FINANCE COMMITTEE AGENDA

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

I. Call to Order *Freda Wang*

Adoption of the March 9, 2026 Minutes

II. Executive Session *Freda Wang*

III. Financial Update *John Ulberg*

IV. Action Item: Patient Transportation NTE Increase *Dr. Sewit Teckie, Nina Rostanski*

Authorizing New York City Health and Hospitals Corporation (the "System") to increase the funding by $38,779,153, which includes a 10% contingency, to its previously negotiated and executed contract with DocGo dba Ambulnz, to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation. The cumulative not to exceed value for services provided by all such firms shall increase from $94,762,581 to $133,541,734 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

VENDEX PENDING:
DocGo dba Ambulnz NY LLC

EEO APPROVED:
DocGo dba Ambulnz NY LLC

V. Action Item: Supplemental Security Staffing Services NTE Increase *Dr. Ted Long, Dr. David Silvestri, Juan Checo*

Authorizing the New York City Health and Hospitals Corporation (the "System") to increase the funding by $71,047,954, which includes a 30% contingency, to its previously negotiated and executed contracts with four supplemental security staffing firms Allied Universal Protection Services, Arrow Security (d.b.a. Aron), Johnson Security Bureau, and Maxxi Building Security & Management, to support temporary staffing needs. The cumulative not to exceed value for services provided by all such firms shall increase from $11,600,000 to $82,647,954 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

VENDEX APPROVED:
Universal Protection Service, LLC

VENDEX PENDING:
Aron Security Inc (dba Arrow Security), Johnson Security Bureau, Inc., Maxxi Building Security and Management Corporation

EEO APPROVED:
Aron Security Inc (dba Arrow Security), Universal Protection Service, LLC

EEO PENDING:
Johnson Security Bureau, Inc., Maxxi Building Security and Management Corporation

VI. Old Business Freda Wang

VII. New Business

VIII. Adjournment

Finance Committee MEETING – March 9, 2026

As Reported By: Freda Wang

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

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 11:02 a.m.

Ms. Wang called for a motion to approve the January 12, 2026 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on January 12, 2026 were adopted.

FINANCIAL UPDATE

Mr. Ulberg opened the presentation with the FY-2026 Quarter 2 Highlights. He conveyed that January closed with $597M (19 days cash-on-hand). The budget underperformed by less than 1% and closed Year-to-Date November (Nov YTD) with a negative Net Budget Variance of -$58.7M.

Mr. Ulberg continued that direct patient care receipts decreased by $63.4M compared to the same period in FY-25, primarily due to a 2.1% decline in IP discharges; the impact of residual or secondary billing from CHC delays carried over from the previous year, which impacted cash payments through November; and timing of UPL conversion payments.

Following Ms. Wang's question, Mr. Ulberg confirmed that the FEMA dollars are not in the plan and added that we would consider those available resources.

Our strategic financial initiatives are on track, with the FY-26 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. Several areas of strong Nov YTD 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.

Mr. Ulberg continued presenting the cash projections for FY-26. The System is estimated to close February with approximately $500 million (16 days cash-on-hand) and expects to close March with approximately $700 million (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.

Ms. Wang inquired on the ACR funds distribution from the plans, will it come to NYC Health + Hospitals in lump sum for the year.

Mr. Cassidy responded that for each plan we have agreements that we will continue to work with them on and since it is a retro period we expect many of them will advance the majority of the dollars in the next month or so.

Ms. Meagher added that it is variable by plan. We do not get one lump sum for each plan as each plan has a divvied-up amount of money which makes it a bit more complicated.

Mr. Ulberg continued that those with the biggest dollar values tend to give us lump sum such as Healthfirst and Metroplus where the bulk of the dollars are. For the remaining plans, we follow a defined process and have requested guidance from the State regarding the direction given to the plans. We encourage the plans to refence this and engage in discussions accordingly. While these transactions are typically resolved, they are unique and require the plans' cooperation, as they also need to reconcile these funds on the backend.

Ms. Wang added that while this will cause a sudden increase in cash flow, it will not have the same impact on an accrual basis.

Mr. Guzman responded that we have accounted for revenue as appropriate for GAAP.

Mr. Ulberg provided an update on Year 2 (2025-26), noting that efforts have been made to create a streamlined plan with the State to ensure a large portion of the funds are disbursed quickly. The goal is to have these funds released by mid-April 2026, understanding the State's busy schedule but emphasizing that we are in the queue and working to expedite the process. For Year 3 (2026-27), the preprint, developed with Manatt's assistance, has been submitted to the State and is currently under review. The submission was made early in the month, keeping the process on track, and we will continue to monitor its progress until the funds are released. Ms. Wang asked if that timing gets more in line with the current year and we will start to see that more in our regular rates.

Mr. Ulberg agreed and added that this also explains why we were drawing DSH dollars in years where we should have not been drawing DSH dollars as these rates were late and we did not have a choice. We drew on DSH and now we have worked out a plan with the State where as they pay us, we can reconcile the prior draws.

Ms. Wang commented that hopefully we can get into a cadence where it is more in the rates and noted that we have been making a lot of progress.

Mr. Ulberg continued presenting the external risks. Several areas of focus are Essential Plan changes, Medicaid, Potential City/State Budget challenges presenting a financial challenge to NYC Health + Hospitals. The government shutdown averted currently does not present a challenge to NYC Health + Hospitals. Further, the Average Commercial Rate (ACR) State Directed Payment (SDP) benchmark and MCO Tax present an opportunity to NYC Health + Hospitals.

Dr. Katz commented that we may gain more insights into the Essential Plan based on the progress of the SNAP efforts, as both programs share similar requirements, with SNAP starting earlier. DHS has been working to encourage doctors to complete disability paperwork for individuals unable to work. Over the next few months, we will learn more about how many individuals are unreachable, as those who meet SNAP requirements should also qualify for Medicaid.

Mr. Ulberg agreed and added that from the State perspective they would like to have the same requirements and those two systems speak to each other for Medicaid eligibility purposes.

Dr. Katz highlighted that this is beneficial because people consistently need food, while healthcare needs are more sporadic, particularly for those who are otherwise healthy. He added that if individuals are motivated to qualify for SNAP, we can use that to identify and enroll them in Medicaid.

Mr. Ulberg added that we have efforts on the way such as the One Stop Benefits where as we are going through the enrollment process for people's health insurance, we also check to see if they are eligible for SNAP and WIC. We are trying to bring our two systems together and hopefully this would help.

Dr. Katz commented that there have been a lot of interest in the success of Bridge to Home at City Hall and a lot of gratitude about the Warming Operations, adding that there is a very nice NY Times article on how effective it has been. Further, he added that the issue with Essential Plan changes risk turning green in the chart is that it will turn green but there is about a third of people who would fall off, and asked if that has changed.

Mr. Ulberg responded that it is only the EP-5 group which we do not have a solution for as of yet but there is plenty of people thinking about it. There is about 450,000 Statewide.

Dr. Katz asked if this would mean 250k are City residents

Mr. Ulberg added that it would be more than that.

Ms. Meagher responded that about 3 quarters are City residents.

Dr. Katz added that this means these people would fall off to nothing.

Mr. Ulberg added that these people could revert back if they had employer insurance but when we have looked at the data the way they got enrolled in EP-5 was due to being uninsured to begin with, so we do not think that they necessarily are going to fall back to employer coverage or go to the Exchange. They will likely fall off to be uninsured.

Dr. Katz mentioned that there have been a lot of interest in NYC Care and asked who the EP-5 population is and if they are legally here.

Ms. Meagher responded that these people are legally here and make between 200 and 250% of the federal poverty level. They have been historically been excluded from a lot of New York State benefits programs that are available because they just make too much money.

Dr. Katz added that they would be eligible on the exchange.

Ms. Meagher agreed and mentioned that they always have.

Dr. Katz asked if there is a silver plan that has no copay for the 200 to 250%.

Ms. Meagher explained that part of the problem is that with the subsidies recently being cut there is much less federal funding to enable this and we do not know how affordable the silver plan is.

Mr. Ulberg continued stating that some states have offered to pick up the subsidy when the federal dollars have dropped off. The states have put together a plan where they would fund the subsidy or a portion of the subsidy. There are probably five or six states that have put forward as an option. There are different proposals that are out there that we are looking at.

Dr. Katz asked if there would be a scenario where it would be financially sensible for us to pay the subsidy and thereby get the insurance.

