INTRODUCTION:

The Council on Governmental Activities reviews federal legislation and regulations of concern to the medical profession or the health care industry, and initiates activities or undertakes appropriate responses on matters of priority interest, consistent with OSMA established goals and policy. It also establishes and maintains relations with federal government entities having statutory or regulatory jurisdiction affecting the medical profession, the delivery of health care, or public health. In cooperation with any other Association councils and committees, it communicates with the medical profession, develops policy recommendations for consideration by the Board of Trustees, prepares testimony, and otherwise conducts the federal legislative program of the Association. The activities of the Council are guided by the Association’s Annual Program of Activities as defined and interpreted by the Board of Trustees.

In order to be more nimble to respond to federal issues, the oversight for the Council on Governmental Activities was transferred to the OSMA Executive Committee beginning in 2013. The Executive Committee welcomes participation from any OSMA member and encourages physicians to get involved in legislative advocacy by contacting members of Congress when they are back in their home districts or joining the Council on Governmental Activities in Hill Visits to Washington DC.

Coalition of State Medical Societies:

To help address the challenges of new practice realities for physicians, the OSMA joined with nine other state medical societies to form the Coalition of State Medical Societies. The Coalition collectively represents over 180,000 physicians nationwide. Included are the four largest medical societies (CA, FL, NY, and TX), and other states with physician members of Congress. The intent was to start with a core group of states and build on a bi-partisan, grassroots initiative that better utilizes the physician members of Congress and their key Congressional allies. In 2013, the Coalition hired Washington Lobbyist Larry Meyers to help coordinate meetings with congressional members for the group. OSMA has renewed its membership each year since.

OSMA Executive staff, Ken King and Kathy Musson, have participated in a number of coalition meetings and congressional visits with the group. The plan is to continue coalition efforts to further refine their mission and develop outlines of potential legislation and a coordinated advocacy strategy.

REVIEW OF 2015 ACTIVITIES:

AMA National Advocacy Conference - 2015:

The 2015 AMA National Advocacy Conference (NAC) was held February 23-25, 2015 in Washington, DC. The AMA NAC provides leaders of the medical community from around the country the opportunity to gather and receive the latest information on various political and advocacy issues of interest to physicians and their patients.

Physicians representing the Oklahoma State Medical Association were President Todd Brockman, MD and President-elect Woody Jenkins, MD. Also in attendance from Oklahoma were Mary Anne McCaffree, MD, AMA Board of Trustees member; D. Robert McCaffree, MD, OSMA Past President, Jack Beller, MD, OSMA Past President and AMA Council on Legislation Member, Doug Folger, MD, 2015 President of the Oklahoma County Medical Society, OSMA Executive Director Ken King, and Associate Executive Director Kathy Musson.
Oklahoma attendees, along with OSMA Federal Lobbyist Michael Preston, made “House Calls” to the Oklahoma Congressional Delegation and had an opportunity to visit offices of all of Oklahoma’s U.S. Senators and Representatives. The primary message to Congress by the physician group was to reiterate OSMA’s opposition to further short-term patches that have made Medicare physician payment cuts more severe and reform even more costly; and to ask Congress to permanently replace the flawed Sustainable Growth Rate (SGR) formula with a new update formula based on medical practice cost increases.

During the visits, Sen. James Lankford told Oklahoma physicians that vehicles to repeal SGR and replace it with updated Medicare payment reform have moved through relevant committees of jurisdiction and they just need full congressional support to “get across the finish line.”

Other Oklahoma members and their healthcare staff indicated that there may be a short-term “patch” proposed to get physicians to Sept. 30 (the end of the Federal Fiscal Year), but that the long-term fix to the SGR is something they hope to complete this year. If a fix is not passed by Congress, this will be the 18th “patch” to the SGR since its inception.

The OSMA delegation also asked for support for the “Medicare Patient Empowerment Act” which would allow Medicare patients and their physicians to enter into private contracts without penalty to either party. Oklahoma physicians also advocated for relief from onerous regulatory burdens, penalties, and programs, including fixing the Meaningful Use program; the challenges of using electronic health records; the troubling changes that will be brought on by the mandate to convert to ICD-10; and addressing problems with the RAC audit process.

**FEDERAL LEGISLATIVE ISSUES:**

At the federal level, the Oklahoma State Medical Association (OSMA) is aggressively involved in advocacy efforts, related to the most vital issues in medicine, including the following:

**Monitor MACRA Implementation to Prevent Another Bureaucratic Catastrophe**

Physicians worked hard with Congress to repeal the old Medicare Sustainable Growth Rate (SGR) formula. The new payment system established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) offers the potential to bring positive changes to how we pay for and deliver health care to seniors. Those changes, rolled out through the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models, also offer the potential for convoluted and counterproductive regulations that far outweigh any improvements. The hopelessly tangled Meaningful Use program is a perfect example of what we must avoid.

