Centers for Medicare & Medicaid Services' ELEVATE Model: *Reforming Medicare Through Whole-Person Lifestyle Intervention*

An Analysis by C. Robinson, February 2026

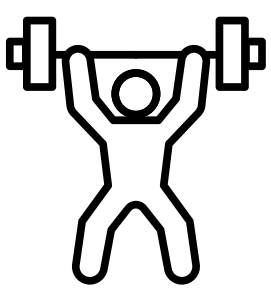
Overview

The CMS Innovation Center's ELEVATE Model is a $100 million initiative launching in late 2025 that aims to shift Medicare from a reactive "sick care" system to a proactive, whole-person wellness approach by funding functional and lifestyle medicine interventions for Original Medicare beneficiaries with chronic conditions.

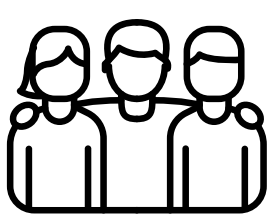
Through up to 30 cooperative agreements (approximately $3 million each over three years), the model supports programs addressing at least one of six domains; nutrition or physical activity (mandatory), restorative sleep, stress management, harmful substance avoidance, and social connection. Three awards are reserved for dementia-focused interventions. Unlike traditional reimbursement, ELEVATE requires rigorous evaluation of clinical outcomes, cost impact, patient-reported outcomes, and program fidelity to determine whether lifestyle interventions can meaningfully improve health and reduce downstream Medicare spending, potentially informing future permanent coverage decisions.

Nutrition (mandatory)

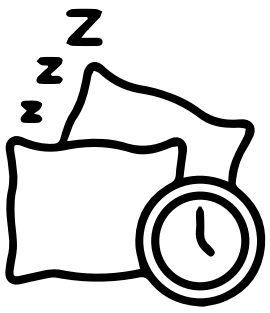
Subtance Avoidance



Physical Activity (mandatory)



Social Connection



Restorative Sleep

Stress Management

Dementia-Focused Intervention Programs (3 awards available)

Robinson Ventures, LLC

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Executive Summary

The "**Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence"** (*ELEVATE*) model is an initiative from the CMS Innovation Center (CMMI). Launched in late 2025 with a total funding pool of **$100 million**, the model seeks to address the root causes of America's chronic disease epidemic. Unlike traditional Medicare, which primarily reimburses for acute care and symptom management, *ELEVATE* funds **functional and lifestyle medicine** interventions.

The model will support up to **30 cooperative agreements** over the course of three years, targeting Original Medicare beneficiaries. By testing non-traditional services such as nutritional coaching, physical activity programs, and stress management, the model aims to generate the clinical and economic evidence needed to potentially integrate these services into permanent Medicare coverage.

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1. Detailed Analysis of the Model

The *ELEVATE* model represents a philosophical shift in federal healthcare policy, moving from a "sick care" system to a "proactive wellness" system.

A. Core Philosophy: The Whole-Person Approach

The model is built on the premise that chronic conditions (which account for nearly 90% of healthcare spending) are largely driven by behavior and environment. It focuses on **Functional Medicine**, which seeks to identify and treat the underlying *causes* of disease, and **Lifestyle Medicine**, which uses evidence-based lifestyle changes to *prevent* and *reverse* conditions.

B. The Six Interconnected Domains

All proposals must address one or more of these pillars, with **nutrition or physical activity** being mandatory components:

1. **Nutrition:** Culinary medicine, meal planning, and "Food as Medicine" counseling (excluding the cost of the food itself).
2. **Physical Activity:** Tailored exercise programs and movement therapy.
3. **Restorative Sleep:** Interventions for sleep hygiene and circadian health.
4. **Stress Management:** Psychological resilience and mindfulness-based interventions.
5. **Harmful Substance Avoidance:** Support for tobacco and alcohol cessation.
6. **Social Connection:** Combating isolation, particularly for dementia patients.

C. Structural Framework

- **Funding:** ~$3 million per awardee over a three-year performance period.
- **Target Population:** Original Medicare (Fee-for-Service) beneficiaries with one or more chronic conditions.

- **Timeline:** The first cohort begins **September 1, 2026**, followed by a second cohort in 2027.
- **Mandatory Focus:** Three awards are specifically reserved for **dementia-focused interventions**, recognizing the high cost and lifestyle sensitivity of cognitive decline.

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2. Pros and Cons

Pros

- **Unlocks New Reimbursement:** Provides a rare funding stream for services (such as nutrition coaching) that have been historically difficult to bill under Medicare.
- **Evidence Generation:** Offers participants a platform to validate their clinical models using CMS-grade data, which is essential for long-term scalability.
- **Pathway to Permanence:** High-performing models may serve as blueprints for future Medicare Part B coverage or new *CMMI* models.
- **Patient Engagement:** Empowers beneficiaries with tools for self-care, potentially improving quality of life and reducing future hospitalizations.

Cons

- **Funding Limitations:** The $100 million budget is minor compared to the scale of the Medicare population, limiting the number of participants.
- **Administrative Burden:** Applicants must demonstrate high "measurement maturity," requiring robust data collection and reporting infrastructure.
- **Unallowable Costs:** CMS has explicitly stated that funds cannot be used to purchase food, which may create barriers for "Food as Medicine" programs that lack external food sourcing partners.
- **Rigorous Evidence Threshold:** Applicants must already have peer-reviewed evidence of efficacy in order to be considered, making it difficult for early-stage startups to enter.

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3. Who Should Apply and Why?

