Payment to	Agency	Report
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A Public Docu	ument
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Payment to Agency Repo	ort	A Public Do	cument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date Sta	mp	California 801
Department of Health Care						Form OUT
Division, Department, or Region (Tor Official Use Only
Administration Division, Hu Street Address	uman Resour	ces Branch				
P.O. Box 997411, MS 130	00					
Area Code/Phone Number Em					nt (ovolain i	n comment section)
(916) 552-8270	ConflictofInter	est@dhcs.ca.	gov			n comment section)
Agency Contact (name and title)				Date of Origin	al Filing: _	(month, day, year)
Conflict of Interest Filing C	Officer					
2. Donor Name and Address						
🗋 Individual			Other	National Ass		of Medicaid Directors
Last Name 444 North Capitol Street, Suite	First N 524	washington			D.C.	lame 20001
Address		City			State	Zip Code
NAMD's mission is to support N	ledicaid Directo	rs in administerin	g the progr	am in cost-eff	ective, e	fficient and visionary way
If "Other" is marked, describe the entity's busin	ness activity (if busine	ss) or its nature and inte	rests.			
If applicable, identi	fy the name of ea	ch source and the	amount(s) re	eceived by the i	tonor for t	his navment [.]
	ly the number of de		amount(o) h			
Name	\$	Amount		Name		\$ Amount
3. Payment Information (Com	-		3.2, 3.3)		NI 45	47.0047
3.1 (a) Travel Payment	Washington, D	.C.		_		-17, 2017 Dates (month, day, year)
Delta Air Lines						otel & Resorts
Transportation Provider	🗌 Rail	Check Applicable Box	—	o 🗌 Other		ame of Lodging Facility
¢ 676.90 \$ 93.0	00	¢ 658.00		78.32		<mark>ر</mark> 1,491.81
Description Descripti Description Description Description Description Descript	eal Expenses	 	enses Þ.	Other Expenses	_	Φ Total Expenses
3.1 (b) Payment(s) not related	to travel:					
			Dates (month, o	<i>,</i>		Total Expenses
3.2. Payment Description. Pro	ovide a specifi	c description of	the paymo	ent and its ag	jency pu	rpose and use.
To attend a joint meeting of improving accountability of held in Washington, DC.						
3.3. Identify the officials who	used the paym	ent in Section 3	5.1 (See instru	ctions)		
Brooks	Sarah	I	Deputy Dire	ector	Hea	Ith Care Delivery System
Last Name	First Name		Pos	ition/Title		Department/Division
Last Name	First Name		Pos	ition/Title		Department/Division
4. Verification I authorized the acceptance of the						



Payment	to Agency	Report
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PAYMENT TO AGENCY REPORT

