FINANCE COMMITTEE AGENDA

Date: September 8, 2026
Time: 11:00 A.M.
Location: 50 Water Street, 17th Floor, Boardroom – In Person

I. Call to Order *Freda Wang*
Adoption of the July 13, 2026 Minutes

II. Executive Session

III. Action Item: General Resolution Amendment *Linda DeHart / Thomas Tran*
Authorizing and approving the adoption of the resolution entitled "Supplemental Resolution to the Amended and Restated General Resolution of the New York City Health and Hospitals Corporation" providing for changes to clarify the intent of certain provisions of the General Resolution in connection with current and future changes in Generally Accepted Accounting Principles (**"GAAP"**) and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board (**"GASB"**)

IV. Financial Update *John Ulberg*

V. Old Business Freda Wang

VI. New Business

VII. Adjournment

NYC HEALTH+ HOSPITALS

Finance Committee MEETING – July 13, 2026

As Reported By: Freda Wang

Committee Members Present: Freda Wang, José Pagán, Patricia Marthone, Tricia Taitt, Sally Hernandez-Piñero, Deborah Brown

CALL TO ORDER

Ms. Wang called the meeting of the New York City Health + Hospitals Board of Directors Finance Committee Meeting to order at 11:04 a.m.

Ms. Wang noted for the record that Deborah Brown is representing Dr. Mitchell Katz in a voting capacity.

Ms. Wang called for a motion to approve the May 11, 2026 minutes of the Finance Committee meeting.

Upon motion made and duly seconded the minutes of the Finance Committee meeting held on May 11, 2026 were adopted.

FINANCIAL UPDATE

Mr. Ulberg opened the presentation with the FY-2026 Quarter 3 Highlights. He conveyed that June closed with $821.7M (26 days cash-on-hand). The budget underperformed by less than 1% (-0.5%) and closed Year-to-Date April (Apr YTD) with a negative Net Budget Variance of -$98.5M.

Mr. Ulberg continued that direct patient care receipts increased by $197.5M compared to the same period in FY-25. Our IP discharges are 1.2% lower than the same time last year, while our OP visits are up by 2.2% for the same period. After adjusting for the IP discharge volume decline, we are still up by $202M in inpatient care revenue as patients we serve in our inpatient settings show higher acuity (higher CMI by 4.4%), and outpatient revenue is $87M higher due to higher volume and rates. Improvements are ongoing as we continue to implement our revenue cycle best practice initiatives, negotiate better contracts and focus on strategic initiatives. The year-to-year improvement in patient care revenue is offset by -$93M, resulting from the timing impact of the FY-25 receipts due to residual/secondary billing payments from CHC delays, and timing of UPL conversion payments offset by the ACR supplementals received.

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 April, we achieved $307M, compared to a financial plan target of $472M. Several areas of strong Apr YTD performance were noted. Additional areas of opportunity and focus include reducing the average length of stay for alternate level of care

(ALC) patients, achieving revenue cycle best-practice performance metrics, and expanding behavioral health services.

Mr. Ulberg continued presenting the cash projections for FY-27. The System is estimated to close July with approximately $1.2 billion (38 days cash-on-hand) and expects to close August with approximately $800 million (25 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 and Medicaid presenting a financial challenge to NYC Health + Hospitals. Further, the Average Commercial Rate (ACR) State Directed Payment (SDP) benchmark presenting an opportunity to NYC Health + Hospitals.

Ms. Wang inquired on H.R.1 and ACR Year 3 approvals in regards to which entities (H+H, State, CMS) need aligned on timing.

Mr. Ulberg responded that it is all of us. CMS has regulations that puts requirements on States as payments should be prospective. We should know what we are going to get paid on the day we provide the service, we bill and we get paid. Everybody shares that goal, even though there are three of us that have to work more closely together to get timelier with promulgation of those payments.

Ms. Wang asked if this is unique to us.

Mr. Ulberg responded that it is not unique to us. The way the program is set up and the approvals that need to be received, amendments to State plans and how that factors into rates. Even as it relates to ACR, in the H.R.1. bill, there is a requirement that the States work again to have those rates be effective so many days prior to beginning of the rate year. Everyone wants to do it, it is just getting it going.

Ms. Wang asked about the implementation timing of the provisions passed in H.R.1 and if once we step down to the Medicare rate, does it remain there forever or does it have to be renewed.

Ms. DeHart responded that we will still need annual approval.

Ms. Wang added that we will need annual approval but the Federal legislation does not have an expiration date where they would reconsider these provisions again.

Mr. Ulberg agreed and added that it would require a revisiting of the current law and that would be a favorable thing for us. That is our risk but we are doing okay here.

Ms. Farag presented the financial performance highlights for FY-26 thru April Net Budget Variance. She noted that April ended with a net budget variance of -$98.5M (-0.5%). Receipts are on target (0%) as direct patient care and risk revenue continue to catch-up; offset by appeals and settlements performing better than target. Disbursement exceeded budget by $81.2M, driven by NYC Health + Hospitals staffing, overtime and Other Than Personnel Services (OTPS) catch-up payments as we continue to work through establishing staffing models.

Ms. Farag provided the FY-26 thru April 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.

Ms. Wang asked on the temps, we have seen it come down which is great, how does that interact with personnel services.

