FINANCE COMMITTEE AGENDA

Date: March 9, 2026
Time: 11:00 A.M.
Location: 50 Water Street, 17th Floor,
Boardroom – In Person

I. Call to Order *Freda Wang*
Adoption of the January 12, 2026 Minutes

II. Financial Update *John Ulberg*

III. Old Business Freda Wang

IV. New Business

V. Adjournment

Finance Committee MEETING – January 12, 2026

As Reported By: Freda Wang

Committee Members Present: Mitchell Katz, MD, Freda Wang, Patricia Marthone

Executive Session

The Board entered 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.

The Board convened an executive session at 10:38 a.m.

The Board reconvened in public session at 11:27 a.m.

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 11:27 a.m.

Ms. Wang called for a motion to approve the November 3, 2025 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on November 3, 2025 were adopted.

ACTION ITEM: 2026 Interim Bond Financing Related to Maimonides

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 "Corporation") to incur indebtedness in the maximum aggregate principal amount not to exceed $200,000,000 for the retirement of certain outstanding bonds of Maimonides Medical Center in connection with the transfer of certain assets of Maimonides Health Resources, Inc.("MHRI") and its subsidiaries and affiliates to New York City Health and Hospitals Corporation.**

Ms. Linda Dehart began by providing the current state of the Maimonides transaction. In November 2025, the Board unanimously voted to allow Health + Hospitals to enter into an Affiliation and Asset Transfer Agreement (ATA) with Maimonides and to take appropriate actions to advance the contemplated transaction. The anticipated "Close" date for the transaction is March 31, 2026. Subsequently, in December 2025, the Board approved creation of two

subsidiary public benefit corporations to hold the assets and liabilities of the Maimonides and Midwood Hospitals. The hospital had existing bond debt issued by Maimonides must be defeased at or prior to the Close. There are two reasons NYC H+H is not able to take on this debt into the corporation as is. First, subsidiaries of H+H cannot issue debt or hold debt, and second, the Maimonides bond covenants conflict with H+H's bond covenants.

Ms. DeHart continued by presenting the Maimonides Bond Debt background. The existing debt issued by Maimonides is estimated at $166 million that is required to defease outstanding bonds from two series. These series are the Series 2013 Bonds with approximately $38 million outstanding and a final maturity of March 2032, currently callable; and Series 2020 Bonds with approximately $127 million outstanding and an expected final maturity of August 2048, not callable until August 2027, respectively. Both of these bonds are insured by an FHA mortgage.

An overview of the bond defeasance strategy was presented by Mr. Thomas Tran. NYC H+H's short-term borrowing strategy is to defease the Maimonides outstanding bond debt through interim loans at, or prior to, the Maimonides transaction Close. The interim loan structure consists of the revenue pledge to be used is subordinate to the H+H bonds issued under the General Bond Resolution. The term of the loan is between 18 to 24 months and is contingent on the completion of the Maimonides transaction. Sometime after the Close, the next step is permanent financing by issuance of H+H bonds to retire the interim loans. NYC H+H anticipates refunding of the interim loans in 2027 to coincide with the next H+H new money financing. Lastly, this debt is a tax-exempt acquisition financing. A chart providing the current timeline and milestones of the loan was also presented.

Mr. Tran continued the presentation by providing the interim loan bank selection. H+H Debt Finance solicited proposals from banks for interim loans up to $200 million under a number of scenarios, including varying maturities, fixed or variable rates, and tax-exempt and taxable structures. H+H received four responses and selected TD Bank based on best rates and terms. A chart providing TD Bank Credit Rating was presented. TD Bank currently provides letter of credit for Series 2008BC and remarketing services for Series 2008CE variable rate bonds. Examples of indicative interest rates for a term of two years were also presented.

The next steps in the interim loan financing include Debt Finance to continue working with H+H's financial advisor and bond counsel to finalize financing plan and negotiate terms for the loan. Additional requirements related to the transaction include appraisal of Maimonides assets to be transferred required for tax-exempt acquisition financing, finalizing loan sizing and structure, and defeasance process that will require work with Maimonides, DASNY and FHA, as well as a defeasance counsel.

Ms. Wang polled the Committee for questions.

Ms. Wang asked if the use of proceeds for the loan is only for the defeasance of the debt or could it be used for other purposes.

Ms. DeHart responded that it would only be for the defeasance of the debt.