**Reform Medicare’s Electronic Health Record Program – Meaningful Use**

More than 80 percent of U.S. physicians have adopted EHRs, yet only 22 percent met the unrealistic Meaningful Use (MU) Stage 2 requirements in 2014, let alone the looming Stage 3 mandates. The program has become administratively burdensome and is neither improving patient care nor ensuring the exchange of vital information. Physicians are dropping out in droves.

The group asked congress to adopt the following reforms immediately in 2016.

- Eliminate the All-or-Nothing Approach. Provide proportional credit for the quality measures and electronic standards that physicians do actually meet.
• Require interoperability with vendor testing to allow physicians, hospitals, labs, and health plans to exchange information. Despite the widespread adoption of EHRs, physicians are still forced to fax information because these systems can’t talk to each other.

• Expand the Hardship Exemptions for EHR vendor problems, cyber attacks, and physicians near retirement who cannot make the investment in HIT, yet whom we need to maintain access to doctors across the country.

• Delay Meaningful Use Stage 3 until Stage 2 is met.

• Provide for HER Vendor accountability. Vendors should be held accountable for the utility and reliability of their products.

Reform Medicare RAC Audits:

Medicare pays Recovery Audit Contractors (RACs) like bounty hunters to find potential overpayments made to physicians. Nearly half of all audit findings are overturned by an Administrative Law Judge when a physician appeals. This demonstrates how badly the program needs reform. We urge Congress to adopt the following long-overdue reforms:

• Prohibit RACs from recouping physician payments until the appeals process is final.

• Make RACs more accountable for improving extrapolation formulas, employing reviewers trained in the same medical specialty, and impose penalties for inaccurate findings.

• Provide incentives for RACs to educate physicians about any incorrect billing practices to avoid future billing errors.

Reauthorize and Increase Funding of Prescription Drug Abuse Monitoring Systems

Prescription drug diversion, abuse, overdose, and death have reached epidemic levels across the U.S. Well-funded state prescription drug monitoring programs (PDMPs) can help to curb the problem. We urge Congress to reauthorize and increase funding for the National All Schedules Prescription Electronic Reporting Act (NASPER). While the Oklahoma PDMP is one of the best in the nation, PDMP databases in many states have been severely underfunded, leaving significant technological barriers that make it difficult for physicians to incorporate this tool into their practices. To ensure the appropriate administration of these programs by experienced health care professionals, they should be housed in state and federal health care – not law enforcement – agencies.

The U.S. House of Representatives has passed its NASPER reauthorization bill, H.R. 1725 and the group strongly encouraged the Senate to act on this important legislation swiftly.

For Telehealth, Ensure Physicians Are Licensed in the State Where the Patient Is Receiving Treatment.

The group asked Congress to amend H.R. 3081 (Nunes/Pallone). Telehealth offers great hope to make health care more available and efficient. The OSMA supports the appropriate expansion and coverage of telehealth services to improve access to care for Medicare, Medicaid, and VA patients, particularly in underserved areas. However, OSMA strongly urges Congress to preserve the jurisdiction of state medical boards to license and discipline physicians in order to protect patient safety. Fundamentally, the practice of medicine takes place where the patient is receiving treatment and physicians should be licensed to practice in the state where this care occurs. In addition, we believe services provided through telehealth should adhere to appropriate standards of care and that these services should be paid for on par with the same services provided in-person, and urges any federal telehealth legislation to adhere to these principles.
Congress was asked to oppose S. 1778 and H.R. 3081, the TELE-MED Act of 2015, by Sen. Mazie Hirono (D-HI) and Rep. Devin Nunes (R-CA) until amended to protect state licensure, and maintain applicable standards of care and payment parity.

Attached to this report are copies of the talking points for the above issues along with a contact list for the Oklahoma Congressional Delegation.

SUMMARY:

The OSMA has maintained a close working relationship with the members of the Oklahoma Congressional Delegation on federal issues of importance to physicians and their patients. OSMA will continue to work with both state and federal representatives to improve the quality of the health care system and to ensure Oklahoma patients’ have access to affordable care. The OSMA executive staff will continue to coordinate federal legislative activities with OSMA Lobbyist Michael Preston and to dialogue with the AMA’s Washington, DC staff regarding federal issues affecting health care.