Ms. Farag responded that one of the things we have been pushing for is that when we need coverage or filling for our staff, we would rather use our own staff to do overtime to fill in these gaps rather than hiring agency staff. That is what is currently driving a bit of our overtime, so we are not necessarily seeing our overtime as a negative thing, in fact, we are seeing it as a positive thing having our own staff fill in for those that go on leave. We are working on our vacancies, we do expect overtime to happen so that we can actually have the coverage and even in some of our models have vacancies that we are working on, so overtime is expected.

The revenue performance for FY-26 thru April was presented by Ms. Farag. FY-26 direct patient care revenue (IP and OP) is $197.5M higher than FY-25 actuals. Year-over-year positive variance is due to OP volume increase and higher IP and OP rates attributable to revenue cycle improvements, managed care and other strategic initiatives as well as higher CMI.

Ms. Taitt inquired on the CMI and how is it reflected based on the chart presented.

Ms. Farag responded that CMI is not separately reflected on the bar, but the scale of the bar represents the higher acuity patients so even though our inpatient volume is lower the patients we are seeing are needier in terms of health, their acuity or the level of care that they need is higher so they are more expensive and for which the reimbursement is higher. Although volume goes down and revenue goes down a bit with volume, the higher CMI produces higher payments for those patients that we continue to serve. The same number of patients but if you have higher acuity, the more revenue you will receive.

Mr. Ulberg added that the way most of our inpatient reimbursement systems work is for example, if the average is $15,000 per discharge and the weight associated with that average is usually indexed to around one point zero (1.0) so we do one-point times 15 and that is your reimbursement. However, if your CMI goes up and say it goes to 1.04 or 4% that gets multiplied by the base, the 15,000 and that drives the additional revenue that you are seeing here. That is a simplified explanation, but that is the way the method generally works. At this point, what we are seeing is not so much coding increase although there could be some of that as we continue to work on it, but underlying is more intense patients that we are serving that are sicker.

Ms. Taitt asked if we are seeing more inpatients or is it that they are staying longer.

Ms. Wang added that it would be fewer inpatients.

Ms. Farag added that it is lower volume.

Mr. Ulberg agreed and added that the length of stay is built into the payment amount, so each one will say for your diagnosis you should be here on average for 4 or 5 days that is built into the CMI but if you are staying 6-7-8 days in essence we are not getting paid as it is indexed. We are being very simple here. Ms. Farag added it would be sicker patients even though the volume is down on the inpatient side. Mr. Ulberg continued, staying longer is not necessarily a good thing and is one of our efforts when we get to next year's budget.

Ms. Meagher provided an update on the CY-2025 Healthfirst VBP Quality Program Results. NYC H+H Medicaid measures scores were improved or maintained at an 89% of average from 2024 to 2025. For Medicare, 85% of average Medicare measure scores improved or maintained from 2024 to 2025. NYC H+H incentive earnings in CY-25, with highest earnings to date at $19.060M. NYC H+H increased earnings by 28% over 2024 and 458% since 2020.

An update on the VBP Quality Program performance was presented by Ms. Meagher. H+H performance in 2024 MetroPlus VBP and P4P programs, earned $11.859M for 2024. MetroPlus earned 84% of max opportunity. Lastly, H+H employed PCPs outperform H+H Community Providers on 67% of Medicaid measures, 80% of EP measures, 83% of HARP measures and 60% of HIV SNP measures.

Ms. Wang asked regarding CY-2024 MetroPlus performance compare to prior year.

Ms. Meagher responded that it was actually slightly higher in the $12.5M range but part of that wiggle room was metrics increase and the compliments of what you are acting towards, but we are pretty much consistent.

Mr. Ulberg added that we are constantly lobbying in Albany that if the State has a dollar to spend on premium versus a dollar to be spent on quality pools, we prefer the dollar goal in the quality pool because we do better than most other plans, most other providers and it is our view that the way the program should be worked it is just get a fair rate to provide services that actually make your margin on the quality, and that is what we strive for and is our model and that is why we spend so much time and attention on this.

Ms. Farag presented an overview of the FY-27 Budget Planning Strategy – Phase III. NYC H+H continues strategizing and raising the bar in Managed Care and Revenue Cycle. Some areas of opportunity on Ambulatory Care OP Growth include provider template optimization and standardization, new patient access innovation, E-consult relaunch, primary care staffing model under development, improved VBP dollars capture and improved billing for clinic-administered medications. Business plans and new cross-facility partnerships emphasis on enterprise radiology, BH IP Model and sustainability and expanded focus on partial hospital and OP BH Models, and BH Centers of Excellence Year 4 Submission. Continued work on developing physician workforce plan budgeting and recruitment investments with focus on strengthen recruitment and retention efforts and on hard-to-fill specialties, collaboration with RCS to enhance RVU reporting, developing sustainable staffing models and standardization across all facilities and continue locums' reductions and progress toward achieving long-term workforce stabilization. Another area of focus is managing increased demand including length of stay reduction investments, overtime management, infrastructure investments, temp agency management and optimizing economies of scale in Supply Chain. Lastly, H+H is focusing on risk mitigation strategies for Essential Plan changes and H.R.1.

Ms. Wang inquired on ALOCs.

Ms. Farag responded that these are some of the long stayers that should have an alternate level of care, so not the high acuity patients. What we want to make sure is that every patient in our bed is staying for the right level of health needs as opposed to staying for a different reason.

