to file a "zero report." If there is not a non-qualifying expenditure to report, no report should be filed.

What clearly must be reported is any expenditure for attorneys' fees or litigation costs paid for out of the Subdivision Fund payments. (There is no need to report anything if attorneys and costs are paid out of the separate cost and fee funds.)

BrownGreer sent out an email in mid-February concerning the first Subdivision Fund report, which is to be made through a subdivision's portal account. **This first report – if one needs to be filed -- is due by March 31, 2023**.

It should be noted that there is a lot of interest in how money from the opioid settlements is spent. While the reporting requirement for Subdivision Fund payments is limited, there may be inquiries from members of the media, public interest groups, and others concerning the use of these funds.

B. Opioid Abatement Fund Payments

Under both settlement agreements, 70% of the remediation funds paid to Tennessee are paid into the State's Opioid Abatement Fund. By statute, 35% of these funds are directed to the counties, to be used future opioid abatement and remediation expenditures approved by the Opioid Abatement Council. As set out below, there are more rules related to the use of funds and more stringent reporting requirements for the Abatement Fund money sent to counties than for the Subdivision Fund payments.

Because the county allocations from the Opioid Abatement Fund flow through the State's trust fund and are then directed to the counties by the Council, the payments to the counties will occur on a different schedule and in a different manner than the direct Subdivision Fund payments. Additionally, the Council will likely combine these payments when transferring the funds to the counties.

1. Allocation Among Counties

The 35% share of the funds directed to the counties is allocated among those counties based on a Tennessee-specific formula set out in Exhibit A of the State-Subdivision Agreement. (Thus, the percentages for each county are different than those used for the Subdivision Fund payments, which are based on a national formula and have shares for certain municipalities.) The Opioid Abatement Fund formula uses county-level data for fatal and non-fatal overdoses, the volume of opioid sales, and population. The formula will be updated every four years, so **a county's allocation percentage will change over time**. The current county allocation percentages are in Attachment D.[7]

2. Initial Payment

The Opioid Abatement Council is in the process of releasing the initial county shares of settlement payments to the Opioid Abatement Fund. These disbursements include the Distributor and J&J/Janssen 2022 payments, adjusted for administrative costs and earned interest. The total amount being directed to the counties is $31,425,152.80. Each county's share is shown in Attachment E.

The Council has reached out to each county regarding these disbursements and the need to enter into a Letter of Agreement regarding the funds. The letter provides some background information regarding the Opioid Abatement Fund and sets out requirements for the receipt and use of the funds. The letter is from Dr. Stephen Loyd, the Council Chair, and Mary Shelton, the Executive Director. Questions concerning the Letter of Agreement may be directed to Ms. Shelton at: Mary.Shelton@tn.gov.

As with the Subdivision Fund, the initial disbursements from the Opioid Abatement Fund are unusually high because they include multiple payments and due to the front-loading of the J&J/Janssen payments. Disbursements from these settlements will be substantially lower in future years.

3. Future Payments

The following information regarding future payments includes figures showing maximum possible scheduled payments from the Distributor and J&J/Janssen settlements. Actual disbursement amounts will be different. At the national level, a company could prepay future scheduled payments, or not make payments as scheduled due to financial distress. Additionally, a small portion of the funds may be needed to pay for the expenses of the national administrator. At the state level, the statutes governing the trust fund allow for payment of the costs of administering the fund and the expenses of the Opioid Abatement Council. Thus, **the actual amounts disbursed to the counties from these settlements will be lower than the maximum payment figures shown below**.

[7] Exhibit A to the State-Subdivision Agreement describes a process for initially holding back 2% of the county funds to make sure there is no dispute over the data. As no county disputed the calculation of the initial county share calculations, the initial allocation percentages have been finalized and full amount of the county shares will be released.

Because the Distributor and J&J/Janssen payments will likely be combined when disbursed by the Council, they are both addressed in the following table rather than set out separately.

Maximum Distributor and J&J/Janssen Abatement Fund Payments 2023-2031

Payment Number	Payment Year	Distributor Maximum TN Abatement Fund Payment	J&J/Janssen Maximum TN Abatement Fund Payment	Total Maximum Abatement Fund Payment	County 35% Share of Maximum Payment
3	2023	$15,674,540.51	---	$15,674,540.51	$5,486,089.18
4	2024	$19,618,907.85	---	$19,618,907.85	$6,866,617.74
5	2025	$19,618,907.85	---	$19,618,907.85	$6,866,617.74
6	2026	$19,618,907.85	$3,011,581.17	$22,630,489.02	$7,920,671.16
7	2027	$19,618,907.85	$3,011,581.14	$22,630,488.99	$7,920,671.15
8	2028	$23,074,199.35	$3,011,581.11	$26,085,780.46	$9,130,023.16
9	2029	$23,074,199.35	$3,834,269.58	$26,908,468.93	$9,417,964.13
10	2030	$23,074,199.35	$3,834,269.59	$26,908,468.94	$9,417,964.13
11	2031	$19,396,193.24	$3,834,269.58	$23,230,462.82	$8,130,661.99
12	2032	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
13	2033	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
14	2034	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
15	2035	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
16	2036	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
17	2037	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
18	2038	$19,396,193.24	---	$19,396,193.24	$6,788,667.63
Total		**$318,542,315.88**	**$20,537,552.17**	**$339,079,868.05**	**$118,677,953.81**

Because the county allocation percentages will be updated every four years, calculations of future maximum payments are just estimates. A county can determine its estimated future maximum Abatement Fund payments from the Distributor and J&J/Janssen settlements by taking the relevant dollar amount from the last column and multiplying it by the county's allocation percentage from Attachment D. For example, Anderson County's allocation percentage is 1.3529267%, so its estimated maximum Opioid Abatement Fund payment in 2023 from the initial settlements would be 1.3529267% of $5,486,089.18, which is $74,222.76.

4. Use of Payments from Opioid Abatement Fund

The Opioid Abatement Fund payments to the counties have more restrictions on them than the direct payments from the Subdivision Fund. The restrictions on these funds come from not only the settlement agreements, but also from state statutes. By statute, Opioid Abatement Fund payments must be spent on **future** remediation and only on expenditures that have been approved by the Opioid Abatement Council. The Council has adopted a broad list of approved expenditures, which can be found on their website: https://www.tn.gov/oac/our-work.html. Attachment C is a copy of the current list but the website should be checked for updates.

The Council's Letter of Agreement with each county addresses the use of disbursements from the Opioid Abatement Fund.

