New York State Medicaid Evidence Based Benefit Review Advisory Committee

Thursday, November 20, 2025
10:00 a.m. – 3:30 p.m. (EDT)

90 Church Street, New York, NY 10007 – Meeting Room 4AB

Meeting Summary

Attendees
Committee Members Present: Edmund Altone, Victor M. Badner, Ronald Braithwaite, Katherine Breslin, Douglas DeLong, James De Meo, Marie-Carmel Garçon, Emily Leish, Sanjiv Shah, Warren Seigel, Thomas Smith (virtual), Joseph Truglio, Jacob Wallace, Kaare Weber, Deirdre Wheat, Douglas Fish, Nathan Graber* ***Committee Members Absent:*** *Elisabeth Benjamin, Miranda Greiner, Peter Newell* **NYS Department of Health (DOH) Staff:** Shirley Belotte, Kate Bliss, Douglas Fish, Nathan Graber, Myla Harrison, Suzette Sadio, Christian Soto (virtual), Thomas Sciortino, Trisha Schell-Guy **Center for Evidence-based Policy Staff:** Liz Brown, Jami Hoffman, Val King, Jesse Baumgartner, Laura Pavlech, Susan Stuard **Public Comment:** Ania Wajnberg, Corita Grudzen, Tiffany Bell, Ann Marie Short, Al Cardillo **Other**: Eve Dorfman, Leah Rosales

*Chair of the Committee

Welcome and Introductions	
Discussion	Nathan Graber welcomed the Committee members, reviewed the role of the Evidence Based Benefit Review Advisory Committee, and confirmed that the Committee had quorum to proceed. Nathan Graber reminded Committee members to see him after opening comments if there has been a change in their conflicts of interest related to the meeting topic. No members had anything new to declare.

	EBBRAC members and Center for Evidence-based Policy staff present introduced themselves. Nathan Graber introduced the NYSDOH staff supporting the Committee.
Action Items /Decisions	None
New York State Department of Health Updates	
Discussion	Trisha Schell-Guy provided an update that NYSDOH is in the process of setting up a Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) in alignment with a 2024 rule from the Centers for Medicare and Medicaid Services (CMS). NYSDOH is currently recruiting for members of both committees. Information and applications are currently available on the NYSDOH website (English and Spanish), and applications in additional languages will be available in the future: https://www.health.ny.gov/health_care/medicaid/mac_bac/. Douglas Fish provided an update on the recently submitted NYSDOH application to CMS for the federal Rural Health Transformation program for up to $1 billion over 5 years. Key initiatives in New York's application included establishing coordinated rural health partnerships, supporting technology-enhanced primary care in rural communities, building a sustainable rural health workforce, and investment in technology innovation and cybersecurity enhancements. CMS has provided guidance that award announcements will come by December 31, the same time that the grant period will begin. Trisha Schell-Guy provided an update that NYSDOH started a phased roll-out of its modernized Medicaid provider enrollment process in September 2025. Newly enrolling individual practitioners in Medicaid will now use the Provider Services Portal, and the roll-out will continue in phases until summer 2026. The modernization effort transitions the enrollment process from paper to digital processes and aims to create a simplified experience for providers and a more efficient workflow for NYSDOH. Provider trainings about using the new system are available on the eMedNY website. Trisha Schell-Guy provided an update that during the recent federal government shutdown, Medicare waivers authorizing broad telehealth flexibilities and the CMS Acute Hospital Care at Home initiative expired on

