

Date: November 03, 2025
Time: 11:00 A.M.
Location: 50 Water Street, 17th Floor,
Boardroom – In Person

I. Call to Order

Freda Wang

Adoption of the October 14, 2025 Minutes

II. Financial Update

John Ulberg

III. Old Business

Freda Wang

IV. New Business

V. Adjournment

Finance Committee MEETING - October 14, 2025

As Reported By: Freda Wang

Committee Members Present: Mitchell Katz, MD, Freda Wang, José Pagán, Tricia Taitt, Sally Hernandez-Piñero, Karen St. Hilaire - representing Molly Wasow-Park in a voting capacity

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 11:29 a.m.

Ms. Wang noted for the record that Karen St. Hilaire is representing Molly Wasow-Park in a voting capacity.

Ms. Wang called for a motion to approve the July 16, 2025 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on July 16, 2025 were adopted.

Executive Session

Ms. Wang called for a motion to enter into an executive session to discuss confidential and privileged information, and quality assurance health information relating to particular patients and matters related to proposed or actual litigation.

Upon motion made and duly seconded the board convened an executive session.

The Board reconvened in public session at 12:03 p.m.

ACTION ITEM: Medicare and Medicaid Reimbursement Consulting Services

Ms. Linda DeHart - Vice President - Finance, read the resolution into the record and proceeded with the presented:

Authorizing New York City Health and Hospitals Corporation (the "System") to execute contracts with Third Party Reimbursement Solutions, LLC, Forvis Mazars, LLP, Baker Tilly Advisory Group, LP (formerly Moss Adams), and Manatt Health Strategies, LLC for Medicare and Medicaid Reimbursement Consulting services at a not to exceed amount of \$10,800,000, which includes a 20% contingency, for a contract term of three years and two one-year renewal options exercisable at the discretion of the System.

Ms. Linda Dehart began by providing the background and current state of Medicaid and Medicare Reimbursement Consulting Services. These essential services are used by healthcare systems to ensure compliance with complex and often changing regulations regarding Medicare and Medicaid reimbursement and reporting. Timely and accurate reporting submissions are required to avoid penalties and secure proper reimbursement for the System. Consultants in this space assist NYC Health + Hospitals in optimizing available reimbursement rates and settlements; and provide advice and assistance regarding supplemental funding streams available to the System. The RFP consolidated several previously separately solicited reimbursement scopes of work incorporating services directly contracted by the Reimbursement Department, as well as additional services related to Supplemental Medicaid and Consolidated Fiscal Report (CFR) submissions that were obtained through other departments. Consulting services procured through this RFP include the following scopes and sub-scopes of work; Medicare Reimbursement and Reporting Consulting, and Medicaid Reimbursement and State Reporting Consulting.

Ms. DeHart continued presenting the current state of Medicaid and Medicare Reimbursement Consulting Services. The Reimbursement Department previously entered into two agreements for Medicare related consulting services with Third Party Reimbursement, LLC for Medicare general reimbursement and cost reporting, and Moss Adams, now Baker Tilly, for Medicare DSH and Uncompensated Care consulting services. The combined final NTE for these two agreements is \$6,787,417 and spend to date is \$6,056,726. Additionally, since FY-21, \$2,791,590 has been spent on the Medicaid Supplemental payment and CFR consulting services scopes of work, which were obtained through other departments vendor agreements with Manatt Health Strategies, LLC and Forvis Mazars LLP.

An overview of the RFP criteria, procurement process, vendor selection and scopes of work were presented by Ms. DeHart. The System will negotiate contracts with the four top scoring proposers across all sub-scopes. The contracts will specify primary scopes of work for each vendor and will also provide flexibility for the System to assign vendors work in other scopes within their expertise as needed, subject to negotiation. The primary scopes of work for each of the vendors were presented.

The vendor performance evaluations for Third Party Reimbursement Solutions, LLC, Moss Adams LLP, now Baker Tilly Advisory Group, LP, Forvis Mazars, LLP, and Manatt Health Strategies, LLC were also presented and all deemed as excellent.

The MWBE analysis for the proposed vendor was presented by Ms. DeHart. The vendor diversity team recommended a 10% diverse vendor component percentage for this solicitation, while noting that most scopes of work under the RFP were likely to be self-performed by the proposing vendors. Manatt Health Strategies, Third Party Reimbursements and Moss Adams were granted waivers based on self-performance of the scope of work.

Ms. Wang polled the Committee for questions.

Ms. Hernandez-Piñero inquired on the vendor's scope of work and whether any of the vendors were able to do all the work or if there was an added advantage to having the work parsed out among them.