Mr. Ulberg responded that we would have to run those numbers and we have a variation of them that we have worked with Metroplus. However, that would be cash out of our pockets.

Dr. Katz asked if someone is in that group and have a medical condition therefore coming for visits, if we were doing it we could theoretically create any criteria we want as long as it is equal. We could say that they must be our patient, it must be Metroplus, must have an illness; create a whole set of scenarios that if it is our patient we could target people who

are likely to cost money. We understand that we need to look at it around DSH. Do we get DSH on outpatient?

Mr. Ulberg responded that we do get DSH on outpatient. Some of the things we are reviewing is how can we leverage if the Essential Plan or an insurance option or the State does not know to put forth its own subsidy dollars, we could enroll folks on some version of NYC Care. We look at the pharmacy benefit, they will have a doctor clinically call their own, but then for inpatient and outpatient we can leverage DSH. Then the federal government can pay half of the inpatient cost. That is what makes that desirable and maybe even more preferable than the subsidy approach as the subsidy would pick up the full cost of care. We are trying to figure out if there is a way to kind of have a partial insurance package coupled with DSH and these are complicated things.

Dr. Katz added that the current administration would be very interested in a plan if we put together an insurance subsidy for people in the 200 to 250% who met a medical need. We do not usually model medical use, we model all cost. If we are going to do this we have to model medical need and figure out how much are we going to get if they go through DSH, as this is only going to give you half. You will get a better payment through the insurance but of course you would have to pay the premium and we do not know what the premium is. Another issue is that we have to figure out what the premium was.

Mr. Ulberg added that we know from our own EP-5 data or Metroplus EP-5 data that EP-5 tends to be more expensive than 1 through 4. It is an interesting group, they are 200 to 250% of federal poverty level and they tend to be the most expensive cohort of all 5.

Dr. Katz inquired on who would be on the other four groups.

Ms. Meagher responded that there would be a cohort who is income eligible for Medicaid but they are in their proof call status, what we call the ALIESSA population, that is the Essential Plan 3 and 4. Essential plan 1 and 2, are for those thresholds that are slightly more than Medicaid, so they do not qualify for mainstream Medicaid, one group is 138 to 150% and another group is 150 to 200%, so it based on their income and Essential Plan it is only for adults importantly. Kids are all covered and would get CHP.

Dr. Katz continued adding that the most likely reason a group is more expensive is adverse selection. Typically, one group is more expensive because the overall group is not only a smaller percentage of going in and the group going in are sicker. So, what we would have to assume is that in that 200 to 250% group, maybe because they are working or see themselves more as middle class and they are not applying for these benefits, except

for the people who are really sick. Usually adverse selection is the answer to why a group is performing, but it fits the theory that if we are going to do this, you would need to do it with a medical indication, not just to recycle the money but really to create a set of criteria where we believe that medical care has a discernible difference and let the other people go to the Eds for their ankle sprains and bad coughs. But people who have diabetes and hypertension where there is really value to every three- or four-month visit as we would have something to offer them and move them into it.

Mr. Ulberg stated that we will look at all options. It is very important that we move quickly as these issues once it happens as it is going to happen fairly quickly. From the DSH perspective, we have set up ourselves nicely as we will be use ACR and a big bolus of DSH dollars available to us so when the effects of H.R.1 happens, depending how it plays out, we will have enough DSH dollars to fall back.

Dr. Katz agreed that the 50% of the DSH is better than the insurance payment minus the subsidy you have to pay. The goal for us should be more about how to turn NYC Care into something that looks more like insurance than it currently is, so we could advertise it as a benefit.

Mr. Ulberg continued, explained, the advocates have put together a very nice paper, Elisabeth Benjamin and her team, everybody is positioning on this issue. A lot will happen, CMS is supposed to decide sometime between now and when the budget is supposed to close in April. They do not have to, they can delay that, but that would certainly provide a lot of continued resources to pick up the 1 through 4 and then that would leave how to deal with the five group.

Dr. Katz inquired for the board's awareness if when the Basic Health Plan reverts to Medicaid the plans takes a huge hit. Do we believe that the Medicaid rate is significantly below cost?

Mr. Ulberg responded no and clarified that is the EP rate is significantly higher than Medicaid. The cut that was taken a couple of months ago was to actually bring the EP rate closer to Medicaid for IP/OP, so they have already made that cut. In part that makes sense as the basic health plan for $9 billion dollars is a fixed pot of money and it will not grow so the State has to make sure that those dollars will carry them two or three years or as far as it will carry them. New monies are not going to come backfill. They are making sure those dollars last so it makes sense to be a little bit more prudent with the rate setting. As long as we can get access to that basic help plan $9 billion dollars. There are some estimates that could carry and cover the 1 through 4 group for two and even three years. That would be the first thing and then that would still leave the EP-5 uncovered taking us back to how do we address their needs. It is a

very complicated budget. In a matter of weeks, the state and legislation can figure out how best to position themselves here. There is a lot of unknowns really coming from the federal government still and everybody is trying to do the best they can with what they know.

Ms. Philogene presented the financial performance highlights for FY-26 thru November Net Budget Variance. She noted that November ended with a net budget variance of -$58.7M (less than 1%). Receipts are less than budget by $0.7M, primarily driven by direct patient care, offset by Risk revenue performing better than target. Disbursement exceeded budget by $57.9M, driven by NYC Health + Hospitals staffing and overtime costs as we continue to work through establishing staffing models.

Ms. Philogene provided the FY-26 thru November performance drivers updates. Cash receipts are on track to meet budget. Cash disbursements are over budget by 1% primarily due to overtime needs and non-model staffing areas as we continue to right size our staffing models.

Dr. Katz commented that this presentation is not about showing that we are off instead to portray how good our budgeting is. We do not assume when the personnel costs or discretionary spend in above, our first assumption is the budget is wrong as the historic health and hospital budgets were somewhat fictional. It is just under John and his teams where the budgets have actually come to reflect what the actual expenses were. The original budgets were just historical documents and had no meaning in the actuals of what people were spending. Some hospitals would be over budgeted and some hospitals would be under but it had nothing to do with the performance of the people there. It was just whatever the budget was set for whatever reason and whatever year it was set, and that was the budget and nobody tried to change it. John and his team have been working very hard at trying to have accurate budgets. So, then you could have a meaningful understanding of why is this over. Given the size of our budget these overages are really quite small and way different than before. The goal is to work with the teams on what is a realistic amount of money required to provide the services needed and then the overages become the question of are you using more than you need to use or do we need to correct something in the budget to make it more accurate.

Ms. Wang commented that it is not just the overages but the underrages with the right living is very precise with never more than a small percent.

Mr. Ulberg provided an update on the CFO star report, noting that the margins are currently running negative. The CFOs have been asked to explain the reasons behind this, and the next step is to discuss potential solutions. A conversation with the CFOs is scheduled, where they will work to clarify the issue and collaborate on finding the best solution.

Dr. Katz explained that while managing expenses works well, revenue is more challenging due to the variety of revenue sources and delays in receiving it. For example, it's difficult to hold a hospital CEO accountable for predicting how much DSH funding will come in, as it depends on factors like the previous year's data and how much other institutions have requested. On the expense side, it’s easier to assess needs, such as whether additional environmental services are necessary or if overtime needs to be controlled. He pointed out that overtime is often approved because it is essential for employees who rely on it to meet personal needs, such as paying rent. Supervisors, knowing that an employee is struggling, may be more likely to approve overtime if they view the employee as a good worker in need.

Ms. Farag agreed and pointed out that this year as previously promised to the committee, they had rebased the budget for FY-26 so now when looking at these variances, we are actually able to explain more instead of just there is more to be adjusted as we go with modification. As we continue having these conversations, now we are pinning down to where those variances are; and on the revenue side, definitely we are looking at these pots of money like pools and these other components in their own bucket and the part where we are having the discussions with the facilities is more on the inpatient and outpatient revenue as well as their expense against budgets so the conversations are much tighter and more meaningful to them. We continue working on our staffing models which have been extremely important for the facilities to assess where they stand and we have made great improvements on the nursing side and on the temp reductions, on the hiring there is a lot of good stories baked on these numbers. On the year over year, due to the cash timing driving the negative although the volume is down impacting the negative but our collectability on the rate side and also our CMI is high when adjusting for volume and timing of UPL and CHS we are actually positive. We continue to look at our net margin in the actuals and timing factors. We are holding ourselves accountable in the actuals which is a higher standard.

