New York State Medicaid Evidence Based Benefit Review Advisory Committee

Friday, April 17, 2026

10:00 A.M. – 3:30 P.M. (EDT)

116 East 55th Street, New York, NY 10022

State University of New York, Global Classroom

Meeting Summary

Attendees
Committee Members Present: Edmund (Russ) Altone, Victor M. Badner, Ronald Braithwaite, Elisabeth Benjamin, Katherine Breslin, Marie-Carmel Garçon, Emily Leish, Peter Newell, Sanjiv Shah, Warren Seigel, Thomas Smith, Jacob Wallace, Deirdre Wheat (virtual), Nathan Graber* ***Committee Members Absent:*** *Douglas DeLong, James De Meo, Miranda Greiner, Joseph Truglio, Kaare Weber* **NYS Department of Health (DOH) Staff:** Shirley Belotte, Kate Bliss, Douglas Fish, Nathan Graber, Myla Harrison, Christian Soto (virtual), Suzette Sadio, Thomas Sciortino, Trisha Schell-Guy **Center for Evidence-based Policy Staff:** Elizabeth Brown, Susan Connor (virtual), Jami Hoffman, Valerie King, Jesse Baumgartner, Laura Pavlech, Susan Stuard **Public Comment:** Peter Caron **Other**: None

*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 (EBBRAC), 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 and Nathan Graber presented updates from NYSDOH. For details, see posted slide deck.
Action Items /Decisions	None
Topic Introduction & Public Comment/Presentations	
Discussion	Nathan Graber introduced the meeting's topic: Acupuncture for the Treatment of Nonspecific Chronic Low Back Pain in Adults. He then introduced a single public commenter, Dr. Peter Caron, a practicing acupuncturist on the Upper West Side of Manhattan and an acupuncture college professor who represents the Acupuncture Society of New York and treats patients with chronic low back pain in his clinic. In his prepared comments, Peter Caron summarized support for acupuncture in the treatment of low back pain, including: • Professional society and organization recommendations • Coverage from Medicare, Veteran Affairs, and certain state Medicaid programs • Data on cost-effectiveness and lower opioid treatment following acupuncture

	Nathan Graber opened the floor for Committee members to ask questions to the public commenter. Committee questions and discussion topics with the public commenter included:
	• The specific definitions and types of acupuncture, and the distinction between acupuncture and dry needling
	  o Peter Caron characterized dry needling as part of acupuncture; he expressed concern about the practice of dry needling by providers not trained and licensed in acupuncture
	• The education, training, and licensure standards and requirements for acupuncturists to practice (including New York specific standards)
	• Whether commercially insured patients are seen in the commenter's practice
	  o Peter Caron advised that he does not currently deal with private insurers in his practice but he typically provides patients with bills that may be submitted to insurance for reimbursement if they have out-of-network coverage; he stated that many private insurers do cover the services and that clinics may have different billing approaches; he also stated that clinics do attempt to provide lower-cost care options in more congregate settings, and that Medicaid coverage would be important for enabling access for more medically complex lower-income patients
	• How likely acupuncturists would be to participate in network for Medicaid reimbursement if the benefit was approved
	  o Peter Caron stated that the final reimbursement rate would matter, but that the services were often already being provided in lower-income communities at almost no cost or through volunteer providers; he felt that providers would work to find sustainable business models, and that Medicaid reimbursement could also provide more opportunities for younger acupuncturists coming out of school/training
	• How acupuncture fits alongside other treatment modalities and care providers for nonspecific chronic low back pain
	• Any pain or discomfort typically experienced during acupuncture, and any differences for dry needling compared to traditional acupuncture
	  o Peter Caron discussed various types and methods of acupuncture and dry needling that may produce different types of intensity, and advised that the field typically has low levels of adverse events with mild bruising or discomfort for 1-2 days after treatment
	• The use of acupuncture in indications beyond chronic low back pain, and how providers might ensure that coverage or payment is limited to the covered condition
	• Personal clinical experiences treating behavioral health and substance use conditions with acupuncture
	• The supply and penetration levels of acupuncturists in regions throughout New York state