Due to the rapidly changing health care environment, Delegates are encouraged to watch for OSMA advocacy alerts or check OSMA’s website at www.okmed.org for updated information on these important topics. Additional information on OSMA’s federal legislative agenda is available by contacting Kathy Musson, OSMA Associate Executive Director at (800) 522-9452 or by e-mail to Musson@okmed.org.

RECOMMENDATIONS:

The Council on Governmental Activities continues to encourage all physicians to become involved in grassroots efforts to get to know their U.S. Senators and U.S. Representatives personally and to call on them when critical issues arise in Congress. For reference, a complete listing of the Oklahoma Congressional Delegation is attached to this report. OSMA physicians are encouraged to respond to OSMA blast federal legislative alerts as needed. In addition, the Council urges all OSMA members to contribute to the Oklahoma Medical Political Action Committee (OMPAC) and the American Medical Political Action Committee (AMPAC) as your involvement enhances their ability to elect and support pro-medicine candidates at the state and federal levels.

Respectfully submitted,

Kathleen A. Musson, CAE, Associate Executive Director
Meaningful Use

Congress enacted the HITECH Act with the best of intentions and, in large part, physicians have achieved the law’s goals of electronic health record (EHR) adoption. In 2001, only 18 percent of physicians used electronic health records. Today, more than 80 percent do.

However, as the regulatory framework for “Meaningful Use” has evolved, layer after layer of new requirements have been added—above and beyond the original intent of the law. What has emerged is a complex web of requirements that has had a significant impact on the patient-physician relationship as physicians must now spend much of the patient visit entering data into a computer. This data entry is required by the Meaningful Use program but is typically unrelated to the immediate needs of the patient.

These program mandates have proven so onerous that, even with the vast majority of physicians now using electronic health records, only a small minority has successfully complied.

Complicating matters is the fact that regulators and software vendors have largely ignored the areas of greatest need—building the infrastructure to ensure systems work together to seamlessly exchange information and providing flexibility so that systems can be designed to support health care decision making by patients and physicians.

Many members of Congress and health information technology stakeholders have urged the Administration to take a different path to achieve the vision originally laid out by Congress in the HITECH Act. We believe that the success of the program hinges on permitting flexibility for physicians in meeting the program's goals, promoting technological interoperability, and allowing innovation to flourish as vendors respond to the demands of physicians and patients rather than the current system, in which vendors must meet the ill-informed, check-the-box requirements of the program.

The Administration has begun to hear these calls for reform. In January, the Centers for Medicare & Medicaid Services (CMS) Acting Administrator Andy Slavitt stated: “The Meaningful Use program as it has existed, will now be effectively over and replaced with something better.” Slavitt outlined pending improvements to the Meaningful Use program aimed at responding to Congressional and stakeholder concerns, as well as supporting the transition to new payment policies under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, aka “SGR repeal”).

Among the steps outlined by CMS are: moving the focus away from the use of specific technology and towards a focus on improved patient outcomes; ensuring that health technology is developed for individual practice needs, not the needs of the government; and concentrating on interoperability.

### Specific Recommendations for Improving Meaningful Use

#### Achieving Seamless Interoperability and Information Exchange

- Electronic health records must focus on essential building blocks of interoperability:
  - Correctly match patients to their medical information
  - Establish a provider directory so physicians can find and direct patient information to each other online
  - Use clinician input to standardize data vocabularies so information has the same meaning and same format
  - Ensure privacy and security

- Interoperability and measures reliant on connecting to other data sources should reflect how data is transported to improve patient care, not simply the quantity of data exchanged

- Technology limitations, e.g., the lack of concise summaries of care, must be resolved before physicians are held accountable for these actions

#### Improving Care Quality and Promoting Innovation

- Prior to adoption, all measures should be assessed based on their:
  - Relevance to all specialties
  - Ability to meet the needs of patients
  - Cost-benefit analysis, including the cost of lost productivity

- Restructure measures away from simple data entry and reduce the burden of documentation

- Measures should reflect purposeful uses and functions of technology and not merely data entry

- Measures should prioritize the reuse of data collected and reduce the burden on documentation

- Reporting period should be less than one year to allow for technology changes and system upgrades

- Penalties should incentivize participation and be proportional to achievement, and not “pass-fail”

(Continued on back.)
These are all important goals that will help to transform the Meaningful Use program from one that frustrates and distracts physicians to one that empowers physicians to provide the highest quality of care possible.

