Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration Division, Human Resources Branch

Street Address

P.O. Box 997411, MS 1300

Area Code/Phone Number: (916) 552-8270

Email: ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name) ☑ Other National Association of Medicaid Directors (Name)

444 Capitol Avenue, Suite 524 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent & support the Medicaid Directors in 56 states, territories & the District of Columbia.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Madison, Wisconsin (Location of Travel) June 10-13, 2018 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) The Edgewater (Name of Lodging Facility)

$585.60 (Lodging Expenses) $64.00 (Meal Expenses) $1,318.57 (Transportation Expenses) $15.00 (Other Expenses) $1,397.57 (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

To attend the National Association of Medicaid Director's (NAMD) Spring Conference from June 10-12, 2018 and NAMD's Scorecard Meeting on June 13, 2018

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Brooks	Sarah	Deputy Director	Health Care Delivery

4. Verification

Original Signed By:

reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 8.1.18 (month, day, year)

Comment:

(Use this space or an attachment for any additional information)

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☑ Other National Association of Medicaid Directors (Name)

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→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Madison, Wisconsin (Location of Travel) | June 10-12, 2018 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | The Edgewater (Name of Lodging Facility)

$390.40 Lodging Expenses | $23.00 Meal Expenses | $636.42 Transportation Expenses | $15.00 Other Expenses | $1,049.82 Total Expenses

3.1 (b) Payment(s) not related to travel:

_____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

To attend the National Association of Medicaid Director's (NAMD) Spring Conference from June 10-12, 2018.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Harrington	Lindy	Deputy Director	Health Care Financing
			L

4. Verification

Original Signed By:

reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 8.1.18 (month, day, year)

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Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Quality Forum (Name)

1030 15th Street, NW Suite 800 (Address) Washington (City) D.C. (State) 20005 (Zip Code)

To improve health & performance of health system by supporting production & use of evidence to inform policy & practice.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Washington, D.C. (Location of Travel)

05/08/2018 - 05/10/2018 (Dates (month, day, year))

United Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Hotel Rouge (Name of Lodging Facility)

$596.68	$31.96	$665.26	$	$1,293.90
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

To attend and participate at the National Quality Forum's Medicaid Adult In-person Meeting in Washington, D.C.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Logan	Julia	Public Health Medical Offic	DHCS/OMD

4. Verification

Original Signed By:

reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 8.1.18 (month, day, year)

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Area Code/Phone Number: (916) 552-8270

Email: ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title) Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other Academy Health (Name)

1666 K St. NW, Suite 1100 (Address) Washington (City) DC (State) 20006 (Zip Code)

AcademyHealth, is the professional home for health services researchers, policy analysts and practitioners.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Washington, DC (Location of Travel) May 2-4, 2018 (Dates (month, day, year))

American Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) The Darcy (Name of Lodging Facility)

$647.21 (Lodging Expenses) $_____ (Meal Expenses) $570.10 (Transportation Expenses) $70.76 (Other Expenses) $1,288.07 (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

To attend the Medicaid Medical Directors Network AcademyHealth Spring Workshop in Washington, D.C.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Logan	Julia	Public Health Medical Offic	DHCS/OMD

4. Verification

[redacted] reported payment(s) as in compliance with FPPC regulations.

Original Signed By:

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 7.31.18 (month, day, year)

Comment:

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Administration Division, Human Resources Branch

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Agency Contact (name and title)

Conflict of Interest Filing Officer

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☐ **Amendment** (explain in comment section)

Date of Original Filing: 06/30/18 (month, day, year)

2. Donor Name and Address

☐ Individual — Last Name — First Name

☑ Other — NASADAD (Name)

1919 Pennsylvania Avenue NW, Suite M-250 (Address) Washington (City) DC (State) 20006 (Zip Code)

NASADAD supports the development of effective substance use disorder programs and policy.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

Name — $ Amount — Name — $ Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Washington D.C. (Location of Travel) — May 21-24, 2018 (Dates (month, day, year))

American Airlines, (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) — Marriott Bethesda, MD (Name of Lodging Facility)

$ 1,012.00	$ 241.50	$ 958.41	$	$ 2,711.91
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: Dates (month, day, year) — $ Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Denise Galvez, as the National Prevention Network and Women's Services Network representative to California, attended the annual business meeting of the National Association of State Alcohol and Drug Abuse Directors. NASADAD provided travel stipends to meeting attendees.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Galvez	Denise	Section Chief	DHCS, SUD-PPFD

4. Verification

Original Signed By:

reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) — Chief Deputy Director (Title) — 8.1.18 (month, day, year)

Comment:

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