5. Reporting for Payments from the Opioid Abatement Fund

By statute, counties must report on the use of funds received through disbursements from the Opioid Abatement Trust Fund. (The Opioid Abatement Council must regularly report on how all funds are spent, not just those paid to counties.) The Council has set out the high-level requirements for the semi-annual reports in the Letters of Agreement with each county, which include identifying the types of abatement and remediation strategies funded and number of people served.

C. Attorneys' Fees and Cost Funds

The Distributor and J&J/Janssen settlement agreements have substantial separate funds for attorneys' fees and expenses available for those who represented local governments in litigating against these companies. Those funds were negotiated so that outside counsel for subdivisions could be paid and reimbursed for costs without having to enforce their contingency fee contracts. Combined, the two agreements set aside $1.6 billion for subdivision's outside attorneys' fees and costs. Details regarding the subdivision counsel fee and cost funds can be found in Exhibit R for both the Distributor and J&J/Janssen agreements.

As set out in Exhibit R, outside counsel for subdivisions are strongly encouraged and incentivized to seek compensation through the dedicated funds. For example, outside counsel for a subdivision seeking compensation from the fund cannot also enforce its contingency fee contracts. However, while a vast majority of subdivision outside counsel are seeking compensation from the dedicated funds, it is possible that some may choose not to apply to those funds and to enforce their contingency fee contracts instead.

V. ABATEMENT FUNDS FROM COMPANIES IN BANKRUPTCY

Multiple opioid manufacturers have filed for bankruptcy and face claims from state and local governments. The largest of these cases are for Purdue Pharma L.P., Mallinckrodt PLC, and Endo International, plc. The bankruptcy cases are in different stages, but in all three the public entity opioid-related claims are being addressed by directing funds to each state for future opioid abatement and remediation. (There is not a three-bucket structure for bankruptcy funds.) Under the Tennessee State-Subdivision Agreement, funds from such bankruptcies generally are paid into the Opioid Abatement Fund, with 35% of the funds being disbursed to the counties under the same conditions as with other settlement funds paid into the trust. (The current State-Subdivision Agreement does not apply to Endo bankruptcy funds, but the proposed amendments to the Agreement would have it apply to Endo funds.)

Mallinckrodt is the only company that has emerged from bankruptcy and begun making payments. It made its initial payment of $4.1 million to the Opioid Abatement Fund earlier this year. It is anticipated that the counties' share will be included in the next disbursement by the Council.

VI. NEW "SECOND WAVE" SETTLEMENTS

Tennessee has joined a broad coalition of states and local political subdivisions in reaching nationwide settlements with two additional manufacturers and three national pharmacy chains. The two manufacturers are Allergan and Teva; the three pharmacy chains are CVS, Walgreens, and Walmart. If all five of the "second wave" settlements are fully adopted nationally, the maximum payments to Tennessee and its qualifying local governments would be more than $490 million. Most states have joined the settlements, but for the agreements to become effective, **a critical mass of subdivisions must sign onto the settlements by April 18, 2023**. A subdivision must submit a participation form for each settlement in order to receive payments from that settlement.

The settlements have the same basic structure as the Distributor and J&J/Janssen settlements that is described in Section II, above. As with the initial settlements, the "second wave" settlements feature three buckets of funds for abatement, separate attorneys' fees and cost funds, and several payment incentives that can be maximized with a statutory bar of public entity claims. With amendments to the opioid settlement statutes to extend the statutes to the new agreements, the allocation of funds for these national agreements will be the same as with the initial settlements.

For the "second wave" settlements, there is a separate agreement for each company. The agreements and additional information can be found on the Attorney General website: https://www.tn.gov/attorneygeneral/working-for-tennessee/filings-of-interest/opioids.html. Information on the joinder process and additional materials about the settlements can be found on the national settlement website: https://nationalopioidsettlement.com.

Basic high-level information regarding each "second wave" settlement is set out below. The dollar figures assume all maximum payments are made as currently scheduled and are not adjusted for administrative costs or other factors that might reduce the actual amount paid. Should the settlements become effective, more detailed figures, including anticipated annual payments, will be provided. The figures are for **total** payments for all years. They are not figures for each annual payment.

A. Settlement Basics for Each Company

1. Allergan

Formal Name: Allergan Finance, LLC
Total TN Maximum Payment: $57 million over 7 years
Subdivision Fund Max Payment: $8,600,942.40
County Share of Abatement Fund Max Payment: $14,048,205.91

2. Teva

Formal Name: Teva Pharmaceutical Industries, Ltd.
Total TN Maximum Payment: $96 million over 13 years

Subdivision Fund Max Payment: $14,437,109.10
County Share of Abatement Fund Max Payment: $23,580,611.53

The settlements with Allergan and Teva are interrelated because of transactions between the companies involving subsidiaries and the ownership of certain products. Therefore, subdivisions must either join the settlements with both companies or not join either settlement.

3. CVS

Formal Name: CVS Health Corporation
Total TN Maximum Payment: $127 million over 10 years
Subdivision Fund Max Payment: $19,096,955.65
County Share of Abatement Fund Max Payment: $31,191,694.23

4. Walgreens

Formal Name: Walgreen Co.
Total TN Maximum Payment: $138 million over 15 years
Subdivision Fund Max Payment: $20,765,939.41
County Share of Abatement Fund Max Payment: $33,917,701.04

5. Walmart

Formal Name: Walmart, Inc.
Total TN Maximum Payment: $72 million, likely in one payment
Subdivision Fund Max Payment: $10,814,310.26
County Share of Abatement Fund Max Payment: $17,663,373.42

It is anticipated that Tennessee will qualify for incentives that would allow for the Walmart payment to be made in one year. If that does not occur, payments would be made within six years.

The **aggregate maximum total amount from all five settlements**, including all payments:

Total TN Maximum Aggregate Payment: $491,435,045.43
Subdivision Fund Max Aggregate Payment: $73,715,256.82
County Share of Abatement Fund Max Aggregate Payment: $120,401,586.13

As with the initial settlements, each agreement has **separate funds for attorneys' fees and costs** for subdivisions that hired outside counsel and litigated. Outside counsel for subdivisions are strongly encouraged to seek payment and cost reimbursement from those funds and to not enforce contingency fee contracts.

B. Calculating a Subdivision's Potential Maximum Payments

As with the initial settlements, subdivisions will receive funds from two sources under the new settlements. There will be direct payments from each settlement's Subdivision Fund to the

counties and qualifying municipalities that participate in the settlement. Additionally, participating counties will receive their allocation of the 35% county share of the Opioid Abatement Fund payments.

