CMS Just Opened a $100M Door for Lifestyle Medicine Startups (And Mos Investors Will Miss It)

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ABSTRACT

The Centers for Medicare and Medicaid Services announced the MAHA ELEVA Model in early 2025, committing approximately $100 million in cooperative agreements to test functional and lifestyle medicine interventions for Original Medicare beneficiaries. This model represents the first time CMS Innovation Ce has explicitly funded whole-person care approaches including nutrition, physica activity, stress management, and other lifestyle interventions as complements to conventional medical care. The model will award up to 30 three-year cooperative agreements across two cohorts starting in September 2026 and 2027, with three awards specifically reserved for dementia interventions. For health tech investor MAHA ELEVATE creates several strategic opportunities: direct funding for por companies or acquisition targets, validation pathways for lifestyle medicine busi models, potential coverage determination precedents, and new evidence generat that could unlock broader Medicare reimbursement. This essay examines the mo

structure, analyzes which types of companies and interventions are best position win awards, explores the downstream market implications for digital health inve and identifies the specific company characteristics and intervention modalities n likely to succeed in the application process.

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WHAT CMS ACTUALLY JUST DID (AND WHY IT MATTERS)

The MAHA ELEVATE model announcement might look like just another CMS Innovation Center pilot program, and if you treat it that way you're going to mis what's actually interesting here. Yes, it's $100 million spread across 30 awards o three years, which in the context of Medicare spending is basically a rounding e But the significance isn't in the absolute dollars, it's in what CMS is explicitly fu for the first time and what that signals about the direction of coverage policy.

Let's start with what makes this different. CMS Innovation Center has run doze models testing various value-based payment arrangements, care coordination programs, and disease management interventions. Almost all of them involve restructuring payment for services that Medicare already covers or creating new

delivery mechanisms for existing covered benefits. MAHA ELEVATE is explicitl
designed to test interventions that Original Medicare does NOT currently cover.
Notice says proposals should include services not already covered by Original
Medicare but with documented evidence of efficacy. That's a fundamentally diff
premise.

What kinds of services are we talking about? The model focuses on functional a
lifestyle medicine, which CMS defines as whole-person approaches combining
psychological, nutritional, and physical interventions. Critical areas of focus inc
nutrition, physical activity, sleep, stress management, harmful substance avoida
and social connection. These are exactly the kinds of interventions that digital h
companies have been building for years but struggling to get Medicare to pay fo
Every proposal must incorporate either nutrition or physical activity as part of t
design, which tells you where CMS thinks the evidence base is strongest.

The timing matters too. This announcement came in early 2025 as part of what C
describes as the Administration's bold plan to reform America's health systems t
address the chronic disease epidemic. Whether you think the political framing i
genuine or performative, the substantive policy shift is real. CMS is acknowledg
that the current reactive, symptom-focused approach to chronic disease manage
isn't working and that proactive lifestyle interventions deserve systematic evalua
in the Medicare population. That's not a small thing.

The chronic disease statistics that CMS cites provide context for why they're doi
this. In 2022, approximately 45% of people with Medicare had four or more chro
conditions, and people with chronic conditions accounted for nearly 90% of tota
health care spending. The American health system primarily focuses on treating
symptoms of these conditions and managing diseases. That's the problem statem
The implied solution is shifting upstream to prevention and lifestyle modificatic
before chronic diseases develop or progress. CMS has talked about this conceptu
for years but hasn't put serious money behind testing lifestyle interventions unt

There's also something culturally significant happening here with the naming. M
stands for Make America Healthy Again, which is obviously political branding. I

the actual model design (Enhancing Lifestyle and Evaluating Value-based Appro Through Evidence) is substantively reasonable. CMS is funding evidence-based interventions with documented prior success, requiring rigorous data collection explicitly positioning these services as supplements to conventional medical care rather than replacements. The safeguards are actually pretty strong. Proposals w evidence of harm or substantial risk of harm will be excluded, recipients must c with HIPAA requirements, and CMS will monitor programs for safety concerns can disenroll recipients who fail to meet quality or safety standards.