	September 30. They were inactive for around 6 weeks until they were temporarily extended on November 12 until January 30, 2026, by the federal continuing resolution. During the period when the waivers were inactive, CMS instructed hospitals participating in the Hospital at Home program to discharge or return patients to traditional brick-and-mortar inpatient facilities and stopped accepting new waiver requests. NYSDOH is monitoring if these waivers will be extended further. Nathan Graber provided an update that the Governor recently released Executive Order No. 52 declaring a state disaster in response to federal actions around vaccine access – specifically, actions taken by the federal Advisory Council on Immunization Practices (ACIP) and adoption of recommendations and determinations by the Centers for Disease Control and Prevention and the US Food and Drug Administration. The order: 1) authorized physicians, nurse practitioners, and pharmacists to prescribe and order a patient specific order to a licensed pharmacist to administer immunizations to prevent COVID-19 to patients 3 years of age or older; 2) authorized pharmacists to administer COVID-19 immunizations according to a non-patient specific regimen or patient specific order; and 3) had the state Commissioner of Health sign a non-patient specific order enabling pharmacists to implement the order. Relatedly, New York state has also been an active member of the Northeast Public Health Collaborative, a regional coalition of state and local public health agencies and leaders formed in early 2025 to share expertise, improve coordination, enhance capacity, strengthen regional readiness, and promote and protect evidence-based public health, with a particular focus on vaccine access and response to federal actions. Nathan Graber provided an update on the coverage status of past EBBRAC meetings. A benefit for the collagen cross-linking procedure for keratoconus is currently under fiscal review. For contingency management for stimulant use disorder, discussions are ongoing with the New York State Office of Addiction Services and Supports and Office of Mental Health in preparation for a possible submission in the next Section 1115 Medicaid waiver cycle. Internal agency reviews are ongoing to consider the Committee's coverage recommendations for the treatment of opioid use disorder delivered exclusively by telehealth and applied behavior analysis therapy provided via telehealth. Sanjiv Shah asked for clarification about the Committee's different recommendations for opioid use disorder treatment via telehealth and applied behavior analysis treatment via telehealth, in relation to the NYSDOH

	coverage deliberations. Nathan Graber said that he would follow up on that point after reviewing the prior meeting's minutes.
Action Items /Decisions	Nathan Graber will follow up with the Committee regarding their recommendations on the two prior telehealth topics and the agency's current coverage review for those benefits.
Topic Introduction	
Discussion	Nathan Graber previewed the meeting's topic: Hospital at Home for Admission Avoidance or Early Hospital Discharge in Adult and Pediatric Patients. He advised that the Committee's charge during the meeting was to examine the presented evidence and consider how effective the CMS model of Hospital at Home care is for improving patient outcomes, improving patient and provider satisfaction, and reducing costs, and whether the evidence supports provision of Hospital at Home benefits for admission avoidance or early discharge, and under what circumstances. The Committee would then consider the NYSDOH draft recommendation for adoption or amendment. Sanjiv Shah noted that the evidence report only included studies on admission avoidance but not early hospital discharge and asked whether the Committee would still be considering the early discharge in its deliberations. Elizabeth Brown from the Center for Evidence-based Policy said that no studies on early hospital discharge met the evidence review criteria and that the Committee would have to decide whether it was included in the final recommendation. Nathan Graber added that the topic was selected based on the specifications of the CMS Acute Hospital Care at Home waiver program, and said that while there were no identified studies on early discharge meeting selection criteria, the Committee also would have clinical experience available to them from its own members and the members of the public providing testimony on the topic.
Action Items /Decisions	None
Public Comment/Presentations	

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<td>Discussion</td>
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Five presenters made public comments and responded to questions from the Committee on the Hospital at Home topic:

Dr. Ania Wajnberg, who leads the Hospital at Home program at Mount Sinai, spoke in support of Medicaid coverage and detailed the Mount Sinai program, its history beginning with a model demonstration project in 2014 funded by the Center for Medicare and Medicaid Innovation, and its positive results to date (including for Medicaid patients).
Dr. Corita Grudzen from Memorial Sloan Kettering Cancer Center read testimony from a cancer patient who was unable to access a home-based care program due to geographic constraints, in support of Medicaid coverage.
Tiffany Bell, a director of nursing at SUNY Upstate University Hospital in Syracuse, spoke in support of Medicaid coverage and detailed the health system's Hospital at Home program and its positive results seen to date.
Ann Marie Short, nurse manager for the home hospital program at NYU Langone Hospital – Long Island, spoke in support of Medicaid coverage and provided an overview of their program's model and its positive results seen to date.
Al Cardillo, president of the Home Care Association of New York State, spoke about the organization's general support for home-based acute care and the importance of collaboration between home health agencies, hospitals, and physicians to create effective care models. He stated that the New York state legislature had recently rejected 2 proposals that would change licensure requirements and eliminate the need for home health care agencies to be part of the care model.

Nathan Graber opened the floor for Committee members to ask questions to the public commenters.