· · · J · · · · · · · · · · · · · · · ·					F	ATMENT TO AGENCT REPORT
1. Agency Name				Date Sta	mp	
Department of Health Care Services						
Division, Department, or Reg	gion (if applicable)			1		For Official Use Only
Administration Division Street Address	<u>ו, Human Resou</u>	rces Branch				
P.O. Box 997411, MS	1300					
Area Code/Phone Number	Email				nt (ovplain in	comment section)
(916) 552-8270	ConflictofInte	rest@dhcs.ca.	qov			
Agency Contact (name and title			<u> </u>	Date of Origina	al Filing:	(month, day, year)
Conflict of Interest Filin	ng Officer					(,),)
2. Donor Name and Addre	SS					
🗌 Individual			Other	National Ass	ociation o	f Medicaid Directors
Last Name		Name	E other			ime
444 North Capitol Street, S Address	uite 524	Washington _{City}			D.C. State	20001 Zip Code
NAMD's mission is to supp	ort Modicaid Diract		a the progr	om in cost off		
If "Other" is marked, describe the entity			• • •		ective, en	ICIEITI AITU VISIOITALY WA
	5 business delivity (ii busine					
If applicable,	identify the name of ea	ach source and the	amount(s) re	eceived by the c	lonor for th	is payment:
	\$					\$
Name	•	Amount		Name		Amount
3. Payment Information (Complete Section	າs 3.1 (a or b), 3	3.2, 3.3)			
3.1 (a) Travel Payment	Washington, D	D.C.		_	Nov. 15-	17, 2017
	L	ocation of Travel				ites (month, day, year)
Delta Air Lines	Rail	🗹 Air 🛛 🗆 Bu	s 🗌 Auto	o 🗌 Other		tel & Resorts
Transportation Provider		Check Applicable Box			Na	me of Lodging Facility
\$ <u>676.90</u>	§ 93.00	\$658.00 Transportation Exp	4	78.32	_	\$
Lodging Expenses	Meal Expenses	Transportation Exp	enses	Other Expenses		Iotal Expenses
3.1 (b) Payment(s) not re	lated to travel:		Dates (month, o	tav vear)		Total Expenses
3.2. Payment Description	Provido a spocif		•			·
	-	-		_		-
To attend a joint meet improving accountabil held in Washington, D	ity of Medicaid o					
3.3. Identify the officials	who used the payr	ment in Section 3	3.1 (See instru	ctions)		
Brooks	Sarah	I	Deputy Dire	ctor	Heal	th Care Delivery System
Last Name	First Nam			ition/Title		Department/Division
Last Name	First Nam	ne <u> </u>	Pos	ition/Title		Department/Division
4. Verification						
I authorized the acceptance	e of the reported pay	yment(s) as in cor	mpliance wi	th FPPC regu	lations.	
				Deputy Direc		
Signature	<u> </u>	Print Name		Title		(month, day, year)

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



Payment	to Agency	Report
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A Public Docu	ument
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Payment to Agency	/ Report	A Public Do	cument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date Sta	amp	California 801
Department of Heal						Form OUT
Division, Department, or	0					T Of Official Ose Offiy
Administration Divis	sion, Human Reso	urces Branch				
P.O. Box 997411, N	VS 1300					
Area Code/Phone Numb					ant (ovelain	in comment section)
(916) 552-8270	ConflictofInte	erest@dhcs.ca.g	ov			in comment section)
Agency Contact (name and				Date of Origin	al Filing:	(month, day, year)
Conflict of Interest F	-iling Officer					
2. Donor Name and Ad	dress					
Individual			Other	National Ass		of Medicaid Directors
Last Name 444 North Capitol Stree		t Name Washington			D.C.	Name 20001
Address	-,	City			State	Zip Code
NAMD's mission is to se	upport Medicaid Direc	tors in administering	g the progr	am in cost-ef	fective, e	fficient and visionary way
If "Other" is marked, describe the	entity's business activity (if busi	iness) or its nature and inter	ests.			
If applicat	ole, identify the name of	each source and the a	amount(s) re	eceived by the	donor for t	this payment:
	, , ,			,		•
Name	\$	Amount		Name		\$Amount
3. Payment Information	n (Complete Sectio	ons 3.1 (a or b), 3	.2, 3.3)			
3.1 (a) Travel Payment	Washington,	D.C.		_		-17, 2017
		Location of Travel		-		Dates (month, day, year)
Delta Air Lines Transportation Provi	ider 🗌 Rail	Check Applicable Boxe	—	o ☐ Other		otel & Resorts lame of Lodging Facility
676.90	93.00	€ 658.00		78.32		_م 1,491.81
Lodging Expenses	⊅ Meal Expenses	⊅ Transportation Expe	nses Þ.	Other Expenses	;	Φ Total Expenses
3.1 (b) Payment(s) no	t related to travel:	-			s	
			Dates (month, o	<i></i>		Total Expenses
3.2. Payment Descript	tion. Provide a spec	ific description of	the paymo	ent and its ag	gency pu	irpose and use.
To attend a joint me improving accounta held in Washington	bility of Medicaid					
3.3. Identify the officia	als who used the pay	ment in Section 3	1 (See instru	ctions)		
Brooks	Sarah	D	eputy Dire	ctor	Hea	alth Care Delivery System
Last Name	First Na	me	Pos	ition/Title		Department/Division
Last Name	First Na	me	Pos	ition/Title		Department/Division
4. Verification						
I authorized the accepta	ince of the reported pa	ayment(s) as in com	pliance wi	th FPPC regu	lations.	