What CMS is NOT doing is also important. They're not making coverage determinations based on this model yet. They're not changing Medicare benefits coverage. They're not allowing these services to replace traditional medical care. Beneficiaries who participate keep all standard Medicare protections and can continue to see any Original Medicare provider. The model is explicitly designed gather and evaluate new data on cost and quality to inform future interventions potentially inform future coverage determinations or future CMS Innovation Ce models. So this is fundamentally an evidence generation exercise with the possib of leading to broader coverage down the road.

THE MONEY MATH AND AWARD STRUCTURE

Let's talk about the actual funding structure because the details matter for understanding who can realistically compete for these awards. CMS will fund up cooperative agreements with a total budget of approximately $100 million over a three-year performance period. That works out to an average of about $3.3 milli award over three years, or roughly $1.1 million per year per recipient. But CMS "up to 30" which means they could fund fewer awards at higher amounts if the proposals warrant it.

The awards will be distributed across two cohorts. The first cohort launches September 1, 2026, and CMS will release the Notice of Funding Opportunity for cohort in early 2026. The second cohort launches in 2027. CMS hasn't specified

split between cohorts but a reasonable assumption is 15 awards in each cohort, though it could skew toward the first cohort being larger if they want to get mor faster.

Three awards will be reserved specifically for interventions that address dement This is interesting because dementia is one of the fastest-growing cost drivers in Medicare and there's limited evidence on whether lifestyle interventions can slo cognitive decline in older populations. CMS is basically creating a carve-out to e they get dementia-focused proposals even if they're not the highest-scoring applications in the general pool. If you have a company or intervention specifica targeting dementia prevention or progression, you're competing for one of three reserved slots rather than one of 27 general slots, which changes your odds significantly.

The cooperative agreement funding can be used to cover whole-person care serv including functional or lifestyle medicine that Original Medicare doesn't cover. only be used for Original Medicare patients. It can also cover costs for administ and data collection and reporting. Importantly, it cannot be used to cover food o services that can be billed to Original Medicare. That food exclusion is going to eliminate certain kinds of nutrition interventions or at least require creative structuring. If your intervention involves delivering medically tailored meals, th funding can't pay for the actual food costs, though it could presumably pay for t nutritional counseling, care coordination, and delivery infrastructure around the

Organizations can submit multiple applications and receive multiple awards, bu proposed intervention must be substantially distinct. CMS may ask organizatio combine related proposals into a single comprehensive proposal. This means if y a company with several different program modalities or target populations, you potentially capture multiple awards. But you need to be strategic about how dist your proposals actually are, because if CMS views them as variations on the sam intervention they'll force you to consolidate.

The performance period is three years, which is long enough to generate meanin outcomes data but short enough that companies need interventions that show re

relatively quickly. If your theory of change requires five years to demonstrate im on chronic disease progression, this probably isn't the right funding mechanism wants to see documented improvements in health within the three-year window they can make informed decisions about broader coverage or follow-on models.

Awardees will work with CMS to create a plan for data collection, quality measurement, recruitment and cost containment. This is cooperative agreement language, which means it's not just a grant where CMS gives you money and you your thing. CMS will be actively involved in shaping your data collection protoc quality metrics, and program design. If you're a startup that's never worked with before, this collaboration could be either incredibly valuable for future coverage pathways or incredibly painful depending on how bureaucratic the process beco

WHO'S POSITIONED TO WIN THESE AWARDS

The Notice provides pretty clear criteria for what CMS is looking for, and if you those criteria against the current landscape of lifestyle medicine and digital heal companies, certain archetypes emerge as stronger candidates.

