

AMENDMENT TO
MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND
AGREEMENT REGARDING USE OF SETTLEMENT FUNDS

Whereas, the State of Maine, through its Attorney General, and certain Subdivisions, through their elected representatives and counsel, entered into a Memorandum of Understanding (“MOU”), dated January 26, 2022, entitled “MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND AGREEMENT REGARDING USE OF SETTLEMENT FUNDS”; and

Whereas the State and its Subdivisions desire to amend the MOU;

Now therefore, the State and its Subdivisions hereby agree to amend the MOU in its entirety, to read as follows:

MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND
AGREEMENT REGARDING USE OF SETTLEMENT FUNDS

Whereas, the people of the State of Maine and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and,

Whereas, the State of Maine, through its Attorney General, and certain Subdivisions, through their elected representatives and counsel, are separately engaged in litigation seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance; and,

Whereas, the State of Maine, through its Attorney General, and its Subdivisions share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State of Maine;

Now therefore, the State and its Subdivisions, subject to completion of formal documents effectuating the Parties' agreements, enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements described.

This agreement is subject to the requirements of the National Opioid Settlement, as well as applicable law. Terms used in this MOU have the same meaning as in those used in the National Opioid Settlement unless otherwise defined herein.

I. DEFINITIONS

A. "Approved Uses" shall mean those uses identified in the List of Opioid Remediation Uses, attached as Exhibit E to the National Opioid Settlement, and those uses identified as "Approved Opioid Abatement Uses" in Schedules A and B to Exhibit G to the Notice of

Filing of Eighth Plan Supplement Pursuant to the Fifth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors, In re: Purdue Pharma L.P., et al., Case No. 19-23649-RDD, Dkt. 3121 (Bankr. S.D. N.Y. July 8, 2021), and attached as Exhibits I and 2 to this Memorandum of Understanding.

B. "Direct Share Subdivisions" means a plaintiff subdivision that has filed a complaint against a Pharmaceutical Supply Chain entity and/or a subdivision with a population equal to or greater than 10,000. For the avoidance of doubt, the 39 eligible Direct Share Subdivisions are as identified on Exhibit 3 hereto.

C. "Effective Date" means the date on which a court of competent jurisdiction, including any bankruptcy court, enters the first Settlement by order or consent decree. The Parties anticipate that more than one Settlement will be administered according to the terms of this MOU, but that the first entered Settlement will trigger the formation of the Recovery Council.

D. The "Maine Recovery Fund" means the fund created by this Agreement, the funds of which will be used for the purposes of opioid abatement.

E. The "National Opioid Settlement" means the National Distributor and J&J Settlements Agreement, dated as of July 21, 2021, and any revision thereto.

F. "Pharmaceutical Supply Chain" shall mean the process and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

G. "Recovery Fund Council" means the Council created in Section III of this MOU.

II. DISTRIBUTION OF FUNDS

A. **Applicability of Agreement.** These terms shall apply to the National Distributor Settlement, the Purdue Pharma and Mallinckrodt bankruptcy settlements.

B. **Approved Uses.** All Opioid Funds, regardless of allocation, shall be utilized for approved uses.

C. **Division of Funds.** All Opioids Funds allocated to the State of Maine and the Subdivisions are to be distributed as follows:

1. **20%** to the State of Maine Attorney General to be used on Approved Uses.
2. **30%** to the Direct Share Subdivisions for spending on Approved Uses to be allocated in accordance with Exhibit 3.
3. **50%** to be placed in the Maine Recovery Fund which are to be spent on Approved Uses as directed by the Recovery Council.

D. The Direct Share Subdivisions' shares shall be distributed directly to each Direct Share Subdivision by the National Settlement Administrator. Monies in the Maine Recovery Fund shall be distributed by the Treasurer of the State as described below. Any Direct Share Subdivision may

form agreements or ventures or otherwise work in collaboration with federal, state, local, tribal or private sector entities in pursuing Opioid Remediation activities funded from their directshare distribution or funded by the Recovery Fund.

III. THE MAINE RECOVERY COUNCIL

A Recovery Fund Council (the "Council") consisting of representatives appointed by the State and subdivisions, shall be created to direct the disbursement of recovery funds for recovery purposes on a statewide basis for the uses allowed by this MOU.

Membership: The Recovery Council shall consist of eleven (11) members, who shall serve in their official capacity only.

Subdivision Members: The Recovery Council shall include at least 4 members from the plaintiff cities or counties to be selected by them.

State Members. Four (4) members shall be appointed by the State as follows:

- a. The Governor shall appoint two members
- b. The Speaker of the House or his designee
- c. The President of the Senate or his designee

Public Members. The Attorney General shall appoint three (3) public members from among the following:

- a. Individuals or family members impacted by the Opioid Crisis
- b. Individuals with substance use disorder and recovery community experience,
- c. Public health experts in treatment and or prevention.

The Legislature may add members to the Council for up to a maximum of fifteen (15).

Terms: The Recovery Council shall be established within ninety (90) days of the Effective Date and initial members appointed. Members may serve no more than two (2) consecutive two-year terms, for a total of four (4) consecutive years.

Duties: The Recovery Council is primarily responsible for ensuring that the distribution of Recovery Funds complies with the terms of the MOU and the Agreement entitled "Maine School Administrative Units' Inclusion in Maine's Recovery Fund".. It shall meet at least twice within each calendar year either in person or via a remote meeting method as allowed by Maine law.

Governance: The Recovery Council shall draft its own bylaws or other governing documents, which must include appropriate conflict of interest provisions, in accordance with this MOU and the following principles:

- a. Authority: The Recovery Council does not have any rulemaking authority. The terms of the MOU and Agreement and any Settlement, as entered by a Court of competent jurisdiction control the authority of the Recovery Council and the Recovery Council shall not stray outside the bounds of the authority and power vested by this MOU and any Court approved Settlement.

- b. Administration: The Recovery Council is responsible for accounting of all Recovery Funds. and for releasing Recovery Funds.

Transparency: The Recovery Council shall operate with all reasonable transparency and in compliance with Maine's Freedom of Access Law 1 MRS sections 401 et seq.

A. The Recovery Council shall develop a centralized public dashboard or other repository for publication of expenditure data from any party or Regional Council that receives Recovery Funds. The Council may require outcome related data from any entity that receives Recovery Funds. For purposes of funding the centralized dashboard, the Council shall make every effort to use existing state resources.

Collaboration: The Recovery Council shall facilitate collaboration among the State, subdivisions, Regional Councils and other stakeholders for the purposes of sharing data, outcomes, strategies and other relevant information related to abating the opioid crisis in Maine.

Decision Making: The Recovery Council shall make all decisions by consensus. In the event consensus cannot be achieved, unless otherwise required by this MOU, the Council shall make decisions by 3/5 vote of its members.