Eligible Organization Type	Why Apply?
Accountable Care Organizations (ACOs)	To integrate lifestyle medicine into their value-based care workflows and reduce total cost of care.
Digital Health Platforms	To validate hybrid or virtual care models (e.g., behavior change apps) for the geriatric population.
Academic Medical Centers	To lead the evidence-generation effort and study the longitudinal impact of functional medicine.

Private Medical Practices	Specialized practices (e.g., integrative, or functional clinics) can now finally receive funding for their core service offerings.
Community-Based Groups	Organizations already doing the "on-the-ground" work of nutrition and fitness can gain federal recognition and scale.

Why apply now? The model offers a "first-mover advantage." Organizations that successfully participate in *ELEVATE* will be positioned as the primary authorities on lifestyle medicine within the Medicare framework, giving them a significant lead if these services become standard reimbursable benefits in the late 2020s.

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4. Conclusions

The ELEVATE model is a strategic "evidence-generation exercise." While its immediate financial footprint is modest, its policy implications are vast. It signals a federal willingness to move beyond the traditional "pills and procedures" model. Successful applicants will receive both funding and the opportunity to **define the future of American healthcare** by proving that lifestyle interventions can bend the cost curve of chronic disease.

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5. Work/Sources Cited

1. CMS Innovation Center. **MAHA ELEVATE Model** (program overview, funding, eligibility, requirements, timeline, FAQs). (CMS)
2. **Centers for Medicare & Medicaid Services (CMS).** (2025). *MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) Model Overview.*
3. **Epstein Becker & Green (EBG Law).** (2026). *Integrating Whole-Person Care into Original Medicare: Analysis of MAHA ELEVATE.*
4. **American Occupational Therapy Association (AOTA).** (2025). *OT Opportunities in CMS MAHA ELEVATE Model.*
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7. Fierce Healthcare. “CMS unveils new model aimed at functional, lifestyle medicine” (announcement context, quotes, framing, timing). (Fierce Healthcare)
8. Becker’s Hospital Review. “CMS launches ‘MAHA Elevate’ to test lifestyle medicine in Medicare” (timing, funding structure summary, industry reactions). (Becker's Hospital Review)

9. CDC. **Fast Facts: Health and Economic Costs of Chronic Conditions** (spending share for chronic/mental health conditions). (CDC)
10. HHS. **Make America Healthy Again (MAHA)** page (context for MAHA agenda referenced by CMS). (HHS.gov)

APPENDIX

Detailed analysis: How *ELEVATE* works in practice

Cooperative agreements imply "delivery + evaluation," not just service provision

Unlike traditional claims reimbursement, the cooperative agreement structure means awardees should expect:

- **Ongoing coordination with CMS** on measurement, recruitment, cost containment, and reporting
- A need for **implementation discipline** (standard operating procedures, training, fidelity monitoring)
- A research-like posture toward outcomes and safety surveillance

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What CMS is trying to learn

CMS states the interventions assessed will inform **future Original Medicare coverage determinations** or **future CMS Innovation Center models**.
In practical terms, *ELEVATE* is likely to test:

Clinical Value

- Which interventions work best for older adults (and for which conditions)?
- Are outcomes clinically meaningful (not just statistically significant)?

Economic Value

- Do interventions reduce downstream costs (admissions, ED use, post-acute spending)?
- Do program costs justify effects?

Operational Replicability

- Can interventions be standardized enough to scale across Original Medicare?
- What staffing models work (coaches, community health workers, allied health, clinicians)?

Evaluation domains and metrics (inferred from CMS goals + typical CMMI models)

CMS emphasizes "cost and quality data" and the goal of building a novel evidence base. Applicants should be prepared to track outcomes across:

1) Clinical and functional outcomes

- Condition-specific endpoints (e.g., A1c, BP, weight, lipid markers where relevant),
- Functional status, mobility, ADLs,
- Cognitive measures for dementia proposals.

2) Utilization and cost

- Hospitalizations, ED visits, readmissions,
- Total cost of care (TCOC) style analyses (depending on CMS guidance in the NOFO).

3) Patient-reported outcomes

- Quality of life, sleep, stress, loneliness/social connection.

Program process/fidelity

- Engagement, adherence, retention, dose delivered.
- Safety events and escalation protocols.

(Note: CMS will specify required measures in the NOFO; the above is a practical preparation lens, and not a claim about final requirements.)

Patient safety and beneficiary protections

CMS highlights:

- Proposals with evidence of or substantial risk of harm will be excluded,
- CMS monitoring during implementation and disenrollment for quality/safety failures,
- HIPAA compliance and federal privacy/security requirements,
- Beneficiaries keep all Original Medicare protections and can continue seeing any provider.

Strategic recommendations for applicants (how to improve odds of success)

1. **Pick a tight clinical scope**
   Choose one or two conditions with clear endpoints and a credible mechanism of action (e.g., cardiometabolic risk, MSK function, mild cognitive impairment support).
2. **Make the intervention replicable**
   Document protocols, staffing ratios, training, escalation pathways, and fidelity checks.
3. **Treat data as a "product," not an afterthought**
   Build reporting pipelines early; ensure outcomes can be captured reliably and timely (*CMS emphasizes this*).
4. **Design for engagement and retention**
   Older adults may face barriers (transportation, tech literacy, comorbidities). Program design should include accessibility supports.
5. **Partner if you lack a core capability**
   Common partnership patterns:
   - Provider group + community-based org (delivery reach),
   - Senior living + clinical program,
   - Academic evaluator + operator.