Dr. Katz revisited the overtime issue, emphasizing its complexity. While managers often view overtime as a negative, many low-income workers depend on it to cover essential costs like rent. While it's not necessarily the role of management to understand personal finances or approve overtime when it’s not needed, cutting overtime can create significant challenges. Employees have come to rely on a certain amount of overtime, integrating it into their personal budgets. When managers introduce a new model that eliminates overtime, it can lead to frustration, as employees are left struggling to meet their financial obligations.

Mr. Ulberg added that we try to create enough flexibilities to make that choice. Do they want to fill that vacant position or do you want to do more overtime? Those choices are important. We try to do the same with our

physicians. Do they want to convert sessional hours into a full time equivalent or do the doctors just want to work more hours? We try to create those choices for them.

Ms. Wang asked what is the right wage, as from a financial management standpoint, you have to have stability, so if we know what the staffing needs are and what the wage is.

Ms. Farag added that one of the major positives we have made is focusing on our own staff and filling in for the non-productive time or orientation and things like that as opposed to temps so that is dollars going into our own staffs.

Dr. Katz added that we do not want temps nor Registry.

Ms. Farag continued that it is actually one of the major steps we have taken.

Dr. Marthone added that the CMI increasing is very important to overtime hours and if you notice it is nursing and environmental, which is directly proportional to the care needs of the patients. If that is where the money is going then it is a good thing, it is not a bad thing. As you need more nursing hour care, not just RNs, but all classes to help that patient because the higher the CMI the more issues they have that they need contact; and then environmental because they are going to have to keep cleaning up. The longer the patient is in bed, the more issues they have and people are not caring about where they are throwing things when they are caring for the patient, so it is directly proportional and should not be of much concern considering that the numbers are not.

Mr. Ulberg mentioned that it is a good point and also if we are trying to turn over the beds more efficiently those beds need to be cleaned and those things have to be taken into consideration. We try our best there and the CMI is a very important point if needs are going up.

Ms. Farag added that the facilities have been doing a tremendous job staying within the models even with overtime on inpatient side they are still staying within our models; specifically on the inpatient side, we have level of appropriate nursing coverage and there is not anything on keeping that down in relation to what the needs as the models are driven by our census and definitely on the CMI which is in the context of what types of units are being covered is a big thing.

Mr. Ulberg commented that Natalia wants the CMI adjusted in the model at some point when we can do that. Ms. Farag added that it is something we need to figure out how to.

Dr. Marthone added that it is also very important for the nursing care hours that if we do not account for it we cannot see why the overtime is there.

The revenue performance for FY-26 thru November was presented by Ms. Philogene. FY-26 direct patient care revenue (IP and OP) is $63.4M 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 and timing of UPL Conversion payments. Compared to budget, YTD November performance is on track for IP/OP as initiatives continue to ramp up in the first half of the year.

Ms. Karlin provided an update on NYC NYC Health + Hospitals Road to Best Practice Revenue Cycle performance and reinforcement of standard workflows. NYC NYC Health + Hospitals identified improvements in standardizing individual facility performance to internal best practices. In FY-26, NYC NYC Health + Hospitals is raising the level of performance for facilities not performing in certain areas as well as other NYC Health + Hospitals facilities. In identifying H+H's best practice, 8 metrics have been selected across the System. These metrics include improving Eligibility Denial Rates, Authorization Denial Rates, PCP Alignment, Financial Counseling Rates, reducing Coding days, reducing DRG Downgrade Denials, reducing Net AR Days and improving Insurance Net Collection Rate. A chart providing the target amounts for each of these metrics was presented. The metrics selected provide NYC Health + Hospitals the opportunity to bring all of our facilities up to H+H's internal best practices and overall industry best practice in all areas. NYC Health + Hospitals ongoing work improving some of these metrics reflect smaller targets. NYC Health + Hospitals has calculated a gap across the System and identified an opportunity if facilities achieve internal best practice of $200 million. H+H's largest opportunities are improving overall AR Days and Insurance Net Collection Ratio with $54 million in the FY-26 budget and the rest in FY-27. NYC Health + Hospitals facilities are implementing standard work and creating initiatives to achieve targets by FY-27.

An overview on the facilities performing well through January was presented by Ms. Karlin. Through January, facilities have achieved $45 million of the $54 million target. Most of these achievements are due to improvements in Insurance Net Collection rates and AR Days. NYC Health + Hospitals is working on implementing targeted improvement plan themes consistently across facilities including implementing standard workflows such as retraining and reinforcement; Collaboration with interdepartmental teamwork; staffing and reorganization by optimizing internal structure; and root cause analysis by identifying underlying issues.

Ms. Wang added that this is consistent with having good eyesight on the expenses and the same with revenue.

Dr. Katz commented that one idea that has been raised and would affect Rev Cycle, is to try to schedule doctors for closing notes. An example of this would be with training. Some doctors complained about the trainings, periodically we send out notes that these trainings are due by end of year. They complain that it should be sent at the beginning of the year in order to assign it to the appropriate staff. It would work best for them if we knew what the trainings were in advance and similarly it would be great to do the same for closing records. Physicians could be assigned an hour to do records and not see patients during this time. There are many doctors with many unclosed charts and they have a back log as they would prioritize seeing patients. Maybe we would get more dollars if we do it this way as even the more inspiring doctors will often have a large unclosed chart since they will always put patients first. It would change the dynamic if they are scheduled an hour to close these records and this is your job for this hour. You would remove the issue of whether or not you should prioritize this.

Ms. Karlin added that they are trying to attack this in multiple ways coming at it from all angles. The good news is that in the last twelve or so month they have reduced the open charts by 60% and the Rev Cycle team has been working with the facilities and talking to doctors in understanding what their barriers are, to be able to work through those issues. In some practices there are many doctors that are very busy where they see lots of patients in a couple of hour blocks, and in other practices it might not make as much sense to do this as it would not be as busy. We have heard everything from doctors. A lot of times it is not about the time and sometimes it is.

Mr. Ulberg mentioned the affiliates have been pretty good in partnering with us on open charts and trainings. We have created some incentives if they close the open charts they are paid out of the FPP. We have discovered that it is more about wanting to be a good member of the community, that is the domain we have called it. Once you put the name up on the board that you are behind and everyone sees it that creates an effect as no one wants to be on the board.

Dr. Katz added that Dr. Gagliardi sends him all providers a clinician to clinician excel spreadsheet on Fridays with everybody’s name and open charts. His name has not been on the list as he closes all his charts.

Ms. Meagher provided an update on VBP Strategy and connecting risk members to the most appropriate insurance plan. NYC NYC Health + Hospitals 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. This fiscal year, NYC Health + Hospitals is working on telephonic outreach to eligible members by central office staff and facility-based CHWs to guide them on converting; developing Epic tools to identify eligible members at the point of registration and/or care; and training facility staff on workflows to help convert patients' insurance. A chart showing the 2025 conversions and eligible members as well as the change in average surplus PMPM by product was presented.

Dr. Katz asked if we have people sited at the safety net clinics? There is somebody who is physically there as they are high volume homeless.

Ms. Meagher agreed and added that we have been doing a lot of work trying to make those connections, that even having folks make the connection that if the patient is an adult primary care but they would be eligible for the Safety Net Clinic they may be better served there. Not only is it about changing their insurance but trying to make that soft transfer.

Dr. Katz inquired on the SHOW Vans.

Ms. Meagher responded that we also engage the SHOW Vans. One of the limitations we have had is trying that we have been trying to focus this just on the Metroplus population and the SHOW vans and the Safety Net Clinics could be reaching patients that have any kind of insurance. So that has been a little bit of a limitation that Metroplus really wants us to keep it focused on the Metroplus patient population, but we are working through that and we are trying to figure out all the different service areas where we might be encountering homeless individuals that we want them to be trained and understanding that this is an opportunity for the patient.

Dr. Katz asked Ms. Meagher if she had had much interaction with counterparts at Maimonides. Ms. Meagher responded that she had, speaking with the managed care lead who handles all contracting, in an effort to understand their terms, as they have not yet seen any of the details of their contract.

Dr. Katz acknowledged that legal constraints make it difficult to share certain information until everything is finalized. Due to signed agreements, certain details cannot be disclosed, such as specific payment amounts to vendors or insurance rates. While it's assumed there is significant overlap with insurers, Dr. Katz asked if Ms. Meagher was aware of any arrangements at Maimonides that might differ from their own.