**Ask your Senators and Member of Congress to encourage CMS to act this year to implement necessary Meaningful Use reforms.**

- PQRS or qualified clinical data registry participation should automatically satisfy MU quality reporting, to avoid duplication.
- Patient engagement measures should be broadened to encourage innovative uses of new technology

**Moving to MIPS and Advanced Payment and Delivery Models**
- Measures must be aligned with MACRA implementation
- Allow pilot programs to test new measures and technology to satisfy MU requirements, providing a glide path towards APMs
- Pilot programs could target specific specialties (radiology, anesthesiology, etc.) that have been unable to participate in the MU program due to lack of relevant measures
Strategies to combat opioid misuse

Ending the epidemic of overdose deaths due to prescription opioid analgesics is a high priority for the American Medical Association. According to the Centers for Disease Control and Prevention, there were more than 160,000 overdose deaths due to opioids or heroin in the past decade, surpassing the total number of deaths during the first decade of the AIDS epidemic.

The AMA believes physicians should be leaders in preventing and reducing misuse, addiction, overdose, and death from prescription drugs, and that a comprehensive, multi-pronged public health approach is needed. This approach must balance the treatment needs of pain patients with efforts to promote safe and appropriate prescribing, reduce diversion and misuse, promote an understanding that substance use disorders are chronic conditions that respond to treatment, and expand access to treatment for individuals with substance use disorders.

These are complex problems with no single solution. The AMA is working on multiple fronts through the AMA Task Force to Reduce Opioid Abuse as well as continuing our work with Congress and the Administration, with the nation's state and specialty medical societies, and with stakeholders in both the private and public sectors to combat this national crisis.

The AMA strongly supports the following legislative reforms, which we believe would help to reduce prescription opioid misuse, addiction, overdose and overdose deaths:

1. **Reauthorize and fully fund the National All Schedules Prescription Electronic Reporting Act to enable the modernization of prescription drug monitoring programs.**

The AMA strongly encourages physicians and other prescribers to register for and use prescription drug monitoring programs (PDMPs). These programs can serve as a helpful clinical tool in the fight against prescription drug misuse. The AMA applauds the U.S. House of Representatives for passage of the “National All Schedules Prescription Electronic Reporting Reauthorization Act (NASPER)” (S. 480/H.R. 1725) and encourages the U.S. Senate to take up this critically important legislation. The reauthorization of NASPER and full appropriations are necessary to ensure that physicians across the country have patient-specific information through PDMPs at the point of care and to promote further implementation of best practices and information sharing between states.

2. **Increase coverage for—and access to—comprehensive treatment for opioid use disorder, including medication-assisted treatment.**

Opioid use disorder is a chronic disease that can be effectively treated. However, effective treatment requires care coordination and ongoing management. More resources are needed to ensure availability of, and access to, evidence-based treatment. A public health-based approach to harmful drug use requires having comprehensive treatment services available for those with opioid use disorders and insurance coverage for such treatment. Coverage limits and inadequate payment rates make it difficult to provide needed treatment services to patients.

Medication-assisted treatment (MAT) is the use of medications in combination with counseling, behavioral therapies, and other treatment and recovery support services, to provide a comprehensive approach to the treatment of opioid use disorders. The U.S. Food and Drug Administration (FDA)-approved medications used to treat opioid addiction include methadone, buprenorphine (alone or in combination with naloxone) and naltrexone.
Types of behavioral therapies include individual therapy, group counseling, family behavioral therapy, motivational incentives and other modalities. MAT has been shown to be highly effective in the treatment of opioid addiction.

The AMA strongly supports increased access to and coverage for treatment for drug addiction and physician office-based treatment of opioid addiction. The Drug Addiction Treatment Act of 2000 provided for an office-based option for opiate treatment that uses buprenorphine, a drug that can help facilitate recovery from opiate addiction. However, limits remain on the number of patients a physician may treat using this drug.

There is broad consensus in the medical community that buprenorphine is a successful tool to help fight addiction. Lifting the cap would allow physicians to treat more patients with this highly effective drug, and would provide an incentive for more physicians to get the required training to offer this service in their practices. Legislation to accomplish this goal, such as the “Recovery Enhancement for Addiction Recovery Act” (H.R. 2536/S. 1455), would make major strides in expanding treatment capacity.

3. Increase access to overdose prevention measures, such as naloxone, and expand Good Samaritan protections.

The AMA strongly supports the national trend of states enacting new laws to increase access to naloxone, which is a safe and effective FDA-approved medication that reverses prescription opioid and heroin overdoses and helps save lives. Naloxone has no psychoactive effects and does not present any potential for abuse. AMA advocacy has supported state laws that put naloxone into the hands of appropriately trained first responders as well as friends and family members who may be in a position to help save lives. The AMA encourages physicians to co-prescribe naloxone to their patients at risk who are taking opioid analgesics.