	• The longevity of treatment effects evaluated within the EBBRAC evidence report o Peter Caron stated that depending on the specific cause of low back pain, acupuncture services may need to continue indefinitely for some patients, compared to a small number of visits for other patients • Whether acupuncturists become involved with worker's compensation patients or insurance; the considerations around treatment length and acupuncture service requests for work-related injuries, and the dynamics between Medicaid coverage and worker's compensation • The definitions of "nonspecific" and "chronic" within diagnosis language for chronic low back pain • The Medicare coverage requirement that acupuncturists operate under the supervision of other clinical providers (e.g., physician), and the administrative role that those clinical providers may play within health systems that employ acupuncturists (e.g., physicians with an acupuncture certification) • The scientific and biological mechanisms underpinning acupuncture treatment Nathan Graber also pointed EBBRAC members to Peter Caron's written comments submitted in advance of the meeting.
Action Items /Decisions	None
Topic: Acupuncture for the Treatment of Nonspecific Chronic Low Back Pain in Adults	

Discussion	The Center for Evidence-based Policy's Elizabeth Brown presented an overview of the evidence for acupuncture services for the treatment of nonspecific chronic low back pain, 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:
	• Why the review was limited to chronic low back pain, given acupuncture's use within other areas like infertility treatment
	  o Center for Evidence-based Policy staff advised on the need to balance the size of the evidence review with time constraints
	  o Nathan Graber noted that New York Medicaid currently does not cover acupuncture and that coverage would require a state plan amendment (SPA); he noted that if approved for the initial indication, other conditions may eventually be considered within the department's Internal Benefit Review Advisory Committee

	(IBRAC); he also noted the department's interest in alignment with the ongoing development of state pain management guidelines, and affirmed Committee discussion about the high prevalence of low back pain among Medicaid members and importance of alternative pain management approaches to reduce the use of opioids and subsequent risks for addiction. • How to consider and interpret studies using sham acupuncture as a comparator within reviewed studies in the report, whether sham acupuncture could also be considered another form of treatment, and the differences between sham acupuncture and dry needling o Center for Evidence-based Policy staff noted that the review specifically groups studies comparing acupuncture to usual care separately from those comparing acupuncture to sham acupuncture; they advised that Committee members may consider that the sham acupuncture comparator could be underestimating an effect from traditional acupuncture (if one is present) o Center staff noted that only 1 study included all 3 options compared together (acupuncture, sham, usual care), and labeled the considerations around sham acupuncture as a limitation of the research base o Center staff noted that although it is not a perfect placebo, sham acupuncture was generally used as a study comparison tool to measure the efficacy of traditional acupuncture; they noted that the studies did not compare specific acupuncture techniques and could not advise on whether sham acupuncture is also a potential treatment methodology used by some providers o Center staff clarified that dry needling differs from sham acupuncture in that it targets points directly related to pain • Which provider types are allowed to perform acupuncture under federal coverage policies for acupuncture o Center staff noted that under Medicare's national coverage determination, licensed acupuncturists generally have to be supervised by certain other provider types (e.g., physicians) • The interpretation of a high variability coefficient for the functional outcome scores within the studies of acupuncture vs. sham acupuncture o Center staff stated this measure indicates high variability between the studies and may also reflect potential differences in the design of the studies; they also noted that the GRADE ratings of certainty take this into account • Whether each individual study measuring functional status met the threshold of minimally clinically important difference for that specific scale o Center for Evidence-based Policy staff reviewed the studies and noted that some studies in the report data tables did not include