There being no further questions, Ms. Wang thanked the team.

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-2026 Quarter 1 Highlights. He conveyed that December closed with $634M (20 days cash-on-hand). The budget underperformed by 1% and closed Q1 with a negative Net Budget Variance of -$55.4M.

Mr. Ulberg continued that direct patient care receipts came in $40.1M lower than the same period in FY-25 due to a slight decrease in IP discharges (OP visits are up 4.0% and IP discharges down -0.7% from Q1 of FY-25) as well as FY-25 cash payments included residual or secondary billing from CHC delays from the previous year.

Inpatient (IP) patient care volume in FY-26 continues to surpass FY-20 pre-COVID levels with IP discharges up by 2.5%, and outpatient (OP) visits are up by 17%. Our strategic financial initiatives are progressing as planned. The FY-26 incremental target has been adjusted to reflect baselined initiatives, as consistent, reliable performance has been demonstrated over the years. In Q1, H+H has achieved $104M against a financial plan target of $472M. Several areas of strong Q1 performance were noted. Additional areas of opportunity and focus include reducing the average length of stay, achieving revenue cycle best-practice performance metrics, and expanding behavioral health services. These initiatives will continue to advance as we refine staffing models and strengthen system efficiencies.

Dr. Katz commented on direct patient care receipts, and noted that this is what a successful mission driven System should do. It should push up the outpatient visits and decrease the inpatient visits. Part of the problem of how health care is financed in the U.S. is that this is a bad financial thing. This is part of the reason so many systems create ways to hospitalize people who do not necessarily need to be hospitalized, as this is how money is made. The aim is to have a System over time to increase outpatient visits and decrease inpatient visits; it is ironic that due to this our receipts are down by $40 million for doing the right thing and bringing out the right outcome. It is a fascinating comment about healthcare in the U.S.

Mr. Ulberg continued presenting the cash projections for FY-26. The System is estimated to close January with approximately $500 million (16 days cash-on-hand) and expects to close February with approximately $450 million (14 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 are Essential Plan changes, Medicaid, MCO Tax, Potential City/State Budget challenges as well as a potential Government Shutdown presenting a financial challenge to H+H. Further, the Average Commercial Rate (ACR) State Directed Payment (SDP) benchmark presents an opportunity to H+H.

Ms. Wang inquired on the Year 1 ACR funds, H+H have not seen these dollars yet.

Mr. Ulberg agreed, and added that the State is close on calculating the value of the distribution to each of the plans as it requires them to do some analysis which Megan and our team has been working with Healthfirst and Metroplus to triangulate on a set of numbers that have been provided to the State to ensure we are all on the same page with the analysis. At the end we have to reconcile to a year-end number, and the 2024 and 2025 numbers are all well known. We are hopeful those dollars will come to be released soon for both years. The Year 3 preprint should not be a problem as it is for the most part a continuation. There may have to be some decisions to be made there, but certainly we are trying to do this in such a way that hopefully it is just a performance approval with CMS without them making any sort of special accommodations there.

Ms. Wang asked if we have clarity on years 1 and 2, and if that means year 3 should be on track.

Mr. Ulberg responded that it is our hope that it is on track following the rules that were laid out by CMS and the new administration. We will have to start incorporating the ramp down to the Medicare rate which starts in 2028. CMS is working on clarifying regulations as it relates to the State Directed Payments across the nation but we have not seen any specifics. We tend to be very conservative for their estimates, and try to anticipate what some of those decisions might be but we will not know until the final regs are released.

Ms. Wang commented that staffing has remained the same at CMS.

Mr. Ulberg added that it is the same group of people at the level that we deal with, which is good as these are very complicated transactions and the knowledge they have and the history.

Dr. Katz agreed, and noted that this is not true for CDC or FDA. People are noticing that CMS is continuing to operate as a professional organization with the knowledgeable people staying in place, not feeling like they need to leave, not being swayed by political mandates, but just doing their job.

Ms. Philogene presented the financial performance highlights for FY-26 thru September Net Budget Variance. She noted that September ended with a net budget variance of -$55.4M (-1%). Receipts are less than budget by $26.1M, primarily driven by patient care and Risk revenue. Risk is lower due to timing of Payments and lower PMPM. Disbursement exceeded budget by $29.3M, mainly driven by overtime spend and some discretionary cash spend on medical and other supplies.