Ms. Meagher responded that they have an IPA, which is more complicated than a lot of their value-based contracts are through the IPA. Maimonides is a participant in the IPA but many community groups are also providers that are participating in the IPA. They also have the ACO that is separate than

the IPA. They have a value-based contract with Fidelis that runs through their IPA as opposed to Maimonides proper.

Dr. Katz asked to be reminded on the advantages of the IPA.

Ms. Meagher answered that it is just a larger universe of primary care physicians to build on the attribution, as opposed to just having it be at one physical hospital location. The idea is that you could coordinate care, if you have specialists, if you have nursing homes in your IPA, you could financially incentivize them. And if you are doing a good job, you can share in those savings.

Dr. Katz added that presumably the plans are contracting with the IPA, the IPA is taking the risks and the IPA is paying out the providers.

Ms. Meagher added that they would pay whatever they might earn in incentive dollars or quality dollars and they would have methodologies to disburse that money.

Dr. Katz added that we do not have an IPA. We have an ACO but our ACO is limited to, as all ACOs, Medicare fee for service declining population. We could be an IPA, but we have not had the need to be an IPA. One of the big differences is that we keep getting into with Maimonides from a financial point of view is that we have always had more patients than we can take care of. They are always focused on how do we get referrals, they are all about trying to increase volume and we are all about trying to meet the need. It is very interesting to try to adjust mechanisms to figure out what makes sense as we go forward together.

Ms. Wang added that we will not get into this today.

Ms. Wang polled the committee for questions.

Ms. Wang thanked the team for the financial update and added that it was a very comprehensive presentation. There a lot of things coming to NYC Health + Hospitals as always. Listening to all of the initiatives, the focus and the efforts are really impressive. Glad for the comments from the committee members bringing out how great this work is.

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 12:06 p.m.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "**System**") to increase the funding by $38,779,153, which includes a 10% contingency, to its previously negotiated and executed contract with DocGo dba Ambulnz, to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation. The cumulative not to exceed value for services provided by all such firms shall increase from $94,762,581 to $133,541,734 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

WHEREAS, New York City Health + Hospitals' requires a transportation contract to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation; and

WHEREAS, the System requires a single vendor to provide ambulance and ambulette transportation services as a single vendor facilitates timely transfer of patients between facilities, supports better continuity of care, increases access to specialized services, aides in patient retention efforts, and supports more timely discharges, which reduces length of stay and improves patient and staff satisfaction; and

WHEREAS, Since these services were procured, DocGo dba Ambulnz has provided The System with three distinct scopes of work as part of the Patient Transportation Services Contract, including Scope 1: Resources to support emergent inter-facility transfers; Scope 2: All other ambulance and ambulette transportation including non-emergent transfers and routine discharges; and Scope 3: Transfer Center services; and

WHEREAS, Unlike the previous systemwide vendor which had a fee-for-service model, DocGo dba Ambulnz operates under a leased hour model where NYC Health + Hospitals is billed at hourly rates based on modality and anticipated demand. This leased hour arrangement was a new model for the system, making it difficult to accurately project the expense of the resources required to meet the System's demand, leading to higher than anticipated spend; and

WHEREAS, System-wide ambulance and ambulette transportation was procured through a competitive RFP process and the procurement was approved by the CRC in December 2022 and the Board of Directors in January 2023, with an NTE of $94,762,581, one contract was awarded to the above-referenced vendor to provide such needed services; and

WHEREAS, DocGo dba Ambulnz continues to be responsive to the System's needs and has the capacity and expertise to provide these additional services; and

WHEREAS, the Vice President and Chief Medical Officer, Clinical Affairs and Business Strategy, will be responsible for the management of the proposed contract.

NOW THEREFORE, be it

RESOLVED, that New York City Health and Hospitals Corporation be and hereby is authorized to increase the funding by $38,779,153, which includes a 10% contingency, for its previously negotiated and executed contracts with DocGo dba Ambulnz, to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation. The cumulative not to exceed value for services provided by all such firms shall increase from $94,762,581 to $133,541,734 for the remainder of the contract term.

EXECUTIVE SUMMARY
PATIENT TRANSPORTATION SERVICES
AGREEMENT(S) WITH
DocGo dba Ambulnz.

OVERVIEW: NYC Health + Hospitals seeks to increase the not to exceed value of the previously procured contract by $38,779,153, which includes a 10% contingency, to provide additional transportation services.

NEED: **NYC Health + Hospitals** requires a single vendor to provide ambulance and ambulette transportation services as a single vendor facilitates timely transfer of patients between facilities, supports better continuity of care, increases access to specialized services, aides in patient retention efforts, and supports more timely discharges, which reduces length of stay and improves patient and staff satisfaction. Unfamiliarity with DocGo dba Ambulnz's leased-hour payment structure made it difficult to accurately project the expense of the resources required to meet the System's demand, leading to higher than anticipated spend, especially in the initial contract year. While efforts to optimize resources and improve efficiencies are ongoing, an increase to the current NTE is needed to ensure continuity of this essential service over the remainder of the contract period.

COSTS: The total not-to-exceed cost for the proposed contract over the remaining contract term of two, one-year renewal options is $133,541,734.

MWBE: The Vendor Diversity team recommended a 10% diverse vendor component percentage for this solicitation. To date, the utilization has been 3%.

Exhibit A

Awardee

1. DocGo dba Ambulnz

To: Colicia Hercules
Chief of Staff, Office of the Chair

From: Carina P. Zupa
Contract Attorney
Corporate Supply Chain Legal

Zupa, Carina Digitally signed by Zupa, Carina
Date: 2026.04.21 11:48:17
-04'00'

Re: Vendor Responsibility, EEO and MWBE status for Board review of contract(s) for Patient Transportation Services Agreement(S) with Docgo Dba Ambulnz.

Date: April 20, 2026

The below chart indicates the vendor's status as to vendor responsibility, EEO and MWBE:

Vendor Legal Name	**Vendor Responsibility**	**EEO**	**MWBE**
DocGo dba Ambulnz NY LLC	Pending	Approved	10%

The above status is consistent and appropriate with the applicable laws, regulations, and operating procedures to allow the Board of Directors to approve this contract.

Patient Transportation Services Application to Increase an NTE with DocGo dba Ambulnz NY LLC

Finance Committee Meeting
5/11/2026

Dr. Sewit Teckie, VP and System Chief Medical Officer
Nina Rostanski, AVP
Clinical Affairs and Business Strategy

For Finance Committee Consideration

- Authorizing the New York City Health and Hospitals Corporation (the "System") to increase the funding by $38,779,153, which includes a 10% contingency, to its previously negotiated and executed contract with DocGo dba Ambulnz, to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation. The cumulative not to exceed value for services provided by all such firms shall increase from $94,762,581 to $133,541,734 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

Background & Current State

- NYC Health + Hospitals requires a single vendor transportation contract to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation.
  - The first single vendor transportation contract was initiated in April 2019
- Supporting inter-facility transfers within the System has been a priority for the system and a reliable ambulance service is necessary for achieving this goal.
  - The ability to timely transfer patients between facilities helps to support better continuity of care, increased access to specialized services, and patient retention efforts.
  - Systemwide investments in centralized transfer center services, an integrated electronic medical record (EMR), and coordinated planning of clinical services growth across sites, have helped to further strengthen and support these efforts.
- The single vendor transportation contract also supports more timely discharges, reducing length of stay and improving patient and staff satisfaction.

NYC HEALTH+ HOSPITALS

Overview / History of Contract

- This contract was procured through a competitive RFP process in August 2022 and DocGo dba Ambulnz was selected as the highest rated proposer.
- The procurement was approved by the CRC in December 2022 and the Board of Directors in January 2023 with an NTE of $94,762,581. A three-year contract with two one-year renewal options was executed in March 2023 and a one-year renewal option was exercised in March 2026.
- Since March 2023, Ambulnz NY LLC has provided The System with three distinct scopes of work as part of the Patient Transportation Services Contract:
  - Scope 1: Resources to support emergent inter-facility transfers;
  - Scope 2: All other ambulance and ambulette transportation including non-emergent transfers and routine discharges; and
  - Scope 3: Transfer Center services.

Current Spend/NTE Request

- Current contract cost is approximately $25,000,000 annually, and spend since inception of the contract is approximately $80,000,000.
- Based on the current contract spend, we project that we will need an additional $38,779,153 to carry out the scope of work through the remaining contract years.
- 10% contingency on projected spend reflects the need to account for unknowns in potential resource utilization (e.g. unanticipated increases in transport volume due to level-loading or other surge events, new transfer workflows).