	raw functional score outcomes (e.g., only reporting mean differences between groups); the Center plans to follow up with the Committee with available information • Why there was no meta-analysis completed for the comparison of acupuncture vs. usual care on physical and mental quality of life outcomes o Center staff explained that the studies including usual care did not report outcomes in a way that could be used in a pooled analysis • The broader uncertainty and challenges around making a Committee determination due to the variability between studies regarding: time points when outcomes were measured, different types of outcomes, the durability of effects, and the considerations around sham acupuncture as a comparator o Nathan Graber commented on the possibility that the results may reflect significant real-world variation in the use and types of clinical acupuncture services • The approach that the DeBar et al study (2025) took to selecting and randomizing patients • The potential for adverse events if patients are diverted to acupuncture and do not enter or complete typical pathways for evaluation, diagnosis, and treatment of a condition o Center staff did not identify acupuncture studies that provided this type of information or analysis and noted that the focus on chronic vs acute low back pain may make these types of events slightly less likely • The importance of limiting the Committee's inquiry to adverse events directly attributable to acupuncture procedures • Whether states record adverse events reported for acupuncturists • Whether the Committee is limiting its review to services given by clinicians who are licensed to provide them o Nathan Graber clarified that the Committee did not need to consider acupuncture scope of practice or licensure recommendations, but could recommend which currently licensed acupuncture providers would be eligible for reimbursement for acupuncture services provided under the Medicaid program • Review of randomization methods and methodological limitations for the 1 cost-effectiveness study reviewed (Herman et al, 2026), including: o Wide confidence intervals o The measurement of cost based on relative change to baseline cost in each group without reporting the full absolute post-intervention cost amount, and the higher baseline costs observed for the enhanced acupuncture group (meaning savings could still be found even if post-intervention costs are the same across groups)

	o Questions around the potential for reversion to the mean from a regression perspective • The potential additional savings or costs averted associated with acupuncture treatment if it interrupts unsafe opioid use • Why acupuncture recommendations from the Society of Physical Medicine and Rehabilitation, the Society of Orthopaedic Surgeons, and the American College of Physicians were not included in the clinical practice guidelines review o Center for Evidence-based Policy staff noted the review protocol specifies evidence-based guidelines from the past 5 years; the American College of Physicians recommended acupuncture as first-line treatment in 2017 and currently lists the guideline as "inactive" o Center staff also noted that a guideline from the American Academy of Family Physicians did not meet the evidence review standard, and that the Society of Physical Medicine and Rehabilitation endorses the current North American Spine Society guideline • Why clinical practice guideline review is limited to 5 years o Center for Evidence-based Policy staff commented that 3 to 5 years tends to be a time period when new information or guidelines emerge; they also noted that certain guidelines may not change because of established science or practice, and that many professional organizations periodically re-affirm guidelines in those instances (though not always) • Why private health plans generally do not mention dry needling in their coverage policies, while many Medicaid programs do o Center for Evidence-based Policy staff noted that Medicaid agencies typically maintain full public fee schedules, which could include the codes that are specific for acupuncture and for dry needling, which can make it easier to determine coverage status • The different elements and considerations around coverage policies for acupuncture, including which codes are covered (e.g., dry needling) and which providers are licensed and enrolled o Clarification that the MetroPlusHealth Medicare Advantage plan directly enrolls and pays acupuncturists, even though they are technically under clinical supervision based on the Medicare national coverage determination; and that the MetroPlusHealth Medicaid managed care plan does not currently provide any coverage of acupuncture • How Medicaid managed care plans in New York state would currently be able to cover acupuncture services if they wanted to o Trisha Schell-Guy advised that technically it should be an in-lieu-of service so that members know it is available and being reimbursed, and that acupuncturists should be enrolled providers – however,