Legal Representation: The Attorney General shall provide legal counsel and administrative support to the Recovery Council. The Council may use funds to hire additional administration support if necessary.

Compensation: No member of the Recovery Council shall be compensated for their work related to the Abatement Council.

IV. THE MAINE RECOVERY FUND

A. Fund Established. The **Maine Recovery Fund** is established for the purposes specified in this chapter as a separate and distinct fund for accounting and budgetary reporting purposes.

B. Sources of Fund. The State Controller shall credit to the fund:

1. All money designated to the Maine Recovery Fund for abatement in this agreement in settlement of litigation by the state or one of its subdivisions against Johnson & Johnson, Janssen Pharmaceuticals, Inc., Purdue Pharma L.P., Mallinckrodt, PLC, Cardinal Health, Inc., AmerisourceBergen Corporation, and McKesson Corporation.
2. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and
3. Interest earned or other investment income on balances in the fund.

C. Unencumbered Balances. Any unencumbered balance remaining at the end of any fiscal year lapses back to the Maine Recovery Fund, the account within the Office of the Attorney General established pursuant to this section, and may not be made available for expenditure without specific legislative approval.

D. General Fund Limitation. Notwithstanding any provision to the contrary in this section, any program, expansion of a program, expenditure or transfer authorized by the Legislature using the Maine Recovery Fund may not be transferred to the General Fund without specific legislative approval.

E. Report by Attorney General. The Attorney General shall report at least annually on or before the 2nd Friday in December to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must summarize the activity in any funds or accounts directly related to this section.

F. Restricted Accounts. The State Controller is authorized to establish separate accounts within the fund in order to segregate money received by the fund from any source, whether public or private, that requires as a condition of the contribution to the fund that the use of the money contributed be restricted to approved uses. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

G. Adjustment to Allocations. For state fiscal years beginning on or after July 1, the State Budget Officer is authorized to adjust allocations if actual revenue collections for the fiscal year are less than the approved legislative allocations. The State Budget Officer shall review the programs receiving funds from the fund and shall adjust the funding in the All Other line category to stay within available resources. These adjustments must be calculated in proportion to each account's allocation in the All Other line category in relation to the total All Other allocation for fund programs. Notwithstanding any other provision of law, the allocation for the identified amounts may be reduced by financial order upon the recommendation of the State Budget Officer and approval of the Governor. The State Budget Officer shall report annually on the allocation adjustments made pursuant to this subsection to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters by May 15th.

H. Separate Accounts; Annual Reporting. A state agency that receives allocations from the fund, and a county, a city, and a contractor or vendor that receives funding allocated from the fund shall maintain that money in a separate account and shall report by September 1st of each year to the Recovery Council providing a description of how those funds for the prior state fiscal year were targeted to the Approved Uses. The Attorney General shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the Legislature.

I. Legislative Committee Review of Legislation. Whenever a proposal in a resolve or bill before the Legislature, including but not limited to a budget bill, affects the fund, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among members of the committee. If there is support for the proposal among a majority of the members of the committee, the committee shall request the joint standing committee of the Legislature having jurisdiction over health and human services matters to review and evaluate the proposal as it pertains to the fund. The joint standing committee of the Legislature having jurisdiction over health and human services matters shall conduct the review and report to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.

V. PAYMENT OF COUNSEL AND LITIGATION EXPENSES.

National Attorney Fee Fund. The National Settlement Agreements provide for the payment of all or a portion of the attorney fees and costs owed by the litigating subdivisions to private attorneys retained to file suit in the national opioid litigation. Private attorneys for subdivisions must waive enforcement of their contingent fee agreements to receive payment from the National Attorney Fee Fund. Judge Polster recognized that a state backstop fund can be designed to incentivize private attorneys to waive their right to enforce contingent fee agreements and instead apply to the National Attorney Fee Fund, with the goal of achieving greater subdivision participation and higher total payouts to Maine. Accordingly, in order to seek payment from the Backstop Fund, Counsel must agree to waive enforcement of their contingency fee agreements with the subdivisions and first apply to the National Attorneys Fee Fund.

The Parties agree that the litigation and nonlitigating (i.e., participating) subdivisions will create a supplemental attorney fees fund (the "Backstop Fund") to be used to compensate private attorneys that filed opioid lawsuits on or before December 31, 2019.

Backstop Fund Source. The Backstop Fund will be funded by seven percent (7%) of the share of each payment made to the participating subdivisions from the National Opioid settlement agreements. Counsel for Participating Subdivisions may apply to the Backstop Fund for only a shortfall, that is, the difference between what their fee agreements would entitle them to as set forth in Judge Polster's order dated August 6, 2021 Exhibit 4 hereto, minus what they have been awarded from the Common Benefit Fund (including both the "common benefit" and "contingency fee" calculations, if any). If they are awarded fees/costs for common benefit work in the national fee fund, these fees/costs will be allocated proportionally across all their local government opioid clients based on the allocation model used in the Negotiation Class website to allocate the appropriate portion to the specific litigating Maine client represented by the law firm.

Special Master. A Special Master will administer the Backstop Fund, including overseeing any distribution, evaluating requests of counsel for payment and determining the amount of any payment. The Special Master will be compensated from the backstop fund. The Special Master shall be selected jointly as follows. The participating subdivisions shall provide a list of at least (3) three candidates for the Special Master position to the Attorney General. The Attorney General shall select the Special Master from those names provided by the subdivisions. The Attorney General may ask the subdivisions to provide additional names. Any successor backstop special master will be selected in the same manner.

Special Master Determinations. The Special Master will determine the amount and timing of any payment to Counsel from the Backstop Fund. The Special Master shall make one determination regarding payment of attorney's fees to Counsel, which will apply through the term of the recovery from the National Opioid Settlement. In making such determinations, the Special Master will consider the amounts that have been or will be received by the private attorney's firm from the National Opioid Settlement common benefit and contingency fee funds relating to subdivisions, the dollar amount of recovery for the Maine subdivisions, the complexity of the legal issues involved in the opioid litigation, and work done to directly benefit the Maine subdivisions. In the interest of transparency, Counsel shall provide information in their initial fee application

about the total amount of fees that Counsel have received or will receive from the National Attorney Fee common benefit and contingency fee funds related to litigating subdivisions. For subdivisions that have not entered into contingency fee agreements, the total fees paid to counsel, including from the National Opioid Settlement's Contingency Fee and Common Benefit Funds, may not exceed fifteen 15% of the total gross recovery of the subdivisions' share of funds from the National Opioid Settlement. Counsel seeking payment from the Backstop Fund may also provide written submissions to the Special Master, which may include declarations from counsel, summaries relating to the factors described above, and/or attestation regarding total payments awarded or anticipated from the National Settlement Agreements' contingency fee and common benefit funds. Private attorneys shall not be required to disclose work product, proprietary or confidential information, included but not limited to detailed billing or lodestar records. Any documents filed with the Special Master shall be public and the special master's fee awards shall be transparent, public, final and not appealable.