NTE Request	
Original NTE Amount (including 5% contingency)	$94,762,581
Total Actual Spend	$78,881,298
Projected Spend (March FY 26 - Feb FY28)	$49,691,305
5-Year Total Expense	$128,572,603
Contingency (10%)	$4,969,131
New Requested Total NTE	$133,541,734
NTE Increase	**$38,779,153**

Spend/Contract Management

- Unlike the previous system wide vendor which had a fee-for-service model, Ambulnz operates under a leased hour model where NYC Health + Hospitals is billed at hourly rates based on modality and anticipated demand:
  - NYC Health + Hospitals is invoiced at the contract hourly rate with credits applied for revenue Ambulnz receives from insurance for ambulance and ambulette transports
  - Under leased hour model, The System pays for "leased" resources regardless of utilization, including for "idle time" between trips
  - Leased hours are reviewed on an ongoing basis to assess current and future demand requirements
- The leased hour arrangement was a new model for the system and it was difficult to accurately project the expense required to meet System needs
  - Initial projections anticipated a blended model of leased hour and on-demand (fee-for-service) resources, which led to an underestimation of costs associated with resource idle time
  - Initial projections assumed a gradual six-month ramp-up; however, due to external circumstances the full transition was completed in six weeks, leading to higher spend in the initial contract period than anticipated

Contract Spend

Yearly Cost by Modality, with Total Invoiced Expense to H+H

$40,000,000
$35,000,000
$30,000,000
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$-

FY 23 (Mar - Jun) | FY 24 | FY 25 | FY 26 | FY 27 (projected)

Transfer Center Staffing | FFS Ambulance/Ambulette | Subcontractors (BLS) | Ambulette Leased Hour | CCT Leased Hour | ALS Leased Hour | BLS Leased Hour | TOTAL INVOICED EXPENSE

Spend shown is the amount H+H was invoiced under contract

***Total Invoiced Expense** line represents actual expense to H+H after credits applied for revenue vendor receives from insurance reimbursements*

- After initial ramp-up period (Mar - June 2023), spend was highest in the first full fiscal year due to the adjustment to the new leased hour model and allocation of resources across the system. Titration of resources, especially ambulette leased hours, led to reduced expenditure in FY25.
- Although volume has trended upward year-over-year during the contract period, expenses have decreased and then remained steady through continued focus on resource optimization and efficiencies, including a 10 percentage point reduction in overall resource idle time across ambulance modalities.

Contract Utilization

- Over the life of this contract (March 2023 - March 2026), there have been a total of 155,266 Ambulance transports and 28,826 Ambulette transports
  - Total Ambulance transports consist of:
    - 131,046 BLS (Basic Life Support) ambulance transports
    - 22,660 ALS (Advanced Life Support) ambulance transports
    - 1,560 CCT (Critical Care Transports) ambulance transports
- Annually Ambulnz completes approximately 10,500 inter-facility transfers and 42,500 routine transports
  - Under the current contract, average ambulance transports in the system are 20% higher annually compared to volume under the previous vendor (10% higher for transfers)
- Since initiating the current contract, NYC Health + Hospitals has seen significantly improved timeliness for both inter-facility transfers and discharges under the leased hour model:
  - Emergent inter-facility transfers: Ambulances have arrived on scene within 30 minutes 85% of the time (contract average), up from 23% under the previous vendor (2022 average)
  - Routine transports (including discharges and non-emergent transfers): Ambulances are meeting timeliness targets approximately 76% of the time (contract average), up from 43% (2022 average)

Optimization Efforts

- There have been several key areas of continued focus for performance improvement in collaboration with facilities and the Ambulnz team.
  - Leased hour model:
    - Weekly meetings with Ambulnz leadership to review leased hours, performance, and contract operations
    - Recurring bi-weekly, monthly and quarterly meetings with the vendor and individual facility leadership to review facility-level performance data, operational indicators impacting resource utilization, and billing metrics
  - Billing improvements and optimizations to maximize insurance reimbursements:
    - Focusing on facility billing workflows to reduce no-auth denials by obtaining authorizations prior to transport
    - Integrating transportation ordering platform with Epic system-wide to maximize insurance capture rate
  - Operational improvements:
    - Staggering discharges to ensure efficient utilization of systemwide leased hour ambulance resources and avoid peak-hour clustering
    - Reducing time spent by crews on-scene ("package time") to improve utilization of resources
    - Reducing overall transportation costs by ensuring requested transport modality matches patient's clinical needs and shifting to least costly modality where appropriate

Vendor Performance

Department of Supply Chain Vendor Performance Evaluation Ambulnz	
DESCRIPTION	**ANSWER**
Did the vendor meet its budgetary goals, exercising reasonable efforts to contain costs, including change order pricing?	Yes
Has the vendor met any/all of the MWBE participation goals and/or Local Business enterprise requirements, to the extent applicable?	No
Did the vendor and any/all subcontractors comply with applicable Prevailing Wage requirements?	
Did the vendor maintain adequate records and logs, and did it submit accurate, complete and timely payment requisitions, fiscal reports and invoices, change order proposals, timesheets and other required daily and periodic record submissions (as applicable)?	Yes
Did the vendor submit its proposed subcontractors for approval in advance of all work by such subcontractors?	Yes
Did the vendor pay its suppliers and subcontractors, if any, promptly?	Yes
Did the vendor and its subcontractors perform the contract with the requisite technical skill and expertise?	Yes
Did the vendor adequately supervise the contract and its personnel, and did its supervisors demonstrate the requisite technical skill and expertise to advance the work	Yes
Did the vendor adequately staff the contract?	Yes
Did the vendor fully comply with all applicable safety standards and maintain the site in an appropriate and safe condition?	Yes
Did the vendor fully cooperate with the agency, e.g., by participating in necessary meetings, responding to agency orders and assisting the agency in addressing complaints from the community during the construction as applicable?	Yes
Did the vendor adequately identify and promptly notify the agency of any issues or conditions that could affect the quality of work or result in delays, and did it adequately and promptly assist the agency in resolving problems?	Yes
Performance and Overall Quality Rating	Good

Vendor Diversity

- Utilization Summary

Prime Vendor	M/WBE Goal (%)	Utilization to Date (%)
DocGo dba Ambulnz	10%	3%
Total Utilization		**3%**

- The Vendor Diversity team recommended a 10% diverse vendor component percentage for this solicitation.
- To date, the utilization has been 3%.
- Based on the latest update from the vendor, M/WBE goals are expected to be met by the end of the contract period for the full contract value.

For Finance Committee Consideration

- Authorizing the New York City Health and Hospitals Corporation (the "System") to increase the funding by $38,779,153, which includes a 10% contingency, to its previously negotiated and executed contract with DocGo dba Ambulnz, to ensure reliable access to ambulance and ambulette transportation for inter-facility transfers and routine discharge transportation. The cumulative not to exceed value for services provided by all such firms shall increase from $94,762,581 to $133,541,734 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "**System**") to increase the funding by $71,047,954, which includes a 30% contingency, to its previously negotiated and executed contracts with four supplemental security staffing firms Allied Universal Protection Services, Arrow Security (d.b.a Aron), Johnson Security Bureau, and Maxxi Building Security & Management, to support temporary staffing needs. The cumulative not to exceed value for services provided by all such firms shall increase from $11,600,000 to $82,647,954 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

WHEREAS, New York City Health + Hospitals' need for supplemental security staffing has significantly increased due to various System-wide policy changes and initiatives; and

WHEREAS, the System requires vendors to provide supplemental security staffing for all System-wide facilities, including Central Office, three (3) Acute facilities, one (1) Post-Acute care facility, and two (2) Gotham facilities; and

WHEREAS, Since these services were procured, expanded revenue cycle business needs including expanded visitation policies and re-opening of access points post-COVID-19, short-term increased security use during labor action responses, and introduction of 24/7 weapon detection systems across all Acute facilities, necessitate the expansion of the vendor's scope of work; and

WHEREAS, System-wide supplemental security staffing was procured through a competitive RFP process and the procurement was approved by the CRC in February 2022 and by the Board of Directors in March 2022, with a combined 5-year NTE of $11,600,000, contracts were awarded to the above-referenced four vendors to provide such needed services; and

WHEREAS, Allied Universal Protection Services, Arrow Security (d.b.a Aron), Johnson Security Bureau, and Maxxi Building Security & Management continue to be responsive to the System's needs and have the capacity and expertise to provide these additional services; and

WHEREAS, the Senior Vice President of Ambulatory Care Operations, will be responsible for the management of the proposed contract(s).