Ms. Philogene provided the FY-26 thru September performance drivers updates. Cash receipts are 1% behind of budget. Much of the deficit can be attributed to timing of patient care and Risk revenue as targets were increased in FY-26. FY-26 thru September, cash disbursements are over budget by 1% primarily due to overtime needs as we continue to right size our staffing models and also the timing of payments for discretionary spending.

The revenue performance for FY-26 thru September was presented by Ms. Philogene. FY-26 direct patient care revenue (IP and OP) is $40.1M lower than FY-25 actuals. Year-over-year variances are due to slightly lower IP discharge volume and timing of cash payment, including CHC cash recoupment in FY-25. Compared to budget, Q1 is behind target by 1% in IP/OP, primarily due to timing of receipts and as initiatives ramp up in the first half of the year. Risk Pool is $7M behind the Q1 target, however is tracking to meet year-end expectations.

Ms. Wang added that the Board has been accustomed to meeting after meeting exceeding the target, and it is a modest amount less than 1%. The team has clearly done a good job identifying where the differences are and a lot of it is timing, so we do expect to catch up on the expense side, the focus group on the overtime, etc. getting that under control. We feel comfortable overall.

Ms. Wang inquired on the lower than anticipated per member per month rates, is it something continuing or is that just a blip in time.

Ms. Meagher responded that this will be an ongoing concern.

Ms. Wang added if we have worked that into some of our forecast and projections, Ms. Meagher agreed, and Ms. Wang continued, if this means it is worse than expected.

Ms. Meagher responded that it is not worse than we expected. The change with the Essential Plan premiums previously discussed by John that was unexpected, so it creates immediate pressure in the short-term to figure

out what is going to happen. The larger Federal disruptions that make the premiums more vulnerable is more of the ongoing concern. We need to try to mitigate some of those loses with more intention and is precarious for H+H but not worse than anticipated.

Ms. Wang inquired on the change in rates, is it shown in the first quarter or is it a future impact.

Ms. Meagher responded that it is not shown in the first quarter and is more of a future impact.

Ms. Karlin provided an update on NYC H+H patients facing challenges obtaining and maintaining insurance coverage. Upcoming legislation and other Federal changes related to insurance coverage create challenges for Medicaid recipients and individuals with coverage through the Health Insurance Marketplace. NYC H+H anticipates that additional resources will be needed to help patients comply with the additional administrative steps to obtain and maintain coverage. Some of these changes include States must conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults; Compliance with work requirements for Medicaid recipients; Provisions effectively ending automatic renewals of coverage. The expiration of ACA subsidies; Essential plan eligibility changes; Reductions in retroactive Medicaid coverage; Medicaid data sharing with ICE and Changes to public charge rule. H+H anticipates over 424,000 annual redeterminations, an increase in financial counseling interactions for those potentially losing coverage, and over 130 financial counselors costing $11 Million.

Ms. Wang inquired on H+H's current annual redetermination. Ms. Hartmann responded that is close to 1 million. Ms. Karlin reiterated that there is also an anticipation of an increase in uninsured individuals requiring financial counseling.

An overview on revenue cycle mitigation strategies and work in progress were presented by Ms. Hartmann. H+H is working on implementing a number of different strategies to address the anticipated challenges. All of these strategies are ongoing and meant to build off existing financial counseling workforce. Those which have improved significantly over time and do continue to demonstrate strong results. H+H's current areas of focus are first improving pre-service financial counseling rates, coordinate strategies with payer partners to ensure success, pursue additional automation to supplement financial counseling workflow, and enhance patient self-service workflows.

Ms. Meagher provided an update on H+H Risk Pool performance. H+H Risk Pool surplus is down $7M compared to January through June 2024. Risk Pool is producing less surplus but it is largely tracking to budget. A chart showing

the different insurance products and performance was presented. Some of the main drivers are essential plan earning $49 per member per month (PMPM) less than 2024. Medicaid product earning $7 PMPM less than 2024. Offset by improvement in Medicare performance ($142 PMPM better) and commercial performance ($37 PMPM better).

Ms. Meagher continued presenting the Opportunities to Mitigate Lagging Risk Pool performance. Enrolling members in Medicaid or Medicare plans that best match their eligibility. Continued work to improve diagnosis capture for risk attributed members so that plans are receiving adequate premium to pay health claims, and Follow up outreach to risk attributed members who are hospitalized to try to prevent readmissions and unnecessary claims spend.

