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 Academy Health (Name)

1666 K Street, NW, Suite 1100 (Address) Washington, (City) D.C. (State) 20006 (Zip Code)

Academy Health is a national organization for health services researchers, policymakers, practitioners, and stakeholders.

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) 11/16/2025 - 11/19/2025 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) The Alexandrian (Name of Lodging Facility)

$525.00 (Lodging Expenses) $_____ (Meal Expenses) $364.67 (Transportation Expenses) $110.00 (Other Expenses) $999.67 (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's participation was essential to stay informed on high-priority medical quality issues identified by the Centers for Medicare & Medicaid Services (CMS). Donor paid for transportation, conference fees, and lodging.

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

Last Name	First Name	Position/Title	Department/Division
Mark	Karen	Medical Director	DHCS/QPHM

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) 01/30/26 (month, day, year)

Comment:

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

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