NOW THEREFORE, be it

RESOLVED, that New York City Health and Hospitals Corporation be and hereby is authorized to increase the funding by $71,047,954, which includes a 30% contingency, for its previously negotiated and executed contracts with four supplemental security staffing firms Allied Universal Protection Services, Arrow Security (d.b.a Aron), Johnson Security Bureau, and Maxxi Building Security & Management, to support temporary staffing needs. The cumulative not to exceed value for services provided by all such firms shall increase from $11,600,000 to $82,647,954 for the remainder of the contract term.

EXECUTIVE SUMMARY
SUPPLEMENTAL SECURITY STAFFING SERVICES
AGREEMENT(S) WITH
ALLIED UNIVERSAL PROTECTION SERVICES, ARROW SECURITY (D.B.A ARON), JOHNSON SECURITY BUREAU, AND MAXXI BUILDING SECURITY & MANAGEMENT.

OVERVIEW: NYC Health + Hospitals seeks to increase the not to exceed value of the previously procured three contracts by $71,047,954, which includes a 30% contingency, to provide additional security staffing services.

NEED: **NYC Health + Hospitals** requires supplemental security staffing services across The System. Additional Revenue Cycle business needs, including expanded visitation policies and re-opening of access points post-COVID-19, short-term increased security use during labor action responses, and introduction of 24/7 weapon detection systems across all Acute facilities, necessitate the expansion of the vendor's scope of work, necessitate an increase to the current NTE.

COSTS: The total not-to-exceed cost for the proposed contract over the contract term of two, one-year renewal options is $82,647,954.

MWBE: The Vendor Diversity team recommended a 30% diverse vendor component percentage for this solicitation. Johnson Security Bureau is a NYS/NYC certified M/WBE. Both Arrow Security and Allied Universal Protection Services provided a 30% M/WBE utilization plan. Their utilization to date is 17%. Maxxi Building Security is a NYC certified MBE, however they had no spend on this contract.

Exhibit A

Awardees

1.

1. Allied Universal Protection Services
2. Arrow Security (d.b.a. Aron)
3. Johnson Security Bureau
4. Maxxi Building Security & Management

To: Colicia Hercules
Chief of Staff, Office of the Chair

From: Carina P. Zupa
Contract Attorney
Corporate Supply Chain Legal

Zupa, Carina
Digitally signed by Zupa, Carina
Date: 2026.04.21 16:48:57 -04'00'

Re: Vendor Responsibility, EEO and MWBE status for Board review of contract(s) for Supplemental Security Staffing Services Agreement(S) with Allied Universal Protection Services, Arrow Security (D.B.A Aron), Johnson Security Bureau, And Maxxi Building Security & Management.

Date: April 20, 2026

The below chart indicates the vendor's status as to vendor responsibility, EEO and MWBE:

Vendor Legal Name	**Vendor Responsibility**	**EEO**	**MWBE**
Aron Security Inc (dba Arrow Security)	Pending	Approved	30%
Johnson Security Bureau, Inc.	Pending	Pending	MWBE
Universal Protection Service, Llc	Approved	Approved	30%
Maxxi Building Security and Management Corporation	Pending	Pending	MWBE

The above status is consistent and appropriate with the applicable laws, regulations, and operating procedures to allow the Board of Directors to approve this contract.

Supplemental Security Staffing Services Application to Increase an NTE with Allied Universal Protection Service LLC, Johnson Security Bureau, Inc., Maxxi Building Security and Management Corporation, and Aron Security, Inc.

Finance Committee Meeting
May 11, 2026

Dr. Ted Long, Senior Vice President
Dr. David Silvestri, Sr. Assistant Vice President
Juan Checo, Chief Security Officer

Request for Finance Committee Consideration

- Authorizing the New York City Health and Hospitals Corporation (the "System") to increase the funding by $71,047,954, which includes a 30% contingency, to its previously negotiated and executed contracts with four supplemental security staffing firms Allied Universal Protection Services, Arrow Security (d.b.a Aron), Johnson Security Bureau, and Maxxi Building Security & Management, to support temporary staffing needs. The cumulative not to exceed value for services provided by all such firms shall increase from $11,600,000 to $82,647,954 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

Background & Current State

- Historically, NYC Health + Hospitals has used supplemental security staffing services vendors at Acute, Post-Acute, Gotham, and Central Office facilities as a temporary means to address full-time security staffing shortages or short-term increases in security needs.
- Hospital Police & Security services operate at all NYC H+H facilities and support several critical business and safety functions:
  - Routine Surveillance
    - (e.g., Patrols, Access Control, Weapon Detection System)
  - Incident Response
    - (e.g., De-escalation, Conflict Response, Missing Persons)
  - Property Protection
    - (e.g., Building/Assets, Patient Valuables, Evidence Preservation)
  - Staff & Patient Support
    - (e.g., Patient/Visitor Support, Staff Protection/Escorts)
- Security staffing services have provided the following titles:
  - Security Guard and Security Guard Supervisor
  - Fire Watch Personnel and Fire Safety Officer

Background & Current State

- In 2021, NYC Health + Hospitals conducted a systemwide HP staffing assessment to identify base HP staffing needs at each facility. Simultaneously, strategies to address staffing gaps through recruitment and rehiring were revised.
- In October 2021, as part of this system-wide staffing strategy, NYC Health + Hospitals issued an RFP for systemwide supplemental security staffing services to support temporary staffing needs. The procurement was approved by CRC in February 2022, and by the Board of Directors in March 2022, with a combined five-year NTE of $11,600,000.
- Four vendors were selected through the competitive RFP process, and signed to three-year contracts with two optional one-year renewals:
    - Allied Universal Protection Services
    - Arrow Security (d.b.a Aron)
    - Johnson Security Bureau
    - Maxxi Building Security & Management

Background & Current State

Recent review suggests the original NTE of $11,600,000 underrepresented the actual expected spend for a five year system-wide contract:

- Temporary security staff utilization for the 12 months prior to RFP (March 2020 - April 2021) indicates that vendor security spend for a subset of systemwide facilities (Central Office, three Acute facilities, one Post-Acute Care facility, two Gotham facilities) was $3,092,548 (excluding COVID-related spending).
    - The original NTE was calculated based on a subset of facilities, while the contract was intended and approved for use by all facilities.
- Original NTE did not include any contingency, including for unanticipated increases to staffing need. Since the 2022 procurement, however, several trends for hospital security needs have developed that increase staffing need:
    - Expanded visitation policies and re-opening of access points post-COVID
    - Short-term increases to security use during labor action responses
    - Introduction of 24/7 weapon detection systems across all Acute facilities
    - Mayoral/City initiatives during extreme weather events (e.g., Warming Centers)

Current Spend / NTE Request

- The first three year contract spend for all facilities is $47,623,349.
  - This exceeds the five year NTE by $36,023,349
- The expected System-wide spend for the final two contract years, based on recent annual utilization of supplemental security staffing vendors, will be approximately $13,776,000/yr. This calculation is consistent with pre-RFP historic spend per facility, though now accounts for all facilities.
  - No change to services, scope, or intended use (i.e., system security staffing gaps)
- Additional contingency is needed to support unanticipated security staffing needs, including specifically in relation to major Summer 2026 security events (FIFA World Cup, Sail 250, Code Red / extreme weather events).
- As a result, the NTE will need to be increased to $82,647,954 through the end of the contract, if all optional renewal terms are exercised.

NTE Request Calculation		
	Original NTE Amount	$11,600,000
	Exceeded NTE Value (Current spend to date over NTE)	$36,023,349
	Projected spend for next 2 years	$27,552,000
	Contingency (Base) - 10%	$6,357,535
	Contingency (FIFA WC/Summer 2026 Events) - 20%	$12,715,070
	Revised Total NTE	**$82,647,954**

Optimization Efforts

- Numerous concurrent efforts are underway to reduce use of supplemental security staffing services across all facilities.
  - Recalibration of Hospital Police/Security staffing model:
    - Currently under review with all facilities – target completion: End of CY26
    - Identifying opportunities to improve efficiencies in HP/Security posts
      - Leveraging technology investments (e.g., turnstiles, ID card readers)
      - Narrowing timing of non-primary entry/ exit points
      - Conversion of two+ fixed posts to one patrolling post
    - Any reduction in posts will reduce need for supplemental vendor security staff without impacting recruitment or hiring of full-time staff
  - Improvements to Hospital Police recruitment and retention:
    - Positive benefits from compensation changes (base salary, differentials)
    - Recruitment: Stable/increased size of the HP Academy recruit classes
    - Retention: ~50% reduced Special Officer resignations within one-year of start
  - Central visibility into Supplemental Security Staffing purchase orders
  - A new RFP will be developed during the remaining contract term, which will incorporate many of these efforts.