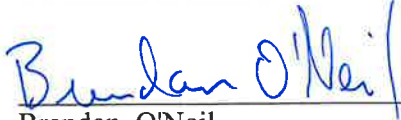
To the extent the Special Master determines that the Backstop Fund exceeds the amount necessary for payment to Counsel, the special master shall distribute any excess amount to the subdivisions according to the percentages set forth in Exhibit 3.

The Backstop Fund will be administered for (a) the length of the National Litigation Settlement Payments; or (b) until all Counsel for the litigating subdivisions have either (i) received payments equal to the Backstop Fund payment cap, above or (ii) received the full amount determined by the Special Master, whichever occurs first.

For the avoidance of doubt no portion of the State recovery fund will be used to Fund the Backstop Fund or in any other way to fund any subdivisions' attorney's fees and expenses.

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Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“**Core Strategies**”).¹

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. 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

¹ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the National Opioid Abatement Trust Distribution Procedures.



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

D. EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME

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 2016 CDC guidelines, including providers at hospitals (academic detailing);
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 (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following¹:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

¹ As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the National Opioid Abatement Trust Distribution Procedures.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.
4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance

programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

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

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.
14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.

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

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

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

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
 2. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
 3. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
 5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail

or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.
6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.
10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

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

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

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 1. Increase the number of prescribers using PDMPs;
 2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increase electronic prescribing to prevent diversion or forgery.
8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Fund community anti-drug coalitions that engage in drug prevention efforts.
6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
7. Engage non-profits and faith-based communities as systems to support prevention.
8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

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

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

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities providing free naloxone to anyone in the community.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide

care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT E

List of Opioid Remediation Uses

**Schedule A
Core Strategies**

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“*Core Strategies*”).¹⁴

- 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.

¹⁴ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.



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 2016 CDC guidelines, including providers at hospitals (academic detailing);
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 (“*SUD/MH*”) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:¹⁵

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.

¹⁵ As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

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 of 2000 (“*DATA 2000*”) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
14. 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 medication 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 (“*PAARF*”);
 2. Active outreach strategies such as the Drug Abuse Response Team (“*DART*”) model;
 3. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (“*LEAD*”) model;
 5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison 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 (“CTP”), 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 child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.
10. 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 medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. 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

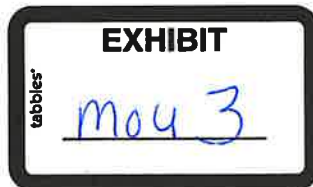
Support opioid abatement research that may include, but is not limited to, the following:

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.

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State	County	City	Consolidated State Allocation
ME	ANDROSCOGGIN COUNTY		1.6799535986%
ME	ANDROSCOGGIN COUNTY	Lewiston city	4.3451006968%
ME	ANDROSCOGGIN COUNTY	Auburn city	2.6283332826%
ME	AROOSTOOK COUNTY		4.0537116218%
ME	CUMBERLAND COUNTY		3.5025701951%
ME	CUMBERLAND COUNTY	Portland city	7.2016026249%
ME	CUMBERLAND COUNTY	South Portland city	2.2275994495%
ME	CUMBERLAND COUNTY	SCARBOROUGH TOWN	1.8363769930%
ME	CUMBERLAND COUNTY	BRUNSWICK TOWN	1.6113929261%
ME	CUMBERLAND COUNTY	Westbrook city	1.5416150467%
ME	CUMBERLAND COUNTY	GORHAM TOWN	1.4582940317%
ME	CUMBERLAND COUNTY	FALMOUTH TOWN	1.2353278939%
ME	CUMBERLAND COUNTY	WINDHAM TOWN	0.1935482073%
ME	CUMBERLAND COUNTY	STANDISH TOWN	0.0664145731%
ME	FRANKLIN COUNTY		1.9717572454%
ME	HANCOCK COUNTY		3.8494340111%
ME	KENNEBEC COUNTY		4.9959268385%
ME	KENNEBEC COUNTY	Augusta city	3.6779545807%
ME	KENNEBEC COUNTY	Waterville city	2.8132809688%
ME	KNOX COUNTY		2.1010369789%
ME	KNOX COUNTY	Rockland city	0.6184398003%
ME	LINCOLN COUNTY		2.1621727981%
ME	OXFORD COUNTY		3.8454418782%
ME	PENOBSCOT COUNTY		6.7801027597%
ME	PENOBSCOT COUNTY	Bangor city	5.2042873123%
ME	PENOBSCOT COUNTY	ORONO TOWN	0.2094180830%
ME	PISCATAQUIS COUNTY		1.2760851978%
ME	SAGADAHOC COUNTY		1.9708146889%
ME	SOMERSET COUNTY		3.6977198467%
ME	WALDO COUNTY		2.4723925078%
ME	WASHINGTON COUNTY		2.6998574469%
ME	WASHINGTON COUNTY	Calais city	0.8369049504%
ME	YORK COUNTY		6.7950503019%
ME	YORK COUNTY	Biddeford city	2.7393997300%
ME	YORK COUNTY	Sanford city	2.6908215844%
ME	YORK COUNTY	YORK TOWN	2.1005084476%
ME	YORK COUNTY	Saco city	0.4366518238%
ME	YORK COUNTY	WELLS TOWN	0.2541311729%
ME	YORK COUNTY	KENNEBUNK TOWN	0.2185679049%



UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION) MDL 2804
OPIATE LITIGATION)
) Case No. 1:17-md-2804
THIS DOCUMENT RELATES TO:)
) Judge Dan Aaron Polster
All Cases)
) ORDER

This Order addresses contingent attorney fee contracts between all States and political subdivisions eligible to participate in the Opioid Settlement Agreements and their counsel.

For the reasons stated below, the Court hereby notifies all eligible participants to the July 21, 2021 Settlement Agreements, and also notifies their private counsel, that a contingent fee in excess of 15% of the participant's award under the Settlement Agreements is presumptively unreasonable. Accordingly, the Court caps all applicable contingent fee agreements at 15%.

This fee cap order applies *only* if counsel seeks to enforce a fee contract.¹ It does not apply to limit fees that may be received from the Settlement Agreement Attorney Fee Fund and any applicable "State Back-Stop."²

The Court **ORDERS** all counsel for any client that is eligible to participate in the recently-announced Settlement Agreements to share this Order with all of those clients. Further, the Court **ORDERS** the Plaintiffs Executive Committee to broadly publicize this Order.

¹ Further, this percentage cap applies *only* to distributions received by a State or subdivision under the two Settlement Agreements discussed below. The Court does not now decide whether this or any other fee cap will apply to any future settlement agreement (global or otherwise), or to any verdict in any case. That said, it is extremely likely a similar cap will apply to any global settlement between the Settling Defendants and any Indian Tribe.