Committee questions and discussion points with the public commenters included:

Experience with pediatric patients in Hospital at Home care models

Tiffany Bell from SUNY Upstate commented that their program did not currently serve pediatric patients, but hoped to
Committee member Joseph Truglio noted his personal clinical experience in a different pediatric home-based hospital care program

How patients are screened for a safe home environment under Hospital at Home programs, and the role of technology access

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Ania Wajnberg from Mount Sinai described the checklist that they use to ensure home safety and the devices they use to ensure constant access to communication
The risk of not having 24/7 on-site monitoring when an emergent health issue occurs for a patient, and the comparative rates of vital sign checks in the Hospital at Home model compared to traditional inpatient care
Public commenters and Committee members suggested that at-home patients may receive higher rates of monitoring, especially since some programs have continuous vital sign monitoring technology for their at-home patients
Clarification on the New York state executive budget proposals in fiscal years 2025 and 2026, which would have provided NYSDOH with authority to set a reimbursement rate for a Hospital at Home benefit under the CMS waiver model (neither passed)
Whether hospitals using the Hospital at Home model needed a home care agency involved or felt capable of providing the services with their own staff
Tiffany Bell from SUNY Upstate advised that its program contracts with a home health agency
Ann Marie Short from NYU Langone advised that its program uses its own inpatient nurses but partners with a home health agency for other services such as social work and physical and occupational therapy
Al Cardillo from the Home Care Association of New York State pointed to state regulations for different provider types and care settings. Using examples such as a hospital wanting to provide emergency medical services (EMS) needing to be certified under article 30 of New York law, he said the state has an important decision around licensing for who can provide home-based care
Potential variation in urban versus rural settings regarding the application of technology and the average provider response times for Hospital at Home patients needing emergent care
Tiffany Bell from SUNY Upstate spoke on the range of their program, working with home health nurses and EMS to ensure a 30-minute response time in the event of an emergency, and the challenges of treating patients who live in more rural areas, such as scheduling home nurses, and delivering equipment and prescriptions
The distribution of early discharge versus admission avoidance entries into Hospital at Home programs

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	◦ Public commenters noted a high number of early discharge entrants, in contrast to studies found in the evidence review; they also noted that the two types may be reported together and blend the outcomes in published studies • The role of advanced directives in Hospital at Home programs • The recent pause of the CMS Hospital at Home waiver program during the government shutdown and its impact on Hospital at Home programs ◦ Commenters noted experiences with program waiting lists, increased capacity issues within brick-and-mortar hospitals, and maintaining relationships with contracted agencies • Whether evidence examining the impact of Hospital at Home programs on improved hospital capacity exists more generally • Inequities around access to Hospital at Home programs, including specifically for Medicaid patients Kaare Weber asked for clarification if the Committee was responsible for determining how the Hospital at Home program is implemented (e.g., with or without a home health care agency). Nathan Graber advised that the Committee was responsible for making a recommendation about Hospital at Home generally, and NYSDOH would be responsible for policy implementation details (while drawing on the Committee's expertise and discussion).
Action Items /Decisions	None.
Topic: Hospital at Home for Admission Avoidance or Early Hospital Discharge in Adult and Pediatric Patients	
Discussion	The Center for Evidence-based Policy's Elizabeth Brown presented an overview of the evidence for Hospital at Home services for admission avoidance or early hospital discharge in adult and pediatric patients, the policy and regulatory landscape around the CMS Hospital at Home waiver program, and a review of clinical practice guidelines and coverage policies from private insurers, state Medicaid programs, and Medicare. For full details, see the report available on the EBBRAC website. Committee questions and discussion points included: • Whether the CMS Hospital at Home waiver only applied to Medicare

	◦ Center for Evidence-based Policy staff clarified that it also applied to Medicaid fee-for-service programs in states that chose to opt in and cover the benefit • The reasons for excluding the 2024 CMS data analysis report on Medicare Hospital at Home patients treated under the CMS waiver from the main EBBRAC evidence review ◦ Center for Evidence-based Policy staff noted several limitations, including: the CMS analysis categorized all data from patients in the program as "Hospital at Home" even if the patient also spent significant time in a traditional inpatient hospital or was escalated back to the physical facility; the analysis did not control for differences between Hospital at Home programs and patient selection criteria; and CMS did not to certify that certain Hospital at Home programs met the waiver's criteria • The relationship between the CMS Hospital at Home waiver and recent New York state executive budget efforts to set Medicaid rates for Hospital at Home services ◦ Nathan Graber and Elizabeth Brown clarified that state Medicaid programs must individually decide whether to cover services delivered under the CMS waiver for their fee-for-service program ◦ Nathan Graber added that the New York Medicaid program must also receive statutory authority to set rates for those services and stated that if the Committee recommended pursuing coverage, NYSDOH would reengage about establishing that authority to enact the benefit • Further information on the age breakdown of patients included in the CMS 2024 analysis report on the Hospital at Home waiver program ◦ Center for Evidence-based Policy staff noted that patients with primary Medicaid coverage were not included in the analysis due to data quality and comparability issues • Whether any explanations were given for observed racial and socioeconomic disparities in program participation in the CMS 2024 study ◦ Center for Evidence-based Policy staff advised that the publication was descriptive and did not attempt to identify reasons for the differences • Any frequency standards within the CMS waiver for how often hospitals had to monitor patient vital signs ◦ Center for Evidence-based Policy staff clarified that remote monitoring could be continuous or intermittent, and the intensity should be appropriate to each patient