Ms. DeHart responded that we've combined a number of scopes into this RFP for the first time. Previously, these scopes of work were solicited separately, and it was with the anticipation that potentially, one vendor could take multiple scopes of work which we have as there are seven sub-scopes of work. Some of the vendors have more than one scope of work in this RFP. We received ten proposals and six of the proposals did bid on all sub-scopes. In the end, it was based on the scoring. There were vendors whose expertise stood out amongst other vendors and we wanted the best in class in each of the areas. We will continue to evaluate over time, and that is the reason we wanted to have flexibility in the contracts to parse some piece out and see how vendor do, and potentially in the future, we could further consolidate.

Ms. Hernandez-Piñero thanked the team.

Upon motion made and duly seconded, the Committee unanimously approved the resolution for consideration by the Board.

ACTION ITEM: Medical Respite Operations and Services NTE Amendment

Ms. Leora Jontef - Senior AVP - Housing + Real Estate, read the resolution into the record and proceeded with the presented:

Authorizing New York City Health and Hospitals Corporation (the "System") to increase the funding by \$10,896,459 for its previously executed agreements with each of Institute for Community Living, Inc. ("ICL") and Comunilife, Inc. ("Comunilife") for the provision of medical respite beds and services such that the funding is increased from \$17,960,500 to \$28,856,959 thereby funding the increasing capacity of the program from 51 beds to 75 beds.

Ms. Leora Jontef began by providing the background of Housing for Health. NYC H+H's Housing for Health connects patients experiencing homelessness with housing supports and opportunities in order to stabilize their lives

and improve their health. In 2024, over 80,000 H+H patients experienced homelessness or are marginally housed, and over 50% are also DHS clients. Medical Respite is one of H+H's strategies to provide transitional to permanent housing for its patients. These patients are medically and socially complex and Housing for Health provides an access point to housing from the healthcare System. Expediting this population into stable housing saves lives, improves health outcomes, and reduces expensive emergency health care and in-patient resources. On average, patients experiencing homelessness visited the Emergency Department three times more often than other patients. Patients experiencing homelessness were more likely to have an in-patient visit and stayed four times longer across their admissions. Through FY-25, over 3,000 patients and their families have benefited from Housing for Health's navigation and medical respite programming, and nearly 1,500 patient households have been stably housed.

Ms. Jontef presented the background and current state of Medical Respite Services. Patients experiencing homelessness have greater medical acuity and longer hospital stays. When medically cleared for discharge, they often cannot return to a shelter or street due to their post-surgical, medical and behavioral health needs. After a hospital stay, patients experiencing homelessness are more vulnerable. Medical respite provides a solution, offering a safe place in the community with access to home based clinical services. It is one of the System's initiatives focused on reduction of length of stay. Nationally, there are 240 medical respite programs delivering a range of services with the largest program in California. Almost 40% of H+H medical respite patients had a very high-risk flag, in the top 1% of acute care utilization in our System.

Medical Respite is an interim housing option with 24/7 staffing that allows patients to access additional services in the community to aide in their recuperation. These services include an onsite RN who conducts clinical assessments and monitor care plan, home based services with medication support and visiting nurse, and connections to longitudinal care, intensive housing case management, and medication support and education. H+H contracts with two vendors for both real estate and service delivery of combined 75 beds. Alongside other continuum of care services to tackle Length of Stay, including SNF placements, complex discharge escalation team and Bridge to Home. Over 400 patients have been served annually and approximately 1,600 patients serviced through September 2025. Lastly, the average Length of Stay at respite is 73 days.

An overview of the Medical Respite system and patient benefits was presented by Ms. Jontef. Medical Respite reduces in-patient Length of Stay for patients who no longer require hospitalization but could otherwise not safely discharge. Patients who are transferred to Medical Respite have an average in-patient LOS of 4 weeks. Medical Respite cost per bed day is many times lower than the cost of an in-patient acute bed and provides a more

appropriate setting for patient's recovery. Medical Respite facilities earlier discharge of patients who would otherwise have no alternative option. In addition, medical respite frees up hospital beds for new patient admissions. Based on a conservative estimate of avoided hospital stays, average of 14 days per respite enrollment, medical respite helps to increase in-patient med-surg throughput. The resulting backfill capacity is valued at approximately \$6 million in annual net patient care revenue, which supports the program's operating costs.