² *But see* footnote 17.



The Settlement Agreements

Recently, AmerisourceBergen, Cardinal Health, McKesson, and Johnson & Johnson (the “Settling Defendants”) reached Settlement Agreements with: (a) a group of State Attorneys General (“AGs”) (representing the interests of the 50 States and U.S. territories), and (b) the MDL Plaintiffs’ Executive Committee (“PEC”) (which represents the interests of, among others, political subdivisions – *e.g.*, individual cities and counties within the States) to resolve the lawsuits against those Defendants related to the opioid crisis.³ The Agreements are virtually unprecedented in their size and complexity and represent years of difficult negotiation among the several parties, having required hundreds of thousands of hours of work by various stakeholders, their representatives, and counsel, as well as the Court and Special Masters.

The Settlement Agreements provide for total payments of \$26.0 Billion, assuming full participation by all States and political subdivisions (payments may be reduced if States and political subdivisions opt out of the Agreements). Of this amount, \$2.3 Billion, or about 8.8%, is reserved for payment of attorney fees. Specifically, \$1.6 Billion will be placed into an Attorney Fee Fund, from which privately-retained counsel (“Individually-Retained Plaintiff’s Attorneys” or “IRPAs”) can receive payment upon application to an independent fee-panel. The \$1.6 Billion is divided into a sub-fund of 60% (\$960 Million) to pay for common benefit fees and 40% (\$640 Million) to pay for contingent fees otherwise owed to IRPAs by participating subdivisions. Another \$350 Million is reserved for reimbursement and payment of attorney fees incurred by State Attorneys General for outside-counsel; and \$350 Million is also reserved for reimbursement

³ Specifically, the parties entered into two Settlement Agreements: (1) the “Distributors Master Settlement Agreement,” settling claims against the “Big Three Distributor Defendants,” AmerisourceBergen, Cardinal Health, and McKesson, dated July 21, 2021; and (2) the “J&J Master Settlement Agreement,” settling claims against Manufacturer Defendant Johnson & Johnson, dated July 21, 2021. These two Agreements are posted at www.NationalOpioidSettlement.com. The general discussion below of settlement amounts refers to the combined amounts under both Settlement Agreements.

of attorney fees and costs incurred by State Attorneys General for in-house-counsel.⁵ Various other amounts are designated for payment of litigation costs, administrative costs, and so on. Ultimately, about \$23.5 Billion will be allocated to plaintiffs for abating social ills caused by the opioid crisis. Roughly half of this amount will be paid to States and Territories, and the other half to political subdivisions.⁷

The amounts set aside for payment of attorney fees are the result of a multiple-years-long negotiation between the Settling Defendants, the AGs, and the PEC, with additional input from plaintiffs' counsel nationwide (including those litigating Opioid cases only in State courts). The amounts reflect a consensus, after significant deliberation and with this Court's assistance, on what is a reasonable amount for attorney's fees payable to IRPAs in this case.

To be eligible for payment from the Attorney Fee Fund, an IRPA must submit an application and also waive any right to enforce a contingent fee contract with their subdivision-client.⁸ Given that an IRPA may have a contingent fee contract calling for the subdivision-client to pay 20% (or 25%, or an even-higher share) of any recovery the subdivision ultimately receives, an IRPA is very likely to receive from the Attorney Fee Fund an amount far less than the contract would otherwise require.⁹ All of the firms that are members of the PEC have agreed to this

⁵ See Distributors Master Settlement Agreement, Exhs. S, T.

⁷ More precisely, the Settlement Agreements have a "default allocation" providing that 15% will go to States, 15% will go to subdivisions, and 70% will go to a fund shared by States and subdivisions. See Distributors Master Settlement Agreement §V.C.1, at 29. A given State and its subdivisions can agree to modify this allocation. This raises the question of what should be the amount against which an IRPA may charge their contingent fee. For ease of calculation, the Court assumes the amount against which a contingent fee is charged by an IRPA representing a political subdivision would be 50% of the total default allocation—that is, the 15% the subdivision receives directly, plus half of the 70% shared fund. See also footnote 28, below.

⁸ See Distributors Master Settlement Agreement, Exh. R §§G.2 & G.3.a.

⁹ Of the 35,000 or so political subdivisions in the United States that are eligible to participate in the Settlement Agreements, about 75% by population entered into contingent fee contracts with IRPAs. If every one of these contracts calls for payment of only a 20% contingent fee (which is clearly a low estimate), and assuming half of the \$23.5 Billion is allocated to the subdivisions (with the rest allocated to the States), then total contingent fees owed

arrangement.¹⁰ This last sentence is worth repeating – the plaintiffs’ attorneys who have actually shouldered the enormous load in obtaining the Settlement Agreements (and expended well over \$100 Million in out-of-pocket expenses) have committed to waiving all of their contingent fee contracts and accepting instead the amount of contingent fees available from the Attorney Fee Fund. This amount is almost certain to be less than 10%.¹¹

That said, a few States have put into place what the parties refer to as a “Back-Stop,” which may provide additional funds to further compensate IRPAs who represent participating subdivisions within that State.¹² The Back-Stop is designed to further incentivize IRPAs to waive their right to enforce contingent fee contracts and instead apply to the Attorney Fee Fund, by making additional funds available to compensate IRPAs. Thus, for example, an IRPA representing a State subdivision may: (1) waive their right to enforce their 25% contingent fee contract; (2) apply for payment from the Attorney Fee Fund and receive a 7.5% fee; and (3) also apply for payment from the State Back-Stop and receive an additional 7.5% fee.¹⁴ Alternatively, the IRPA

would be roughly \$1.76 Billion ($\$23.5 \text{ Billion} \times 75\% \times 20\% \times 50\%$)—which is more than the entire Attorney Fee Fund.

¹⁰ PEC attorneys have agreed to waive their contingent fee contracts with subdivision clients who, as a group, stand to be allocated over half of the settlement funds.

¹¹ Back-of-the-envelope calculations suggest an IRPA who applies to the Attorney Fee Fund for payment of fees otherwise owed by a client-subdivision under a contingent fee contract may receive in the range of 6-10% of the amount allocated to the subdivision. Specifically: (1) 40% of the Attorney Fee Fund (\$640 Million) is reserved for payment of IRPAs’ contingent fees; (2) assuming half of the \$23.5 Billion is allocated to the subdivisions, they will receive \$11.75 Billion; (3) about 75% of the \$11.75 Billion (\$8.8125 Billion) is subject to a contingent fee contract; and (4) the resulting ratio is 7.3% ($\$640\text{M} / \8.8125B). Allocation of contingent fees from the Attorney Fee Fund, however, will not be uniformly pro rata, so a given IRPA’s percentage will fall within a range near 7%.