- Maximum Subdivision Fund Payment Calculation: A subdivision's allocation percentage is set out in Exhibit G of each agreement. For the new settlements, the Exhibit G list and percentages are the same as in the J&J/Janssen Exhibit G. The Tennessee allocation percentages are copied in Attachment B.[8] To determine the estimated total maximum payment to a subdivision from the Subdivision Fund of each agreement, take the "Subdivision Fund Max Payment" figure listed for each agreement above and multiply it by the allocable share percentage in Exhibit G. This provides the total maximum Subdivision Fund payment to be made from that agreement. For example, the estimated total maximum Subdivision Fund payment for Anderson County from the Allergan settlement is $103,755.31 ($8,600,942.40 multiplied by 1.2063249026%).

- Maximum Abatement Fund Distribution Calculation: In addition to the Subdivision Fund direct payment, counties will also receive a share of the Abatement Fund payments. (This assumes the statutes have been amended to extend to the additional settlements.) The companies' Abatement Fund payments will go through the Opioid Abatement Fund, 35% of which will be disbursed to the counties. A county's Abatement Fund allocation percentage for the new agreements is the same as for the existing agreements, which are listed in Attachment D. To determine the estimated total maximum disbursement from the Abatement Fund payments for each agreement, take the "County Share of Abatement Fund Max Payment" figure listed for each agreement above and multiply it by the allocable share percentage in Attachment D. This provides the county's total maximum Abatement Fund distribution to be made from that agreement's payments. For example, the estimated maximum Abatement Fund disbursement for Anderson County from the Allergan settlement is $190,061.93 ($14,048,205.91 multiplied by 1.3529267%).

C. Amending State-Subdivision Agreement and Statutes to Address New Settlements

The Tennessee State-Subdivision Opioid Abatement Agreement and two statutes related to opioid settlements are being amended to extend the structure of the initial settlement agreements with the Distributors and J&J/Janssen to the new settlements.

The new settlement participation packets sent to subdivisions include a request to approve three amendments to the State-Subdivision Agreement. The first amendment extends the agreement to cover the five new national settlements. The second amendment addresses an accounting issue for certain counties and streamlines the process. The third amendment extends the agreement to funds from the Endo International plc bankruptcy. A summary of the amendments and the amendment language can be found in Attachment F.

Legislation has been introduced that would treat the new settlements in the same manner as the Distributor and J&J/Janssen settlements. As with the earlier settlements, maximum

[8] As stated in the introductory language of Exhibit G in each of the new settlement agreements, the exhibits are not locked down until the end of the initial joinder period and are also subject to amendment. However, it is not anticipated that there will be any significant change to the Tennessee subdivision section of the exhibits.

payments are dependent on all settlement incentives being reached. The legislation allows for the release of all State and subdivision claims against these companies if the settlements become effective and this process should ensure maximum payments are earned. Additionally, the legislation would direct 35% of the Opioid Abatement Funds from these agreements to the counties.

D. Joinder Process

The joinder process for the five new national settlements will be very much as it was for the Distributor and J&J/Janssen settlements. Subdivision sign-on is being coordinated by Rubris, which communicates with subdivisions via email as the "National Opioid Settlements Implementation Administrator." Rubis has sent out an email packet with a process to complete participation forms to join the five settlements and to approve the amendments to the State-Subdivision Agreement. It is important that all fields be filled out for each participation form. The email sets out different means of submitting the participation forms, but using the electronic signature through the DocuSign portal is strongly encouraged as it allows for the most efficient tracking of the forms from across the country.

If needed, a model resolution for joining the new settlements and approving the amendments to the State-Subdivision Agreement can be found in Attachment G. A Word version is on the Attorney General website. While the model resolution is drafted for a county commission, it can be amended for municipalities.

While the deadline for subdivision joinder is not until April 18, subdivisions are encouraged to join as soon as possible. The national settlements will not become effective if a critical mass of participating subdivisions is not reached. Early momentum in the sign-on process will assist in reaching the goal of having five new national agreements.

Attachment A

Distributor Settlement Agreement

Exhibit G

Pages with Tennessee Subdivision Allocations

Allocation percentages to be used in calculating Distributor settlement payments.

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State ID	Qualifying Subdivision	Consolidated State Allocation
TN1	Alexandria Town, Tennessee	0.0027913085%
TN2	Algood City, Tennessee	0.0032741136%
TN3	Anderson County, Tennessee	1.2063249026%
TN5	Arlington Town, Tennessee	0.0036566309%
TN8	Bartlett City, Tennessee	0.0730561566%
TN9	Baxter Town, Tennessee	0.0004972097%
TN10	Bedford County, Tennessee	0.5276238893%
TN12	Benton County, Tennessee	0.5216608068%
TN13	Bledsoe County, Tennessee	0.1398580820%
TN14	Blount County, Tennessee	1.9196465581%
TN15	Bradley County, Tennessee	1.0430217552%
TN16	Brentwood City, Tennessee	0.0478208600%
TN17	Bristol City, Tennessee	0.5426871150%
TN19	Campbell County, Tennessee	1.5974370559%
TN20	Cannon County, Tennessee	0.3205453950%
TN21	Carroll County, Tennessee	0.4438060785%
TN22	Carter County, Tennessee	0.8435596891%
TN23	Celina City, Tennessee	0.0277813920%
TN24	Centertown, Tennessee	0.0001321538%
TN26	Chapel Hill Town, Tennessee	0.0043601529%
TN27	Chattanooga City, Tennessee	0.4981237028%
TN28	Cheatham County, Tennessee	0.8209998781%
TN29	Chester County, Tennessee	0.1751399118%
TN30	Claiborne County, Tennessee	1.1929412357%
TN31	Clarksville City, Tennessee	0.2296815192%
TN32	Clay County, Tennessee	0.2983695250%
TN33	Cleveland City, Tennessee	0.5531282252%
TN34	Clifton City, Tennessee	0.0022427615%
TN36	Cocke County, Tennessee	0.8746257470%
TN37	Coffee County, Tennessee	0.8953551698%
TN39	Collierville Town, Tennessee	0.0617375387%
TN41	Columbia City, Tennessee	0.0390894158%
TN42	Cookeville City, Tennessee	0.8404101920%
TN43	Cornersville Town, Tennessee	0.0025527953%
TN45	Crockett County, Tennessee	0.1232062476%
TN46	Crossville City, Tennessee	0.0619543195%
TN47	Cumberland County, Tennessee	0.8165125963%
TN48	Dandridge Town, Tennessee	0.0109089663%
TN49	De Kalb County, Tennessee	0.4253694564%
TN50	Decatur County, Tennessee	0.3607195939%
TN51	Decatur Town, Tennessee	0.0050599481%
TN53	Dickson County, Tennessee	0.8341347308%