Ms. Wang polled the committee for questions.

Ms. Wang commented that we had been doing a lot of work on improving our capture of risk and diagnosis.

Ms. Meagher added that we have and one positive note is that despite this recent essential plan premium, the premiums were lowered starting

January 1st 2026. Metroplus is going to see more premium revenue due to risk adjustments, so their risk despite the rates going down, will be offset by a significant increase in their risk performance. That is a real-life example of how we can try to mitigate some of these things.

Mr. Ulberg added that this is pretty significant in dollar value about 100 million. The Risk Pool performance chart Megan presented shows the same profile across all of Metroplus and Healthfirst. They are all seeing the same margin by type of plan. Medicaid is losing money and essential plan has a positive. It is not just H+H as ours may actually be mitigated compared to Healthfirst and Metroplus. It makes the point of Medicaid rates should come up a little and Essential Plan could come down and that balances out as we can see for the most part we are losing $2 dollars PMPM for every member we serve.

Dr. Katz added that this is due to the State paying 10% to the Essential Plan and 50% to Medicaid. They are making one as low as possible and one as high as possible and hopes that it equalizes but that their share is smaller. It exists for a reason, it is not irrational that Medicaid is low and Essential Plan is high, a lot of people on Medicaid will remain eligible but may or may not be able to fill out the paperwork and people on essential plan may not be eligible and may fall off and become uninsured people.

Mr. Ulberg agreed and continued, they are trying to make their Global Cap. You need to try to find the right balance. A lot of dynamics in play.

Ms. Wang inquired on the impact on H+H is it more severe as we have higher Medicaid population.

Mr. Ulberg responded that in some ways it is, but is all working out the base we already established. If we were making $7 PMPM in Medicaid and now we are losing $2, is that difference that got factored into the lower risk pool. We would like to advocate for a better balance. The State has an obligation to set a rate that is actually sound and part of what this indicates is that it may need to come up a little bit. The other thing to point out is that whenever we move somebody from Medicaid right down to special needs plan, right plan and right program, you can see going from losing $2 to making $900. And they have done a nice job as it is a better program for those people that are special needs eligible. We are doing a good job there. We can always do better.

Dr. Katz added that we heard Metroplus is the number one special needs HIV plan in the whole State. This is in part the reason the amount is so great because you are getting incentivized of how well our performance is.

Mr. Ulberg noted that the homeless qualify for this as well and the movement of homeless patients into the HIV program is beneficial.

Ms. Wang added that this is excellent and these opportunities, you are laser focused on and it seems that there could be good opportunity there to help navigate this landscape.

Ms. Wang thanked the team for the financial update and added that the Committee looks forward to hearing how things continue with all of the risks that have been identified.

Ms. Wang polled the Committee for questions. There being no further questions, Ms. Wang thanked and commended the team for the great work.

ADJOURNMENT

There being no further business to bring before this committee, the meeting adjourned at 12:11 P.M.

NYC Health + Hospitals
Finance Committee Meeting
March 9, 2026

FY26 Quarter 2 Highlights

- The system closed January with $597M (19 days cash-on-hand).
- Closed YTD Nov with a **negative Net Budget Variance of -$58.7M (less than 1%).**
- Direct Patient Care Receipts (IP/OP) **decreased by $63.4M compared to the same period in FY25**, primarily due to a 2.1% decline in inpatient discharges; the impact of residual/secondary billing from CHC delays carried over from the previous year, which impacted cash payments through November; and timing of UPL conversion payments.
- Strategic financial initiatives are on track, with the FY26 incremental target adjusted to reflect baselined initiatives, demonstrating consistent and reliable performance over time. Through November, we achieved $148.5M, compared to a financial plan target of $472M (31%), and we expect to catch up by end of fiscal year. Key performance categories include :
  - Growth and Other Service Line Improvements ($38.5M)
  - Revenue Cycle Operations ($70.9M)
  - System Efficiencies ($11.3M)
  - VBP and Managed Care Initiatives ($27.8M)
- Additional areas of opportunity and focus include reducing the average length of stay, achieving best-practice performance metrics, and expanding behavioral health services.