Based on EMR analysis, patients show reductions in acute care utilization and increase in connections to outpatient care one year after respite. With 40% reduction in Emergency Department visits, reduction in med/surg days about 75% and psych in-patient days - nearly 90%, and almost three times increase in out-patient visits with H+H primary and specialty care. There is a high rate of housing placement from respite. Nearly 70% of patients who complete the program and are eligible for housing subsidies are placed into permanent housing. Further evaluation of the impact is ongoing. Reducing acute care utilization for risk-attributed patients, Medical Respite can lower total medical expense, contributing to improved margins and potential shared-savings opportunities. Ongoing collaborations with MetroPlus and actuarial services to evaluate impact of respite and housing on patient outcomes utilizing claims data for our risk-attributed patients.

Ms. Jontef continued presenting Medical Respite Services and Meeting Program Demands. In 2024, the System experienced 4-week long waitlists for medical respite beds. It is critical that respite capacity meets System demand to minimize waitlists, avoidable bed days, worsening of capacity strain and missed revenue. To better address System demand, program capacity was increased from 51 to 75 beds with appropriate services to meet patients needs. We are closely monitoring impact of expansion to meet System demand to determine right-sizing of medical respite services for H+H. In order to meet System demand for remaining two years of the current 5-year contracts, additional funding is needed.

The vendor performance evaluations for Institute for Community Living, (ICL), and Comunilife were deemed as excellent.

Ms. Jontef continued by providing an overview of the vendor diversity. This procurement was only open to non-profit/community-based organizations. In terms of MWBE, Non-profit community-based organizations are exempt from the MWBE requirement.

Ms. Wang polled the committee for questions.

Ms. Hernandez-Piñero commended the team for the tremendous work in helping this population. We could not have anticipated all of these efforts. The ability to place formerly homeless people into permanent housing to provide needed medical attention We may be able to take this opportunity to look

at what has worked for other programs as well and look at different program's audits and see what has been most productive.

Ms. Jontef responded that we are working closely with Finance looking at the actuarial savings, and in terms of operational savings, we keep optimizing ways of being more efficient in taking referrals from the System, where are intake points for housing navigation services and how can we work more closely with people who are in-patient as well as people that are getting referred to us from the out-patient safety net clinics. We continue to fine tune our operations and also continue to work closely with our sister agencies. We work very closely with DSS, HPD, HRA, DHS and those are the kinds of things that we continue to evolve.

Ms. Taitt commended the team for the amazing efforts and inquire on the cost per bed.

Ms. Jontef responded that when we signed the contract in 2022 the cost was a bit under \$200 per day. We anticipated for the last two years that it would be \$250 per bed per day. There have been a couple of things driving that change, real estate costs have been going up over time and we have had patients that are sicker. For which we have had to ask our vendors to add more clinical supports on site. Initially we did not require an onsite RN and things like that have been adding more to the services on site. For the last two years, it should be around \$250 per bed per day. The beds in the first three years were a bit less.

Ms. Taitt continued, the calculation is higher than this at about \$350, do we know where is the differential?

Ms. Jontef responded that we have a calculation at \$250 for the last two years and would have to go back and check as that is what we are anticipating for our budget. Part of it also is that we have not yet spent down the original 2022 contract. We are at a point for December 1st to exercise our two one-year options and the prudent thing to do is come to the board prior to exercising that option to make sure that we are getting the last two years fully funded. So, there is still residual money rolling into it, about 30% of the 4th year but in order to exercise our option, we needed to properly come to the board and ask for the full amount. We are happy to look at it again after and we can correspond to make sure that the amounts match.

Mr. Ulberg added as a comparison point, that the same person may be in the hospital for \$2,000 a day. So that is the savings we are trying to pick up. In addition, the patient does not really need to be in the hospital so we

are just trying to find another safer location to transition for them. That is the actuarial analysis that we are going to do. We are studying this carefully.

Ms. Wang added that the results in backfill capacity is valued at approximately \$6 million and asked if that is a gross approximation of the fees?

Ms. Jontef responded that these fees are on a very conservative approach, anticipating backfill revenue for opening up the beds. It is not even the cost savings from the patients themselves. There also savings in terms of the patient population that we know already that are coming to the ED less frequently. We know that they are having shorter in-patient stays, and so that alone has other savings. Our Finance team is working on that and we just did a very conservative estimate to say that the backfill revenue alone annually should be sufficient to cover annual cost for the program and we feel good with that conservative estimate.

