Federal Issues
Legislative

House Committee to Investigate Health, Dental Insurers’ COVID-19 Activity
U.S. House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) on Thursday announced an investigation into health and dental insurance companies’ business practices as they pertain to the COVID-19 pandemic.

Why it matters: The move comes in light of reports that many companies are experiencing record profit margins during the COVID-19 pandemic. In announcing the investigation, Pallone asserted that insurers “should be doing more” to help enrollees and providers.

Relief initiatives he suggested insurers could take would be to reduce premiums, extend policies to eliminate cost-sharing for COVID-19 treatment, and provide low or zero interest loans to community providers. He also said he was “deeply concerned by reports that many insurers are denying coverage for COVID-19 tests while sitting on large cash reserves.”

Next steps: According to the announcement, the Committee will send oversight letters to a series of health and dental insurance companies asking them if

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Negotiations on Coronavirus Package Stall, Prompting Executive Actions

After little progress was made on a fourth coronavirus legislative package between White House negotiators and Congressional Democrats over the last two weeks, President Trump issued four executive actions over the weekend aimed at providing additional financial relief from the effects of the coronavirus.

The actions: The three memoranda and one executive order signed by President Trump are targeted to address enhanced unemployment, eviction relief, student loan deferrals, and a payroll tax suspension.

Why this matters: The move seemingly takes the highest profile issue – the July 31 expiration of enhanced unemployment benefits – off the table for President Trump, but increases the odds that we will go into the fall with other key issues unaddressed. They include: funding for testing; additional small business loans through the paycheck protection program; funding for schools to reopen; and funding for health care providers.

Next steps: Democrats and some conservatives panned the actions by the White House, which are likely to be challenged in court, leaving some degree of uncertainty about the outcome. While negotiations on a broader package may continue, a resolution seems unlikely before September and, with the election looming, it is unclear whether any additional COVID-19 relief will be passed before November.

CMS Proposes to Retroactively Include Medicare Advantage Days in Medicare Disproportionate Share Hospital (DSH) Calculation

The Centers for Medicare & Medicaid Services August 6 published a proposed rule that would retroactively incorporate Medicare Advantage days into the Medicare fraction of a hospital’s disproportionate patient percentage for the Medicare Disproportionate Share Hospital program.

CMS has included MA days in the Medicare fraction since finalizing the policy in the fiscal year 2014 inpatient prospective payment system final rule.

In the new rule, CMS proposes to retroactively include MA days in the Medicare fraction for discharges before October 1, 2013, the effective date of the FY 2014 inpatient PPS final rule. It previously vacated the
policy for the time period before October 1, 2013 in light of legal challenges, including a ruling by the Supreme Court.

**Why this matters:** A group of hospitals challenged CMS' retroactive policy change, arguing that the government had failed to meet the Medicare Act's requirement to provide public notice and a 60-day comment period. Over a five year period, the *Allina* case moved through the courts until it finally reached the Supreme Court.

In 2019, the Supreme Court upheld a D.C. Circuit Court decision vacating CMS' policy that would have "dramatically – and retroactively – reduced payments to hospitals serving low-income patients." *Azar v. Allina Health Services*, 587 U.S. ___ at 1 (2019). The Supreme Court's *Allina* opinion is critically important for hospitals that rely on Medicare disproportionate share payments and has broader implications for the way that CMS issues the voluminous guidance, including sub-regulatory guidance that the agency applies to Medicare-participating providers and suppliers and other CMS-contracted entities.

The Court's decision is a triumph for hospitals, in the face of a CMS policy change that was promulgated retroactively and with no notice, cutting millions of dollars of payments that hospitals had reasonably expected to receive and could ill afford to lose. While CMS may certainly shift its policy on disproportionate share payment calculation going forward, it will at least be clearly required to give affected stakeholders at least a minimal heads-up.

Comments on the proposed rule are due October 5.

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**CMS Finalizes Annual Payment Rule for Providers in FY 2021; Proposes New Rules**

**Physician Fee Schedule Rule:** The Centers for Medicare & Medicaid Services (CMS) released a proposed rule that would update physician fee schedule (PFS) payments for the calendar year (CY) 2021, and continue implementation of the quality payment program (QPP) created by the Medicare Access and CHIP Reauthorization Act of 2015. The rule proposes a net decrease in payment rates of 10.61%.