First, CMS wants proposals with documented scientific evidence of the interven safety, efficacy and cost impact for the target population. They're also requiring applicants to provide data showing outcomes from their own program implemen prior to applying. This is a big deal because it eliminates purely theoretical interventions or early-stage companies without operational track records. You n published evidence supporting your intervention modality AND you need your c real-world data from prior program implementation. That combination points to companies that have been operating for at least a few years, have served enough patients to generate meaningful outcomes data, and ideally have published peer-reviewed research or have their interventions based on published research proto

Companies that come to mind include Omada Health for diabetes prevention an chronic disease management, Noom for weight management with a behavior cha focus, Virta Health for type 2 diabetes reversal through nutritional ketosis, Fooc

(formerly Zipongo) for nutrition-based chronic disease management, and Headsp or Calm for mental health and stress management interventions. These compani have published outcomes data, have served thousands or tens of thousands of pa and have interventions grounded in evidence-based protocols.

The requirement that all proposals must incorporate nutrition or physical activi part of the design further narrows the field. Pure mental health or sleep interver won't qualify unless they incorporate a nutrition or physical activity component. favors companies with integrated whole-person approaches rather than point solutions. It also favors companies working in metabolic health, weight manager diabetes prevention, and cardiovascular disease management, since those condit have the strongest evidence base connecting lifestyle interventions to clinical outcomes.

CMS also wants applicants who can demonstrate past experience with data colle or the ability to accurately collect and report all required data from beneficiary enrollees in a timely manner, with appropriate data protections in place. This is companies with health plan contracts or prior CMS program experience have an advantage. If you've already been collecting and reporting HEDIS measures for Medicare Advantage plans or participating in other CMS programs, you underst the data infrastructure and compliance requirements. If you're a consumer wellr app that's never dealt with HIPAA-compliant data collection and reporting to CI you're going to have a steep learning curve.

The model is also looking for organizations with experience integrating and measuring the impact of approaches to health and wellness with scientifically documented improvements in health. The word "integrating" suggests CMS valu organizations that can coordinate across multiple intervention types rather than delivering a single modality in isolation. This points toward platform companies integrated delivery organizations rather than single-purpose apps.

Provider organizations are probably going to be strong candidates too. Function medicine clinics like Cleveland Clinic's Center for Functional Medicine or acad medical centers with lifestyle medicine programs have the clinical infrastructure

collection capabilities, and published research that CMS is looking for. They ma be as tech-forward as digital health startups, but they have credibility with CMS established patient populations.

Another category that might do well is community-based organizations with trac records in chronic disease prevention. YMCA's Diabetes Prevention Program is canonical example, having gone through the CDC recognition process and estab evidence of effectiveness. Organizations like that have the documented outcome experience with program delivery at scale, and relationships with Medicare beneficiaries that CMS values.

One interesting dynamic is whether digital health companies will apply directly partner with provider organizations or community-based organizations to apply jointly. A digital health company might have the technology platform and interv design but lack the clinical credibility or patient recruitment capabilities that a system or community organization could provide. Conversely, provider organiza might have the patients and clinical infrastructure but lack the technology and c analytics capabilities that digital health companies offer. Strategic partnerships the application process could strengthen proposals on both sides.

The three reserved awards for dementia interventions create a specific opportun companies working in brain health and cognitive decline. Companies like Brain(for cognitive assessment, Linus Health for brain health management, or Bold (formerly Neurotrack) for cognitive health and dementia risk reduction could be candidates. The challenge is that the evidence base for lifestyle interventions reversing or slowing dementia progression is still emerging, so applicants will ne be careful about what outcomes they promise and what existing evidence they ca point to.

THE STRATEGIC VALUE BEYOND THE FUNDING

If you're evaluating this purely on the direct funding math, $1.1 million per year three years is nice but not transformative for most companies. An early-stage sta

might find that material, but for companies that have already raised Series A or l rounds, it's not make-or-break money. The real value is strategic, and there are s layers to unpack.

First, winning a MAHA ELEVATE award is a major validation signal. CMS is essentially saying your intervention has sufficient evidence and promise that tax should fund research on it with Medicare beneficiaries. That's incredibly valuab future fundraising conversations, health plan sales discussions, and provider partnerships. You can credibly say you're a CMS Innovation Center testing partı which puts you in a different category than competitors who haven't achieved th status.