Dr. Katz added that the team is bringing this RFP today with the higher amount, solving the possibility of an NTE problem for a successful program. We are all very happy that they are growing. This RFP was brought ahead of time so that the committee can approve an increase, so this is part of that. The real goal is to be able to demonstrate the reason why for some population Medicaid should pay. We get paid \$2,000 per day, not the \$250. One of the things that is critical on the financial analysis is whose money are we talking about. This is not necessarily saving us money. It is saving the System money. Now, there are exceptions, in case someone does not have a payor, if someone comes in and no longer has an approved day pay, it is all sorts of different levels on which this program works. Someone could be undocumented and, in our hospital, in that case maybe it is a huge savings but the real goal here is to say in the analysis that you are not even necessarily proving that the whole program saves for Medicaid as most Medicaid programs have eligibility. People for whom the program saves money are people in these categories, even if the whole program did not save Medicaid money we could imagine ultimately what we would want to do which is to be able to go to the State and say this is a program to decrease hospital expenses, but we have to be able to show them in the analysis. There is a whole pool analysis.

Also, when we look at the data in a granular way, the real savings comes if the person is over 50 and they have more than three conditions. Imagine how that leads to an eligibility requirement under Medicaid that Medicaid will pay for this. It is incredibly exciting. One of the groups had just released a very lengthy report about the success of Respite and what we

think is the special ingredient is flexibility. That is how respite is in some ways different than a phenomenal program for pregnant women with opioid use. This is a program that works pretty much for everybody, all comers who are stuck at the hospital. It begins with what does the client need and it really meets our patients where they are. That is our success and the success of the team.

Ms. Hernandez-Piñero added that the 70% placement rate is extraordinary, and inquired, do we think that this is because of the treatment while in respite? or do we get patients who are healthier when they come into the program?

Ms. Jontef responded that the 70% of the people who are eligible for supportive housing is quite complex. We have very responsible partners who have housing portfolios, which has helped. Also, good collaboration with our sister agencies. Nobody wants people who have spent four weeks in the hospital who are typically vulnerable, and then 70 more days recovering at respite, so really return to shelter. We have invested so much time and effort, and there is a collective understanding with our colleagues, that this is the right path. We have had very flexible partners, but it is administratively intensive to move someone from any spot into supportive housing and most people are 100% going to supportive housing.

Ms. Wang added that there is a lot of interest from the committee to see the actual study and the reports to the State for coverage and reimbursement or all of those things. It is a wonderful program and clearly the statistics provided are prove that the value, the need and the success, and thanked the team for getting ahead of the NTE, as that is something the board have been very focused on and it is very appreciated.

Mr. Pagán commented on the quality of life side, if we are able to capture quality of life or measures around that, not just a financial calculation, you will make even a stronger case that this is important for this patient population. Mr. Pagán and Ms. Wang thanked the team for the presentation.

Ms. Taitt asked if the total \$28 million, is it increasing the funding for the current amount of the contract or the NTE?

Ms. Wang clarified that we were at risk of violating the prior not to exceed of the contract so we are increasing the current amount of the contract by \$10.896M for a new not to exceed of \$28.856 million.

Upon motion made and duly seconded, the Committee unanimously approved the resolution for consideration by the Board.

FINANCIAL UPDATE

Mr. Ulberg opened the presentation with the FY-25 Year-End Highlights. He conveyed that June closed with \$649.9 million (20 days cash-on-hand). The budget overperformed by 0.5% and closed June with a positive Net Budget Variance of \$103.3 million.

Mr. Ulberg continued that receipts exceeded budget by \$337 million primarily driven by Patient Care and Risk Revenue. Disbursements exceeded budget by \$234 million, which includes expenses associated with Medical/Surgical supplies, Assets, and PS/Overtime coverage, non-model expense and fringe.

Direct Patient Care Receipts (IP and OP) came in \$959.5 million higher than the same period in FY-24 due to continued increases in IP and OP services in FY-25 (OP visits up 3.0% and IP discharges up 1.4% from FY-24), UPL Conversion, Medicaid rate increases and residual/secondary billing from Change Health Care (CHC) billing delays from prior year.

IP Patient care volume in FY-25 has surpassed FY-20 pre-COVID levels with IP discharges up by 2.5%, and OP visits up by 17%. Revenue base remains strong and resilient primarily driven by returning volume and higher average collectability rate over the base. Compared to last year, Risk Pool performance decreased slightly, however, it continues to perform better than pre-COVID levels - bringing in \$634 million in receipts in FY-25, 76% better than FY-19.