Ms. Wang asked what are we doing as far as investments to try to help them.

Ms. Farag answered that we have initiatives across the System to find the appropriate placement for them. There are initiatives on the front end and there are ones for the ones already reaching that status to make sure we find appropriate placement for them.

Mr. Ulberg added that we spend a lot of time from a Finance perspective trying to understand this population group and we spend over an hour of cabinet on this topic. Our clinical staff have deemed that they are no

longer in need of inpatient level of care but they are not capable of going home or back to shelter.

Ms. Wang added that some of the projects we have approved to help them such as respite.

Mr. Ulberg agreed and continued, we want to build more respite, more beds, we would like to partner more with the Department of Homeless Services. Most have insurance coverage. However, partnering with DHS is in the works and we also have contracts in place with private nursing homes and we would refer to them and they do a nice job establishing insurances for people. This is a big issue as we put more pressure on bringing down the average length of stay to approach somewhere near an average for a safety net system because this is what really makes running a safety net system so difficult as where do you send the patient to and we have an obligation to make sure that they are going to be safe so more to come on this but it is a very active issue across the System and everybody is really engaged to try to make something.

Follow-up: Mr. Pagán commented that it would be good to have a conversation not only on the Finance side but also in the clinical side. It would be good to know how much does it cost us to go beyond one extra day beyond what you are supposed to do. Also, what models have we explored. John mentioned private Nursing Homes. A few years back CMS was interested in hospital at home. I am not sure we did much in that direction or if they killed the initiative anyway.

Mr. Ulberg added that the State has a plan being developed to establish Medical respite, and we are not the only system; all hospital systems are struggling with something similar here. Medical Respite is a very promising model and we would welcome a chance to come back and talk about it and we would bring the clinical team that gets very excited about the conversation.

Ms. Hernandez-Piñero inquired regarding homeless services or HPD that would pay a certain amount of money and then provide a red subsidy, and users could go to New Jersey and in fact, quite a few of them ended up going to New Jersey as it was a good sensible project, are they still doing that or not. Mr. Ulberg agreed. Ms. Hernandez-Pinero continued, in terms of respite care, did the Federal government just freeze nursing homes or respite care as they felt it was an abusive account.

Mr. Ulberg responded that we always have to deal with that issue. Our view is of course it is not abuse, we just try to find the right location for our patients. We have a conversation later in the week with our partners at home services to see if we can come up with some sort of more innovative approach as we all recognize that these are not H+H patients, these are our

patients together. Hopefully we will have some good news and we will keep this as a measure that we will report back to the Board on how we are doing.

Ms. Hernandez-Piñero added that the Mayor is very supportive of these kinds of efforts and trying to bringing housing in will take time. He is very open to these new ideas.

Mr. Ulberg added that we appreciate that too and we appreciate this new environment of collaboration and there is a lot we can do here. These patients do cut across multiple City Systems and by us coordinating together this would be a good example about how I think we can work together and that is exactly what we have been asked to do. Linda has been leading up our efforts as the Chief Savings Officer that is a current theme, where are those synergies across the City that we could take advantage of.

Ms. Taitt inquired on H+H's top three issues for the CFOs.

Ms. Farag responded that all of the above are important, but the three main focus for the CFOs as it is finance would be revenue cycle, maximizing the reimbursement for the things that we should be collecting.

Mr. Ulberg added that staffing models is another one as we have all embraced staffing models. Many years ago, we were one of the firsts to step forward and say we are embracing nursing staffing models. As budget folks, we very much endorse it as it allows us to budget resources to the bed and gives us peace of mind to know that at least there is enough money at the bedside to provide the nurses that are required for that intensity of bed or care that is being provided. Now we can do better at that, but the staffing models is something that the CFOs also will appreciate as it helps us standardize some sort of benchmark across all, it could be food service, it could be clinical, non-clinical, so they gave us a list when we first started the budget development and we have been paying attention to that list and seeing if we can build out models for each of the areas that they have identified.. We will reserve money just so we are all committed to the idea that we will have models. Marji and team have models for revenue cycle that helps, as we can see if we have to hire more, helps us try to stay ahead of the recruitment cycle as it takes a long time to go through and recruit people, the more we can get to model based, the stronger the budget is and it provides the CFOs an assurance that at least the dollars that they are requesting going into the budget are benchmarked to something. It is an interesting question, but they have their own needs, additional OTPS, frequently struggle with the pipe bursts, fixing the pipe overtime goes up so we may need to set aside funds for those events so they feel that there are resources available for emergency maintenance that can be unpredictable, that is where overtime is a powerful tool. We are trying to modernize our infrastructure so that is Mitch's top of the list. In the middle of the night something happens and it is always costly.

Ms. Farag added that it is being standardize also through the perspective of the staffing models. As these are usually emergency projects, there is no planning but there are some preventive measures from a preventive maintenance perspective before it gets to that state, working with our facilities team and talks about the all hands-on deck so we continue.

Ms. Taitt asked regarding the preventive measures and the construction services contracts for example the broken pipes.

Ms. Wang responded that there is no money set aside for that. That is a contract approval limit. The money being held aside is in the budgets that they work with the facilities.