Second, the evidence generation process creates potential pathways to broader Medicare coverage. CMS explicitly states that interventions tested in MAHA ELEVATE will inform future Original Medicare coverage determinations or pote future CMS Innovation Center models. If your intervention demonstrates strong clinical outcomes and cost savings during the three-year performance period, yo created the evidence base that CMS needs to make a national coverage determin or design a follow-on model with broader reach and potentially fee-for-service reimbursement. That's the ultimate prize because it unlocks the entire $900 bill Medicare market rather than just a $100 million pilot.

The coverage determination pathway is worth dwelling on because it's historical been nearly impossible for lifestyle interventions to achieve. CMS coverage is dr by the "reasonable and necessary" standard, which requires clinical evidence tha intervention improves health outcomes for the Medicare population specifically. lifestyle medicine interventions have evidence in younger populations or in cont research settings, but limited data in the Medicare fee-for-service population. M ELEVATE creates a mechanism for generating exactly that evidence. If you can s that your nutrition intervention reduces HbA1c in Medicare beneficiaries with T diabetes and reduces total cost of care over three years, you've built the evidenti foundation for a coverage claim.

Third, participating in MAHA ELEVATE gives you deep operational experience CMS processes, data requirements, and quality measurement. This is valuable institutional knowledge that makes you more competitive for future CMS progr You'll understand how to structure interventions to meet CMS quality measures to recruit and retain Medicare beneficiaries, how to collect and report data in C compatible formats, and how to navigate the cooperative agreement relationship of that makes you more attractive to health plans and other payers who want ver with proven CMS experience.

Fourth, the model gives you access to Original Medicare beneficiaries, which is a population that's historically been hard for digital health companies to reach. Medicare Advantage plans are more accessible because they're commercial entit with flexibility to cover innovative services, but Original Medicare beneficiaries have less awareness of digital health options and fewer pathways to access servic covered by traditional Medicare. MAHA ELEVATE creates a mechanism for enr those beneficiaries in your program with CMS funding and support.

Fifth, there's a competitive moat dynamic. If only 30 organizations receive award three years is enough time to generate compelling evidence, the winners could establish themselves as the evidence-backed leaders in their respective intervent categories. Future health plans or CMS programs looking to contract for lifestyl medicine services will naturally gravitate toward organizations that participated MAHA ELEVATE and demonstrated results. Being outside that group of 30 mea you're competing without the CMS seal of approval.

The flip side is that participating in MAHA ELEVATE also carries risks and cos The cooperative agreement structure means CMS involvement in program desig operations, which could slow down iteration and innovation. The data collection reporting requirements will consume internal resources. If your intervention do demonstrate positive results during the three-year period, you've generated evid against your own business model. And if CMS publicizes results across all 30 recipients, negative results or mediocre performance could damage your market position.

WHAT THIS MEANS FOR YOUR PORTFOI (CURRENT AND FUTURE)

If you're a health tech angel investor, there are several immediate tactical implic and some longer-term strategic considerations.

On the tactical side, if you have portfolio companies that fit the MAHA ELEVAT profile, you should be pushing them to apply. The Notice of Funding Opportuni comes out in early 2026 for the first cohort, so companies need to start preparin applications in the next few months. That means pulling together evidence documentation, prior program outcomes data, intervention protocols, data colle plans, and quality measurement frameworks. For companies that have been oper in metabolic health, diabetes prevention, cardiovascular disease management, or cognitive health with nutrition or physical activity components, this is probably highest-ROI use of BD resources in 2025.

The application process for federal cooperative agreements is usually rigorous a time-consuming. Companies without prior grant writing experience may want to bring in consultants who understand federal application processes. The good ne that CMS says they'll release detailed criteria in the NOFO, so companies will ha clear guidance on what to include. The bad news is that competition will likely b fierce, and writing a winning application requires both substantive program stre and strong presentation.

For new investments, MAHA ELEVATE should influence how you evaluate lifes medicine and chronic disease management companies. Companies with evidence based interventions, demonstrated outcomes in their target populations, and dat infrastructure capable of supporting CMS reporting requirements just became r valuable. The optionality of MAHA ELEVATE funding and the potential for futu coverage determinations is now part of the bull case. Conversely, companies witl interventions that lack published evidence or don't fit the nutrition-physical act requirement are less likely to benefit from this tailwind.