Mr. Ulberg provided an overview of FY-25 Accomplishments and the journey we have been on. Direct Patient Care Revenue surpassed \$5.7 billion - an increase of over \$2.5 billion from FY-19. Durable growth in IP census and unique primary care patients, surpassing pre-COVID levels; Increased MetroPlus membership to current level of 691,000, 175,000 members above pre-pandemic levels. H+H facilities filled up the Top 10 Healthfirst Network for Overall Quality Rating. Earned top clinical quality scores in NYC through value based managed care contracts with MetroPlus and Healthfirst. Increased engagement with patients through our Epic electronic medical records (EMR) system with over 85% patients empaneled to NYC H+H primary care with activations in our MyChart system. Our Strategic Financial initiatives generated over \$1.3 billion against the FY-25 target of \$1.2B. Several areas of strong Q4 performance were noted.

Mr. Ulberg continued by presenting an overview of the FY-26 Keys to success strategies for managing volume and raising revenue targets. FY-26 requires continued revenue generation to meet the commitments we have made to invest in our staff, our facilities, and our communities. Several areas of focus include raising the bar in managed care and revenue cycle targets. While at the same time targeting our patient access to make it more accessible for patients. Expanding our cross-facility partnerships and shared

services; further integrating productivity expectations into Physician workforce planning. Managing increasing demand by length of stay reduction investments, and infrastructure investments. MetroPlusHealth membership - Gold enrollment push for City workers, and getting the right plan for the right patient. Continued effort of stabilizing our workforce across the system to provide quality care to our patients by building new staffing models in areas where they do not yet exist, and developing glidepath solutions for overtime spending.

Mr. Cassidy continued presenting the cash projections for FY-26. The System is estimated to close September with approximately \$535 million (17 days cash-on-hand) and expects to close October with approximately \$500 million (16 days cash-on-hand). We continue to work closely with the City on our remaining liabilities due to them as we continue to closely monitor our cash position.

Mr. Ulberg continued presenting the external risks. Several areas of focus include Essential Plan changes, Medicaid Work requirements and other Medicaid enrollment barriers starting in Jan. 2027 which continue to present a financial challenge. The HMO Tax presents a low risk to H+H, and the Government Shutdown impact presenting a minimal immediate impact to Medicare and Medicaid. DSH cuts are technically underway; possible further delay under discussion. Further, the Average Commercial Rate (ACR) State Directed Payment (SDP) benchmark presents an opportunity to H+H as CMS approval received for Year 1 and awaiting information on application for Year 2.

Ms. Wang polled the Committee for questions. There being no further questions, Ms. Wang thanked the team and noted that due to time constraints a meeting will be set in November to finalize the Finance Committee presentation.

ADJOURNMENT

There being no further business to bring before this committee, the meeting adjourned at 12:38 P.M.

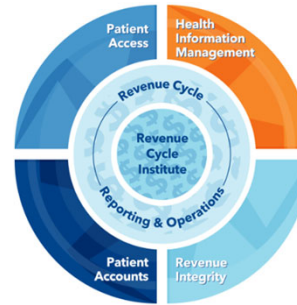


NYC Health + Hospitals
Finance Committee Meeting
November 3, 2025

Revenue Cycle



FY25 Revenue Cycle Accomplishments Drove \$309 Million in *Incremental* Revenue (>\$2 Billion in 5 years)



**Revenue Cycle Initiatives
Generated *Total* of \$760 Million in
FY 2025**

**Newly designed Intranet Site:
[Revenue Cycle Services](#)**

- ✓ Improved overall financial counseling performance generating **\$202 million**
- ✓ **CDI improvements generated \$171 million**
- ✓ Reduced AR days by **31%**, accelerating **>\$50 million**
- ✓ **No Claim Left Behind Initiative generated \$14 million based on reduction in write-offs**
- ✓ **14,210 class completions (Instructor led & eLearning combined), including 382 Graduates from the RC-New Employee Onboarding Program**
- ✓ **Focus on DRG Validation and Downgrade appeals yielded >\$10 million**
- ✓ Developed internal process to review payment variances, **saving over \$3 million** in vendor fees.
- ✓ **Led initiative to reduce provider's open charts by 58%, generating >\$8.4 million**
- ✓ RC-Quality Assurance team audited **9,300** accounts for 1,465 individuals
- ✓ **One Stop Benefits expanded from a pilot to the full telephonic team and has screened over 7,000 patients and completed referrals/applications for over 10,000 benefits.**
- ✓ Developed and deployed AI UM screening tool to reduce inpatient medical necessity denials

LOOKING AHEAD

- Facilitate implementation of best practice workflows to uniformly achieve H+H best practice metrics at all facilities; journey toward Epic best practice
- Redesign financial counseling process incorporating AI to handle anticipated increase in Medicaid redeterminations

H+H Targeting Best Practice Revenue Cycle

Identified improvement in standardizing individual facility performance to internal best practices

