Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration, Human Resources Division

Street Address

PO Box 997411, MS 1300, Sacramento CA 95899-7411

Area Code/Phone Number: 916-552-8270

Email: ConflictOfinterestinquiry@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

Date Stamp

California Form 801

For Official Use Only

☐ **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 Street Ste 850 (Address) Sacramento (City) CA (State) 95814 (Zip Code)

CAHP is a non profit 501(c) statewide trade association representing public and private health care plans.

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

Palm Desert, CA (Location of Travel)

10/23/2023 - 10/24/2023 (Dates (month, day, year))

_____ (Transportation Provider)

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

Marriott Desert Springs Resort (Name of Lodging Facility)

$326.05 (Lodging Expenses) $_____ (Meal Expenses) $_____ (Transportation Expenses) $_____ (Other Expenses) $326.05 (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.

The official was invited to speak at the California Association of Health Plans Conference to present on the 2024 Managed Care Plan (MCP) Contract Highlights. Donor paid for lodging.

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

Last Name	First Name	Position/Title	Department/Division
Baass	Michelle	Director	Director's Office

4. Verification

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

[redacted] (Signature) Erika Sperbeck (Print Name) Chief Deputy Director (Title) 10/08/24 (month, day, year)

Comment:

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

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