It is well documented that naloxone has saved thousands of lives across the nation. Despite this progress, however, barriers still exist to optimal use of naloxone in preventing overdose deaths. One way to reduce barriers to the use of naloxone is passage of Good Samaritan laws to protect from liability first responders, friends and family members, or bystanders who may witness an overdose and have access to naloxone. We urge Congress to provide funding for increased access to naloxone overdose prevention programs and to encourage the adoption of broad Good Samaritan protections.

4. Delink Hospital Consumer Assessment of Healthcare Providers and Systems survey pain questions from reimbursement determinations under the Hospital Value-Based Purchasing program

Patient experience measures for the Hospital Value-Based Purchasing (VBP) program are derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national, standardized, publicly reported survey of patients' perspectives of hospital care during a recent overnight stay. Since 2007, hospitals subject to the inpatient prospective payment systems collect and submit HCAHPS data in order to receive their full annual payment update. As a further incentive to improve patient experience, the Affordable Care Act specifically included HCAHPS performance in the calculation of the value-based incentive payment in the hospital VBP beginning with Oct. 2012 discharges.

There is a growing body of evidence, as highlighted in a recent Hastings Center Report, that patient satisfaction surveys can have repercussions that impede rather than enhance the quality of care. The AMA has heard from many physicians that pain-related questions in the HCAHPS survey, in particular, are having the unintended consequence of promoting inappropriate prescribing of opioids and thereby contributing to the epidemic of opioid misuse, overdose and death.

The AMA supports H.R. 4499, the “Promoting Responsible Opioid Prescribing Act of 2016,” which would delink pain related measures from hospital reimbursement under the Value-Based Purchasing program.
Bipartisan Telemedicine Legislation: CONNECT for Health Act

The “Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2484/H.R. 4442),” introduced by Senator Brian Schatz (D-HI) and Rep. Diane Black (R-TN), would advance the practice of telemedicine.

Passage of the CONNECT for Health Act would ensure that patients and their physicians are able to use new technologies that remove barriers to timely, high-quality care. This legislation would also accelerate the adoption of health care delivery models that promote coordinated and patient-centered care. Importantly, the bill would maintain high standards whether a patient is seeing a physician in an office or via telemedicine.

Provisions of current law that pre-date the Internet limit Medicare telemedicine coverage by:

- **Originating site restrictions** – the patient may only be located at certain clinical sites
- **Geographic limitations** – the patient may only be located in certain rural areas

The CONNECT for Health Act is a bipartisan approach to increase the use of telemedicine and remote patient monitoring through Medicare. The bill would remove outdated restrictions on Medicare coverage of telemedicine that limit beneficiary access to these services.

Specifically, the legislation would:

- Establish a bridge program to help physicians and other providers meet the goals of the Medicare Access and CHIP Reauthorization Act (MACRA) and the Merit-based Incentive Payment System (MIPS) through the use of telehealth and remote patient monitoring (RPM)
- Allow telehealth and RPM to be used by qualifying participants in alternative payment models
- Significantly expand physician telemedicine services to promptly identify and diagnose strokes
- Increase telehealth and RPM services in community health centers and rural health clinics
- Allow telehealth and RPM to be basic benefits in Medicare Advantage
- Potentially save $1.8 billion over 10 years, according to an independent study by Avalere Health
- Preserve state-based licensure for physicians

State-based licensure solutions

The AMA strongly affirms that physicians should continue to be required to be licensed or otherwise authorized to practice in the state where the patient receives services. The AMA opposes legislation that would create a federal physician license or pre-empt the states’ traditional role of regulating medical care provided within their own state borders. The AMA recognizes that it is time consuming and expensive to get licenses issued from multiple states under current processes.

To address this problem, the AMA is supporting the Interstate Physician Licensure Compact. The compact allow physicians and physician assistants to obtain licenses from multiple compact states through a single streamlined process. This expedited process will help facilitate license portability and allow physicians to practice medicine—including telemedicine—in a safe and accountable manner while protecting patients and expanding access to care.

Twelve states have joined the compact since January 1, 2015: Alabama, Idaho, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, Wyoming, Iowa, Illinois and Wisconsin. An additional fourteen states are considering joining the compact including Alaska, Arizona, Colorado, Kansas, Maryland, Michigan, Nebraska, New Hampshire, Oklahoma, Pennsylvania, Rhode Island, Texas, Vermont and Washington.

Ask your Senators and Representative to cosponsor S. 2484/H.R. 4442, the “CONNECT for Health Act.”
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02/17/2016