- Selected 8 Metrics, identifying H+H Best Practice
 - AR Days
 - Insurance Net Collection %
 - Eligibility Denial Rate
 - Authorization Denial Rate
 - Financial Counseling Screen Rate
 - Primary Care PCP Alignment Rate
 - Coding Lag
 - DRG Downgrades
- Calculated opportunity if facilities achieve internal best practice; *\$54 Million in FY 26 budget growing to \$187 Million in FY 27*
- Facilities implementing standard work and creating initiatives to achieve targets

FY26

VBP Update

- Since 2013 NYC Health + Hospitals Accountable Care Organization (ACO) has participated in the Medicare Shared Savings Program (MSSP) run by the Center for Medicare and Medicaid Services (CMS).
-
- As of 2025 there are 476 ACOs that participate nationwide, of which 13 are from New York State.
 - Goal of program is to manage the care of attributed patients with Traditional Medicare coverage (Parts A&B) and savings achieved by the MSSP are then shared back to the ACO.
 - The NYC H+H ACO has about 5,400 patients managed by:
 - Doctors practicing primary care at NYC H+H (96% of ACO)
 - Remaining doctors are affiliated with the federally qualified health center Community Healthcare Network.
 - Since 2019 the NYC H+H ACO has held an ENHANCED track contract (two-sided risk) with CMS whereby the ACO is taking the greatest amount of risk (75% of program savings).

NYC H+H Medicare Shared Savings ACO

CMS recently announced that our MSSP ACO has achieved twelve consecutive years of shared savings, earning \$7.2M in 2024.

	PY 2019 (Jul-Dec)	PY 2020	PY 2021	PY 2022	PY 2023	PY 2024
Savings to Medicare (\$)	4,456,171	15,712,618	5,451,716	10,907,994	8,314,840	9,811,908
Quality Score (%)	92.17	96.87	79.54*	74.65*	80.92*	78.06*
Earned Performance Payment (\$)	3,080,377	11,415,300	4,007,011	8,017,376	6,111,407	7,211,752

Total Savings and Earned Performance Payment since inception (2013-2024):

- Total Savings to Medicare: **\$101,798,649**
- Total Earned Performance Payment: **\$60,457,412**

* New ACO Quality Scoring Methodology



NYC Health + Hospitals participates in several Value Based Payment (VBP) programs with payers in the NYC market

	# of Years in Program	Members Enrolled as of Aug 2025	Upside and Downside Risk?	Shared Savings Earned in 2024	Quality Incentive Payments
MetroPlus	23	368,677	Y	\$332 million	\$13.6 million (2023)
Healthfirst	22	176,231	Y	\$83.8 million	\$14.8 million (2024)
MSSP	13	5,469	Y	\$7.2 million	<i>Embedded in shared savings</i>
Fidelis	5	9,338	<i>Limited</i>	TBD (likely \$1 million)	<i>Embedded in shared savings</i>
TOTAL		559,715		\$424 million	\$28.4 million

Value Based Programs reward NYC H+H for investing in preventative outreach and care coordination (*translation: better care for patients*) by compensating for quality outcomes.

As the NYC H+H Managed Care team continues to advance the VBP portfolio, there are also key strategic initiatives owned by Managed Care that drive significant revenue.

	Strategic Initiatives- Managed Care Performance				
	<u>FY21</u>	<u>FY22</u>	<u>FY23</u>	<u>FY24</u>	<u>FY25</u>
Negotiations, Settlements and Outliers	\$114M	\$178M	\$292M	\$379M	\$495M

Here is a quick snapshot of some financial wins negotiated with our contracted insurance plans:

New revenue streams	Direct contracts with employer groups	Settling claims issues
As of FY25, all 7 NYC Medicaid plans are now contractually obligated to reimburse additional revenue to H+H for encounters that qualify for high cost outliers, generating more than \$100M annually for NYC H+H.	Since 2022 NYC H+H has held a contract with a large NYC union as a preferred provider of bariatric surgery procedures for employees that the union refers to H+H. Initial successes (76 surgeries) have led to continued conversations for expanding to additional service areas.	• In FY25 H+H concluded a multi-year settlement with a payer on 2020-21 encounters (mostly outpatient) worth over \$16M. • Mis-adjudication of COVID test claims was settled through a rate increase with a different payer, which will yield compounding value over time.

