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 Arcadia (Name)

77 Sleeper St. (Address) | Boston (City) | MA (State) | 02210 (Zip Code)

Healthcare data and analytics company specializing in population health management.

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

Las Vegas, NV (Location of Travel) | 10/14/2025 - 10/16/2025 (Dates (month, day, year))

United, Southwest (Transportation Provider)

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

Cosmopolitan of Las Vegas (Name of Lodging Facility)

$876.00	$340.00	$891.62	$1,750.00	$3,857.62
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.

The officials were invited to speak at the Arcadia "Aggregate" conference to improve the reach and effectiveness of the RSST algorithm, critical to the release of Medi-Cal Connect, AKA the Population Health Management Service. Donor paid for lodging, meals, transportation, and registration fees.

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

Last Name	First Name	Position/Title	Department/Division
Neighbor	Hope	Division Chief	DHCS/PHMD
n/a	n/a	Medical Consultant II	DHCS/PHMD

4. Verification

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

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

Comment:

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

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