¹² See Distributors Master Settlement Agreement, Exh R §I.R (defining “State Back-Stop Agreement” as “Any agreement by a Settling State and private counsel for Participating Subdivisions in that State (or legislation enacted in that State) to provide, adjust, or guarantee attorneys’ fees and costs, whether from the Attorney Fee Fund or any other source recognized in the agreement or legislation.”).

¹⁴ This example is hypothetical. The Court does not know exactly how much an attorney might expect to receive from the Attorney Fee Fund for contingent fees, or from any State Back-Stop, because multiple factors go into those calculations. Further, different States have put into place, or are contemplating, different Back-Stop provisions with different payout rates, different Back-Stop fee caps, and so on. Indeed, it may even be the case (for example) that a State Back-Stop allows for payment of additional contingent fees up to another 15% (on top of the 7.5% from the

may choose to forgo compensation from the Attorney Fee Fund and State Back-Stop and instead enforce their 25% contingent fee contract—which, of course, would lead to the subdivision-client ultimately receiving 25% less for abatement of opioid-related social ills than if the IRPA waived the contract and applied to the Attorney Fee Fund.¹⁵

Finally, it is critical to note that, *even taking into account State Back-Stops*, the Settlement Agreements still provide for an over-all attorney fee cap: “In no event may less than eighty-five percent (85%) of the [total settlement funds] . . . be spent on Opioid Remediation.”¹⁶

With all of those mechanisms and considerations in mind, and for the reasons discussed below, the Court now orders that contingent fee contracts for all IRPAs representing entities that participate in the Settlement Agreements shall be capped at 15% – which is still a much higher percentage than PEC attorneys will receive.¹⁷ In other words, IRPAs who represent any subdivision that **opts in** to the Settlement Agreements have the following choice: (1) forgo payment of any kind from the Attorney Fee Fund and any State Back-Stop, and instead enforce their contingent fee contract, *but the contingent amount is hereby capped at 15%*; or (2) waive

Attorney Fee Fund), but State funds earmarked to pay for those additional contingent fees are sufficient to pay only a supplemental 10%.

The fundamental reason for a State’s adoption of a Back-Stop is that the Settlement Agreements call for different payment levels to the States and subdivisions depending upon participation rates; and subdivision participation rates will be higher if subdivisions know they will not have to pay a percentage of their recovery to an IRPA (even though they agreed to do so). Put simply, the Attorney Fee Fund and Back-Stops combine to incentivize greater subdivision participation and thus higher ultimate payouts by the Settling Defendants to both the States and subdivisions. A State may therefore rationally conclude that a portion of the settlement funds it receives is well-spent on payment of a portion of contingent fees otherwise owed to attorneys representing subdivisions within the State.

¹⁵ Because the Settlement Agreements provide for payment to subdivisions over 18 years, IRPAs who choose to enforce their contingent fee contract will receive their fees over that same time period. In contrast, IRPAs who choose to waive their contingent fee contract and apply to the Attorney Fee Fund will be paid their contingent fees over seven years. *See* Distributors Master Settlement Agreement, Exh. R §II.A.

¹⁶ Distributors Master Settlement Agreement §V.B.1, at 28.

¹⁷ As did the court in *In re Oil Spill by the Oil Rig DEEPWATER HORIZON in the Gulf of Mexico, on Apr. 20, 2010*, this Court addresses contingent attorney fees now, prior to final consummation of the settlement agreement, so that subdivisions contemplating participation can fully weigh their options and the parties can more quickly gauge participation levels. *See* 2012 WL 2236737, at *1, n.1 (E.D. La. June 15, 2012).

their right to enforce their contingent fee contract, apply to the Attorney Fee Fund for contingent and common benefit fees, and also apply for any applicable State Back-Stop funding.¹⁸

A subdivision may choose not to participate in the Settlement Agreements at all (that is, **opt out**), in which case this Order has no effect on any contingent fee contract the subdivision may have with an IRPA. If the subdivision does participate in the Settlement Agreements, however, then any contingent fee contract that subdivision has with an IRPA is hereby capped at 15%.¹⁹ Stated differently, the 15% cap the Court imposes with this Order applies to all contingent fee contracts any IRPA has with any entity that chooses to participate in the Settlement Agreements—including subdivisions that have not filed any litigation against the Settling Defendants, those that have filed litigation pending in State courts, and those that have cases pending in this MDL.²¹ The Court's reasons and jurisdictional basis for this Order are set out below.

¹⁸ This Order does *not* prohibit an IRPA from receiving more than a total of a 15% fee *if received from the Attorney Fee Fund and/or a State Back-Stop*. Those funds have already been reserved for payment of fees and an IRPA's receipt of payment through that mechanism will not work directly to decrease the amount of funds the IRPA's subdivision-client finally obtains for abatement of the opioid crisis. This Order only prohibits an IRPA from receiving more than a total of a 15% fee if subtracted directly from the settlement proceeds received by the subdivision-client (which would, of course, work to decrease what the subdivision-client can ultimately spend on abatement of the opioid crisis). The reason for this difference is that what makes for a "reasonable fee" depends in large part on how the fee affects the client's net recovery. All of that said, **the Court further believes it begins to become unreasonable if the total contingent fees an attorney receives from the Attorney Fee Fund and any State Back-Stop combined exceeds 15%**. But the Court chooses not to strictly cap contingent fees available from State Back-Stops at this time. In any event, it appears the State Back-Stop agreements currently in place generally provide for supplemental funding that yields a total fee at or below 15% of the local governments' total share of the settlement.

¹⁹ This Order does not address an IRPA's contractual right to recover costs. It addresses only attorney fees.

²¹ This Order also caps contingent fees owed to attorneys who have contracted with State Attorneys General, although those attorneys will receive a portion of their fees from a different settlement fund. *See* Distributors Master Settlement Agreement Exh. S (creating a "State Outside Counsel Fee Fund"). The Court is quick to confirm, however, as it has before, that it is not exercising jurisdiction over any case filed by any Attorney General; it is exercising jurisdiction only over attorneys who come to the MDL Court to seek attorney fees pursuant to the Settlement Agreements. *See* docket no. 146 at 1 ("The Court recognizes it has no jurisdiction over (i) the AGs or their representatives, (ii) the State cases they have filed, or (iii) any civil investigations they may be conducting."). Of course, all of the attorneys who will seek fees from the State Outside Counsel Fee Fund will also be seeking fees from the Attorney Fee Fund, which this Court is administering.

Discussion

Mass tort MDLs, such as this Opioid Crisis Litigation, can serve an invaluable public good.²² As Judge Weinstein observed, “[l]itigations like the present one are an important tool for the protection of consumers in our modern corporate society, and they must be conducted so that they will not be viewed as abusive by the public; they are in fact highly beneficial to the public when adequately controlled.” *In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 494 (2006).