- Joseph Truglio said from his personal clinical experience that this may also vary by the attending practitioner
- The definition of radiology services within the CMS waiver
  - Joseph Truglio said from his personal clinical experience that these would typically be X-ray and ultrasound services
- Any distinction in the CMS waiver between physicians, nurses, physician assistants or registered nurses
  - Center for Evidence-based Policy staff said that the requirement for 24-hour clinician availability did not specify differences between hospital-level providers, although state-level licensure regulations may come into play
- How the concept of patients leaving hospitals against medical advice translates to the Hospital at Home setting
  - No immediate answer was available, but after the break Sanjiv Shah reported that the public commenter from NYU Langone – Long Island explained that patients in their Hospital at Home program are required to wear a tracking device, and they are removed from the program if they are detected leaving the home unit (not necessarily a requirement of all Hospital at Home programs)
- Clarification on which clinical components of the CMS waiver model need to be done in person
  - Center for Evidence-based Policy staff stated that the first physician home visit needed to be in person, while subsequent visits could be virtual
  - 2 daily visits by nurses or designated paramedics must be in person
  - 24-hour availability by nurses or physicians is remote, but programs must be able to respond to emergent clinical issues within 30 minutes of notification
- Question about the staffing standards for a Hospital at Home program compared to a traditional hospital facility, and a concern that implementation of a Hospital at Home benefit would need to combat the potential for a 2-tier system with differing levels of expertise and resources that is paid at the same reimbursement level (creating potential financial incentives to move patients into the home care setting with less intensive resources)
  - Nathan Graber noted the concern and reminded the Committee that Hospital at Home programs still have to follow the same requirements and practices for admission that the state requires generally for hospital care

	- Center for Evidence-based Policy staff reiterated that the CMS model does not waive state-specific regulations and standards - Question about the billing mechanism for Hospital at Home services - Nathan Graber affirmed the billing should be linked to a diagnosis-related group, the same as is in a brick-and-mortar facility - Explanation for why observational studies might move from a "low" rating to a "moderate" rating during the evidence review - Center for Evidence-based Policy staff provided reasons related to methodological quality, such as stronger comparator group design or a result that still shows a strong effect despite biases that would likely push the result in the opposite direction - Observation that the overall evidence base for Hospital at Home clinical outcomes appeared strong, and explanation for why some observational studies in the evidence review were given risk of bias ratings of "moderate" while some of the randomized controlled trial studies were graded as "high" - Center for Evidence-based Policy staff concurred that the evidence base for Hospital at Home was strong and relatively consistent, and clarified that randomized controlled trials and observational studies have different grading criteria for risk of bias - Discussion about observation status periods being completed prior to entering Hospital at Home programs, and whether reviewed studies had consistent criteria around observation periods - Center for Evidence-based Policy staff advised that this level of detail did not exist in many studies (especially those conducted internationally) but that patients would need to meet inpatient-level criteria in all cases at the hospital decision point - Joseph Truglio commented from his personal clinical experience that patients meeting observation status criteria are generally not admitted to Hospital at Home programs while in observation status, but may then be eligible after the 48-hour period elapses - Whether readmission rates reported in the studies were those relating to the patient's primary or initial diagnosis, or all causes - Confirmation that the CMS waiver model has used 30-day readmissions as a quality measure - Observation that caregiver burden trends higher in the Hospital at Home setting, though not statistically significant - Request for looking at the raw absolute numbers of different adverse events reported in the reviewed studies (Table 11 in the full report) - Confirmation that no data was identified in studies about financial costs to family members for taking time off work in Hospital at Home setting

