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, 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

☐ **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)

601 New Jersey Avenue, NW Suite 740 (Address) | Washington (City) | D.C. (State) | 20001 (Zip Code)

NAMD addresses the myriad content areas and issues that impact Medicaid Directors and their teams.

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

National Harbor, MD (Location of Travel) | 11/18/2025 - 11/21/2025 (Dates (month, day, year))

Alaska Airlines; United Airlines (Transportation Provider)

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

Gaylord National Resort & Conv (Name of Lodging Facility)

$1,939.34	$	$743.78	$	$2,683.12
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.

Tyler has a scholarship with NAMD and was invited to collaborate on a wide variety of critical sessions on current and relevant topics. Donor paid for his airfare and all nights of lodging. Palav and Yingjia were invited to speak, and the donor covered one night of lodging for each.

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

Last Name	First Name	Position/Title	Department/Division
Sadwith	Tyler	State Medicaid Director	DHCS/Director's Office
Babaria	Palav	Deputy Director/CQMO	DHCS/Quality & Population

Huang, Yingjia; Deputy Director; DHCS/Health Care Benefits & Eligibility

4. Verification

I certify that I have reviewed this report and that to the best of my knowledge the reported payment(s) as in compliance with FPPC regulations.

[redacted]	Erika Sperbeck	Chief Deputy Director	01/30/26
Signature	Print Name	Title	(month, day, year)

Comment:

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

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