Ms. Farag agreed and added that the contracts we look at them as ceilings that you are spending within, but if you do not need to hit that, you do not. Given contracts spend multiple years and our budget is annual, we have to figure out what do we truly need for that year and that is what we budgeted for. Now, handling emergencies can happen through a combination of these contracts or staff, like facility staff that we have on our payroll. That is determined by our facilities group on what is more appropriate. There are some things you just have to hit a contract quickly as you may not have resources right then and there to handle it, but if we have our own teams that cannot do it, they do it through that emergency like part overtime.

Dr. Marthone asked if we are subject to the same cash-on-hand as other safety nets.

Mr. Ulberg responded that cash-on-hand for us in this year's budget is about 25 days is sort of where we operate but it fluctuates. It shows one of the challenges running a safety net system where today we can have a billion dollar in the bank and then it goes way up or goes way down. We monitor this all the time, but as a matter of reference, the more well-resourced hospitals in the City, it would not be uncommon if they run within 300 days.

Dr. Marthone inquired regarding the grants received, is there a maximum amount of cash-on-hand you can have to qualify for these.

Ms. DeHart responded that there are cash requirements that are related to exited debt test for what we are borrowing, but there are no limitations and we are not aware of any grants limitation that is driving how we end up on cash basis, it is really more to do with the nature of how our funds come in more than anything else.

Dr. Marthone clarified that we can save as much as we want and that is not a problem for funding. Mr. Ulberg agreed and added that we tend to spend pretty much every dollar we get.

Ms. Wang added that is part of the reasons we are trying to get the prospective rates, smoothing out so we don't end up all of a sudden like we have a billion dollars now as that is not usually the case.

Mr. Ulberg added that not having that stability or cushion just makes it more challenging to plan going forward in some ways. You are always trying to get a clearer picture on how that future looks like. If we did have a bolus of dollars, if we come to find as we are doing the budget, we would like to reserve some of that for future capital projects as we know we have huge demands, just take care of the basics. We have to find ways to invest more capital dollars into our system just pretty much to keep the lights on. We are always looking for those dollars to make that sort of balance.

Ms. Karlin provided an update on NYC Health + Hospitals H.R.1 Mitigation Strategies. Ensuring that H+H is raising staff and patient awareness about what is changing that includes sharing plans and information with staff via awareness sessions, RCS Hot Topics and H+H insider as well as sharing information and resources with patients via MyChart/email and website. Addressing the expiration of ACA subsidies, as of January 2026, and the changes in Essential Plan eligibility, as of July 2026, by assisting patients transitioning between coverages or into a financial assistance program. Additional mitigation strategies for changes starting in January 2027 include looking for opportunities to address reductions in retroactive Medicaid coverage by improving pre-service financial counseling rates and help our patients get enrolled prior to the receipt of services to avoid the need to apply for retroactive coverages.

Supporting patients with 6-month recertification requirements by pursuing automation to supplement financial counseling workflows, enhancing patients' self-service workflows and coordinating strategies with payer partners to ensure success. Additionally, helping patients comply with Medicaid work requirements by tracking NYS implementation of work requirements, advocating for cross-program data sharing, supporting patients with documenting compliance or exemptions, and coordinating with other City agencies on processes to support patients. Lastly, ensuring we are supporting immigrant patients by educating staff, providing scripting to help address patient questions and concerns, and referring patients to Legal Health attorneys for personalized immigration legal assistance.

An overview of the Essential Plan Changes effective July 1, 2026 was presented By Ms. Hartmann. Some of the changes H.R.1. presented was it eliminated premium tax credit eligibility for lawfully present immigrants, effectively reducing Federal funding for the Essential Plan "EP". NYS made changes to preserve coverage for EP 1-4 members but has not taken actions to preserve coverage for individuals in EP 5. The results of these changes impacts eligibility across a number of different populations including

pregnant individuals that can stay continuously enrolled in either Medicaid or another EP level depending on their due date, U.S. Citizens and those lawfully present with income above 200% FPL are eligible for a Qualified Health Plan ("QHP") but will be responsible for premiums and higher cost sharing than under an EP plan, Deferred Action for Childhood Arrivals ("DACA") recipients with incomes under 138% FPL will transition to Medicaid and those with higher incomes are no longer eligible for any public health insurance programs, and individuals who are not U.S. Citizens or lawfully present with incomes over 138% FPL are no longer eligible for any public health insurance programs. This impacts about 450,000 New Yorkers, 280,000 NYC residents, and over 35,000 H+H patients who had an encounter within the last year and a half that was covered by EP 5 and are potentially impacted by these changes.

NYC Health + Hospital mitigation strategies are multi-pronged. H+H started proactively communicating with patients since April raising awareness about the upcoming changes. Some of these efforts include sending email blasts to patients with an EP plan information on how to contact an H+H financial counselor if they received a letter indicating they are no longer eligible for coverage. Proactive outreach to patients who were enrolled by an H+H Financial Counselor and were identified as eligible for a QHP or no longer eligible for coverage. Continued outreach to patients with an EP 5 plan with upcoming appointment after July 1, 2026 while prioritizing established primary care patients. Collaboratively working with MetroPlus and exploring additional outreach to MetroPlus EP 5 members with chronic conditions to ensure continuity of care. Our goal is to help patients maintain coverage, including enrolling in a qualified health plan if they have an affordable option. Lastly, NYC Care is available to all New Yorkers who are not eligible for affordable health insurance coverage to access high qualify, low-to-no-cost healthcare services in the NYC H+H network.