Payment	to Agency	Report
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A Public Docu	ument
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Payment to Agency	/ Report	A Public Do	cument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date Sta	amp	California 801
Department of Heal						Form OUT
Division, Department, or	0					T Of Official Ose Offiy
Administration Divis	sion, Human Reso	urces Branch				
P.O. Box 997411, N	VS 1300					
Area Code/Phone Numb					ant (ovelain	in comment section)
(916) 552-8270	ConflictofInte	erest@dhcs.ca.g	ov			in comment section)
Agency Contact (name and				Date of Origin	al Filing:	(month, day, year)
Conflict of Interest F	-iling Officer					
2. Donor Name and Ad	dress					
Individual			Other	National Ass		of Medicaid Directors
Last Name 444 North Capitol Stree		t Name Washington			D.C.	Name 20001
Address	-,	City			State	Zip Code
NAMD's mission is to se	upport Medicaid Direc	tors in administering	g the progr	am in cost-ef	fective, e	fficient and visionary way
If "Other" is marked, describe the	entity's business activity (if busi	iness) or its nature and inter	ests.			
If applicat	ole, identify the name of	each source and the a	amount(s) re	eceived by the	donor for t	this payment:
	, , ,			,		•
Name	\$	Amount		Name		\$Amount
3. Payment Information	n (Complete Sectio	ons 3.1 (a or b), 3	.2, 3.3)			
3.1 (a) Travel Payment	Washington,	D.C.		_		-17, 2017
		Location of Travel		-		Dates (month, day, year)
Delta Air Lines Transportation Provi	ider 🗌 Rail	Check Applicable Boxe	—	o ☐ Other		otel & Resorts lame of Lodging Facility
676.90	93.00	€ 658.00		78.32		_م 1,491.81
Lodging Expenses	⊅ Meal Expenses	⊅ Transportation Expe	nses Þ.	Other Expenses	;	Φ Total Expenses
3.1 (b) Payment(s) no	t related to travel:	-			s	
			Dates (month, o	<i></i>		Total Expenses
3.2. Payment Descript	tion. Provide a spec	ific description of	the paymo	ent and its ag	gency pu	irpose and use.
To attend a joint me improving accounta held in Washington	bility of Medicaid					
3.3. Identify the officia	als who used the pay	ment in Section 3	1 (See instru	ctions)		
Brooks	Sarah	D	eputy Dire	ctor	Hea	alth Care Delivery System
Last Name	First Na	me	Pos	ition/Title		Department/Division
Last Name	First Na	me	Pos	ition/Title		Department/Division
4. Verification						
I authorized the accepta	ince of the reported pa	ayment(s) as in com	pliance wi	th FPPC regu	lations.	