	Sanjiv Shah noted the lack of evidence presented on the early discharge Hospital at Home pathway and asked for clarification if the Committee should focus its recommendation deliberations on the admission avoidance pathway. Center for Evidence-based Policy staff clarified that among the studies included in the report, there were 2 randomized controlled trials in which early discharge patients could have been included (in addition to admission avoidance). Nathan Graber advised that the Committee's decision was whether to recommend coverage of the full CMS waiver model (both admission avoidance and early discharge) and said the department would have further opportunities to monitor and look for additional data around use in the early discharge setting. Douglas DeLong expressed support for the program while noting potential fiscal concerns about cost shifting to patients and motioned for discussion to begin on the NYSDOH draft recommendation. James De Meo seconded the motion, and the Committee voted unanimously to consider the recommendation. Joseph Truglio commented that in his experience and professional correspondence, Hospital at Home programs do not formally distinguish between the admission avoidance and early discharge settings. He suggested that the data from reviewed studies may not reflect the reality that hospitals generally do not view Hospital at Home eligibility within that framework. NYSDOH put forward a recommendation for the Committee's consideration: *To prevent in-hospital admission or enable earlier transition of care to the home following the Centers for Medicare and Medicaid Services definition of Hospital at Home:* • *The Department of Health should review current policies to assess their impact on accessibility to the components necessary for a Hospital at Home benefit.* • *The Department of Health should monitor actions taken by other State Medicaid Agencies related to Medicaid coverage of Hospital at Home services and assess whether similar actions are appropriate in New York State.* Based on the initial discussion, Nathan Graber recommended removing the following phrase in the 1st paragraph: "To prevent in-hospital admission or enable earlier transition of care"

	Edmund Altone suggested that the recommendation should more directly address whether Hospital at Home services should become a Medicaid benefit, and Joseph Truglio suggested affirmative language from the Committee recommending coverage. Nathan Graber recommended the Committee make desired edits and said that one option would be starting with language saying that: "EBBRAC recommends that Hospital at Home becomes a benefit within the New York state Medicaid program." Sanjiv Shah asked if a goal for the Committee was to implement benefits that will be revenue neutral or cost saving. Nathan Graber clarified that it is one consideration for the Committee, but ultimately it is the state's consideration through the budgetary process. Sanjiv Shah expressed concern about ensuring that Hospital at Home was not overused and did not lead to cost escalation through admissions that could be handled through lower intensity services and reimbursement pathways. Emily Leish commented that the acute care level required for Hospital at Home admission should be the same in both Hospital at Home and traditional hospital settings, and Joseph Truglio asked for clarification if the concern was that patients may essentially be "upcoded" into the Hospital at Home setting. Nathan Graber appreciated the concern and said considerations would need to be built into the policy if the benefit moved forward. He also noted from prior discussions that Hospital at Home services require a certain amount of lead time to arrange care resources and equipment within the home setting, which may deter overuse. Deirdre Wheat said it would be important to ensure that similar expertise is available within both Hospital at Home settings and the in-hospital setting. The 1st paragraph of the recommendation was amended to: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends NYSDOH pursue coverage of a benefit following the Center for Medicare and Medicaid Services definition of Hospital at Home.* Jacob Wallace expressed support for this edited version and noted the strong clinical effects from the evidence review, including notable results around reductions in discharges to long-term care and hospital readmissions. Edmund Altone suggested adding a clear statement within the recommendation that the Committee does not believe the evidence supports the application of Hospital at Home to children. Warren Seigel agreed. Joseph

	Truglio commented that the CMS Hospital at Home waiver model requires the patient to go to the emergency room to enter the program and does not allow them to be admitted from home, which may create unnecessary care transitions; he recommended looking at this limitation in a future phase of policy development. Joseph Truglio also commented from his personal experience as a medical pediatrics clinician that Hospital at Home would be a meaningful benefit for children with complex medical issues and suggested leaving the decision to individual pediatricians. Nathan Graber noted interest in the Hospital at Home model from the pediatric medically fragile stakeholder community. Edmund Altone noted the lack of evidence presented on Hospital at Home in the pediatric setting and suggested not ruling out pediatric use but paying special attention to that setting within future policymaking. Joseph Truglio talked about his clinical experience with a home visit program for children that provided hospital-level care but would not have met the evidence review inclusion criteria. Douglas DeLong said he would feel comfortable leaving the pediatric setting flexible within the Committee's recommendation and not being too prescriptive. Jacob Wallace asked if Medicaid patients would have a choice about whether or not to use a Hospital at Home benefit. Nathan Graber affirmed that they would, and Elizabeth Brown noted that patient choice was identified as an important consideration in the literature review. Edmund Altone suggested a potential addition to the recommendation about the importance of informed patient consent within a Hospital at Home benefit. The Committee re-reviewed the 1 study on pediatric Hospital at Home care, and Elizabeth Brown noted that the literature review did identify additional pediatric Hospital at Home studies that did not meet the evidence review's inclusion criteria. The Committee reviewed an updated 1st paragraph of the draft recommendation to specify "adults": *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends NYSDOH pursue coverage of a benefit for adults following the Center for Medicare and Medicaid Services definition of Hospital at Home.* Victor Badner suggested adding a 3rd bullet within the recommendation to reflect the Committee's discussion on the pediatric setting and specify that the department would monitor actions taken by other state Medicaid agencies around pediatric Hospital at Home care, so that New York could potentially expand the benefit scope when the evidence was there to support