The Medicaid work requirements were presented by Ms. Hartmann. These changes will go into effect on January 1, 2027. Adults aged 19-64 will need to prove they are working, going to school, helping out in the community, or participating in job training for a total of 80 hours per month to keep their Medicaid coverage. Individuals who are pregnant, disabled, caretakers or guardians of children under 14 or disabled, etc. are exempt. NYS will leverage Federal, State and third-party data sources to automatically verify exemptions and compliance when possible. Otherwise, individuals will need to prove that they meet requirements through some combination of employment or other activities. Timing is very important as new applicants need to meet the requirements in the month prior to submitting their application while individuals renewing coverage will need to meet the requirement in any one month since their last redetermination. As these requirements have not gone into effect yet, H+H is focusing on gearing up to communicate with

patients in order to raise awareness about the upcoming requirements by sharing information and resources with patients via MyChart, email, website and social media as details become available. Since H.R.1 was introduce H+H has focused on ongoing advocacy to CMS and State to delay start date, maximize data sharing to reduce need for manual verification, and reduce barriers to medical frailty exemption. NYC Health + Hospitals ongoing efforts to prepare to support our patients include training financial counselors and other staff to help patients who are exempt with demonstrating exemption, who are subject with demonstrating compliance by connecting patients to employment, education, training and volunteer opportunities in coordination with other City agencies. Lastly, build off existing SNAP workflows to enable clinicians to support patients with exemptions.

Ms. Wang polled the Committee for questions.

Ms. Taitt inquired of the over 35,000 H+H patients affected with this change if we foresee needing more financial counselors or just using the ones that with have overtime.

Ms. Hartmann responded that we are looking at the whole coast of H.R.1. related changes not just Essential Plan changes and what that impact is in our financial counseling workloads and what that could mean in terms of a workforce need. We are also looking at other ways to mitigate that impact including streamlining our workflows and taking advantage of various automation tools. However, we do anticipate the need to increase our financial counseling workforce, but for this particular change, we are just leveraging our existing staffing and redeploying them from other assignments to proactively outreach to the impacted population.

Ms. Taitt asked regarding automation, when we consider automation how are we accommodating the population that may be obliterate, senior, above a certain age, or not really tech savvy and that may want to speak to a person.

Ms. Karlin responded that one of the potential automations is in fact patient self-service. We are hoping to make as much as possible for patients who want to self-serve, we are hoping to foster that while recognizing that a lot of our patients need to be shepherded through the process. Some of the automation that we are looking to put in place is actually for our staff.

Mr. Ulberg noted that one of the issues discussed with cabinet was setting a goal of having individuals that are presenting to us to reschedule a visit on a non-emergent basis using this as a first step is to initiate a conversation with a financial counselor. If they call let’s say three weeks before their appointment, we want to take advantage of that insurance

coverage because it is going to get more complicated and if we have three-week window to help establish their insurance, it does a couple of things; one is they know if they have coverage or they do not, we want them to have coverage or we want them to enroll in NYC Care one of those pathways we are shooting for. We also want them to have their insurance established prior to meeting their clinicians, we are not taking the patients time when they are there to see their doctor to go through the financial counseling process. We think it will help with the flow of patients through our facility and when they show up at the hospital they are there to do one thing and that is to see their provider not the problem. We are trying that at three facilities and thus far everyone likes the idea of it, it is just how do we execute.

Ms. Karlin added that we have been working at that workflow for a few years now, and have improved from single digit percentages of patients getting financially counseled prior to the point of service to about 50% at this point. We have been hovering at that 50% mark for a couple of years. We have work going into going live this week at three of our facilities to really try to move that needle off of the 50% to really have the vast majority of patients financially counseled prior to that point of service, it helps the patients, it helps the throughput in the offices, it helps the providers, it is all for good.

Ms. Hernandez-Piñero mentioned that getting people recertified after they did not have to during COVID was extraordinary and even with the State participating H+H, MetroPlus, this has to be twice as hard as they now have to do it twice a year. The big problem for us is that their addresses are wrong or the phone numbers are wrong, and the unknown of how you can even actually do an interview, write things down, and then they still come up wrong. It is a huge challenge in front of us and a lot of what John has spoken about makes a great deal of sense and by all of us working together, agencies that do not always work hand in hand around an issue is a joint issue, and we can do it.

There being no further questions, Ms. Wang thanked the committee for their questions and commended the team for all the great work being done.

ADJOURNMENT

There being no further business to bring before this committee, the meeting adjourned at 12:05 P.M.