Vendor Performance

- Four vendors were selected through the competitive RFP process for this pooled contract:
  - Allied Universal Protection Services
  - Arrow Security (d.b.a Aron)
  - Johnson Security Bureau
  - Maxxi Building Security & Management
- As a pooled contract, all vendors are available for use to fill needs.
- Selection of vendors and assignment of work at the facility level is at the discretion of each facility's Hospital Police Chief. Several factors contribute to vendor selection:
  - Historical performance at any NYC Health + Hospitals facility
  - Vendor's ability to meet time-sensitivity and/or volume requirements
  - Negotiated hourly rates for needed titles
  - Communication/responsiveness of vendor
- Maxxi Building Security & Management has not performed work on this contract.

Vendor Performance

Department of Supply Chain Vendor Performance Evaluation Allied Universal	
DESCRIPTION	ANSWER
Did the vendor meet its budgetary goals, exercising reasonable efforts to contain costs, including change order pricing?	Yes
Has the vendor met any/all of the MWBE participation goals and/or Local Business enterprise requirements, to the extent applicable?	*No*
Did the vendor and any/all subcontractors comply with applicable Prevailing Wage requirements?	Yes
Did the vendor maintain adequate records and logs, and did it submit accurate, complete and timely payment requisitions, fiscal reports and invoices, change order proposals, timesheets and other required daily and periodic record submissions (as applicable)?	Yes
Did the vendor submit its proposed subcontractors for approval in advance of all work by such subcontractors?	No
Did the vendor pay its suppliers and subcontractors, if any, promptly?	Unknown
Did the vendor and its subcontractors perform the contract with the requisite technical skill and expertise?	Yes
Did the vendor adequately supervise the contract and its personnel, and did its supervisors demonstrate the requisite technical skill and expertise to advance the work	Yes
Did the vendor adequately staff the contract?	Not Always
Did the vendor fully comply with all applicable safety standards and maintain the site in an appropriate and safe condition?	Yes
Did the vendor fully cooperate with the agency, e.g., by participating in necessary meetings, responding to agency orders and assisting the agency in addressing complaints from the community during the construction as applicable?	Yes
Did the vendor adequately identify and promptly notify the agency of any issues or conditions that could affect the quality of work or result in delays, and did it adequately and promptly assist the agency in resolving problems?	Yes
Performance and Overall Quality Rating	Satisfactory

Vendor Performance

Department of Supply Chain Vendor Performance Evaluation Johnson Security Bureau	
DESCRIPTION	**ANSWER**
Did the vendor meet its budgetary goals, exercising reasonable efforts to contain costs, including change order pricing?	No
Has the vendor met any/all of the MWBE participation goals and/or Local Business enterprise requirements, to the extent applicable?	*Yes*
Did the vendor and any/all subcontractors comply with applicable Prevailing Wage requirements?	Yes
Did the vendor maintain adequate records and logs, and did it submit accurate, complete and timely payment requisitions, fiscal reports and invoices, change order proposals, timesheets and other required daily and periodic record submissions (as applicable)?	Yes
Did the vendor submit its proposed subcontractors for approval in advance of all work by such subcontractors?	Yes
Did the vendor pay its suppliers and subcontractors, if any, promptly?	Yes
Did the vendor and its subcontractors perform the contract with the requisite technical skill and expertise?	Yes
Did the vendor adequately supervise the contract and its personnel, and did its supervisors demonstrate the requisite technical skill and expertise to advance the work	No
Did the vendor adequately staff the contract?	Yes
Did the vendor fully comply with all applicable safety standards and maintain the site in an appropriate and safe condition?	Yes
Did the vendor fully cooperate with the agency, e.g., by participating in necessary meetings, responding to agency orders and assisting the agency in addressing complaints from the community during the construction as applicable?	Yes
Did the vendor adequately identify and promptly notify the agency of any issues or conditions that could affect the quality of work or result in delays, and did it adequately and promptly assist the agency in resolving problems?	Yes
Performance and Overall Quality Rating	Satisfactory

Vendor Performance

Department of Supply Chain Vendor Performance Evaluation Arrow Security	
DESCRIPTION	ANSWER
Did the vendor meet its budgetary goals, exercising reasonable efforts to	Yes
Has the vendor met any/all of the MWBE participation goals and/or Local	Yes
Did the vendor and any/all subcontractors comply with applicable Prevailing	Yes
Did the vendor maintain adequate records and logs, and did it submit	Yes
Did the vendor submit its proposed subcontractors for approval in advance	No
Did the vendor pay its suppliers and subcontractors, if any, promptly?	Yes
Did the vendor and its subcontractors perform the contract with the	Yes
Did the vendor adequately supervise the contract and its personnel, and did	Not Always
Did the vendor adequately staff the contract?	Yes
Did the vendor fully comply with all applicable safety standards and	Yes
Did the vendor fully cooperate with the agency, e.g., by participating in	Yes
Did the vendor adequately identify and promptly notify the agency of any	Yes
Performance and Overall Quality Rating	Good

Vendor Diversity

- The Vendor Diversity team recommended a 30% diverse vendor component percentage for this solicitation.
- Johnson Security Bureau is a NYS/NYC certified M/WBE. Both Arrow Security and Allied Universal Protection Services provided a 30% M/WBE utilization plan.
- Maxxi Building Security is a NYC certified MBE, however they had no spend on this contract.
- MWBE Utilization to date has not yet met the set contract goal, but has improved over the three years of the contract.

Prime Vendor	M/WBE Goal (%)	Utilization to Date (%)
Arrow Security	30%	17%
Allied Universal Protection Services		
Johnson Security Bureau		

Request for Finance Committee Approval

- Authorizing the New York City Health and Hospitals Corporation (the "System") to increase the funding by $71,047,954, which includes a 30% contingency, to its previously negotiated and executed contracts with four supplemental security staffing firms Allied Universal Protection Services, Arrow Security (d.b.a Aron), Johnson Security Bureau, and Maxxi Building Security & Management, to support temporary staffing needs. The cumulative not to exceed value for services provided by all such firms shall increase from $11,600,000 to $82,647,954 for the remainder of the contract term of two, one-year renewal options exercisable at the discretion of NYC Health + Hospitals.

NYC Health + Hospitals
Finance Committee Meeting
May 11, 2026

FY26 Quarter 3 Highlights

- The system closed March with $1.09B (34 days cash-on-hand).

- Closed YTD Feb with a **negative Net Budget Variance of -$96.2M (-0.7%).**

- Direct Patient Care Receipts **(IP/OP) increased by $59.7M compared to the same period in FY25**. Our Inpatient discharges are 1.8% lower than the same time last year, while our Outpatient visits are up by 1.3% for the same period.
  - After adjusting for the IP discharge volume decline, we are still **up by $162M in patient care revenue** as patients we serve in our inpatient settings show higher acuity (higher CMI) and as we continue to implement our revenue cycle best practices initiatives, negotiate better contracts and focus on strategic initiatives.
  - The year to year improvement in patient care revenue is **offset by -$102M, resulting from the timing impact of the FY25** residual/secondary billing **payments from CHC delays** carried over from the previous year, 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 February, we achieved $204.5M, compared to a financial plan target of $472M. Key performance categories include:
  - Growth and Other Service Line Improvements ($38.5M)
  - Revenue Cycle Operations ($117.6M)
  - System Efficiencies ($18.4M)
  - VBP and Managed Care Initiatives ($35.1M)

- Additional areas of opportunity and focus include reducing the average length of stay for alternate level of care (ALC) patients, achieving best-practice performance metrics, and expanding behavioral health services.