City Initiatives:

Humanitarian Emergency Response and Relief Centers (HERRC)

HERRC Program Highlights

HERRC Overview

- ☐ Provided temporary shelter and services to 140,000+ asylum seekers, including 40,000 children.
- ☐ At peak, operated 16 humanitarian centers housing 25,000+ people, approximately three quarters of whom were families with children.
- ☐ Delivered over 40 million culturally-relevant, Halal-certified meals.
- ☐ Distributed over 10 million baby wipes, 2.6 million diapers, 700,000 formula bottles & baby food jars.

NYC Arrival Center

- ☐ Provided services to 155,000 individuals from 160+ countries, 60+ languages.
- ☐ Managed more than 300,000 visits from May 2023 to June 2025.
- ☐ Coordinated arrivals of asylum seekers received from 800+ buses and 7 planes.
- ☐ Provided over 100,000 vaccinations (majority to children entering schools).

HERRC Program Highlights

HERRC Case Management Program

- ☐ Conducted approximately 1 million case management meetings.
- ☐ Reached 99% of humanitarian center guests with ongoing support.
- ☐ Helped asylum seekers complete over 111,000 work authorization, TPS, and asylum applications.
- ☐ 90%+ of eligible adults applied for or received work authorization.

Case Management Community Advisory Board (CAB)

- ☐ Launched in April 2023 with ~30 community organizations.
- ☐ Informed case management workflows to better meet asylum seekers' needs.
- ☐ Connected asylum seekers to legal services, resource fairs, job fairs.
- ☐ Strengthened collaboration with immigrant, refugee, and homeless service orgs.
- ☐ Ensured services were responsive, community-informed, and effective.

HERRC Financial Overview

- ❑ H+H currently oversees 1 H+H HERRC site serving ~3,000 daily guests.
- ❑ H+H committed \$868M of HERRC expenses in FY25 Q1-Q4 on behalf of the City.
- ❑ The City has allocated the following to H+H HERRC in the City FY26 Adopt Plan:

Fiscal Year	FY25	FY26
Total	\$960.2M	\$76.4M

- ❑ OMB has provided H+H with revenue to cover committed expenses to date through the HERRC MOU with the Mayor's Office.

2025 Bond Issuance Update

2025 Series A Bonds Financing Summary

- On August 27, 2025, NYC H+H issued \$242.85 million tax-exempt fixed rate Health System Bonds.
- Bond proceeds provided \$250 million of capital project fund, with the remainder to finance the capital reserve and costs of issuance. Thus far, \$30.2 million has been drawn for various capital projects.
- The 2025A bonds were well received with strong subscription from retail and institutional accounts, 37 accounts participated in the order period, leading to oversubscription in all maturities.

Financing Statistics

2025 Financing			
Assumptions		Financing Statistics (\$000s)	
Dated/Delivery Date	8/27/2025	Interest Rate Adjusted for Cost (All-In TIC)	4.296%
Call Date	8/15/2034	Average Life (Yrs)	11.952
Final Maturity	2/15/2042	Weighted Avg Maturity (Yrs)	11.861
Structure	Wrapped		
		Total Interest	145,129
		Total Debt Service	387,979
Sources (\$000s)			
Par Amount	242,850	Maximum Annual Debt Service	29,239
Original Issue Premium	17,877	Average Annual Debt Service	23,561
Total Sources	260,727	Ratings (Moody's/S&P/Fitch)	Aa3 / A+ / AA-
Uses (\$000s)			
Project Fund	250,000		
Capital Reserve Fund	8,497		
Cost of Issuance	2,230		
Total Uses	260,727		

NEW ISSUE Book-Entry Only

In the opinion of Hawkins Delafield & Wood LLP, Co-Bond Counsel to the Corporation, under existing statutes and court decisions and assuming continuing compliance with certain tax covenants described herein, (i) interest on the 2025 Series Bonds is excluded from gross income for federal income tax purposes pursuant to Section 103 of the Internal Revenue Code of 1986, as amended (the "Code"), and (ii) interest on the 2025 Series Bonds is not treated as a preference item in calculating the alternative minimum tax under the Code, however, interest on the 2025 Series Bonds is included in the "adjusted financial statement income" of certain corporations that are subject to the alternative minimum tax under Section 55 of the Code. In addition, Hawkins Delafield & Wood LLP and Bryant Rabbino LLP, Co-Bond Counsel to the Corporation, are of the opinion that, under existing law, interest on the 2025 Series Bonds is exempt from personal income taxes imposed by the State of New York or any political subdivision thereof, including The City of New York. See "TAX MATTERS" herein.

RATINGS: See "RATINGS" herein.