Recognizing the value of mass torts, contingent fee contracts are accepted in the American legal system to incentivize attorneys to bring these cases. Contingent fee contracts are often viewed skeptically by the public, however, especially when the amounts earned by plaintiffs’ attorneys are extremely large. Because mass tort MDLs, by definition, affect vast numbers of individuals in our society—which is undeniably the case in the opioid crisis—these MDLs are closely followed and highly scrutinized by the media and the public. This is even more true with the Opioid MDL, because plaintiffs are, in large part, governmental entities stewarded by politicians who are obligated to share the progress of the case with their constituents.

When attorneys’ contingent fee contracts yield unreasonable or excessive amounts, the outsized payments to lawyers can undermine public faith in the judicial system. *See In re Guidant Corp. Implantable Defibrillators Prods. Liab. Litig.*, 2008 WL 682174, at *17 (D. Minn. Mar. 7, 2008) (“The fairness of the terms of such agreements reflects directly on the Court and the legal profession.”); *see also Fla. Patient’s Comp. Fund v. Rowe*, 472 So. 2d 1145, 1149-50 (Fla. 1985), *holding modified by Standard Guar. Ins. Co. v. Quanstrom*, 555 So. 2d 828 (Fla. 1990) (quoting *Baruch v. Giblin*, 122 Fla. 59, 63, 164 So. 831, 833 (1935)) (“The attorney’s fee is, therefore, a

²² *See Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105, 111 (2006) (“The purposes of mass tort litigation are to deter activities that harm people and to compensate people who are harmed.”).

very important factor in the administration of justice, and if it is not determined with proper relation to that fact it results in a species of social malpractice that undermines the confidence of the public in the bench and bar. It does more than that. It brings the court into disrepute and destroys its power to perform adequately the function of its creation.”). This is why rules of professional conduct invariably impose upon contingency fee contracts a “requirement of reasonableness.” *In re Vioxx Prods. Liab. Litig.*, 650 F.Supp.2d 549, 559 (2009) (citing Model Rules of Professional Conduct R. 1.5(a)).

It is incumbent, then, upon this Court to maintain public confidence in the legal system by ensuring the contingent fee contracts applicable to funds distributed under the Settlement Agreements are “reasonable under the circumstances.” *Bowling v. Pfizer, Inc.*, 102 F.3d 777, 779 (6th Cir. 1996). The Court is also cognizant that “the circumstances” include the economic realities of bringing mass tort cases such as the Opioid Crisis Litigation. Aggregation of large numbers of cases can be expensive to administer and prosecute. There are enormous overhead costs in the early stages of litigation. And the contingent nature of the fee arrangements can make the cases risky to bring. Given these factors, the Court must carefully balance appropriate compensation for high-quality attorneys against those same lawyers’ ethical obligation to charge no more than a reasonable fee.²³

Although orders capping fees are often unpopular with the plaintiffs’ bar,²⁴ it is indisputable that the Court has the authority to examine and modify attorneys’ contingent fee

²³ For a thorough discussion of the competing incentives that must be balanced when contemplating the regulation of contingent fee contracts, see *Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105 (2006) (cited favorably by J. Fallon in his opinions in *In re Vioxx*, 574 F.Supp.2d 606 (2008), and 650 F.Supp.2d 549 (2009)).

²⁴ See Eldon E. Fallon, *Common Benefit Fees in Multidistrict Litigation*, 74 La. L. Rev. 371, 379 (2014) (“At the outset, it is important to recognize that judicial review of the fee arrangements of the attorneys appearing before the court is not only controversial but unpleasant.”).

contracts. Specifically, “[i]n the context of mass tort litigation, ‘a court that exercise[s] inherent power to prevent a violation of the lawyers’ professional responsibility to charge only reasonable rates would be acting within the parameters of inherent authority as described by the Supreme Court.’” *In re Vioxx*, 650 F.Supp.2d at 560 (quoting *Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105, 127 (2006)). See also *In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 492 (2006) (“The judiciary has well-established authority to exercise ethical supervision of the bar in both individual and mass actions. This authority includes the power to review contingent fee contracts for fairness.”); *In re Rio Hair Naturalizer Prod. Liab. Litig.*, 1996 WL 780512, at *20 (E.D. Mich. Dec. 20, 1996) (“It is well-settled that the court has the inherent authority to regulate contingency fees to ensure that they are not excessive or unreasonable.”) (quoting *In re A.H. Robbins Co., Inc.*, 86 F.3d 364 (4th Cir. 1996)).²⁵

In addition to this inherent supervisory authority to regulate contingent fees, several courts have relied upon their equitable powers under a quasi-class action theory. See *In re Vioxx*, 650 F.Supp.2d at 558-59; *In re Zyprexa*, 424 F.Supp.2d at 491-92; *In re Guidant*, 2008 WL 682174, at *17. The Opioid MDL is not a class action and the Settlement Agreements are not class action settlements.²⁶ Other MDL courts overseeing cases that also were not class actions, however, found equitable authority for fee cap orders in the text of the MDL statute, 28 U.S.C. § 1407. Judge Fallon again:

Admittedly, the Federal Rules of Civil Procedure expressly provide that district courts may require reasonable fees in class actions while the MDL statute lacks an analogous provision. Compare Fed. R. Civ. P. 23(g)(1)(C)(iii), and Fed. R. Civ. P.

²⁵ See also *In re Guidant*, 2008 WL 682174, at *18 (same); Expert Report of William B. Rubenstein, MDL No. 2323, Doc. No. 9526 (Dec. 11, 2017) (adopted by *In re Nat'l Football League Players' Concussion Inj. Litig.*, 2018 WL 1658808, at *3 (E.D. Pa. Apr. 5, 2018) (“Myriad prior class action and non-class action MDL courts have concluded that a court’s inherent authority over lawyers practicing before it enables the court to cap contingent fee contracts.”) (listing cases).

²⁶ See *In re Nat'l Prescription Opiate Litig.*, 976 F.3d 664 (6th Cir. 2020) (Doc. 3509) (reversing certification of a settlement “negotiation class”).

23(h), *with* 28 U.S.C. § 1407. This statutory difference, however, is not the end of the story. First, the MDL statute requires that transferee courts “promote the just and efficient conduct of such actions.” 28 U.S.C. § 1407(a). In the context of contingent fee arrangements, implementing a reasonable cap promotes justice for all parties by allowing claimants to benefit (as their attorneys have) from the economies of scale and increased efficiency that an MDL provides. Certainly, this statutory language lends support to the proposition that MDL courts, like class action courts, can exercise equitable authority to examine the reasonableness of fees.

In re Vioxx, 650 F.Supp.2d at 558.