Importantly, the proposed rule takes steps to build on telehealth and scope of practice flexibilities which have expanded access to care and workforce capacity during the COVID-19 pandemic. Among other telehealth provisions, the rule would:

- Add several services to the approved list of Medicare telehealth services;
- Temporarily extend payment for other telehealth services added during the pandemic, such as emergency department visits through the calendar year in which the public health emergency ends; and
- Clarify that licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) can furnish brief online assessment and management services, offer virtual check-ins and remote evaluation services, as well as bill for these services.

Key policies to enable health care professionals to practice at the top of their licenses and professional training include:

- Making permanent the policy to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests;
• Reiterating the clarification that pharmacists fall within the regulatory definition of auxiliary personnel under “incident to” regulations;
• Making permanent the policy to allow PTs and OTs the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a physical therapist assistant (PTA) or an occupational therapy assistant;
• Clarifying medical record documentation, providing that physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS, and that therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and directly bills Medicare for their professional services may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist; and
• Extending or making permanent certain payments for teaching physicians’ services.

Also important, the proposed rule would delay the next Clinical Laboratory Fee Schedule (CLFS) data reporting period by an additional year so that hospital outreach laboratories would not need to report private payer data until January 1, 2022 through March 31, 2022. It would also eliminate the phase-in of CLFS payment cuts in 2021—providing no reduction for CY 2021—and payment may not be reduced by more than 15% for CYs 2022 through 2024.

The proposed rule continues implementation of the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, including Medicare coverage for opioid treatment programs (OTPs), screening for substance use disorder in Medicare physicals and electronic prescribing of controlled substances.

Two areas of specific concern: the redistributive effect of CMS’s proposed increases in the payment rates for office/outpatient evaluation and management (E/M) visits as well as other proposed payment changes, and the pricing methodology for drugs administered as part of the OTPs.

Relative to quality initiatives, the proposed rule would:
• Defer implementation of specific Merit-Based Incentive Payment System (MIPS) Value Pathways until at least 2022;
• Implement a new MIPS Advance Payment Model Performance Pathway requiring all APMs to report the same six quality measures; and
• Increase the minimum Medicare Shared Savings Program quality standard and modify the measure set and assignment methodology.

Comments on the proposed rule are due by October 5. The final rule could be published as late as December 2. The policies and payment rates will take effect January 1, 2021.

**Final Inpatient Rehabilitation Facility and Inpatient Psychiatric Facility Prospective Payment Rules:** CMS published final rules for the [inpatient psychiatric facility](#) (IPF) and [inpatient rehabilitation facility](#) (IRF) prospective payment system (PPS) for fiscal year (FY) 2021. These regulations will take effect October 1, 2020.

**Highlights of Final IPF PPS Payment Provisions:**
• 2.3% net increase IPF payments in FY 2021 which reflects a 2.2% market basket update minus a productivity adjustment of 0.0 percentage points, and an additional 0.1 percentage point offset for the outlier fixed-dollar loss threshold amount;
• Alignment of the IPF PPS wage data timeframe with that used by the inpatient PPS. CMS explained that this finalized methodology would result in the most “up-to-date” wage data being used, and be consistent with the methodology used in other Medicare payment systems; and
• Removal of “Independent” from “Licensed Independent Practitioner(s)” to allow advanced practice providers the authority to practice at the top of their licenses, including the authority to record progress notes for patients.

Highlights of Final IRF PPS Payment Provisions:
• 2.8% net increase in payments to IRFs in FY 2021 relative to FY 2020, which includes a 2.4% market-basket update, a zero percent update for productivity (reflective of the disruption caused by the COVID-19 pandemic), and a 0.4% increase in outlier payments;
• Limited expansion of the role of non-physician practitioners in IRF settings. The rule amends the IRF coverage requirements to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner’s scope of practice under applicable state law. Note that CMS significantly scaled back its proposal to allow non-physician practitioners to perform certain IRF services that are currently required to be performed by a rehabilitation physician, such as completing the pre-admission screening, developing the individual overall plan of care, performing three face-to-face visits per week, and leading interdisciplinary team meetings; and
• Elimination of Post-admission Physician Evaluations for all discharges by or after October 1, 2020. The rule makes permanent the temporary waiver issued under the April 6, 2020 interim final rule in response to the COVID-19 public health emergency.