NYC HEALTH+ HOSPITALS

RESOLUTION

Authorizing and approving the adoption of the resolution entitled "Supplemental Resolution to the Amended and Restated General Resolution of the New York City Health and Hospitals Corporation" providing for changes to clarify the intent of certain provisions of the General Resolution in connection with current and future changes in generally accepted accounting principles ("GAAP") and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board ("GASB")

WHEREAS, the New York City Health and Hospitals Corporation (the "Corporation") has been duly and validly created as a body corporate and politic constituting a public benefit corporation of the State of New York pursuant to the provisions of the New York City Health and Hospitals Corporation Act, McKinney's Unconsolidated Laws, Section 7381 to 7406, as amended (the "Act"); and

WHEREAS, the Corporation, directly and through its subsidiaries, has full power to operate the health system facilities leased from The City of New York and to control and direct expenditures for the provision of health care services; and

WHEREAS, the Corporation has previously adopted the Amended and Restated General Resolution adopted by the Corporation on October 29, 2020 and effective on January 5, 2021 (the "Amended and Restated Resolution"), amending and restating the General Resolution adopted by the Corporation on November 19, 1992, as previously amended by a Series Resolution adopted by the Corporation on December 19, 1996 (collectively, the "Original Resolution", and as supplemented hereby and as may be further amended or supplemented from time to time in accordance with the terms thereof, the "Resolution"); and

WHEREAS, in accordance with Sections 901(6) and (11) of the Original Resolution, the Corporation desires to supplement certain provisions of the Original Resolution in order to clarify the intent of certain provisions of the Resolution in connection with current and future changes in generally accepted accounting principles ("GAAP") and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board ("GASB").

NOW THEREFORE, be it

RESOLVED, that the Board of Directors of the Corporation hereby authorizes and approves the adoption of the resolution entitled "Supplemental Resolution to the Amended and Restated General Resolution of the New York City Health and Hospitals Corporation" providing for changes to clarify the intent of certain provisions of the General Resolution in connection with current and future changes in generally accepted accounting principles ("GAAP") and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board ("GASB").

EXECUTIVE SUMMARY

Supplemental Resolution
Supplementing the
Amended and Restated General Resolution

Background: The Corporation finances its capital projects with funds provided by the City derived from its municipal bond sales, with funds raised from its own bonds and, to a lesser extent, from other sources. The Corporation's bonds have been issued in the past under the authority of a General Resolution that is supplemented with authority for each issuance. The General Resolution provides the basic structure for the Corporation's issuance of its bonds and contains various operating and financial covenants. The original General Resolution was adopted in 1992 and amended in 2021. With the recent accounting updates by the Governmental Accounting Standards Board 103, it is necessary to supplement the General Resolution with specific provisions explained in the presentation to maintain the Corporation's bond covenants. None of the supplemental provisions substantially change the basic financial or contractual terms.

Purpose: The proposed supplement to the "Amended and Restated General Resolution of the New York City Health and Hospitals Corporation" supplements to the General Resolution (adopted November 19, 1992; amended by Series Resolution and adopted December 19, 1996 and amended and restated and adopted October 29, 2020 with effective date of January 5, 2021) to add a new section to the General Resolution.

Proposed Changes to General Resolution: The proposed supplemental resolution clarifies the intent of the General Resolution in connection with current and future changes in GAAP standards and GASB pronouncements or guidance. When a change in GAAP occurring after January 2021 has the effect of changing financial covenant calculations in a manner that is inconsistent with the intent of the General Resolution going back to 1992, H+H may elect to complete the calculation in accordance with GAAP as of January 2021, rather than GAPP in effect on the date the calculation is made.

Effective Date of the Supplemental Resolution: Effect immediately upon its adoption.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

SUPPLEMENTAL RESOLUTION
Adopted September 24, 2026

Supplementing the

AMENDED AND RESTATED
GENERAL RESOLUTION

Adopted November 19, 1992
and
As Amended by Series Resolution Adopted December 19, 1996
and
As Amended and Restated and Adopted October 29, 2020
and Effective on January 5, 2021

SUPPLEMENTAL RESOLUTION TO SUPPLEMENT CERTAIN PROVISIONS OF THE GENERAL RESOLUTION OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION RELATING TO THE ISSUANCE OF ITS HEALTH SYSTEM BONDS.

WHEREAS, the New York City Health and Hospitals Corporation (the "Corporation") has been duly and validly created as a body corporate and politic constituting a public benefit corporation of the State of New York pursuant to the provisions of the New York City Health and Hospitals Corporation Act, McKinney's Unconsolidated Laws, Section 7381 to 7406, as amended (the "Act");

WHEREAS, the Corporation, directly and through its subsidiaries, has full power to operate the health system facilities leased from The City of New York and to control and direct expenditures for the provision of health care services;

WHEREAS, the Corporation has previously adopted the Amended and Restated General Resolution adopted by the Corporation on October 29, 2020 and effective on January 5, 2021 (the "Amended and Restated Resolution"), amending and restating the General Resolution adopted by the Corporation on November 19, 1992, as previously amended by a Series Resolution adopted by the Corporation on December 19, 1996 (collectively, the "Original Resolution", and as supplemented hereby and as may be further amended or supplemented from time to time in accordance with the terms thereof, the "Resolution");

WHEREAS, in accordance with Sections 901(6) and (11) of the Original Resolution, the Corporation desires to supplement certain provisions of the Original Resolution in order to clarify the intent of certain provisions of the Resolution in connection with current and future changes in generally accepted accounting principles ("GAAP") and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board ("GASB").