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State ID	Qualifying Subdivision	Consolidated State Allocation
TN56	Dyer County, Tennessee	0.4019088559%
TN58	Eagleville City, Tennessee	0.0010231029%
TN64	Fayette County, Tennessee	0.3157083831%
TN65	Fayetteville City, Tennessee	0.0647238955%
TN66	Fentress County, Tennessee	0.5526714656%
TN67	Franklin City, Tennessee	0.1089989646%
TN68	Franklin County, Tennessee	0.6323371108%
TN69	Gallatin City, Tennessee	0.0760079674%
TN70	Gatlinburg City, Tennessee	0.0507819668%
TN71	Germantown City, Tennessee	0.0687501047%
TN72	Gibson County, Tennessee	0.4940695219%
TN73	Giles County, Tennessee	0.4604367667%
TN75	Grainger County, Tennessee	0.4671260668%
TN76	Greene County, Tennessee	1.2127967101%
TN78	Grundy County, Tennessee	0.3896858892%
TN79	Hamblen County, Tennessee	2.2614488604%
TN80	Hamilton County, Tennessee	4.2055530346%
TN81	Hancock County, Tennessee	0.2089065376%
TN82	Hardeman County, Tennessee	0.2150658408%
TN83	Hardin County, Tennessee	0.5683946644%
TN84	Hartsville/Trousdale County, Tennessee	0.1139641522%
TN85	Hawkins County, Tennessee	1.0968095083%
TN86	Haywood County, Tennessee	0.1104263592%
TN87	Henderson County, Tennessee	0.2498867656%
TN88	Hendersonville City, Tennessee	0.1137407554%
TN89	Henry County, Tennessee	0.6661685991%
TN90	Hickman County, Tennessee	0.2804089244%
TN91	Houston County, Tennessee	0.1198735525%
TN92	Humphreys County, Tennessee	0.2441608982%
TN93	Jackson City, Tennessee	0.0431370644%
TN94	Jackson County, Tennessee	0.2780985367%
TN95	Jefferson County, Tennessee	0.8912247367%
TN96	Johnson City, Tennessee	1.0682855260%
TN97	Johnson County, Tennessee	0.2282065978%
TN98	Kingsport City, Tennessee	0.9871149359%
TN99	Knox County, Tennessee	9.1809198144%
TN100	Knoxville City, Tennessee	1.5417816888%
TN101	La Vergne City, Tennessee	0.0518950147%
TN102	Lake County, Tennessee	0.0671464632%
TN104	Lauderdale County, Tennessee	0.2733775153%
TN105	Lawrence County, Tennessee	0.6479399224%
TN106	Lawrenceburg City, Tennessee	0.0465511203%

State ID	Qualifying Subdivision	Consolidated State Allocation
TN107	Lebanon City, Tennessee	0.1110258247%
TN108	Lewis County, Tennessee	0.1528225920%
TN109	Lewisburg City, Tennessee	0.0396496875%
TN110	Lexington City, Tennessee	0.0796867496%
TN112	Lincoln County, Tennessee	0.3413545456%
TN114	Loretto City, Tennessee	0.0047940075%
TN115	Loudon County, Tennessee	0.8992484296%
TN116	Lynchburg, Moore County Metropolitan Government, Tennessee	0.0579106070%
TN118	Macon County, Tennessee	0.3091017000%
TN119	Madison County, Tennessee	0.8907256845%
TN121	Marion County, Tennessee	0.3637161259%
TN122	Marshall County, Tennessee	0.4956600988%
TN124	Maryville City, Tennessee	0.3223901040%
TN125	Maury County, Tennessee	1.0724162522%
TN126	McMinn County, Tennessee	0.9297273747%
TN128	McNairy County, Tennessee	0.4269884656%
TN129	Meigs County, Tennessee	0.2016450737%
TN130	Memphis City, Tennessee	4.9079216307%
TN131	Millington City, Tennessee	0.0212200583%
TN133	Monroe County, Tennessee	0.7506735593%
TN135	Montgomery County, Tennessee	1.6758545682%
TN136	Morgan County, Tennessee	0.5132562715%
TN138	Morristown City, Tennessee	0.3919462797%
TN139	Mount Juliet City, Tennessee	0.0577622481%
TN140	Mount Pleasant City, Tennessee	0.0048377656%
TN141	Murfreesboro City, Tennessee	0.7283549414%
TN142	Nashville-Davidson Metropolitan Government, Tennessee	8.9810236006%
TN145	Oak Ridge City, Tennessee	0.9598050011%
TN146	Obion County, Tennessee	0.3198033491%
TN147	Overton County, Tennessee	0.5461670803%
TN149	Perry County, Tennessee	0.0857864664%
TN151	Pickett County, Tennessee	0.1471132648%
TN152	Pigeon Forge City, Tennessee	0.0877322588%
TN153	Pleasant Hill Town, Tennessee	0.0000178801%
TN154	Polk County, Tennessee	0.3220131560%
TN157	Putnam County, Tennessee	0.3893182790%
TN159	Rhea County, Tennessee	0.5404420504%
TN160	Ripley City, Tennessee	0.0190759934%
TN161	Roane County, Tennessee	1.6361535854%
TN162	Robertson County, Tennessee	0.9333043197%

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State ID	Qualifying Subdivision	Consolidated State Allocation
TN163	Rutherford County, Tennessee	2.5746747125%
TN164	Scott County, Tennessee	0.5189341096%
TN165	Sequatchie County, Tennessee	0.2433974548%
TN166	Sevier County, Tennessee	1.4412782095%
TN168	Shelby County, Tennessee	3.5255489082%
TN169	Shelbyville City, Tennessee	0.0482670674%
TN170	Smith County, Tennessee	0.5711842980%
TN171	Smithville City, Tennessee	0.0196818237%
TN172	Smyrna Town, Tennessee	0.1314691656%
TN174	Sparta City, Tennessee	0.0168519913%
TN175	Spencer Town, Tennessee	0.0007743306%
TN176	Spring Hill City, Tennessee	0.0244598773%
TN179	Stewart County, Tennessee	0.1459273147%
TN180	Sullivan County, Tennessee	1.4573397906%
TN181	Sumner County, Tennessee	1.7449087187%
TN182	Tipton County, Tennessee	0.6312749815%
TN184	Unicoi County, Tennessee	0.3464527663%
TN186	Union County, Tennessee	0.5606745148%
TN187	Van Buren County, Tennessee	0.0471429229%
TN189	Warren County, Tennessee	0.5717791156%
TN190	Wartrace Town, Tennessee	0.0003753988%
TN191	Washington County, Tennessee	1.1061046159%
TN192	Wayne County, Tennessee	0.2306289980%
TN194	Weakley County, Tennessee	0.3874777573%
TN195	White County, Tennessee	0.3993875079%
TN197	Williamson County, Tennessee	1.6843304984%
TN198	Wilson County, Tennessee	1.4019072760%

Attachment B

J&J/Janssen Settlement Agreement

Exhibit G

Pages with Tennessee Subdivision Allocations

Allocation percentages to be used in calculating J&J/Janssen settlement payments from the Subdivision Fund.

