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 North Capitol St., NW, Suite 267 (Address) | Washington (City) | DC (State) | 20001 (Zip Code)

NAMD's sole function is to represent and support the Medicaid Director's in 50 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

Washington, DC (Location of Travel) | 11/11/18 - 11/14/18 (Dates (month, day, year))

Delta Airlines (Transportation Provider)

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

Washington Hilton (Name of Lodging Facility)

$624.18	$119.00	$688.05	$15.00	$1,446.43
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 the 2018 Fall NAMD Meeting in Washington, DC

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

Last Name	First Name	Position/Title	Department/Division
Cantwell	Mari	Chief Deputy Director	Health Care Programs

4. Verification

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

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 1.14.19 (month, day, year)

Comment:

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

Clear Page

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 North Capitol St., NW, Suite 267 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent and support the Medicaid Director's in 50 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

Washington, DC (Location of Travel) 11/11/2018 - 11/14/2018 (Dates (month, day, year))

Delta Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$624.18 Lodging Expenses | $110.00 Meal Expenses | $655.85 Transportation Expenses | $47.00 Other Expenses | $1,437.03 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 2018 Fall NAMD Meeting in Washington, DC

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 Sys.

4. Verification

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

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.14.19 (month, day, year)

Comment:

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

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

Clear Page

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 California Association of Health Plans (Name)

1415 L St #850 (Address) Sacramento (City) Ca (State) 95814 (Zip Code)

The California Association of Health Plans advocates on behalf of our member health plans before the State Legislature.

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

San Diego, CA (Location of Travel)

10/22/2018 - 10/23/2018 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

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

Manchester Grand Hyatt (Name of Lodging Facility)

$325.78 Lodging Expenses | $23.00 Meal Expenses | $182.62 Transportation Expenses | $5.00 Other Expenses | $536.40 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.

Travel was to attend The CAHP annual conference and speak on "Medi-Cal Care Coordination Initiative".

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	Assistant Deputy Director	Health Care Delivery Sys.

4. Verification

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

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.14.19 (month, day, year)

Comment:

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

Clear Page

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 North Capitol St., NW, Suite 267 (Address) Washington (City) DC (State) _____ (Zip Code)

NAMD's sole function is to represent and support the Medicaid Director's in 50 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

Washington, D.C. (Location of Travel) 11/11/2018 - 11/14/2018 (Dates (month, day, year))

Delta Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$624.18 Lodging Expenses | $110.00 Meal Expenses | $657.14 Transportation Expenses | $15.00 Other Expenses | $1,406.32 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 2018 Fall NAMD Meeting in Washington, DC

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	Assistant Deputy Director	Health Care Delivery Sys.

4. Verification

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

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.14.19 (month, day, year)

Comment:

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

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

Clear Page

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 California School Nurses Organizations (Name)

3511 Del Paso Rd #160 (Address) Sacramento (City) CA (State) 95835 (Zip Code)

CSNO's mission is to ensure that school nurses optimize student health and enhance learning.

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

Baltimore, Maryland (Location of Travel)

10/13/18 -10/17/18 (Dates (month, day, year))

Southwest (Transportation Provider)

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

Renaissance Harbor Place Hote (Name of Lodging Facility)

$873.20 Lodging Expenses | $116.00 Meal Expenses | $492.48 Transportation Expenses | $615.00 Other Expenses | $2,096.68 Total Expenses

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

_____ (Dates (month, day, year)) $ 0.00 (Total Expenses)

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

To attend the National Alliance for Medicaid in Education Annual Conference on October 14-17, 2018 in Baltimore, Maryland. The conference provides an opportunity for professional development with the latest information in research, experience, and best practices for Medicaid in Education.

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

Last Name	First Name	Position/Title	Department/Division
Lai	Betty	Medi-Cal Claims and Servi	DHCS/SNFD

4. Verification

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

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.14.19 (month, day, year)

Comment:

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

Clear Page

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 California School Nurses Organizations (Name)

3511 Del Paso Rd #160 (Address) | Sacramento (City) | CA (State) | 95835 (Zip Code)

CSNO's mission is to ensure that school nurses optimize student health and enhance learning.

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

Baltimore, Maryland (Location of Travel) | 10/13/18 - 10/17/18 (Dates (month, day, year))

Southwest (Transportation Provider)

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

Renaissance Harbor Place Hote (Name of Lodging Facility)

$873.20	$116.00	$543.57	$565.00	$2,097.77
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $ 0.00 (Total Expenses)

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

To attend the National Alliance for Medicaid in Education Annual Conference on October 14-17, 2018 in Baltimore, Maryland. The conference provides an opportunity for professional development with the latest information in research, experience, and best practices for Medicaid in Education.

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

Last Name	First Name	Position/Title	Department/Division
Garcia	Jose	Disproportionate Share Ho	DHCS/SNFD

4. Verification

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

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 1.14.19 (month, day, year)

Comment:

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

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

Clear Page

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 Center for Health Care Strategies (Name)

200 American Metro Blvd, Suite 119 (Address) Hamilton (City) NJ (State) 08619 (Zip Code)

To promote innovations in publicly financed health care, especially for individuals with complex, high-cost needs

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

Atlanta, GA (Location of Travel) 10/07/18 - 10/09/18 (Dates (month, day, year))

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

$391.80 (Lodging Expenses) $_____ (Meal Expenses) $498.60 (Transportation Expenses) $_____ (Other Expenses) $890.40 (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 an in-person meeting as a requirement for a technical assistance opportunity for the Centers for Disease Control and Prevention 6|18 initiative.

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

Last Name	First Name	Position/Title	Department/Division
Patel	Devki	Medical Consultant	DHCS/MCQMD

4. Verification

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

(Signature) Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.14.19 (month, day, year)

Comment:

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

Clear Page

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 Center for Health Care Strategies (Name)

200 American Metro Blvd, Suite 119 (Address) | Hamilton (City) | NJ (State) | 08619 (Zip Code)

To promote innovations in publicly financed health care, especially for individuals with complex, high-cost needs

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

Atlanta, GA (Location of Travel) | 10/07/18 - 10/09/18 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Courtyard Atlanta Decatur (Name of Lodging Facility)

$391.80	$	$498.60	$	$890.40
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 an in-person meeting as a requirement for a technical assistance opportunity for the Centers for Disease Control and Prevention 6|18 initiative.

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

Armendariz	Sydney	Health Program Specialist	DHCS/Benefits
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 1.16.19 (month, day, year)

Comment:

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

Clear Page

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: 01/22/19 (month, day, year)

2. Donor Name and Address

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

☑ Other CA Endowment & CA Health Care Foundatior (Name)

1414 K St, Ste 5000 (Address) Sacramento (City) CA (State) 95814 (Zip Code)

Promotes staff capacity in prevention, public health, the uninsured, health care delivery, access and related policy areas

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

San Diego, CA (Location of Travel) 11/10/18-11/14/18 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Hilton, San Diego (Name of Lodging Facility)

$1,181.40	$188.72	$269.66	$859.84	$2,499.62
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 American Public Health Association's 2018 Meeting and Conference in San Diego, CA.

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

Last Name	First Name	Position/Title	Department/Division
Lee	Patricia	Research Scientist, III	Office of the Medical Directo

4. Verification

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

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 2.14.19 (month, day, year)

Comment: Amended to reflect correct amount of total expenses.

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

Clear Page