You should also be looking at which companies are positioned to win multiple a through distinct intervention proposals. If a company has programs targeting different chronic conditions (diabetes, hypertension, obesity) or different modali (nutrition counseling, physical activity coaching, stress management) that could qualify as substantially distinct interventions, they could potentially capture sev awards and significantly de-risk their business model with federal funding.

The dementia carve-out creates specific opportunities in brain health investing. you're looking at early-stage companies in cognitive health, Alzheimer's prevent dementia care, MAHA ELEVATE just increased the near-term market opportun Three awards reserved specifically for dementia interventions means CMS is act seeking proposals in this space, and companies with any evidence of lifestyle interventions slowing cognitive decline should be applying.

Longer-term, MAHA ELEVATE is a signal about the direction of Medicare polic value-based care more broadly. CMS is explicitly acknowledging that lifestyle interventions deserve systematic evaluation and funding, not just as nice-to-have wellness benefits but as potential core components of chronic disease manageme this model succeeds and generates strong evidence, it could catalyze a broader sh toward prevention and lifestyle medicine in Medicare coverage policy. That mak entire category of companies working in nutrition, physical activity, behavioral h and chronic disease prevention more interesting as long-term investments.

The model also validates the whole-person care and functional medicine approac that some investors have been skeptical about. If CMS is willing to put $100 mil behind testing interventions that combine psychological, nutritional, and physic components to address root causes rather than symptoms, that suggests the mar moving beyond point solutions toward integrated approaches. Companies buildi platforms that can deliver multi-modal interventions across the full spectrum of lifestyle factors (nutrition, physical activity, sleep, stress, social connection) are n aligned with where CMS seems to be headed.

THE GAPS NOBODY'S TALKING ABOUT

There are some interesting things that MAHA ELEVATE doesn't address or that create potential challenges that aren't obvious from the Notice.

First, the three-year performance period may not be long enough to demonstrate full value of lifestyle interventions for chronic disease prevention. If the theory i nutrition and physical activity changes today prevent diabetes or cardiovascular events five or ten years from now, three years might show intermediate outcome improvements (weight loss, HbA1c reduction, blood pressure control) but not necessarily the long-term cost savings that justify coverage. CMS will be measur cost and quality impacts over three years, but the real ROI on prevention plays o over much longer timeframes. This creates a mismatch between the evidence generation timeline and the actual value proposition of these interventions.

Second, the prohibition on using funding to cover food is going to create challer for nutrition interventions. If you're trying to help Medicare beneficiaries eat healthier but can't pay for the actual healthy food, you're limited to education, counseling, and behavior change support. That might work for beneficiaries who afford healthy food but don't know how to select or prepare it, but it doesn't add the economic barriers that prevent many Medicare beneficiaries from accessing nutritious food. Medically tailored meals programs have strong evidence of redu hospitalizations and costs in certain populations, but they won't fit cleanly into MAHA ELEVATE unless they can structure the intervention to separate the food from the services.

Third, the focus on Original Medicare beneficiaries rather than Medicare Advan creates some recruitment and operational challenges. Original Medicare benefic tend to be older, sicker, and less engaged with care management programs comp to Medicare Advantage enrollees. They're also harder to identify and reach since they're not enrolled in managed care plans with care coordination infrastructure Companies will need to develop novel recruitment strategies, potentially partner with providers or community organizations that serve Original Medicare popula The patient activation and engagement levels might also be lower than what companies are used to in commercial or Medicare Advantage populations, which could affect outcomes.

Fourth, there's a potential adverse selection dynamic where the Medicare benefi who choose to participate in lifestyle medicine programs are systematically diffe from those who don't. If program participants are more motivated, more health- literate, and already predisposed to behavior change, the results may not general the broader Medicare population. CMS will need to be thoughtful about how th evaluate intervention effectiveness and whether positive results are due to the intervention itself or selection effects.