FY26 Cash Projections

- The system is estimated to close February with approximately $500M (16 days cash-on-hand).
- The system expects to close March with approximately $700M (22 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.

Managing Risks

Risks	Status	Level
Essential Plan Changes ○ EP changes in H.R. 1 would result in loss of coverage or changes in coverage for certain immigrant population as early as January 1st, 2026. ○ DOH has proposed a rate reduction to Essential Plan premium rates for MCOs.	○ State proposed to CMS to revert to Basic Health Plan for people with EP1-4; State assessing options for EP5. ○ This will have a notable impact on Healthfirst and MetroPlus; H+H analyzing the potential impacts with them.	
Medicaid ○ Medicaid work requirements/ six months recertification and other Medicaid enrollment barriers starting as early as January 1st, 2027 (State can apply for delay).	○ Waiting for federal guidance / State implementation strategy.	
Average Commercial Rate (ACR) State Directed Payment (SDP) ○ ACR SDP initially remains intact via "grandfathering" provision but H.R. 1 requires 10% annual reductions to a maximum of the Medicare benchmark beginning in 2028.	○ CMS/DOH approval received for Year 1 (July 1st, 2024 – March 31st, 2025). Funds expected to start flowing in mid-March. ○ CMS approval received for Year 2 (April 1st , 2025 – March 31st, 2026). ○ H+H is working with the State on the Year 3 submission (April 1st, 2026 – March 31st, 2027).	
MCO Tax ○ H.R. 1 limits State's use of provider taxes.	○ State approval for MCO tax, intended to fund NYS Medicaid rate increases, was extended until December 2026. ○ State will now ultimately receive a total of 8 quarters out of an expected 9 quarters. ○ State added ~$1 billion in all funds in the amendments to reflect this extension of the MCO Tax.	
Potential City/State Budget Challenges ○ City's Preliminary Plan ○ Governor's Executive Budget	○ City's Preliminary Plan released February 17th. Investments in SHOW, Bridge to Home, and warming operations. Upcoming savings targets announced. ○ Governor's Executive Budget was released.	
Government Shutdown averted ○ Federal funding extended through rest of fiscal (September 30th, 2026).	○ DSH cuts delayed until September 2027.	