Hospital Outpatient/ASC Proposed Rule: CMS released the calendar year 2021 outpatient prospective payment system/ambulatory surgical center proposed rule.

In addition to standard updates, the rule would further reduce the payment rate for certain drugs purchased under the 340B drug savings program, expand the list of outpatient services subject to prior authorization, eliminate the inpatient-only list over three years, make significant changes to the hospital star ratings methodology, and change the physician-owned hospital policy.

CMS also proposed revisions to the current hospital star rating system. These revisions are in response to the multiple comments, listening sessions, and workgroup considerations that CMS has held over recent years in an attempt to update and simplify how ratings are calculated.

Highlights of the changes to the methodology include:
• Regrouping measures into five groups, as compared to seven currently;
• Eliminating the latent variable methodology and replacing with a simple average of measures score;
• Stratifying readmission measure group based on a population of dual-eligible patients, as is done with the readmission reduction program;
• Requiring at least three measures in three measure groups, one of which must be mortality or safety of care;
• Tiered peer grouping of hospitals by the number of measure groups reported; and
• Annual publication cycle posted on Hospital Compare.

Public comments are due by October 5, 2020.
**Why this matters:** These proposed and final rules are issued on an annual basis to reflect payment system updates and other policy changes for the following fiscal year.

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**Federal COVID-19 Policy Guidance and Other Developments**

The Department of Health and Human Services (HHS) published a [fact sheet](#) on Operation Warp Speed detailing the groups’ goal, funding, working partners, and actions taken so far in vaccine development, manufacturing, and distribution.

The New York Department of Financial Services (DFS) issued [Circular Letter No. 14 (2020)](#) to provide guidance to health insurance providers that they “should ensure that insureds are not charged fees by participating providers for covered services that go beyond the insured’s financial responsibility as described in the insureds’ policies or contracts.” This includes when participating providers charge insured persons’ fees for the providers’ use of personal protective equipment (PPE).

**HRSA to Start Allocating Next CARES Act Relief for Nursing Homes in Mid-August:** The Health Resources and Services Administration expects in mid-August to distribute half of the $5 billion in Provider Relief Funds announced last month to enhance COVID-19 response at Medicare-certified long-term care facilities, the agency [said](#).

Facilities can use the funding to support increased testing, staffing and personal protective equipment needs. The agency said it expects to distribute the remaining $2.5 billion throughout the fall based on a facility’s performance, which will consider the prevalence of the virus in the local area and the facility’s ability to minimize COVID-19 spread and related fatalities among its residents.

Project ECHO, a consortium of about 250 health system “hubs” across the United States, has partnered with the Agency for Healthcare Research and Quality to pilot a nursing home infection control learning network that will be available to any facility seeking support, the agency said.

**FDA Revokes Authorization for Antibody Test:** The Food and Drug Administration [revoked](#) its emergency use authorization for a SARS-CoV-2 antibody test made by Autobio Diagnostics Co. due to concerns with the accuracy of the test when evaluated at the National Institutes of Health’s Frederick National Laboratory for Cancer Research.

**FEMA Authorized to Use $44 Billion of Disaster Funds for Unemployment Benefits:** President Trump Saturday [authorized](#) the Federal Emergency Management Agency to use up to $44 billion in Stafford Act disaster relief funds to supplement individuals’ wages resulting from lost work due to the COVID-19 public health emergency.

The president’s directive said that states and territories that apply for funds may distribute through their unemployment insurance system $400 per week, including a $300 federal contribution, to individuals who currently receive at least $100 per week of unemployment compensation benefits and can self-certify that they are unemployed or are unable or unavailable to work due to disruptions caused by COVID-19.

The White House and FEMA continue to work on guidance for state distributions and the program will be applied retroactively to the week ending August 1. It can continue no later than December 6, or until the
balance of the Disaster Relief Fund reaches $25 billion or until Congress enacts a separate, replacement unemployment relief program.