The J&J/Janssen allocations are also the current allocations for Exhibit G in the five new national settlement agreements and can be used to calculate settlement payments from the Subdivision Fund for those agreements as well.

State ID	Qualifying Subdivision	Consolidated State Allocation
TN3	Anderson County, Tennessee	1.2063249026%
TN5	Arlington Town, Tennessee	0.0036566309%
TN8	Bartlett City, Tennessee	0.0730561566%
TN10	Bedford County, Tennessee	0.5762663555%
TN12	Benton County, Tennessee	0.5216608068%
TN13	Bledsoe County, Tennessee	0.1398580820%
TN14	Blount County, Tennessee	1.9196465581%
TN15	Bradley County, Tennessee	1.0430217552%
TN16	Brentwood City, Tennessee	0.0478208600%
TN17	Bristol City, Tennessee	0.5426871150%
TN19	Campbell County, Tennessee	1.5974370559%
TN20	Cannon County, Tennessee	0.3205453949%
TN21	Carroll County, Tennessee	0.4438060785%
TN22	Carter County, Tennessee	0.8435596891%
TN27	Chattanooga City, Tennessee	0.4981237028%
TN28	Cheatham County, Tennessee	0.8209998781%
TN29	Chester County, Tennessee	0.1751399118%
TN30	Claiborne County, Tennessee	1.1929412357%
TN31	Clarksville City, Tennessee	0.2296815192%
TN32	Clay County, Tennessee	0.3261509170%
TN33	Cleveland City, Tennessee	0.5531282252%
TN36	Cocke County, Tennessee	0.8746257470%
TN37	Coffee County, Tennessee	0.8953551698%
TN39	Collierville Town, Tennessee	0.0617375387%
TN41	Columbia City, Tennessee	0.0390894158%
TN42	Cookeville City, Tennessee	0.8404101920%
TN45	Crockett County, Tennessee	0.1232062476%
TN47	Cumberland County, Tennessee	0.8784847959%
TN48	Dandridge Town, Tennessee	0.0109089663%
TN49	De Kalb County, Tennessee	0.4478425886%
TN50	Decatur County, Tennessee	0.3607195939%
TN51	Decatur Town, Tennessee	0.0050599481%
TN53	Dickson County, Tennessee	0.8341347308%
TN56	Dyer County, Tennessee	0.4019088559%
TN64	Fayette County, Tennessee	0.3157083831%
TN66	Fentress County, Tennessee	0.5526714656%
TN67	Franklin City, Tennessee	0.1089989646%
TN68	Franklin County, Tennessee	0.6323371108%
TN69	Gallatin City, Tennessee	0.0760079674%
TN70	Gatlinburg City, Tennessee	0.0507819668%
TN71	Germantown City, Tennessee	0.0687501047%
TN72	Gibson County, Tennessee	0.4940695219%
TN73	Giles County, Tennessee	0.4604367666%
TN75	Grainger County, Tennessee	0.4671260668%
TN76	Greene County, Tennessee	1.2127967101%
TN78	Grundy County, Tennessee	0.3896858892%
TN79	Hamblen County, Tennessee	2.2614488604%
TN80	Hamilton County, Tennessee	4.2055530346%
TN81	Hancock County, Tennessee	0.2089065376%

State ID	Qualifying Subdivision	Consolidated State Allocation
TN82	Hardeman County, Tennessee	0.2150658408%
TN83	Hardin County, Tennessee	0.5683946644%
TN84	Hartsville/Trousdale County, Tennessee	0.1139641522%
TN85	Hawkins County, Tennessee	1.0968095083%
TN86	Haywood County, Tennessee	0.1104263592%
TN87	Henderson County, Tennessee	0.2498867656%
TN88	Hendersonville City, Tennessee	0.1137407554%
TN89	Henry County, Tennessee	0.6661685991%
TN90	Hickman County, Tennessee	0.2804089244%
TN91	Houston County, Tennessee	0.1198735525%
TN92	Humphreys County, Tennessee	0.2441608982%
TN93	Jackson City, Tennessee	0.0431370644%
TN94	Jackson County, Tennessee	0.2780985367%
TN95	Jefferson County, Tennessee	0.8912247367%
TN96	Johnson City, Tennessee	1.0682855260%
TN97	Johnson County, Tennessee	0.2282065978%
TN98	Kingsport City, Tennessee	0.9871149359%
TN99	Knox County, Tennessee	9.1809198144%
TN100	Knoxville City, Tennessee	1.5417816888%
TN101	La Vergne City, Tennessee	0.0518950147%
TN102	Lake County, Tennessee	0.0671464632%
TN104	Lauderdale County, Tennessee	0.2733775153%
TN105	Lawrence County, Tennessee	0.6992850503%
TN107	Lebanon City, Tennessee	0.1110258247%
TN108	Lewis County, Tennessee	0.1528225920%
TN110	Lexington City, Tennessee	0.0796867496%
TN112	Lincoln County, Tennessee	0.4060784411%
TN115	Loudon County, Tennessee	0.8992484296%
TN116	Lynchburg, Moore County Metropolitan Government, Tennessee	0.0579106070%
TN118	Macon County, Tennessee	0.3091017000%
TN119	Madison County, Tennessee	0.8907256845%
TN121	Marion County, Tennessee	0.3637161259%
TN122	Marshall County, Tennessee	0.5422227344%
TN124	Maryville City, Tennessee	0.3223901040%
TN125	Maury County, Tennessee	1.0772540178%
TN126	McMinn County, Tennessee	0.9297273747%
TN128	McNairy County, Tennessee	0.4269884656%
TN129	Meigs County, Tennessee	0.2016450737%
TN130	Memphis City, Tennessee	4.9079216307%
TN131	Millington City, Tennessee	0.0212200583%
TN133	Monroe County, Tennessee	0.7506735593%
TN135	Montgomery County, Tennessee	1.6758545682%
TN136	Morgan County, Tennessee	0.5132562715%
TN138	Morristown City, Tennessee	0.3919462797%
TN139	Mount Juliet City, Tennessee	0.0577622481%
TN141	Murfreesboro City, Tennessee	0.7283549414%