FY26 Cash Projections

- The system is estimated to close April with approximately $1.5B (47 days cash-on-hand).
- The system expects to close May with approximately $1.2B (38 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

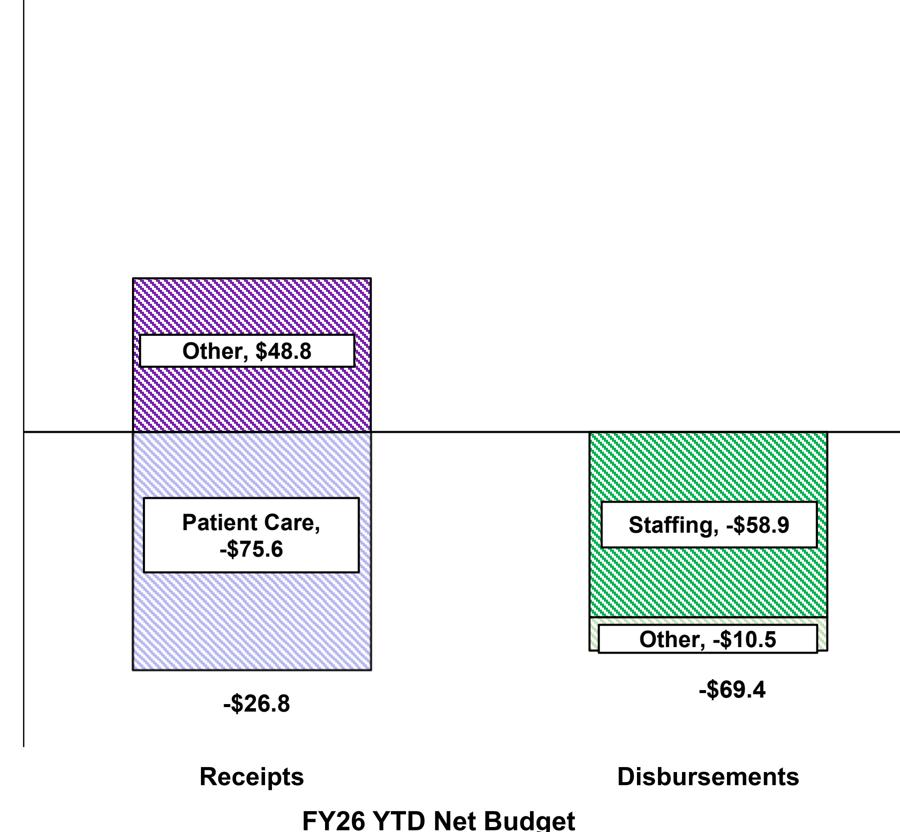
Risks	Status	Level
Essential Plan Changes ○ EP changes in H.R. 1 would result in loss of coverage or changes in coverage for certain immigrant population as early as January 1st, 2026. ○ DOH has proposed a rate reduction to Essential Plan premium rates for MCOs.	○ State received final approval to revert to the Basic Health Plan (BHP) to preserve healthcare coverage for people with EP1-4; State continues to assess options for EP5. ○ Administrative rate adjustments on all EP tiers will have a notable impact on Healthfirst and MetroPlus given risk relationships; 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).	○ Federally mandated Medicaid work requirements require enrollees aged 19-64 in expansion states to complete 80 hours per month of work, education, or community engagement, with exemptions for certain populations, to maintain coverage starting January 1st, 2027. ○ States have flexibility in implementation timing but must comply with federal guidance to ensure continued eligibility.	
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 started flowing in mid-March. ○ CMS/DOH approval received for Year 2 (April 1st, 2025 – March 31st, 2026). ○ The State has formally submitted the Year 3 (April 1st, 2026 – March 31st, 2027) submission on H+H's behalf.	
Potential City/State Budget Challenges ○ City's Executive Plan ○ Governor's Enacted Budget	○ City's Executive Plan is expected to be released in mid-May. ○ Awaiting the SFY26-27 Enacted budget to be released.	

Financial Performance

FY 2026 February YTD

FY26 thru February
Net Budget Variance

Highlights



Ended February with a net budget variance of -$96.2M (-1%) where

- Receipts are less than budget by $26.8M (-0.4%) Primarily driven by Direct Patient Care and Risk Revenue; offset by Appeals & Settlements performing better than target.
- Disbursements exceed budget by $69.4M, driven by H+H staffing, overtime, and Medical Surgical Supplies. We continue to work through establishing staffing models.

Drivers of Revenue Budget Variance

Cash receipts are on track to meet budget.

- IP/OP **(-$67.4M) –** FY26 cash receipts are 1.5% behind target. The slight variance is primarily due to timing lag in receipts associated with regular claims processing, and roll-out timing of new strategic initiatives. Efforts continue to ramp up to meet year-end targets.

- Risk Pool Performance and Timing **(-$8.1M) –** Risk is 3% behind primarily due to timing of payments and lower than anticipated PMPM rates. We expect to catch up by year end due to prior year adjustments and deferred risk payments.

- Other revenue **(+$48.7M) –** Surplus is due to prior year appeals and settlements.

Summary Receipts Performance (FY26 YTD FEB)	YTD Variance against Budget ($M)
IP/OP Volume, Rates, and Cash Performance	($67.4)
Risk Pool	($8.1)
Other	$48.7
Grand Total	**($26.8) [0%]**

Drivers of Expense Budget Variance

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

- Personnel Services **(-$58.9M; -1%) –** A 1% improvement compared to prior period as we rolled out our Post Acute nursing model, and continue to right-size pay components post collective bargaining. As we continue to assess our facilities project needs, establish new staffing models and refine overtime review processes, we will be able to tackle and right-size the remaining 1%.
- OTPS Spend **(-$10.5M; -0.6%) –** The system has achieved great results towards eliminating reliance on temps and achieving alignment with staffing models. The remaining slight variance is primarily driven by additional spend in medical-surgical supplies, increases in other purchased services, and continued push to keep our accounts payable days low.

Summary Disbursements Performance (FY26 YTD FEB)	YTD Variance against Budget ($M)
PS/OT	($58.9)
Discretionary Spend	($10.5)
Grand Total	**($69.4) [-1%]**

FY26 thru February
Revenue Performance

- FY26 direct patient care revenue (I/P & O/P) is $59.7M higher than FY25 actuals. Year over year variance is due to higher prior year receipts from CHC recoupment and timing of UPL conversion for that period offset by FY26 Direct Patient Care Receipts (IP/OP) improvement compared to prior year attributable to revenue cycle, managed care and other strategic initiatives as well as higher CMI.
- Compared to same time last year, discharges are down 1.8%, visits are up 1.3%, and Case Mix Index (CMI) is higher by 5.7%.

	Inpatient Receipts	Outpatient Receipts	Risk Pool Receipts	Total
FY25 Actuals	$3,235	$1,076	$422	$4,733
FY26 Actuals	$3,013	$1,357	$267	$4,637
FY26 Budget	$3,073	$1,364	$275	$4,713

Revenue Cycle

NYC H+H Patients Face Increasing Challenges Obtaining and Maintaining Coverage

Financial Counseling workflows and performance have improved over time but **opportunity remains**

Changes in Federal law and policy are expected to create considerable **headwinds**

Anticipated need for additional resources to help patients with increased barriers to obtain/maintain coverage

Changes Impacting Workflows

- 6 month redeterminations for Medicaid expansion adults
- Compliance with work requirements
- Provisions effectively ending automatic renewals of coverage
- Expiration of ACA subsidies
- Essential Plan eligibility changes and uncertainty
- Reductions in retroactive Medicaid coverage
- Medicaid data sharing with ICE
- Changes to Public Charge rule

NYC H+H Impact

+424k annual redeterminations

+45k+ financial counseling interactions for those potentially losing coverage

+130 Financial Counselors costing **$11 million**

Mitigation Strategies

Strategy	Actions
Advocacy	• System continues to seek delays and improvements at Federal and State level including streamlining and automating insurance enrollment process
Raise Staff and Patient Awareness About What is Changing	• Share plans and information with staff via awareness sessions, RCS Hot Topics and H+H Insider • Share information and resources with patients via MyChart/email and website
Address Expiration of ACA Subsidies (Jan-26) and Changes in Essential Plan Eligibility (Jul-26)	• Assist patients with transitioning between coverages or into a financial assistance program
Address Reductions in Retroactive Medicaid Coverage (Jan-27)	• Improve pre-service financial counseling rates
Support Patients with 6 Month Recertification Requirements (Jan-27)	• Pursue automation to supplement financial counseling workflows • Enhance patient self-service workflows • Coordinate strategies with payer partners to ensure success
Help Patients Comply with Medicaid Work Requirements (Jan-27)	• Track NYS implementation of work requirements • Advocate for cross-progam data sharing • Support patients with documenting compliance or exemptions • Coordinating with other City agencies on processes to support patients
Support Immigrant Patients	• Educate staff and provide scripting to help address patient questions and concerns • Refer patients to LegalHealth attorneys for personalized immigration legal assistance