**CDC Report Examines COVID-19-associated Syndrome in Children**: The Centers for Disease Control and Prevention released a report describing the characteristics of multisystem inflammatory syndrome (MIS-C), a rare but serious condition that states have reported in more than 500 children with COVID-19.

According to the report, most MIS-C cases have features of shock, with cardiac involvement, gastrointestinal symptoms and significantly elevated markers of inflammation. “As the COVID-19 pandemic continues, with the number of cases increasing in many jurisdictions, health care providers should continue to monitor patients to identify children with a hyperinflammatory syndrome with shock and cardiac involvement,” the authors said. “Suspected MIS-C patients should be reported to local and state health departments.”

**FDA Issues EUAs for Ventilator Devices and Surgical Masks**: The Food and Drug Administration authorized the emergency use of three types of ventilator accessories for treating COVID-19 patients.

The Lombardi Undersea subsalve oxygen treatment hood is a patient interface for helmet-based non-invasive positive pressure ventilation; a valve from VORTRAN Medical Technology 1 Inc. provides constant-flow pressure-cycled ventilator support; and a device from Nanotronics Imagining Inc. provides bi-level positive air pressure support.

The FDA also issued an umbrella emergency use authorization to meet supply demands for certain disposable, single-use surgical masks that meet performance requirements for use in health care settings to provide a physical barrier to fluids and particulate materials to prevent exposure to respiratory droplets and large particles.

**First State Launches COVID-19 Contact Tracing App Based on Apple/Google Platform**: Virginia launched the first COVID-19 contact tracing app based on the exposure notifications system application programming interface developed by Apple and Google.

The free COVIDWISE app relies on Bluetooth technology rather than collecting users’ personal information or location data. Developers said the app can notify users if they have come in close contact with someone who has tested positive for COVID-19. COVIDWISE uses random Bluetooth keys that change every 10 to 20 minutes. iOS and Android devices on which the app is installed will anonymously share these random keys if they are within close proximity for at least 15 minutes.

In the event of a match, COVIDWISE may notify the individual, taking into account the date and duration of exposure, and Bluetooth signal strength, which is used to estimate proximity.

**NIH Project to Create COVID-19 Medical Imaging Tools**: The National Institutes of Health announced the Medical Imaging and Data Resource Center, a public-private initiative that will create medical imaging tools to detect and personalize therapies for COVID-19 patients.

“This effort will gather a large repository of COVID-19 chest images, allowing researchers to evaluate both lung and cardiac tissue data, ask critical research questions, and develop predictive COVID-19 imaging signatures that can be delivered to healthcare providers,” said Guoying Liu, program lead for the National Institute of Biomedical Imaging and Bioengineering. University of Chicago radiology professor Maryellen
Giger will lead the effort, which also includes researchers from the American College of Radiology, Radiological Society of North America, and American Association of Physicists in Medicine.

**Study to Evaluate Potential COVID-19 Treatment Regimen in Hospitalized Patients:** The National Institute of Allergy and Infectious Diseases has launched a clinical trial to evaluate a potential COVID-19 treatment regimen for hospitalized patients that combines remdesivir with interferon beta-1a, a medication approved to treat multiple sclerosis that laboratory studies suggest may benefit patients with COVID-19.

The trial expects to enroll more than 1,000 hospitalized adults with COVID-19 in the United States and abroad who have abnormal chest X-rays or need supplemental oxygen or mechanical ventilation. Preliminary results are expected this fall.

**FDA Issues Guidance on Extending ‘In-use Time’ for Shortage Drugs:** Health care facilities or providers facing inadequate supplies of certain drugs needed to treat patients with COVID-19 should not use the products more than four hours beyond the labeled “in-use time” for refrigerated storage or two hours beyond the labeled “in-use time” for room temperature storage, the Food and Drug Administration announced. The guidance applies to 10 specific drug products.

“FDA is aware that some health care facilities and providers are facing challenges in maintaining adequate supplies of certain drugs needed to treat patients with COVID-19,” the agency said. “In particular, health care facilities and providers have reported that care of ventilated patients can be complicated by the need to discard containers of medications before they are fully administered because of the in-use time specified on the FDA-approved label.” The “in-use time” is the maximum amount of time allowed before administering a sterile drug product after penetrating its container-closure system or a lyophilized drug product after it has been reconstituted.