State ID	Qualifying Subdivision	Consolidated State Allocation
TN142	Nashville-Davidson Metropolitan Government, Tennessee	8.9810236006%
TN145	Oak Ridge City, Tennessee	0.9598050011%
TN146	Obion County, Tennessee	0.3198033491%
TN147	Overton County, Tennessee	0.5461670803%
TN149	Perry County, Tennessee	0.0857864664%
TN151	Pickett County, Tennessee	0.1471132648%
TN152	Pigeon Forge City, Tennessee	0.0877322588%
TN154	Polk County, Tennessee	0.3220131560%
TN157	Putnam County, Tennessee	0.3930896023%
TN159	Rhea County, Tennessee	0.5404420504%
TN160	Ripley City, Tennessee	0.0190759934%
TN161	Roane County, Tennessee	1.6361535854%
TN162	Robertson County, Tennessee	0.9333043197%
TN163	Rutherford County, Tennessee	2.5756978154%
TN164	Scott County, Tennessee	0.5189341096%
TN165	Sequatchie County, Tennessee	0.2433974548%
TN166	Sevier County, Tennessee	1.4412782095%
TN168	Shelby County, Tennessee	3.5255489082%
TN170	Smith County, Tennessee	0.5711842980%
TN172	Smyrna Town, Tennessee	0.1314691656%
TN176	Spring Hill City, Tennessee	0.0244598773%
TN179	Stewart County, Tennessee	0.1459273147%
TN180	Sullivan County, Tennessee	1.4573397906%
TN181	Sumner County, Tennessee	1.7449087187%
TN182	Tipton County, Tennessee	0.6312749815%
TN184	Unicoi County, Tennessee	0.3464527663%
TN186	Union County, Tennessee	0.5606745148%
TN187	Van Buren County, Tennessee	0.0479172535%
TN189	Warren County, Tennessee	0.5719112694%
TN191	Washington County, Tennessee	1.1061046159%
TN192	Wayne County, Tennessee	0.2328717594%
TN194	Weakley County, Tennessee	0.3874777573%
TN195	White County, Tennessee	0.4162394991%
TN197	Williamson County, Tennessee	1.6843304984%
TN198	Wilson County, Tennessee	1.4019072760%

Attachment C

Opioid Abatement Council

Tennessee Opioid Abatement and Remediation List

Tennessee Opioid Abatement Council
Revised & Adopted September 30, 2022

EXHIBIT E

Tennessee's Opioid Abatement & Remediation Uses

Schedule A
Core Strategies

A. NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. MEDICATION-ASSISTED TREATMENT *("MAT")* DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

C. PREGNANT & POSTPARTUM WOMEN

1. Expand Screening, Brief Intervention, and Referral to Treatment *("SBIRT")* services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services,

including MAT, for women with co- occurring Opioid Use Disorder *("OUD")* and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME *("NAS")*

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

E. EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. TREATMENT FOR INCARCERATED POPULATION

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and
2. Increase funding for jails to provide treatment to inmates with OUD.

G. PREVENTION PROGRAMS

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the CDC's Updated Clinical Practice Guideline for Prescribing Opioids, the Tennessee Department of Health Chronic Pain Guideline, and current evidence;

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre- arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. EXPANDING SYRINGE SERVICE PROGRAMS

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE

Schedule B
Approved Uses

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 *("SUDMH")* conditions through evidence-based or evidence- informed programs or strategies that may include, but are not limited to, those that:[2]

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. Provide 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.

8. Provide 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. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH 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 of2000 *("DATA 2000")* to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate 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. Develop and disseminate 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 programs or strategies that:

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. Provide 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. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have--or are 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, those that:

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 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. Provide 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, those that:

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 ODD-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 or 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, those that:

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. Provide training for obstetricians or other healthcare personnel who 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; and 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 NAS get referred to appropriate services and receive a plan of safe care.

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

7. Provide enhanced family support and childcare 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. Provide 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. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the CDC's Updated Clinical Practice Guideline for Prescribing Opioids, the Tennessee Department of Health Chronic Pain Guideline, and current evidence.

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

5. Supporting 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. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating 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. Funding 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. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting 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. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding 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 or 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. Increased 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. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expanding, improving, or developing 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. Educating 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. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting 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. Providing 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. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Education of 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, those that:

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.

Attachment D

Opioid Abatement Fund

Initial County Allocation Percentages

Tennessee Initial Opioid Abatement Fund County Allocation Percentages

County	Allocation Percentage
Anderson	1.3529267%
Bedford	0.7147711%
Benton	0.2558695%
Bledsoe	0.2225720%
Blount	2.0533524%
Bradley	1.4648524%
Campbell	0.7492480%
Cannon	0.2830317%
Carroll	0.3845316%
Carter	0.8133771%
Cheatham	0.9247968%
Chester	0.2164707%
Claiborne	0.5410868%
Clay	0.1396219%
Cocke	0.6453452%
Coffee	0.9292878%
Crockett	0.1655486%
Cumberland	0.9377659%
Davidson	10.8999846%
Decatur	0.1784083%
DeKalb	0.3791980%
Dickson	0.9733390%
Dyer	0.4779140%
Fayette	0.5229554%
Fentress	0.3672900%
Franklin	0.6164429%
Gibson	0.6441719%
Giles	0.4460273%
Grainger	0.3563783%
Greene	1.0622152%
Grundy	0.2677408%
Hamblen	0.9270873%
Hamilton	4.7857829%
Hancock	0.1108552%
Hardeman	0.3326917%
Hardin	0.4285971%
Hawkins	0.9214592%
Haywood	0.1952676%
Henderson	0.3890979%
Henry	0.4744302%

Hickman	0.4816033%
Houston	0.1578236%
Humphreys	0.2902618%
Jackson	0.2202072%
Jefferson	0.7742937%
Johnson	0.2220085%
Knox	7.9971725%
Lake	0.1130733%
Lauderdale	0.3225823%
Lawrence	0.6708883%
Lewis	0.2126860%
Lincoln	0.4758274%
Loudon	0.7783832%
Macon	0.3743831%
Madison	1.1728499%
Marion	0.4562305%
Marshall	0.5351692%
Maury	1.3766506%
McMinn	0.8186667%
McNairy	0.3515796%
Meigs	0.1905215%
Monroe	0.6757426%
Montgomery	3.1176576%
Moore	0.0950776%
Morgan	0.3914142%
Obion	0.4278681%
Overton	0.3774135%
Perry	0.1400999%
Pickett	0.0775687%
Polk	0.2477589%
Putnam	1.1154615%
Rhea	0.5123362%
Roane	0.9738860%
Robertson	1.2118923%
Rutherford	4.8157438%
Scott	0.3389911%
Sequatchie	0.2451811%
Sevier	1.5771190%
Shelby	11.3894382%
Smith	0.3466744%
Stewart	0.2587489%
Sullivan	2.3419111%
Sumner	2.8691118%
Tipton	0.8476023%
Trousdale	0.2031046%
Unicoi	0.2910812%