NYC HEALTH+ HOSPITALS

Financial Performance

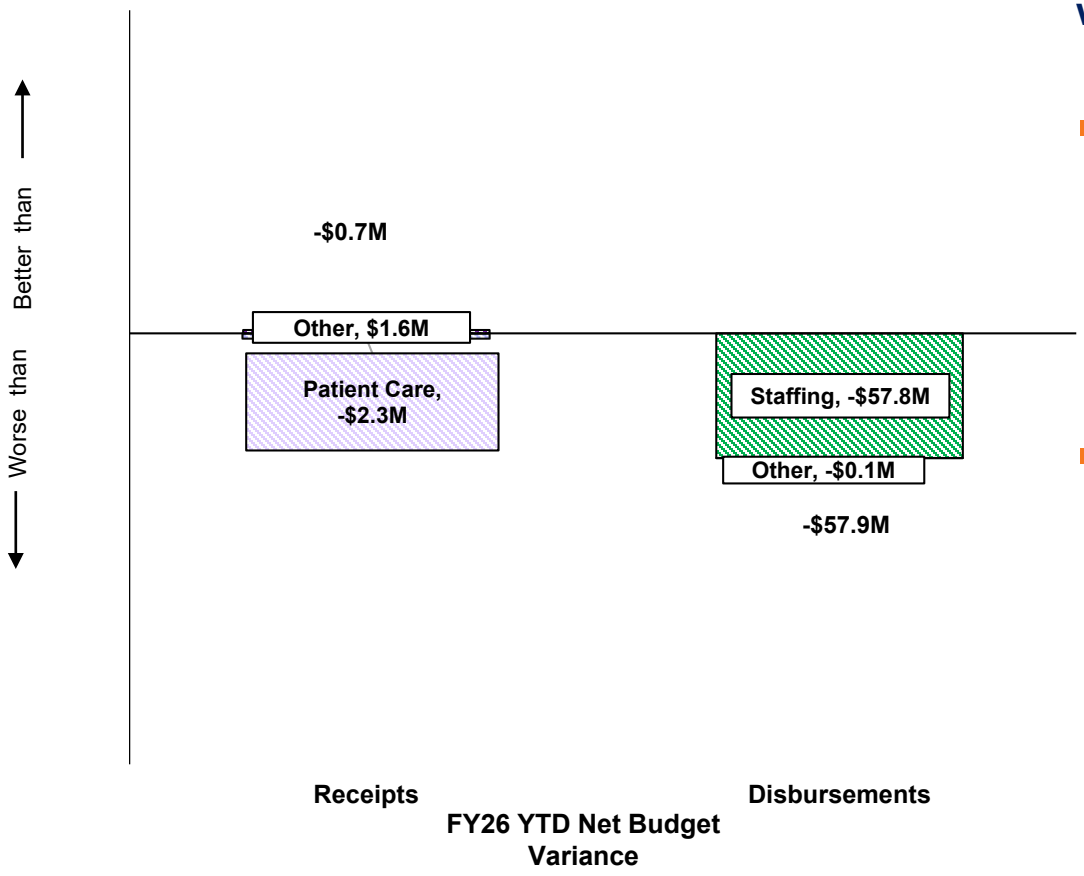
FY 2026 NOV YTD

FY26 thru November
Net Budget Variance

Highlights

Ended November with a net budget variance of -$58.7M (less than 1%) where

- Receipts are less than budget by $0.7M Primarily driven by Direct Patient Care; offset by Risk Revenue performing better than target.
- Disbursements exceed budget by $57.9M, driven by H+H staffing and overtime costs as we continue to work through establishing staffing models.



Drivers of Revenue Budget Variance

Cash receipts are on track to meet budget.

- IP/OP **(-$20.7M) –** FY26 Billing Cash is close to target, (-0.8%). The slight variance is primarily due to timing delays in receipts associated with new strategic initiatives and other cash receipts. Efforts continue to ramp up to meet year-end targets.

- Risk Pool Performance and Timing **(+18.3M) –** Risk is 9% ahead primarily due to timing of payments and prior period adjustments.

- Other revenue **(+$1.6M) –** Variance is due to $7.7M prior year patient care revenue recoupment, offset by -$6.1M due to timing of grants and intra-cities for the period, anticipated to fully receive by year-end.

Summary Receipts Performance (FY26 YTD NOV)	YTD Variance against Budget ($M)
IP/OP Volume, Rates, and Cash Performance	($20.7)
Risk Pool	$18.3
Other	$1.6
Grand Total	**($.7) [0%]**

Drivers of Expense Budget Variance

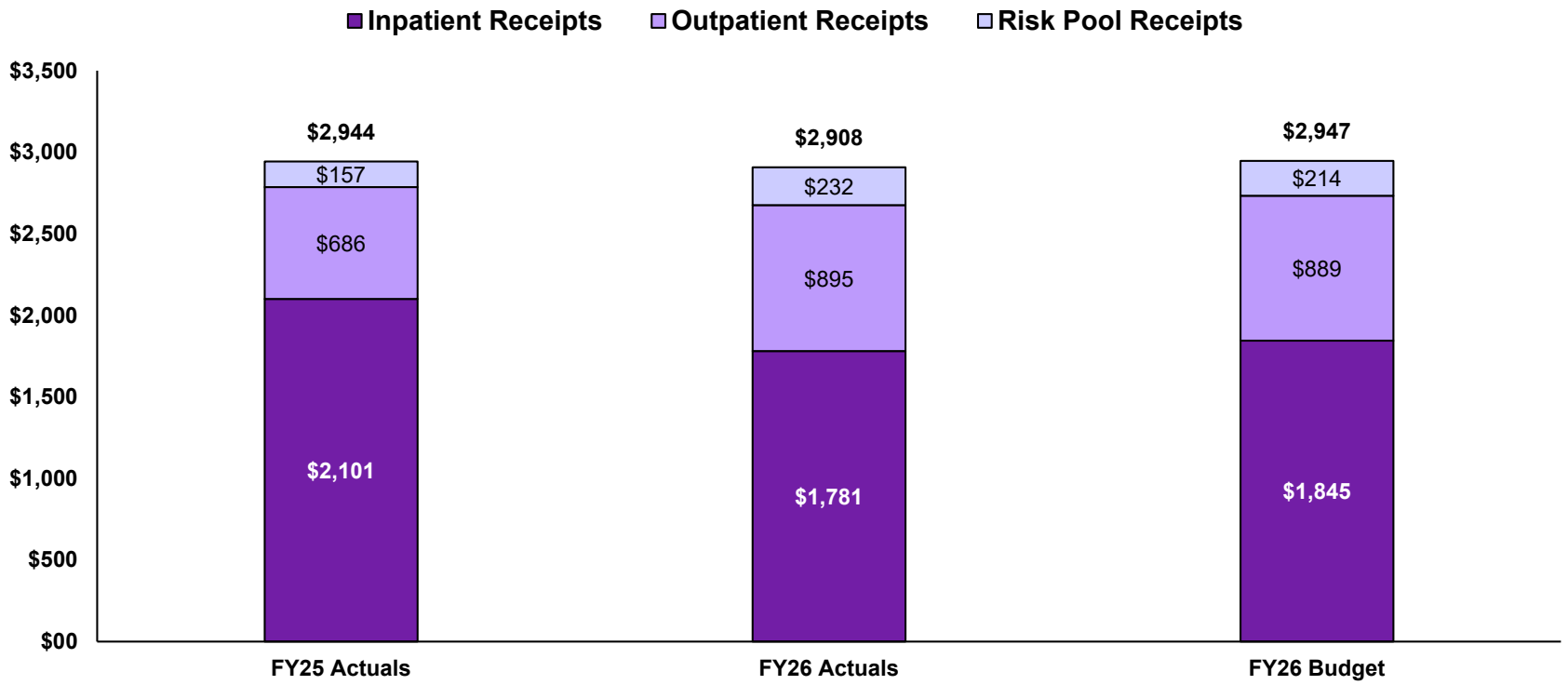
Cash disbursements are over budget by 1% primarily due to overtime needs an non-model staffing areas as we continue to right size our staffing models.