Facilities or providers seeking information on the potential to use other specific FDA-approved drugs for injection beyond the labeled in-use time in COVID-19 patients due to supply issues may email requests for information to CDER-OPQ-Inquiries@fda.hhs.gov.

**Agencies Award $1B Contract to Produce Vaccine Candidate:** The departments of Health and Human Services and Defense will pay Janssen Pharmaceutical Companies of Johnson & Johnson $1 billion to manufacture 100 million doses of its COVID-19 vaccine candidate for use in clinical trials, or to vaccinate Americans if authorized by the Food and Drug Administration. Under the agreement, the government also could acquire additional doses to vaccinate up to 300 million people, the agencies said.

**Summit Examines U.S. Drug Supply Chain as Security Priority:** The American Hospital Association, American Medical Association, American Society of Health-System Pharmacists, and United States Pharmacopeia convened a virtual summit to examine the resilience of the U.S. pharmaceutical supply chain in light of the current state of global pharmaceutical manufacturing. Representatives from clinician groups, industry, the supply chain, and public sector discussed global pharmaceutical manufacturing as a national security priority, noting that the rapid global outbreak of COVID-19 and its negative ripple effect on patients’ access to critical medicines have called attention to increasing concerns about the stability and security of the U.S. drug supply. Summit topics included advanced technologies such as continuous manufacturing and 3-D printing, which may help produce oral and parenteral drugs more efficiently; the role of public-private partnerships in developing and disseminating new technologies; diversifying the global supply chain; and creating a list of essential medicines to produce in the U.S.
NIH to Study Synthetic Antibody Therapy; FDA Authorizes First Serology Tests to Display Estimated Antibodies: The National Institutes of Health announced clinical trials to investigate the safety and efficacy of a synthetic antibody therapy in COVID-19 patients. One study seeks to enroll about 300 volunteers who have been hospitalized with mild to moderate COVID-19; the other seeks to enroll 220 volunteers who report symptoms of COVID-19 and test positive for the virus but do not require hospitalization.

In other news, the Food and Drug Administration authorized two Siemens serology tests for COVID-19 that display an estimated quantity of antibodies present in the individual’s blood.

HHS Releases COVID-19 Laboratory Data Reporting Specifications: The Department of Health and Human Services released specifications for reporting certain COVID-19 laboratory data as required by the Coronavirus Aid, Relief, and Economic Security Act. Under recent HHS guidance, all COVID-19 testing sites must begin reporting the data by August 1 to state or local health departments for each individual tested to detect SARS-CoV-2 or diagnose COVID-19.

Federal Court Invalidates Definition of ‘Health Care Provider’ in DOL Rule Expanding Paid Leave: The U.S. District Court for the Southern District of New York ruled against the Department of Labor regarding its regulations related to certain expanded paid leave authorized by the Families First Coronavirus Response Act.

The FFCRA placed new requirements on certain employers with fewer than 500 employees with respect to family and medical leave, as well as paid leave, related to the COVID-19 pandemic. The law directed the DOL to issue regulations defining which “health care providers” could be exempted from these new leave requirements.

New York state challenged the DOL’s regulations, arguing that the regulations “risk denying vital financial support during an unprecedented crisis and exposing workers, their families, and their communities to unnecessary spread of COVID-19.” Ruling in favor of the state, the court found that the DOL’s interpretation of “health care provider” was overly broad and not supported by the statute.

The decision invalidates the final rule’s definition of “health care provider” as well as certain other provisions challenged by the state, while letting all remaining portions of the final rule stand.

CMS Allows 2020 Premium Credits Associated with COVID-19
The Centers for Medicare & Medicaid Services (CMS) published guidance and a related press release on a Temporary Policy on 2020 Premium Credits Associated with the COVID-19 Public Health Emergency (PHE). The guidance provides flexibility to allow health insurance issuers in the individual and small group markets to temporarily offer premium credits for 2020.