Although not a class action, the Opioid MDL retains many important characteristics of a class action, so treatment as a quasi-class action is appropriate. Most notably, while many mass-tort MDL settlements define eligible claimants as those with pending cases filed by a date certain, the Settlement Agreements here contemplate virtually *all* States and their political subdivisions as eligible claimants, even if they have not filed a case and regardless of whether they have retained counsel. As a practical matter, the Settlement Agreements function much like a class action settlement, where the rights of non-MDL claimants (and non-litigating claimants) are affected. Thus, the Court has the equitable authority and responsibility to carefully monitor the Settlement Agreements and all related fee agreements to ensure they are fair to all potential stakeholders.²⁷

²⁷ In sum, the Court’s authority to enter this fee cap Order derives from: (1) the Court’s inherent supervisory authority to regulate contingent fees and to superintend attorney professional conduct; and (2) its equitable powers under a quasi-class action theory. Judge Fallon also identifies a third source of authority: express authority granted in the agreement itself by the parties to the settlement agreement. This third source of the Court’s authority is also present here. *See, e.g.*, Distributors Master Settlement Agreement, Exh. R, §I.C (defining the “Attorney Fee Fund” as “An account consisting of funds allocated to pay attorneys’ fees approved pursuant to Section II of this Fee Agreement established by Order of, and under the ongoing jurisdiction of, the MDL Court”). Even without this express authority, however, the Court would still be allowed and obligated to cap contingent fee contracts as appropriate.

The Court notes these sources of authority are similar to those frequently cited in common benefit cases, *see* Eldon E. Fallon, *Common Benefit Fees in Multidistrict Litigation*, 74 La. L. Rev. 371, 379 (2014) (“By and large, the legal bases relied on by courts that have reviewed and altered contingent fee contracts in MDL cases for reasonableness are similar to the justifications for creating a common benefit fee fund.”), and common benefit fee assessments on attorneys with cases not before the MDL judge is an unsettled issue. *Compare In re Avandia Mktg., Sales Practs. & Prod. Liab. Litig.*, 617 F. App’x 136, 141 (3d Cir. 2015) and *In re Gen. Motors LLC Ignition Switch Litig.*, 477 F. Supp. 3d 170, 180 (S.D.N.Y. 2020) (allowing the assessment); with *In re Roundup Prods. Liab. Litig.*, No. 16-md-02741-VC (N.D. Cal. Jun. 22, 2021) (ECF. 13192) and *In re Genetically Modified Rice Litig.*, 2010 WL 716190, at

In light of all of these considerations, the Court concludes a cap on individual contingent fee contracts of 15% of the client's total award²⁸ yields a maximum, reasonable fee under the circumstances of this case. Participating subdivisions and their counsel can, of course, agree to something less than the Court's cap under the unique circumstances of their relationship. But the Court is convinced of the reasonableness of its cap for several reasons: (1) it prevents subdivisions from effectively paying attorney fees twice; (2) it promotes equity in the distribution of the fund; (3) the PEC attorneys who negotiated the settlement have indicated to the Court they intend to waive their contingent fee contracts and utilize the Attorney Fee Fund; and (4) the proposed settlement amount is so large that customary contingent fee percentages would disproportionately over-compensate attorneys and reflect poorly on the legal profession. The Court explicates each of these reasons below.

*1 (E.D. Mo. Feb. 24, 2010), *aff'd*, 764 F.3d 864 (8th Cir. 2014) (stating the court did not have jurisdiction to make such an assessment).

While the justifications for the Court's authority are similar and the reasoning of those cases is enlightening, assessment of a common benefit fee to reimburse attorneys who perform common benefit work is not the issue addressed here. In each of those cases, the court determined it had some level of jurisdiction (or not) over non-MDL cases by virtue of counsel in those cases having used common benefit work. *Compare In re Gen. Motors*, 477 F. Supp. 3d at 180 ("If Common Benefit Work Product is used in non-Common Benefit claims or actions, they shall be subject to the assessment."); with *In re Roundup*, No. 16-md-02741-VC at 23-24, 30-31 (ECF. 13192). Here, the Court asserts its authority by virtue of the Settlement Agreements Attorney Fee Fund, and the Court caps contingent fee contracts for subdivisions who opt in to the Agreements and receive funds from the Settlement administered by the Court.

²⁸ It is not entirely clear to the Court how IRPAs representing subdivisions will calculate the amount against which a contingent fee is charged. As noted earlier, the Settlement Agreements have a "default allocation" providing that 15% of the settlement funds will go to States, 15% will go to subdivisions, and 70% will go to a fund shared by States and subdivisions. *See, e.g.*, Distributors Master Settlement Agreement §V.C.1 at 29. Thus, there is room for argument that the contingent fee should be charged against: (a) only the 15% portion that goes directly to the subdivisions; *or* (b) this 15% portion *plus* half (or some other fraction) of the 70% portion shared by the subdivisions with the State; *or* (c) some other division of the settlement payment. Further, State-specific agreements between the State and its subdivisions may alter the default allocation and/or clarify what the share is against which a contingent fee should be charged. The Court takes no firm position on this question here, but it appears the fairest and most equitable result, absent explicit agreement otherwise, is that an IRPA should charge the contingent fee against, at most, 50% of the total allocation. *See* Distributors Master Settlement Agreement, Exh. S, ¶5.b (stating the multiplicand against which the contingency percentage will be applied by IRPAs retained by States will be 50% of the total allocation).

Double Payment

The Attorney Fee Fund, which amounts to \$1.6 Billion, contains a \$640 Million sub-fund specifically for payment of IRPA fees. In other words, money that would otherwise go to political subdivisions to abate the opioid crisis in their communities has already been reserved to pay their individual attorneys as part of the structure of the deal. The same is true for the State Outside Counsel Fee Fund – \$350 Million has been reserved to pay individual attorneys hired by States; this is money that would otherwise go to the States to abate the opioid crisis. This totals nearly \$1 Billion earmarked to pay IRPA fees.

Were the Court to allow IRPAs to collect their *uncapped* contingent fees from their clients' settlement distribution, those clients would effectively be paying attorney fees twice: (1) \$1 Billion of settlement funds otherwise available to participating States and subdivisions under the Settlement Agreements is automatically reserved instead to pay for contingent fees; and (2) if the IRPA opts to enforce their contingency fee contract, then the client must pay the IRPA's fee out of the client's disbursement from the remaining \$23.7 Billion in settlement funds. The fee cap works to limit the second payment, to the extent that payment is required.

While attorneys are still entitled, under the settlement agreement, to forgo the Attorney Fee Fund and instead seek fees from their subdivision-clients' share of the settlement distribution, counsel's contingent fee is now capped to ensure an appropriate share of the money intended for abatement of the opioid crisis is actually used for that purpose. The Court's cap is necessary to ensure that client-subdivisions, and not just their attorneys, benefit from the economies of scale provided by aggregation. *See In re Vioxx*, 650 F.Supp.2d at 558 ("In the context of contingent fee arrangements, implementing a reasonable cap promotes justice for all parties by allowing claimants to benefit (as their attorneys have) from the economies of scale and increased efficiency that an MDL provides.").