- Personnel Services **(-$57.8M)** – Driven by overtime costs in environmental services, facilities support, and nursing services. Work is ongoing to right size overtime use across the system in alignment with established models and assessment of facilities projects across the system, and work on establishing additional models across the system continues and will support the realignment needed between resources and services in those areas.
- Discretionary Spend **(-$0.1M) –** The system has achieved great results towards eliminating reliance on temps and achieving alignment with staffing models. The work and progress continues in other areas as well, creating efficiencies and cost avoidance in areas of non-staffing discretionary spend and catching up on payments bringing AP days down.

Summary Disbursements Performance (FY26 YTD NOV)	YTD Variance against Budget ($M)
PS/OT	($57.8)
Discretionary Spend	($0.1)
Grand Total	**($57.9) [-1%]**

FY26 thru November
Revenue Performance

- FY26 direct patient care revenue (I/P & O/P) is $63.4M lower than FY25 actuals. Year over year variances due to slightly lower IP discharge volume and timing of cash payment, including CHC cash recoupment in FY25 and timing of UPL conversion payments.
- Compared to budget, YTD Nov performance is on track for IP/OP as initiatives continue to ramp up in the first half of the year.
- Compared to same time last year, discharges are down 2.1%, visits are up 2.0%, and Case Mix Index (CMI) is higher by 6.5%.