Payment	to Agency	Report
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A Public Docu	ument
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Payment to Agency	/ Report	A Public Do	cument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date Sta	amp	California 801
Department of Heal						Form OUT
Division, Department, or	0					T Of Official Ose Offiy
Administration Divis	sion, Human Reso	urces Branch				
P.O. Box 997411, M	VS 1300					
Area Code/Phone Numb					ant (ovalain	in comment section)
(916) 552-8270	ConflictofInte	erest@dhcs.ca.g	ov			in comment section)
Agency Contact (name and				Date of Origin	al Filing:	(month, day, year)
Conflict of Interest F	-iling Officer					
2. Donor Name and Ad	dress					
Individual			Other	National Ass		of Medicaid Directors
Last Name 444 North Capitol Stree		t Name Washington			D.C.	Name 20001
Address	-,	City			State	Zip Code
NAMD's mission is to se	upport Medicaid Direc	tors in administering	g the progr	am in cost-ef	fective, e	fficient and visionary way
If "Other" is marked, describe the	entity's business activity (if busi	iness) or its nature and inter	ests.			
If applicat	ole, identify the name of	each source and the a	amount(s) re	eceived by the	donor for t	this payment:
	, , ,			,		•
Name	\$	Amount		Name		\$Amount
3. Payment Information	n (Complete Sectio	ons 3.1 (a or b), 3	.2, 3.3)			
3.1 (a) Travel Payment	Washington,	D.C.		_		-17, 2017
		Location of Travel		-		Dates (month, day, year)
Delta Air Lines Transportation Provi	ider 🗌 Rail	Air Bus Check Applicable Boxe	—	o ☐ Other		otel & Resorts lame of Lodging Facility
676.90	93.00	€ 658.00		78.32		_م 1,491.81
Lodging Expenses	⊅ Meal Expenses	⊅ Transportation Expe	nses Þ.	Other Expenses	;	Φ Total Expenses
3.1 (b) Payment(s) no	t related to travel:	-			s	
			Dates (month, o	<i></i>		Total Expenses
3.2. Payment Descript	tion. Provide a spec	ific description of	the paymo	ent and its ag	gency pu	irpose and use.
To attend a joint me improving accounta held in Washington	bility of Medicaid					
3.3. Identify the officia	als who used the pay	ment in Section 3	1 (See instru	ctions)		
Brooks	Sarah	D	eputy Dire	ctor	Hea	alth Care Delivery System
Last Name	First Na	me	Pos	ition/Title		Department/Division
Last Name	First Na	me	Pos	ition/Title		Department/Division
4. Verification						
I authorized the accepta	ince of the reported pa	ayment(s) as in com	pliance wi	th FPPC regu	lations.	



Payment	to Agency	Report
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A Public Docu	ument
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Payment to Agency	/ Report	A Public Do	cument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date Sta	amp	California 801
Department of Heal						Form OUT
Division, Department, or	0					T Of Official Ose Offiy
Administration Divis	sion, Human Reso	urces Branch				
P.O. Box 997411, M	VS 1300					
Area Code/Phone Numb					ant (ovelain	in comment section)
(916) 552-8270	ConflictofInte	erest@dhcs.ca.g	ov			in comment section)
Agency Contact (name and				Date of Origin	al Filing:	(month, day, year)
Conflict of Interest F	-iling Officer					
2. Donor Name and Ad	dress					
Individual			Other	National Ass		of Medicaid Directors
Last Name 444 North Capitol Stree		t Name Washington			D.C.	Name 20001
Address	-,	City			State	Zip Code
NAMD's mission is to se	upport Medicaid Direc	tors in administering	g the progr	am in cost-ef	fective, e	fficient and visionary way
If "Other" is marked, describe the	entity's business activity (if busi	iness) or its nature and inter	ests.			
If applicat	ole, identify the name of	each source and the a	amount(s) re	eceived by the	donor for t	this payment:
	, , ,			,		•
Name	\$	Amount		Name		\$Amount
3. Payment Information	n (Complete Sectio	ons 3.1 (a or b), 3	.2, 3.3)			
3.1 (a) Travel Payment	Washington,	D.C.		_		-17, 2017
		Location of Travel		-		Dates (month, day, year)
Delta Air Lines Transportation Provi	ider 🗌 Rail	Air Bus Check Applicable Boxe	—	o ☐ Other		otel & Resorts lame of Lodging Facility
676.90	93.00	€ 658.00		78.32		_م 1,491.81
Lodging Expenses	⊅ Meal Expenses	⊅ Transportation Expe	nses Þ.	Other Expenses	;	Φ Total Expenses
3.1 (b) Payment(s) no	t related to travel:	-			s	
			Dates (month, o	<i></i>		Total Expenses
3.2. Payment Descript	tion. Provide a spec	ific description of	the paymo	ent and its ag	gency pu	irpose and use.
To attend a joint me improving accounta held in Washington	bility of Medicaid					
3.3. Identify the officia	als who used the pay	ment in Section 3	1 (See instru	ctions)		
Brooks	Sarah	D	eputy Dire	ctor	Hea	alth Care Delivery System
Last Name	First Na	me	Pos	ition/Title		Department/Division
Last Name	First Na	me	Pos	ition/Title		Department/Division
4. Verification						
I authorized the accepta	ince of the reported pa	ayment(s) as in com	pliance wi	th FPPC regu	lations.	