Union	0.3348429%
Van Buren	0.0893332%
Warren	0.6471045%
Washington	1.6866631%
Wayne	0.2500918%
Weakley	0.4660285%
White	0.4417949%
Williamson	2.4813940%
Wilson	2.1692092%
Total	**100.0000000%**

Attachment E

Opioid Abatement Council

Initial Opioid Abatement Fund Payments to Counties

February 2023

Tennessee Initial Opioid Abatement Fund Payments to Counties
February 2023

County	Allocation Percentage	Dollar Amount for County
Anderson	1.3529267%	$425,159.28
Bedford	0.7147711%	$224,617.91
Benton	0.2558695%	$80,407.37
Bledsoe	0.2225720%	$69,943.58
Blount	2.0533524%	$645,269.14
Bradley	1.4648524%	$460,332.09
Campbell	0.7492480%	$235,452.32
Cannon	0.2830317%	$88,943.16
Carroll	0.3845316%	$120,839.64
Carter	0.8133771%	$255,604.99
Cheatham	0.9247968%	$290,618.82
Chester	0.2164707%	$68,026.24
Claiborne	0.5410868%	$170,037.35
Clay	0.1396219%	$43,876.41
Cocke	0.6453452%	$202,800.72
Coffee	0.9292878%	$292,030.12
Crockett	0.1655486%	$52,023.89
Cumberland	0.9377659%	$294,694.36
Davidson	10.8999846%	$3,425,336.82
Decatur	0.1784083%	$56,065.09
DeKalb	0.3791980%	$119,163.55
Dickson	0.9733390%	$305,873.27
Dyer	0.4779140%	$150,185.21
Fayette	0.5229554%	$164,339.53
Fentress	0.3672900%	$115,421.46
Franklin	0.6164429%	$193,718.11
Gibson	0.6441719%	$202,432.00
Giles	0.4460273%	$140,164.76
Grainger	0.3563783%	$111,992.42
Greene	1.0622152%	$333,802.75
Grundy	0.2677408%	$84,137.96
Hamblen	0.9270873%	$291,338.60
Hamilton	4.7857829%	$1,503,939.60
Hancock	0.1108552%	$34,836.41
Hardeman	0.3326917%	$104,548.87
Hardin	0.4285971%	$134,687.30
Hawkins	0.9214592%	$289,569.96
Haywood	0.1952676%	$61,363.14
Henderson	0.3890979%	$122,274.62

Henry	0.4744302%	$149,090.40
Hickman	0.4816033%	$151,344.58
Houston	0.1578236%	$49,596.30
Humphreys	0.2902618%	$91,215.23
Jackson	0.2202072%	$69,200.45
Jefferson	0.7742937%	$243,322.97
Johnson	0.2220085%	$69,766.52
Knox	7.9971725%	$2,513,123.68
Lake	0.1130733%	$35,533.44
Lauderdale	0.3225823%	$101,371.99
Lawrence	0.6708883%	$210,827.69
Lewis	0.2126860%	$66,836.90
Lincoln	0.4758274%	$149,529.49
Loudon	0.7783832%	$244,608.12
Macon	0.3743831%	$117,650.45
Madison	1.1728499%	$368,569.86
Marion	0.4562305%	$143,371.14
Marshall	0.5351692%	$168,177.75
Maury	1.3766506%	$432,614.55
McMinn	0.8186667%	$257,267.25
McNairy	0.3515796%	$110,484.44
Meigs	0.1905215%	$59,871.66
Monroe	0.6757426%	$212,353.13
Montgomery	3.1176576%	$979,728.66
Moore	0.0950776%	$29,878.28
Morgan	0.3914142%	$123,002.53
Obion	0.4278681%	$134,458.21
Overton	0.3774135%	$118,602.77
Perry	0.1400999%	$44,026.61
Pickett	0.0775687%	$24,376.08
Polk	0.2477589%	$77,858.63
Putnam	1.1154615%	$350,535.48
Rhea	0.5123362%	$161,002.42
Roane	0.9738860%	$306,045.15
Robertson	1.2118923%	$380,839.01
Rutherford	4.8157438%	$1,513,354.86
Scott	0.3389911%	$106,528.48
Sequatchie	0.2451811%	$77,048.53
Sevier	1.5771190%	$495,612.05
Shelby	11.3894382%	$3,579,148.36
Smith	0.3466744%	$108,942.96
Stewart	0.2587489%	$81,312.23
Sullivan	2.3419111%	$735,949.15
Sumner	2.8691118%	$901,622.77
Tipton	0.8476023%	$266,360.30
Trousdale	0.2031046%	$63,825.94

Unicoi	0.2910812%	$91,472.71
Union	0.3348429%	$105,224.89
Van Buren	0.0893332%	$28,073.08
Warren	0.6471045%	$203,353.57
Washington	1.6866631%	$530,036.46
Wayne	0.2500918%	$78,591.73
Weakley	0.4660285%	$146,450.16
White	0.4417949%	$138,834.73
Williamson	2.4813940%	$779,781.87
Wilson	2.1692092%	$681,677.30
Total	**100.0000000%**	**$31,425,152.80**

Attachment F

Tennessee State-Subdivision Agreement

Summary of Proposed Amendments

Summary of 2023 Amendments
to Tennessee State-Subdivision Opioid Abatement Agreement

In addition to being asked to join five new settlements, Tennessee local governments are also being asked to approve amendments to the Tennessee State-Subdivision Opioid Abatement Agreement. There are three proposed amendments, which are summarized below. The settlement participation packet being sent to counties and qualifying municipalities by the national administrator will also include a form to approve the three amendments. The full text of the proposed amendments can be found on the following page.

Summary of Amendment 1:

This amendment simply applies the terms of the State-Subdivision Agreement to the five new settlements with Allergan, Teva, CVS, Walgreens, and Walmart. This will ensure that the structure and procedures that apply to the prior settlements with the three national pharmaceutical distributors and Johnson & Johnson will be the same for the new settlements. For example, the formula for using overdose and other data to allocate funds among the counties would be the same for the new agreements as with the existing ones.

Summary of Amendment 2:

Under the State-Subdivision Agreement, Subdivision Fund allocations for non-litigating municipalities with populations under 30,000 are directed to the counties. Consequently, these municipalities do not receive direct payments, but the money stays with the community. (This provision would continue to apply with the new settlements.) The current language of the provision also places a restriction on the use of the redirected funds, treating the redirected funds like money from the trust fund and unlike the other Subdivision Fund direct payments the county is receiving from the national administrator. This restriction would require a substantial amount of special accounting for a small amount of money. The amendment removes that requirement to streamline accounting for the counties.