\$242,850,000
NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION
Health System Bonds
2025 Series A

Dated: Date of Delivery

Due: February 15, as shown on the inside cover

The New York City Health and Hospitals Corporation Health System Bonds, 2025 Series A (the "2025 Series Bonds") are general obligations of the New York City Health and Hospitals Corporation (the "Corporation"), a public benefit corporation established pursuant to the laws of the State of New York (the "State"), secured by a pledge of (i) Health Care Reimbursement Revenues and (ii) the amounts on deposit in certain funds and accounts established under the Resolution (as defined herein), including the Capital Reserve Fund, all as described herein. See "SECURITY AND SOURCES OF PAYMENT FOR THE 2025 SERIES BONDS" herein.

The 2025 Series Bonds are issuable only as fully registered bonds without coupons, and when issued, will be registered in the name of and held by Cede & Co., as nominee for The Depository Trust Company, New York, New York. So long as Cede & Co. is the registered owner of the 2025 Series Bonds, principal, premium, if any, and interest payments on the 2025 Series Bonds will be made by Manufacturers and Traders Trust Company, as trustee (the "Bond Trustee") to Cede & Co., which in turn will remit such payments to the DTC Participants and DTC Indirect Participants for subsequent disbursement to the beneficial owners of the 2025 Series Bonds. Purchases of the 2025 Series Bonds will be made in book-entry form only and individual purchasers will not receive physical delivery of bond certificates representing their beneficial interest in the 2025 Series Bonds. So long as Cede & Co. is the registered owner of the 2025 Series Bonds, references herein to the holders or registered owners of the 2025 Series Bonds shall mean Cede & Co. and shall not mean the beneficial owners of the 2025 Series Bonds. See "THE 2025 SERIES BONDS - Book-Entry-Only System" herein.

The 2025 Series Bonds will be issued in denominations of \$5,000 or any whole multiple thereof. Interest on the 2025 Series Bonds will be payable semiannually on each February 15 and August 15, commencing February 15, 2026.

The 2025 Series Bonds are subject to redemption prior to maturity as more fully described herein. See "THE 2025 SERIES BONDS - Redemption" herein.

Proceeds of the 2025 Series Bonds will be used to (i) finance, refinance and reimburse the Corporation for the costs of various capital projects and expenditures at the Corporation's facilities, (ii) fund a Capital Reserve Fund and (iii) pay costs of issuance of the 2025 Series Bonds.

The 2025 Series Bonds will not be a debt of the State or of The City of New York (the "City"), and neither the State nor the City shall be liable thereon, nor shall they be payable out of any funds other than those of the Corporation or its wholly-owned subsidiary, HHC Capital Corporation (which collects certain revenues on the Corporation's behalf). Neither the Corporation nor HHC Capital Corporation has any taxing power.

AN INVESTMENT IN THE 2025 SERIES BONDS INVOLVES A DEGREE OF RISK. A PROSPECTIVE INVESTOR IS ADVISED TO READ THE ENTIRE OFFICIAL STATEMENT, INCLUDING THE APPENDICES HERETO. SPECIAL REFERENCE IS MADE TO THE SECTIONS ENTITLED "SECURITY AND SOURCES OF PAYMENT FOR THE 2025 SERIES BONDS" AND "BONDHOLDERS' RISKS" HEREIN FOR A DISCUSSION OF CERTAIN RISK FACTORS WHICH SHOULD BE CONSIDERED IN CONNECTION WITH AN INVESTMENT IN THE 2025 SERIES BONDS.

The 2025 Series Bonds are offered when, as, and if issued, and subject to the approval of legality by Hawkins Delafield & Wood LLP, New York, New York, and Bryant Rabbino LLP, New York, New York, as Co-Bond Counsel to the Corporation, and to certain other conditions. In connection with the issuance of the 2025 Series Bonds, certain legal matters will be passed upon for the Corporation by the Corporation's General Counsel and for the Underwriters by their counsel, Katten Muchin Rosenman LLP, New York, New York. It is expected that the 2025 Series Bonds will be available for delivery to DTC in New York, New York on or about August 27, 2025.

BofA Securities	J.P. Morgan	Jefferies
Morgan Stanley		Ramirez & Co., Inc.
Academy Securities, Inc.	AmeriVet Securities, Inc.	Bancroft Capital, LLC
Barclays	Blaylock Van, LLC	BNY Mellon Capital Markets, LLC
Cabrera Capital Markets LLC	Essex Securities LLC	Janney Montgomery Scott
Loop Capital Markets	Mischler Financial Group, Inc.	Raymond James
Rockflect	Roosevelt & Cross Incorporated	Stern Brothers & Co.
TD Securities		Wells Fargo Securities

Dated: August 12, 2025