Revenue Cycle

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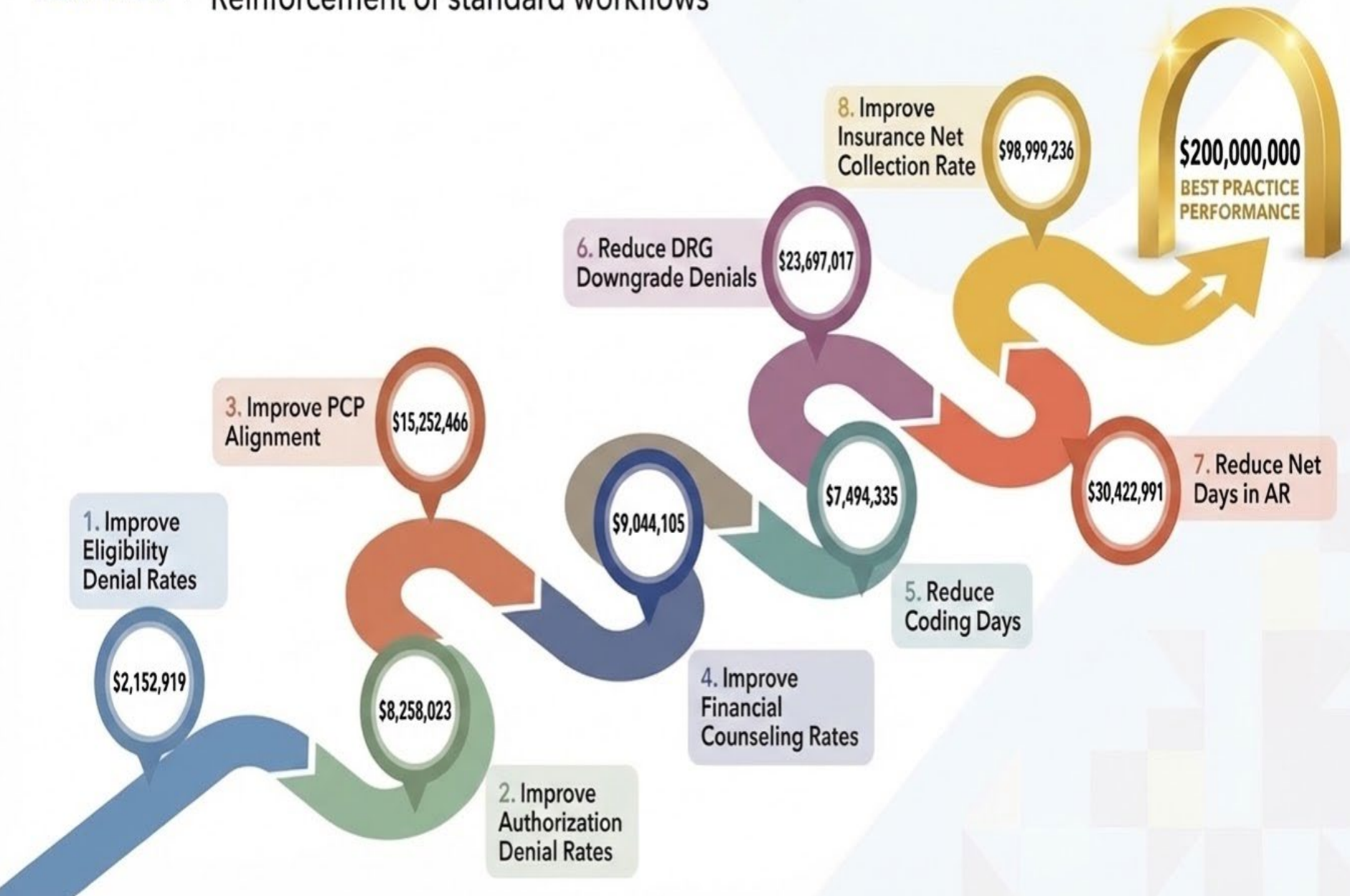
Road to Best Practice Revenue Cycle Performance

Reinforcement of standard workflows



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Facilities Performing Well Through January

FY 26 Budget Progress

Targeted Improvement Plan Themes

Standard Workflows:
Retraining and reinforcement

Collaboration:
Inter-departmental teamwork

Staffing & Reorganization:
Optimizing internal structure

Root Cause Analysis:
Identifying underlying issues

Primary Drivers: Improvements in AR Days and Insurance Net Collection %

NYC HEALTH+ HOSPITALS

FY26

VBP Update

VBP Strategy: Connecting Risk Members to the Most Appropriate Insurance Plan

NYC H+H is connecting eligible patients to facilitated insurance enrollers (whether on-site at the hospital or via telephone) to opt into an insurance product that offers enhanced benefits to meet their needs.

- **Telephonic outreach to eligible members by central office staff and facility-based CHWs to guide them on converting;**
- **Epic tools to identify eligible members at the point of registration and/or care;**
- **Training facility staff on workflows to help convert patients' insurance**

	Who?	2025 Conversions	Eligible members	Change in Avg Surplus (pmpm)
Medicaid → Health and Recovery Plan (HARP)	Identified by NYS with 2+ chronic behavioral health conditions	1,079	826	+$45 pmpm
Medicare → Medicaid Advantage Plus	Requiring 180+ days/yr of long-term support services	646	3,670	+$372 pmpm
Medicaid → Special Needs Plan	• Diagnosed with HIV+/AIDS • People experiencing homelessness (PEH)	• HIV+/AIDS: 127 • PEH: 279	• 626 • 2,203	+$882 pmpm