Summary of Amendment 3:

The third amendment applies the State-Subdivision Agreement to funds from the Endo International plc bankruptcy. Since the Agreement was first negotiated, a group of East Tennessee counties and municipalities reached a settlement with the company, which later filed for bankruptcy. The amendment applies the bankruptcy provisions of the Agreement to Endo funds paid into the State's trust fund, including the provision to direct 35% of the funds to the counties. However, as the previously settling counties have had a substantial recovery from Endo, the amendment does not provide those nine counties a direct allocation. The amendment makes clear that the nine counties would be eligible to receive some of the remaining Endo funds as well as funds from other settlements.

Following Page: Text of Amendments

On the next page is the text of the amendments, which are set out as they should appear in the settlement packets from the national administrator.

Tennessee State-Subdivision Opioid Abatement Agreement – 2023 Amendments

The Tennessee State-Subdivision Opioid Abatement Agreement is amended as follows:

Amendment 1:

Pursuant to Section IV.A, this Agreement shall apply to the following Statewide Opioid Settlement Agreements, should they become effective:

A. Allergan Public Global Opioid Settlement Agreement
B. CVS Settlement Agreement
C. Teva Global Opioid Settlement Agreement
D. Walgreens Settlement Agreement
E. Walmart Settlement Agreement

Amendment 2:

To allow for efficiency and more streamlined accounting, the fifth sentence in Section III.E.2 of the Agreement ("These redirected funds to certain counties shall be spent on future opioid abatement and shall be subject to the same statutory requirements as the Abatement Accounts Fund money the county receives from the Tennessee Opioid Abatement Fund.") shall be considered deleted and given no effect.

Amendment 3:

Notwithstanding the exception provisions in Section IV.B.3 and Section V.C. of the Agreement, Section V shall apply to funds from the Endo International plc bankruptcy (*In re Endo International plc, et al.*, U.S. Bankruptcy Court, S.D.N.Y, No. 22-22549). As they have received funds from a prior settlement with Endo, the following counties shall not receive a share of the 35% of proceeds directed to counties pursuant to Section V.B: Carter, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington. However, nothing in this agreement shall limit the Opioid Abatement Council's discretion in whether or not to approve any requested allocation from the remaining Endo proceeds or other funds to these counties or the municipalities participating in that prior settlement.

Note on adoption of amendments:

Amendment 1 shall be effective if approved as set forth in Section IV.B.2 of the Agreement. Amendments 2 and 3 shall be effective if approved as set forth in Section VII.D of the Agreement.

Attachment G

Model Resolution for Subdivisions to Use for New Opioid Settlements

A Word version of this document is available on the Attorney General's website.

RESOLUTION NO. _____

A RESOLUTION AUTHORIZING _____ COUNTY TO JOIN THE STATE OF TENNESSEE AND OTHER LOCAL GOVERNMENTS IN AMENDING THE TENNESSEE STATE-SUBDIVISION OPIOID ABATEMENT AGREEMENT AND APPROVING THE RELATED SETTLEMENT AGREEMENTS

WHEREAS, the opioid epidemic continues to impact communities in the United States, the State of Tennessee, and ____ County, Tennessee.

WHEREAS, _____ County has suffered harm and will continue to suffer harm as a result of the opioid epidemic;

WHEREAS, the State of Tennessee and some Tennessee local governments have filed lawsuits against opioid manufacturers, distributors, and retailers, including many federal lawsuits by Tennessee counties and cities that are pending in the litigation captioned In re: National Prescription Opiate Litigation, MDL No. 2804 (N.D. Ohio) (the MDL case is referred to as the "Opioid Litigation");

WHEREAS, _____ County has previously joined settlements with three pharmaceutical distributors and a manufacturer;

WHEREAS, certain pharmaceutical manufacturers and retail pharmacy chains have proposed settlements that _____ County finds acceptable and in the best interest of the community;

WHEREAS, the Tennessee legislature enacted Public Chapter No. 491 during the 2021 Regular Session of the 112th Tennessee General Assembly and was signed into law by Governor Bill Lee on May 24, 2021, which addresses the allocation of funds from certain opioid litigation settlements;

WHEREAS, there is currently proposed legislation that would apply the statutory provisions passed in 2021 to the new manufacturer and retail pharmacy chain settlements;

WHEREAS, the State of Tennessee, non-litigating counties, and representatives of various local governments involved in the Opioid Litigation have adopted a unified plan for the allocation and use of certain prospective settlement and bankruptcy funds from opioid related litigation ("Settlement Funds");

WHEREAS, the Tennessee State-Subdivision Opioid Abatement Agreement (the "Tennessee Plan"), attached hereto as "Exhibit A," sets forth the framework of a unified plan for the proposed allocation and use of the Settlement Funds;

WHEREAS, amendments to the Tennessee Plan, attached hereto as "Exhibit B," would extend its terms to the proposed settlements, streamline accounting for certain settlement funds, and address the allocation of certain funds from a manufacturer in bankruptcy; and

WHEREAS, participation in the settlements by a large majority of Tennessee cities and counties will materially increase the amount of settlement funds that Tennessee will receive from pending proposed opioid settlements;

NOW, THEREFORE, BE IT RESOLVED BY THE COUNTY COMMISSION OF _____ COUNTY, TENNESSEE,

Section 1. That _____ County finds that the amendments to the Tennessee Plan are in the best interest of _____ County and its citizens because they would ensure an effective structure for the commitment of Settlement Funds to abate and seek to resolve the opioid epidemic.

Section 2. That _____ County hereby expresses its support for a unified plan for the allocation and use of Settlement Funds as generally described in the Tennessee Plan.

Section 3. That the _____ County Mayor is hereby expressly authorized to execute the amendments to the Tennessee Plan in substantially the form attached as Exhibit "B" and the County Mayor is hereby authorized to execute any formal agreements necessary to implement a

unified plan for the allocation and use of Settlement Funds that is substantially consistent with the Tennessee Plan and this Resolution.

Section 4. That the _____County Mayor is hereby expressly authorized to execute any formal agreement and related documents evidencing _____ County's agreement to the settlement of claims [and litigation] specifically related to Teva Pharmaceutical Industries, Ltd., Allergan Finance, LLC, CVS Health Corporation, Walgreen Co., Walmart, Inc., and any other settlement of opioid-related claims that Tennessee has joined.

[Section 5. That the _____ County Mayor is authorized to take such other action as necessary and appropriate to effectuate _____ County's participation in the Tennessee Plan and these settlements.]

Section 6. This Resolution is effective upon adoption, the welfare of ____ County, Tennessee requiring it.

ADOPTED this the day of , 2023.

ATTEST: _____