

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
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 Other California Association of Health Plans
Last Name First Name Name
1415 L Street Ste 850 Sacramento CA 95814
Address City State Zip Code

CAHP is a non profit 501 (c)(6) statewide trade association representing public and private health care plans in CA.
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
9/29/2025 - 9/30/2025 Dates (month, day, year)
Rail Air Bus Auto Other JW Marriott Desert Springs Name of Lodging Facility
Check Applicable Boxes
\$342.01 Lodging Expenses \$ Meal Expenses \$ Transportation Expenses \$ Other Expenses \$342.01 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 CAHP Conference to provide updates on key Department of Health Care Services initiatives and preview priorities for 2026. Donor paid for lodging.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Baass Michelle Director DHCS/Director's Office
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.
Signature Erika Sperbeck Chief Deputy Director 10/27/25
Print Name Title (month, day, year)

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