ayment to Agency R	eport A Public Docu	ment			PAYMENT TO AGENCY RE
. Agency Name			Date Sta	amp	California R
Department of Health			Form OU		
Division, Department, or Reg	gion (if applicable)				For Official Use Only
Administration Division	, Human Resources Branch				
Street Address					
P.O. Box 997411, MS	1300				
Area Code/Phone Number	Email			ent (explain i	n comment section)
(916) 552-8270	conflictofinterest@dhcs.ca.gov				
/			Date of Origin	al Filing: _	
Agency Contact (name and title) Conflict of Interest Filing Officer					(month, day, year)
Donor Name and Addre	255				
Individual		Other	National Ass	sociation	of Medicaid Director
Last Name	First Name	Other		Ν	lame
444 North Capitol Street, S	Suite 524 Washington			D.C.	20001
Address	City			State	Zip Code
NAMD's mission is to supp	ort Medicaid Directors in administering the	e progr	am in cost-ef	fective, et	fficient and visionary
If "Other" is marked, describe the entity	's business activity (if business) or its nature and interests.				
	identify the name of each source and the amo	unt(s) re	ceived by the	donor for t	his navment:
Name	\$ Amount		Name		\$ Amount
Payment Information (0	Complete Sections 3.1 (a or b), 3.2,	3.3)			
3.1 (a) Travel Payment	Washington, D.C.	- 1		Nov. 15	-17, 2017
	Location of Travel		-		ates (month, day, year)
Delta Air Lines				Omni H	otel & Resorts
	🗋 Rail 🛛 Air 🔄 Bus	🗌 Auto	o □ Other		

Transportation Prov	ider	Check Applicable Boxes		Name of Lodging Facility
\$ 676.90	\$ 93.00	\$ 658.00	\$ ^{78.32}	\$_ ^{1,491.81}
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
3.1 (b) Payment(s) no	t related to travel:		\$	
		Dates (n	nonth, day, year)	Total Expenses

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

To attend a joint meeting of NAMD and CMS entitled Outcomes and Evaluation Initiative aimed at improving accountability of Medicaid outcomes, and streaming regulatory or process requirements held in Washington, DC.

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

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

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

ORIGINAL ON FILE	Erika Sperbeck	Chief Deputy Director	
Signature	Print Name	Title	(month, day, year)
Comment:			

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



Payment to Agency R	eport	A Public D	ocument			PAYMENT TO AGENCY REPO
. Agency Name				Date Sta	mp	California 201
Department of Health Care	Services					Form OU
Division, Department, or Reg	Division, Department, or Region (if applicable)					For Official Use Only
Administration Division, Hu	man Resources Br	anch				
Street Address						
P.O. Box 997411, MS 1300)					
Area Code/Phone Number (916) 552-8270	Email ConflictofInterest	t@dhcs.ca.gov		Amendme	nt (explain i	n comment section)
Agency Contact (name and title) Conflict of Interest Filing Officer				Date of Origin	al Filing: _	(month, day, year)
. Donor Name and Addre)SS					
Individual Last Name	First	t Name	Other	National Ass		of Medicaid Directors
444 North Capitol Street, S		Washington			D.C.	20001
Address		City			State	Zip Code
If applicable, Name	identify the name of e	each source and th	e amount(s) re	eceived by the o	lonor for t	his payment: \$ Amount
. Payment Information (C	Complete Sectio	ns 3.1 (a or b).	3.2. 3.3)			
3.1 (a) Travel Payment	Washington, I	• •	, ,		Nov. 15	-17, 2017
		Location of Travel		_	C	Dates (month, day, year)
Delta Air Lines	Rail	🖸 Air 🔲 B	us □Auto	o ∏Other	Omni H	otel & Resorts
Transportation Provider		Check Applicable E	—		N	ame of Lodging Facility
\$ 676.90 Lodging Expenses	93.00 Meal Expenses	\$658.00	<u></u> .	78.32 Other Expenses	_	\$
3.1 (b) Payment(s) not re						
			Dates (month, o	· ·		Total Expenses
3.2. Payment Description	. Provide a speci	fic description	of the payme	ent and its ag	ency pu	