	acupuncturists are not currently able to enroll in the New York Medicaid program o There is an option for a physician to perform acupuncture as an ancillary service under a broader evaluation and management service code alongside other care services, but it cannot be separately billed; managed care plans could also choose to cover it with their own funds but not receive any federal matching share (the same options apply to dry needling services) • Whether there was any lower age limit listed within reviewed clinical practice guidelines and coverage policies (none found) After conclusion of the presentation, the Committee moved into discussion and the development of a recommendation. Edmund (Russ) Altone asked about the reason for limiting the EBBRAC review to adults only. Center for Evidence-based Policy staff advised that children are unlikely to be diagnosed with unspecified chronic pain, and Trisha Schell-Guy added that the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) federal regulations require Medicaid programs to cover anything medically necessary for children, regardless of whether the state plan includes it. Nathan Graber said that NYSDOH would not propose an initial recommendation for this meeting and invited Committee members to discuss their initial impressions; depending on the direction, NYSDOH staff could then display 1 of 2 draft recommendations to work from if needed. Sanjiv Shah asked if the recommendation around acupuncture would include dry needling within the scope. Nathan Graber commented that the presentation had shown a potential distinction, but that both are within the scope of a licensed acupuncturist and that the Committee could potentially be agnostic on the differentiation and allow the Medicaid agency to make decisions on code activations and the corresponding eligible providers or care delivery settings. He left it to the Committee to weigh in on differentiation between the two services and whether dry needling needs to be addressed in a different way under the policy. Marie-Carmel Garçon also said dry needling could be an add-on code under a policy. Edmund (Russ) Altone put forth an initial recommendation to the Committee: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends the Department of Health provide Medicaid coverage for adults receiving both acupuncture and dry needling treatment performed by a licensed acupuncturist or acupuncture-certified physician for the treatment of nonspecific chronic low back*

	pain for up to 12 sessions in a 90-day period, with an additional 8 sessions permitted if improvement is shown. *However, auricular acupuncture for the treatment of low back pain shall be excluded from such coverage.* Katherine Breslin seconded the motion to begin discussion. Emily Leish circled back to prior discussion about the low study GRADE ratings. Nathan Graber reiterated that there would be real-world variation in acupuncture practice delivery and that the studies were imperfect with varying degrees of standardization, which may be reflective of how acupuncture delivery looks in the real world. Nathan Graber commented that although the studies were open to many different variables and potential influences, in general it provided him with more confidence that the evidence being presented was showing a finding that acupuncture is effective in managing pain for adults with chronic low back pain. Jacob Wallace asked if it was within the purview of the Committee to recommend a pilot program, as compared to a statewide benefit. Nathan Graber advised that it was outside of the Committee's scope. He also noted the prior NYSDOH SPA request in 2020 to cover acupuncture for low back pain in adults through a regional pilot structure, which CMS denied (SPA was withdrawn). Deirdre Wheat suggested specifying that acupuncture treatment is "inclusive of dry needling" to avoid ambiguity. She inquired whether treatment providers could also include independent nurse practitioners and whether they could be certified in acupuncture. Trisha Schell-Guy clarified that nurse practitioners and physician assistants were not currently included within the state statute permitting the practice of acupuncture, which only specifies physicians, dentists, or special assistants. Douglas Fish commented that EBBRAC recommendations typically did not need to specify session quantity limitations or other granular details because it could limit the Medicaid program in the future. Katherine Breslin agreed and affirmed the Committee's advisory role to provide NYSDOH with parameters to eventually come up with detailed policies. Edmund (Russ) Altone clarified that the goal was to emphasize that the evidence indicates acupuncture should not be a one-off service and may need to be done repeatedly. Elisabeth Benjamin suggested the substitution of "course of treatment" to capture the sentiment. Sanjiv Shah asked about the regulation and monitoring of acupuncture offices or delivery sites, given that it would be an entire new provider category for