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, AS FOLLOWS:

Section 101. New Section Added to Original Resolution. A new Section 105 is hereby added to the Resolution as follows:

"Section 105. Generally Accepted Accounting Principles. Notwithstanding any provision in the Resolution to the contrary or any provision in the Resolution referring to "generally accepted accounting principles then in effect", if any change in generally accepted accounting principles ("GAAP") from those in effect on January 5, 2021 (being the effective date of the Amended and Restated Resolution) results from the promulgation of new or amended rules, regulations, pronouncements, opinions, clarifications or interpretive guidance by, or required by, the Governmental Accounting Standards Board or other authoritative bodies that determine GAAP, and such change has the effect of modifying the calculation of any financial covenant or changing the nature of or treatment of any asset or liability or items of income or expense or other accounting term used in such calculation in a way that is inconsistent with the intent of the Amended and Restated Resolution as in effect on its effective date or the calculation of such financial covenant

or the treatment of any asset or liability or items of income or expense or other accounting term that would have resulted if such calculation had been done without regard to any such change in GAAP or any such new or amended rules, regulations, pronouncements, opinions, clarifications or interpretative guidance, then, in such case, in making any such financial covenant calculation under the Resolution, at the election and sole discretion of the Corporation, GAAP shall be deemed to mean GAAP in effect on either (i) the date on which such financial covenant calculation or determination or computation is being made under the Resolution, or (ii) January 5, 2021 (being the effective date of the Amended and Restated Resolution), without regard to such change in GAAP or such new rules, regulations, pronouncements, opinions, clarifications or interpretive guidance. In the event that the Corporation elects, pursuant to this Section 105, to calculate any financial covenant under the Resolution in such a manner that modifies, offsets or disregards GAAP as in effect on the date of any such covenant calculation, the Corporation shall describe any such changes in GAAP and resulting elections made by the Corporation under this Section 105 in any certificate of an Authorized Officer of the Corporation required to be furnished hereunder demonstrating compliance with any of the covenants in Article VIII of the Resolution, and shall represent and warrant in such certificate that such election has been made by the Corporation so that the criteria for evaluating compliance with such financial covenant shall be substantially the same as the criteria for evaluating compliance with such covenant as was intended under the Amended and Restated Resolution on its effective date of January 5, 2021, as if such change in GAAP or new rules, regulations pronouncements, opinions, clarifications or interpretive guidance had not been implemented. For avoidance of doubt, pursuant to this Section 105, changes in the characterization and classification of operating and non-operating revenues as implemented by GASB Statement No. 103 may, at the election of the Corporation, be disregarded by the Corporation in the calculation of any financial covenant under the Resolution upon the furnishing of a certificate of an Authorized Officer as set forth in this Section 105. ”

Section 102. Conflict. All resolutions or parts of resolutions or other proceedings of the Corporation in conflict herewith shall be and the same are repealed insofar as such conflict exists.

Section 103. Effective Date. This Resolution shall take effect immediately upon its adoption.

Supplemental Resolution to the Amended and Restated General Resolution

Clarifying certain General Resolution provisions in relation to changes in accounting principles and standards

Finance Committee Meeting
September 8, 2026

Linda Dehart – Vice President Reimbursement Consulting
Thomas Tran – Senior Director Reimbursement consulting

For Finance Committee Consideration

- Authorizing and approving the adoption of the resolution entitled “Supplemental Resolution to the Amended and Restated General Resolution of the New York City Health and Hospitals Corporation” providing for changes to clarify the intent of certain provisions of the General Resolution in connection with current and future changes in Generally Accepted Accounting Principles (“GAAP”) and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board (“GASB”)

The General Resolution

- The General Resolution, first adopted in November 1992, authorizes and governs the System's bond financing program.
  - Sets the structure and parameters of the bond financing program.
  - Provides for security and payment of System bonds.
  - Establishes terms and conditions agreed to by bond purchasers.
- Specific financing transactions are authorized by the Board through Series Resolutions under the General Resolution.
- The General Resolution was amended and restated in October 2020, with an effective date in January 2021 following completion of the Series 2020 bond sale.
  - Amendments changing material bondholder terms and conditions requires approval by a majority of the System's bondholders in addition to the board.
  - Supplements to the General Resolution clarifying existing terms and conditions and supplements providing for changes that would not adversely affect the bonds' ratings, may be approved by the Board alone.

NYC HEALTH+ HOSPITALS

Bond Covenants

- The General Resolution details certain covenants that the System makes regarding its bonds program, finances and operations that constitute a binding agreement with the System's bond purchasers.
- Broadly, these covenants include the following (among other requirements):
  - Achievement of certain financial performance metrics regarding revenues and net cash available to meet debt service obligations, including for issuance of additional debt.
  - Maintenance of the capital reserve fund and pledge of the system's Health Care Reimbursement Revenues to the Capital Corporation to meet debt service obligations.
  - Commitment to make required payments, take all necessary actions to facilitate payments and related funds flows, and to comply with all applicable tax requirements.
  - Maintenance of audited financial records, adherence to appropriate financial procedures, and ongoing disclosure of financial and operating information.
- NYC Health + Hospitals is required to annually certify that it has complied with its bond covenants.