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

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

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

	Erika Sperbeck	Chief Deputy Director	
Signature	Print Name	Title	(month, day, year)
Comment:			
(Lise this space or an attachment	for any additional information)		

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



Payment to Agency Penert

Α	Pub	lic	Document	
• •				

Payment to Agency	Report	A Public Documen	t	PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	California 801
Department of Health Care Services				Form OUI
Division, Department, or Region (if applicable)				For Official Use Only
Administration Divisi	on, Human Resou	urces Branch	4	
P.O. Box 997411, M		ento, CA 95899-7411		
Area Code/Phone Numbe			Amendment (exp	plain in comment section)
(916) 552-8270		erest@dhcs.ca.gov	Date of Original Filir	a
Agency Contact (name and Conflict of Interest F				(month, day, year)
2. Donor Name and Add	Iress			
🗌 Individual		I Other	National Associat	ion of Medicaid Directors
Last Name 444 North Capitol Street		Washington	D.C	Name 20001
Address		City	State	Zip Code
NAMD's mission is to su	pport Medicaid Direct	tors in administering the prog	gram in cost-effective	e, efficient and visionary way
If "Other" is marked, describe the en	ntity's business activity (if busin	ness) or its nature and interests.		
If applicabl	e, identify the name of e	each source and the amount(s)	received by the donor	for this payment:
	¢			¢
Name	ψ	Amount	Name	Amount
3. Payment Information	(Complete Section	ns 3.1 (a or b), 3.2, 3.3)		
3.1 (a) Travel Payment	Washington, I		Nov	. 15-17, 2017
-		Location of Travel		Dates (month, day, year)
Delta Air Lines	🗋 Rail	🗹 Air 🔲 Bus 🗌 Au	to □Other Omr	ni Hotel & Resorts
Transportation Provid		Check Applicable Boxes	70.00	Name of Lodging Facility
\$ 676.90 Lodging Expenses	\$ Meal Expenses	\$ Transportation Expenses	578.32 Other Expenses	\$
3.1 (b) Payment(s) not		Transportation Expenses	Suiler Expenses	
5.1 (b) Fayment(s) not	related to travel.	Dates (month	· · · · · · · · · · · · · · · · · · ·	Total Expenses
3.2. Payment Descripti	on. Provide a speci	fic description of the payn	nent and its agency	v purpose and use.
-	pility of Medicaid c	d CMS entitled Outcom outcomes, and streamin		
3.3. Identify the official	s who used the pay	ment in Section 3.1 (See inst	ructions)	
Brooks	Sarah	Deputy Dir	rector	Health Care Delivery Syster
Last Name	First Nan	ne Po	sition/Title	Department/Division
Last Name	First Nar	ne Pc	psition/Title	Department/Division
4. Verification	ace of the reported pa	avment(s) as in compliance v	vith FPPC regulation	IS

ice of the reported payment(s) as in compliance with ²C regulations autition zeu ine accepia

ORIGINAL ON FILE	Erika Sperbeck	Chief Deputy Director	
Signature	Print Name	Title	(month, day, year)
Comment:			

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