	the Medicaid program. Trisha Schell-Guy advised that physical facility oversight would flow through the provider licenses regulated by the New York State Education Department. The Medicaid program could create an acupuncture category of service for provider enrollment and a set of enrollment application requirements (e.g., license copy, background check). Nathan Graber affirmed that issues related to licensure and scope are outside of the Medicaid program's purview and highlighted certain Medicaid-specific standards that acupuncturists would be subject to if they become an enrolled provider type (e.g., billing and claims standards, designated provider facility settings eligible for payment). Nathan Graber recommended removing the sentence in the draft recommendation that excluded auricular acupuncture, as the review did not examine which specific methods of acupuncture were more effective. Elisabeth Benjamin again recommended adding "course of treatment" to indicate it is not just a single treatment. Marie-Carmel Garçon expressed concern about overuse of the benefit if treatment volume limitations were not included in a coverage policy and recommended specifying acupuncture-certified "providers" rather than "physicians." The updated draft recommendation was: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends the Department of Health provide Medicaid coverage for adults receiving both acupuncture and dry needling treatment performed by a licensed acupuncturist or acupuncture-certified provider for a course of treatment of nonspecific chronic low back pain.* Nathan Graber suggested that the recommendation should not explicitly define the term "course of treatment" with specific parameters, given that it may change over time and could vary significantly across patients; he commented that NYSDOH could more nimbly address the issue through an eventual specific coverage policy. Elisabeth Benjamin noted that the term provides the ability to more easily incorporate future evidence. Thomas Smith questioned whether including "course of treatment" raised immediate questions about the term's definition and suggested that the Committee's recommendation may not need to go beyond the simple term "treatment." Trisha Schell-Guy recommended using the term "treatment" and leaving specific treatment definitions and limitations or utilization management considerations to the NYSDOH policy team. Emily Leish agreed with this approach. Katherine Breslin asked if acupuncture providers needed a location code, or if the services could be completed within a patient's home. Trisha Schell-Guy affirmed that defining reimbursement-eligible treatment locations would be

	within the purview of the Medicaid program, and that the provider would need to have a license and be enrolled within the Medicaid program. Elizabeth Brown noted that past EBBRAC recommendations stated that NYSDOH should "pursue" rather than "provide" Medicaid coverage. Trisha Schell-Guy and Nathan Graber agreed it should say "pursue" because NYSDOH would need to seek an SPA and additional approvals to enact a full benefit. Emily Leish asked if the term "dry needling" would be taken out of the recommendation since it was included among the services an acupuncturist is licensed to perform. Thomas Smith noted that some other state Medicaid programs make a distinction and suggested including both in the recommendation. Sanjiv Shah agreed, and Deirdre Wheat suggested that the recommendation specify "acupuncture, inclusive of dry needling." Nathan Graber agreed with this approach, and Trisha Schell-Guy noted the approach was consistent with the Medicare coverage policy. The final draft recommendation was: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends the Department of Health pursue Medicaid coverage of acupuncture, inclusive of dry needling, performed by a licensed acupuncturist or acupuncture-certified provider for treatment of nonspecific chronic low back pain in adults.* Nathan Graber asked if there was a motion to accept the amended recommendation. Thomas Smith made the motion, and Warren Seigel seconded it.
Action Items /Decisions	The Committee voted to approve the motion and accept the recommendation (13 yeas, 0 nay; 1 departed prior to vote) Final, accepted recommendation: *The Evidence Based Benefit Review Advisory Committee (EBBRAC) recommends the Department of Health pursue Medicaid coverage of acupuncture, inclusive of dry needling, performed by a licensed acupuncturist or acupuncture-certified provider for treatment of nonspecific chronic low back pain in adults.*

Final Comments	
Discussion	Nathan Graber thanked the Committee members for their time and discussion. He announced that the next EBBRAC meeting will be July 23, 2026, in Albany and will address 2 topics: • Heartflow Fractional Flow Reserve from Computed Tomography (FFR-CT) Analysis for Noninvasive Identification of Coronary Artery Disease • Artificial Intelligence-Enabled Devices for Autonomous Detection of Diabetic Retinopathy The Committee will also participate in a workshop on evidence-based policy with a focus on artificial intelligence in health care on July 22, 2026, the day prior to the EBBRAC meeting. He also reminded Committee members of the date for the 3rd scheduled EBBRAC meeting in 2026: • November 12, 2026 (New York City)
Action Items /Decisions	Nathan Graber adjourned the meeting.