GASB 103

- The Governmental Accounting Standards Board (GASB) establishes accounting and financial reporting standards for state and local governments that constitute Generally Accepted Accounting Principles (GAAP) for those entities. From time to time, GASB issues pronouncements that explain, refine or revise those standards.
- GASB Pronouncement 103 issued in April 2024 and effective for fiscal years beginning after June 15, 2025 will result in a significant change in the presentation of information in the System's fiscal year 2026 financial statements.
- A new format for the Income Statement will identify grants and funds received from the City in the new category of Non-Capital Subsidies, shifting those revenues from operating funds to non-operating funds.
  - Anticipated future GASB guidance may shift additional revenue categories to non-operating funds in future years.
- If this shift in characterization of a significant amount the System's revenues were carried through into calculations for purposes of meeting the bond covenants under the Resolution, the System's compliance would be significantly impacted. As non-operating funds, these revenues would be excluded from the calculation of cash available to meet debt service obligations, whereas they have been included since the original adoption of the General Resolution in 1992.

Clarifying the General Resolution

- The reporting change required by GASB 103 does not reflect any actual change in the system's current financial condition or ongoing stability, and use of the new reporting format in determining available cash for the purpose of debt covenant calculations would be inconsistent with the original intent of the General Resolution going back to 1992, and the intent of the Amended and Restated Resolution which contemplated reporting standards and practices in use as of the last amendment effective January 2021.
- The proposed Supplemental Resolution clarifies the intent of the General Resolution in connection with current and future changes in GAAP standards and GASB pronouncements or guidance.
  - When a change in GAAP occurring after January 2021 has the effect of changing financial covenant calculations in a manner that is inconsistent with the intent of the General Resolution, H+H may elect to complete the calculation in accordance with GAAP as of January 2021, rather than GAAP in effect on the date the calculation is made.
  - The proposed clarifying language is consistent with similar provisions in the governing bond documents of health care systems across the country.
  - Bondholder approval is not required for this common clarification, and the System's bond counsel will render requisite opinions as required under the General Resolution with respect to the adoption of the clarifying Supplemental Resolution.

Finance Committee Approval Request

- Authorizing and approving the adoption of the resolution entitled “Supplemental Resolution to the Amended and Restated General Resolution of the New York City Health and Hospitals Corporation” providing for changes to clarify the intent of certain provisions of the General Resolution in connection with current and future changes in Generally Accepted Accounting Principles (“GAAP”) and changes from time to time in rules and standards adopted by the Governmental Accounting Standards Board (“GASB”)

NYC HEALTH+ HOSPITALS

NYC Health + Hospitals
Finance Committee Meeting
September 8, 2026

FY26 Highlights

- Closed **YTD May** with a **negative Net Budget Variance of -$90.1M (-0.5%)**

- Direct Patient Care Receipts **(IP/OP) increased by $260M compared to the same period in FY25**. Our Inpatient discharges are **1.2%** lower than the same time last year, while our Outpatient visits are up by **1.8**% for the same period.
  - After adjusting for the IP discharge volume decline, we are still **up by approximately $229M in inpatient care revenue** as patients we serve in our inpatient settings show higher acuity (higher CMI by 4.1%), and **outpatient revenue is approximately $70M higher** due to higher volume and rates. Improvements are ongoing as we continue to implement our revenue cycle best practices initiatives, negotiate better contracts and focus on strategic initiatives.
  - Year over year revenue improvement is offset by **-$39M** due to FY25 secondary/residual billing payments related to CHC delays.

- Strategic financial initiatives are on track, with the FY26 incremental target adjusted to reflect baselined initiatives, demonstrating consistent and reliable performance over time. **Through May**, we achieved an estimated $400M, compared to a financial plan target of $472M. Key performance categories include:
  - Growth and Other Service Line Improvements ($76M)
  - Revenue Cycle Operations ($157M)
  - System Efficiencies ($28M)
  - VBP and Managed Care Initiatives ($138M)

The Journey We've Been On
– FY26 Accomplishments

- The system closed June with $821.7M (26 days cash-on-hand)
  - ✓ *Closed last three fiscal years with an average of $685 million cash-on-hand*
- Direct Patient Care Revenue surpassed $6.6B—an increase of over $3.1B from FY19
- Continued growth in number of patients served overall, with unique primary care patients hitting its highest level (over 462K) through our most recent reporting period
- In CY25, we had our highest Healthfirst VBP Quality Program earnings to date ($19.1M) – an increase of 28% over CY24 and 458% higher than CY20
- Financial Performance & Billing Revenue
  - Improved financial counseling performance, now generating $221 million annually
  - Professional Billing revenue increased by 20%
  - Charge capture reconciliation and payment variance resolution drove $34 million
- Patient Support & Benefits Access
  - Processed 130,000 insurance applications/renewals and >190,000 financial assistance applications for nearly 210,000 unique patients
  - Screened and referred ~16,000 patients for >31,000 benefits via the One Stop Benefits Initiative
- Best Practice & Process Efficiency
  - Exceeded Best Practice targets, showing significant gains in AR Days and Insurance Net Collection %
  - Improved claims processing, yielding a **5 percentage point increase** in "no-touch" submissions
  - > 15,000 completed revenue cycle classes; conducted more than 2,000 quality reviews

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. ○ Coverage loss for patients with EP5 began on July 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; ○ For individuals with EP5, H+H is working to support them in finding other coverage options. **Through July, 56% of all EP5 members found alternate coverage via EP1-4, Medicaid, or QHP.** ○ Administrative rate adjustments on all EP tiers will have a notable impact on Healthfirst and MetroPlus given risk relationships.	
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). Funds started flowing in mid-June. ○ The State has formally submitted the Year 3 (April 1st, 2026 – March 31st, 2027) submission on H+H's behalf.