In sum, the Settlement Agreements already provide for payment of a fair portion of an IRPA's contingent fee; this Order ensures an IRPA will not over-reach and require their client to pay still more contingent fees beyond a reasonable amount.

Equitable Distribution

The Court again makes clear that the 15% fee cap applies to *all* contracts between *all* participating States and political subdivisions and their IRPAs, not just those who may have cases already transferred into the MDL. Any entity that opts in to the Settlement Agreements subjects its counsel to the jurisdiction of this Court for the limited purpose of ensuring counsel receives no more than reasonable fees.

Indeed, to hold otherwise would produce deeply inequitable and even absurd results. Consider the following hypothetical. Two similarly-sized and -populated counties in the same State—County A and County B—opt in to the proposed settlement agreement and are each entitled to receive \$1 Million of settlement funds. Both Counties signed 25% contingent fee contracts with an IRPA. County A's IRPA drafted and filed a complaint in the MDL, reviewed ARCOS data, and amended County A's complaint appropriately. In contrast, County B's IRPA did nothing beyond entering into a contingent fee contract for 25% of his client's settlement proceeds.

If the Court were to cap the contingent fees of only those attorneys with cases in the MDL, then:

- **County A's attorney** would choose between: (1) a capped 15% contingent fee of \$150,000; or (2) payment from the Attorney Fee Fund and State Back-Stop, amounting to (say) \$160,000; but
- **County B's attorney** could enforce his contingent fee contract for \$250,000, receiving almost twice the fees for virtually no work.

This result not only provides compensation far in excess of a reasonable fee for the work County B's attorney performed, it is also terribly inequitable between the two attorneys and their client-subdivisions. County A would ultimately receive either \$850,000 (if the IRPA enforced the capped contingent fee contract) or \$1 Million (if the IRPA waived his contract and obtained payment under the Settlement Agreements) to abate the opioid crisis. County B, which received far fewer services from its attorney, would receive only \$750,000.²⁹ The Court's contingent fee cap, therefore, adds a deep measure of uniformity and equity to the extraordinarily complicated Settlement Agreements. The fee cap will work to benefit IRPAs who worked diligently on behalf of their clients, the clients themselves, and also the individuals in this country who are suffering the social ills caused by the opioid crisis.

Ultimately, the fee cap ensures local governments will receive more resources to address and abate the opioid crisis, so that the general public is the true beneficiary of the Settlement Agreements.

PEC Attorneys

The Court is also persuaded of the reasonableness of its cap by the fact that all of the PEC attorneys, who have worked diligently for well over three years to attain these extraordinary settlements, negotiated the structure of the Attorney Fee Fund and have committed to using it themselves. The Court puts great weight on the judgment of those attorneys—all of whom have their own individual subdivision-clients—who have invested immense amounts of time and money into this MDL. That they believe the Attorney Fee Fund is reasonable and intend to use it themselves in lieu of their own contingent fee agreements indicates to the Court that the percentage

²⁹ Notably, a hypothetical, similarly-situated County C, which did not retain counsel at all, would receive the entire \$1 Million settlement distribution.

they implicitly negotiated (roughly 6-10%) is reasonable. The Court is skeptical, therefore, of the reasonableness of contingent fee contracts that would allow IRPAs to receive fees far in excess of what they could receive through the Attorney Fee Fund. From this perspective, a 15% cap is generous.

Proportionality

The settlement in this case easily qualifies as a “mega fund.”³⁰ It is among the largest in our nation’s history. Were the Court to allow IRPA contingent fees to exceed the Court’s capped percentage, total attorney fee awards would be enormous. This would reflect poorly on the legal profession and the judicial system.³¹ Further, the fees would be “in excess of a *reasonable fee*” measured against the work performed, and so would violate an IRPA’s ethics rules. Ohio Rules of Professional Conduct, R. 1.5(a) (2020) (emphasis in original). This conclusion is buttressed most strongly by the fact that *all parties* to the Settlement Agreements concurred that at least 85% of the total settlement funds must be spent on remediation of the opioid crisis.

Having carefully considered all of the factors discussed above, the various positive and negative incentives engendered by a fee cap, and the ultimate goal of the MDL, the Court concludes a 15% fee cap is reasonable to compensate IRPAs for their work. A contingent fee in

³⁰ As the value of the monetary relief in a settlement goes up, contingent fees should generally go down. See FEDERAL JUDICIAL CENTER, MANUAL FOR COMPLEX LITIGATION (Fourth) §14.121 at 188-89 (citing *In re Prudential Ins. Co. of Am. Sales Practices Litig.*, 148 F.3d 283, 339-40 (3d Cir. 1998)) (“Accordingly, in ‘mega-cases’ in which large settlements or awards serve as the basis for calculating a percentage, courts have often found considerably lower percentages of recovery to be appropriate. One court’s survey of fee awards in class actions with recoveries exceeding \$100 million found fee percentages ranging from 4.1% to 17.92%.”); see also *In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 495-96 (2006) (reviewing state laws that reduce the percentage an attorney can accept on contingency as the value of the award goes up).

³¹ See Dennis E. Curtis & Judith Resnik, *Contingency Fees in Mass Torts: Access, Risk, and the Provision of Legal Services When Layers of Lawyers Work for Individuals and Collectives of Clients*, 47 DePaul L. Rev. 425, 434 n.27 (1998) (discussing how “a one-third attorney fee in million and billion dollar cases stuns even professionals accustomed to large payments.”) (citing *Fight over Attorney Fees Overshadows Tobacco Deal*, Orlando Sentinel, Oct. 5, 1997).

excess of 15% of the client's total award under the Settlement Agreements is presumptively unreasonable.

* * * * *

Finally, the Court allows that some IRPAs may have performed extraordinary work on behalf of their subdivision-clients and taken on substantial risk that is far beyond the norm in these opioid cases. A 15% fee cap is reasonable to compensate IRPAs for the work actually performed litigating against the Settling Defendants in the vast majority of opioid cases, but it is conceivable, in rare circumstances, that a 15% capped contingent fee would not adequately compensate an IRPA for work actually performed. *See In re Vioxx Prods. Liab. Litig.*, 650 F.Supp.2d 549, 564-65 (2009). In those rare cases, the Court will permit an IRPA who forgoes application to the Attorney Fee Fund and instead enforces their contingent fee contract to move for an upward departure from the fee cap and present evidence of exceptional work, extraordinary risk, and insufficient compensation.

IT IS SO ORDERED.

/s/ Dan Aaron Polster August 6, 2021
DAN AARON POLSTER
UNITED STATES DISTRICT JUDGE