	it. Warren Seigel suggested language to accomplish this purpose, and the updated recommendation draft read: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends NYSDOH pursue coverage of a benefit for adults following the Center for Medicare and Medicaid Services definition of Hospital at Home.* • *The Department of Health should review current policies to assess their impact on accessibility to the components necessary for a Hospital at Home benefit.* • *The Department of Health should monitor actions taken by other State Medicaid Agencies related to Medicaid coverage of Hospital at Home services and assess whether similar actions are appropriate in New York State.* • *The Department of Health should continue to review current policies and monitor actions taken by other Medicaid agencies related to coverage of Hospital at Home for pediatric patients.* Nathan Graber told the Committee that their discussions on the public record are part of the department's considerations for developing an eventual policy. Douglas DeLong suggested that the new 3rd bullet on pediatrics may not be needed or could be combined into the 2nd bullet. Victor Badner supported having the recommendation specifically reflect the Committee's discussion on the pediatric setting since the 1st paragraph of the recommendation now specified an adult population. Nathan Graber noted the excitement around the potential future inclusion of a pediatric Hospital at Home program and suggested that both the sentiment and the current level of evidence was captured in the current recommendation draft. Trisha Schell-Guy suggested adding "for adults and children" to the 2nd bullet and removing the 3rd bullet. She also noted that a state stakeholder group for medically fragile children has an interest in Hospital at Home for that population. The updated recommendation draft read: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends NYSDOH pursue coverage of a benefit for adults following the Center for Medicare and Medicaid Services definition of Hospital at Home.* • *The Department of Health should review current policies to assess their impact on accessibility to the components necessary for a Hospital at Home benefit.* • *The Department of Health should monitor actions taken by other State Medicaid Agencies related to Medicaid coverage of Hospital at Home*

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services for adults and children and assess whether similar actions are appropriate in New York State.

Elizabeth Brown noted that the Center for Evidence-based Policy could conduct a follow-on evidence review for Hospital at Home in the pediatric population with different inclusion criteria. Emily Leish asked what changes would allow those studies to be included, and Elizabeth Brown said they had not met the specific definition of the CMS waiver model.

Emily Leish asked whether NYSDOH would decide to add a pediatric Hospital at Home benefit on its own or come back to the Committee to review more evidence. Nathan Graber said it depended on the circumstances and noted that a state stakeholder group for medically fragile children may be a key resource in helping to make that decision. He advised that application of the Hospital at Home model to areas outside of physical health (e.g., mental health) may be different enough to require Committee discussion.

Nathan Graber asked if there was a motion to accept the amended recommendation. Sanjiv Shah made the motion, and Ronald Braithwaite seconded it.
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<tr><td>Action Items /Decisions</td><td>
The Committee voted to approve the motion and accept the recommendation (16 yeas, 0 nay; 1 departed prior to vote)

Final, accepted recommendation:

The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends NYSDOH pursue coverage of a benefit for adults following the Center for Medicare and Medicaid Services definition of Hospital at Home.

The Department of Health should review current policies to assess their impact on accessibility to the components necessary for a Hospital at Home benefit.
The Department of Health should monitor actions taken by other State Medicaid Agencies related to Medicaid coverage of Hospital at Home services for adults and children and assess whether similar actions are appropriate in New York State.

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<tr><td>Discussion</td><td>Nathan Graber thanked the Committee members for their time and discussion and highlighted the value of the robust public commentary and dialogue during the first portion of the meeting. He announced that the next EBBRAC meeting will be April 16, 2026, in New York City and will address one topic:
Acupuncture for low back pain
He also announced the dates for the remaining EBBRAC meetings in 2026:
July 23, 2026 (Albany, with a focus on artificial intelligence-enabled health care products and services; workshop to be held on July 22)
November 12, 2026 (New York City)</td></tr>
<tr><td>Action Items /Decisions</td><td>Nathan Graber adjourned the meeting.</td></tr>
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