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 Filling Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

■ Other America's Health Insurance Plans (Name)

601 Pennsylvania Ave NW South Bldg Ste 500 (Address) Washington (City) D.C. (State) 20008 (Zip Code)

AHIP represents health coverage providers and promotes market-based, public-private solutions for affordable care.

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)

03/23/2026 - 03/24/2026 (Dates (month, day, year))

United Airlines (Transportation Provider)

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

_____ (Name of Lodging Facility)

$_____ (Lodging Expenses) $59.00 (Meal Expenses) $1,058.00 (Transportation Expenses) $_____ (Other Expenses) $1,117.00 (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 present DHCS' progress in managed care oversight and enforcement at the Medicare, Medicaid, Duals and Commercial Markets Forum hosted by America's Health Insurance Plans. Donor paid for transportation and meals.

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

Last Name	First Name	Position/Title	Department/Division
Babaria	Palav	Deputy Director	DHCS/QPHM

4. Verification

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

[redacted] (Signature) Lindy Harrington (Print Name) Chief Deputy Director (Title) 04/27/26 (month, day, year)

Comment:

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

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