Fifth, the model doesn't directly address reimbursement sustainability after the year performance period ends. If an intervention demonstrates strong results an beneficiaries want to continue receiving services, what happens when the cooper agreement funding runs out? Unless CMS makes a coverage determination or cr a follow-on model, there's no automatic payment mechanism. Companies could f themselves with strong evidence of effectiveness but no way to get paid for ongo service delivery. This creates a risk that successful programs create unmet dema without solving the fundamental payment problem.

Sixth, the competitive dynamic among the 30 award recipients could get weird. C is funding multiple interventions to test which work best, which means recipien implicitly competing against each other for future coverage or follow-on models Companies might be reluctant to collaborate or share learnings if they view othe recipients as competitors for the ultimate prize of Medicare coverage. CMS will to structure the cooperative agreement relationships carefully to encourage evid generation and shared learning rather than zero-sum competition.

HOW TO THINK ABOUT THIS AS AN INVESTOR

MAHA ELEVATE is fundamentally a de-risking mechanism for a category of healthcare interventions that have struggled with Medicare reimbursement. Life medicine and chronic disease prevention companies have always had a chicken-a egg problem where they couldn't get Medicare coverage without evidence of effectiveness in the Medicare population, but they couldn't generate that eviden

without funding to serve Medicare beneficiaries. MAHA ELEVATE solves that problem for up to 30 organizations by providing the funding to generate the evi

As an investor, you should view this as reducing execution risk for companies in portfolio that win awards and increasing competitive risk for companies that do your portfolio company applies and wins, they get validation, funding, evidence generation, and optionality on future coverage. If they apply and lose, they need understand why their proposal wasn't competitive and whether that signals fundamental weaknesses in their evidence base or intervention design. If they d apply at all, you need to understand whether that's because they don't fit the cri or because they're not thinking strategically about Medicare market access.

The $100 million funding pool is small enough that not every good company wil an award, so losing doesn't necessarily mean the business is flawed. But winning creates meaningful strategic value that compounds over time through coverage pathways, CMS relationships, and competitive positioning. Companies that are serious about the Medicare market should be treating MAHA ELEVATE as a hig priority opportunity.

For new investments, MAHA ELEVATE changes the risk-reward calculus for lif medicine and chronic disease prevention companies. The existence of this mode makes it more likely that strong interventions can achieve Medicare coverage, w significantly increases total addressable market. But it also means the competiti landscape will include CMS-validated players with published evidence from thr year Medicare population studies. If you're investing in a company that wouldn' competitive for MAHA ELEVATE awards, you need to understand what their pa Medicare market access looks like without CMS support.

The broader signal is that CMS is serious about shifting toward prevention and lifestyle interventions as complements to conventional medical care. That doesn mean every lifestyle medicine company will succeed or that Medicare coverage i guaranteed for interventions that show positive results in MAHA ELEVATE. Bu does mean the policy environment is more favorable than it has been historicall

companies that can generate rigorous evidence of clinical effectiveness and cost savings in Medicare populations have a viable path to reimbursement.

One final consideration is that MAHA ELEVATE creates information asymmetri that sophisticated investors can exploit. Most healthcare investors aren't paying attention to CMS Innovation Center model announcements or thinking about cooperative agreement opportunities. If you're actively monitoring these prograı and helping portfolio companies navigate the application process, you're creatin value that less engaged investors won't capture. Similarly, understanding which companies are applying for awards and how their applications are structured giv you insight into their strategic positioning and evidence strength that isn't visib from public disclosures.

The Notice of Funding Opportunity in early 2026 will provide much more detail application requirements, evaluation criteria, and program specifics. That's whe tactical opportunities become clearer. But the strategic opportunity is already vi CMS is putting real money behind testing lifestyle interventions in Medicare, ar companies that execute well have a path to transforming evidence into coverage coverage into sustainable business models at scale. For investors who understan Medicare market and can identify companies with the right combination of evid operational capabilities, and intervention design, MAHA ELEVATE just made th category considerably more interesting.

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