CMS will adopt a policy of relaxed enforcement of several regulations on a temporary basis, to allow health insurance providers to offer premium credits for 2020 coverage. Offering premium credits under the guidance is optional for health insurance issuers. Before offering the premium credits described in the bulletin, health insurance issuers must receive State regulator and, if applicable, Exchange approval. In states where CMS is the primary enforcer of the applicable requirements, CMS approval is required rather than the State’s.

Credits must be:
Prospective;
Set as a percentage of monthly premium;
Apply for a full month;
End by the end of 2020; and
Offered in a nondiscriminatory manner.

The guidance also includes preliminary information on how this option interplays with the rules related to medical loss ratio (MLR), premium tax credits (PTC), and risk adjustment. More guidance on those issues is expected in the future and we will notify members as new information becomes available.

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**CMS Publishes Guidance on ACA Risk Adjustment in Telehealth during the COVID-19 Pandemic**

CMS released updated guidance addressing the treatment of certain telehealth services under the ACA risk adjustment program. The guidance clarifies which telehealth services -- including telephone only services -- are valid for data submissions under the risk adjustment program.

CMS' guidance designates nine e-visit codes as valid for 2020 benefit year risk adjustment data submissions, subject to applicable state law requirements. Risk adjustment eligible diagnosis codes provided via allowable telehealth and virtual services will be validated in the same manner as risk adjustment diagnosis codes provided via in-person services are validated. CMS has also considered the treatment of telephone-only services in the ACA risk adjustment program and the guidance announces that additional codes will be valid for 2020 benefit year data submissions for the risk adjustment program.

While the guidance does not pertain to MA plans, it does set a precedent for CMS incorporating diagnoses obtained through audio-only telehealth for MA risk adjustment purposes.

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**White House Issues Executive Order to Boost Telehealth and Rural Health Care**

The White House issued an executive order to enhance rural health care and the sustainability of broad-based telehealth adoption after the COVID-19 pandemic subsides. The order focuses on an Administration effort to create new ways of financing rural health care, as well as to propose a permanent extension for some telehealth policies. Under the executive order, within the next 30 days:

- The Department of Health and Human Services (HHS) will announce a new model to test innovative payment mechanisms to give rural providers flexibilities from existing Medicare rules and encourage movement to value-based care.
- HHS, the Secretary of Agriculture, and the Federal Communications Commission (FCC) will develop and implement a strategy to improve rural health by improving the physical and communications healthcare infrastructure available to rural Americans.
- HHS will submit a report to the President on policy initiatives to increase rural access to healthcare by eliminating regulatory burdens; develop a rural specific effort to improve health outcomes; reduce maternal mortality and morbidity; and improve mental health in rural communities.

Finally, the EO states within 60 days, HHS shall propose a regulation to extend additional telehealth services offered to Medicare beneficiaries and the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas.
President Signs Executive Order on Domestic Drug Manufacturing
President Trump signed an Executive Order (EO), “Ensuring Essential Medicines, Medical Countermeasures, and Critical Inputs Are Made in the United States”, directing the Department of Health and Human Services (HHS) to procure “essential” medicines and other equipment through the Defense Production Act from U.S. manufacturers rather than from overseas companies. The EO instructs the Food and Drug Administration (FDA) to develop a list of "essential" medicines, medical countermeasures, and critical inputs needed for public health in America within the next 90 days.

The order also aims to foster the domestic production of active pharmaceutical ingredients (API) by directing the FDA and Environmental Protection Agency (EPA) to prioritize applications from domestic manufacturers and to speed up the regulatory review process accordingly. Further, the EO directs the FDA to negotiate with other countries producing these essential medical products and medicines for export to the U.S. and provides increased authority to conduct unannounced inspections of those facilities to protect the public’s safety.

State Issues

Delaware
Regulatory

Governor John Carney Formally Extends the State of Emergency Declaration
The Governor has again extended the State of Emergency in Delaware, finding that the conditions necessitating a State of Emergency continue to exist.

This order extends the State of Emergency another 30 days, from August 5, 2020. To find a testing site near you, visit Delaware’s coronavirus website.
Interested in reviewing a copy of a bill(s)? Access the following web sites:

Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).
West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/).

For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).
If you have any questions about a DE, PA, WV or congressional bill, contact the Government Affairs Department at (717).302.3978.

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