Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-Based Approaches Through Evidence (MAHA ELEVATE) Model Webinar

March 31, 2026

Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Speakers

Aisha Pittman
Senior Vice President,
Government Affairs
NAACOS

Melissa Medeiros
Vice President,
Health Systems Innovation and Payment
Hart Health Strategies

Overview

- **Three-year voluntary model** launching with two cohorts:
  - October 2026 → first cohort starts
  - October 2027 → second cohort starts
- Designed to test innovative, evidence-based clinical interventions rooted in **"whole-person functional and lifestyle medicine (FLM)"** not currently covered under Original Medicare
  - Focuses on proactive, comprehensive interventions that integrate psychological care, nutrition, physical activity, and personalized lifestyle-based strategies for prevention and early treatment
  - Goal is to evaluate whether FLM interventions improve health outcomes and chronic condition management when integrated into daily life and care plans
  - Findings could inform future Medicare coverage or full-scale models
- **Approx. $100 million available through Cooperative Agreement Awards**
  - 30 recipients split into two cohorts; Approx. $3.3 million available to each recipient over three-year period
  - 3 awards set aside for programs focused on dementia and cognitive decline
- **Upcoming deadlines:**
  - April 10, 2026: Required letter of intent
  - May 15, 2026: Application deadline

Foundational Pillars

Model is adapted from the **American College of Lifestyle Medicine (ACLM) six foundational pillars** for chronic condition prevention and management:

Whole-Person FLM Interventions

Lifestyle Medicine

- Focuses on preventing and treating chronic disease through evidence-based behavioral changes
- *Examples: Nutrition, physical activity, sleep, stress management, social connection, and avoidance of harmful substances*

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Functional Medicine

- Uses systems-based, individualized approach that aims to identify and address root causes of illness by examining interactions among genetic, environment, and lifestyle

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- Whole-person FLM interventions intended to support – not replace – conventional medical care for chronic conditions
- Must incorporate nutrition or physical activity as part of intervention
- Must include at least one service not covered by Original Medicare and provide evidence of efficacy in target population
  - May include combo of whole-person FLM and conventional interventions

Eligibility Requirements

- **Organization Type:** Demonstrate clinical oversight capabilities to ensure appropriate care delivery and beneficiary safety
  - Not required to be a clinical entity → can partner with one
- **Legally Recognized Entity:** Must have valid Tax Identification Number (TIN), National Provider Identifier (NPI), CMS Certification Number (CCN), and/or Employer Identification Number (EIN)
- **Original Medicare Enrollment:** CMS strongly recommends organizations enroll in Medicare
  - If providing covered Medicare services as part of intervention, must enroll before start of model
  - If not enrolled in Medicare, must verify ability to enroll Medicare beneficiaries by partnering with a clinical entity
- **Ability to recruit and meet beneficiary minimum and sample size**
- **Data capabilities:** Must demonstrate experience with data collection and ability to accurately collect and report all required data for patient enrollees in timely manner
  - Appropriate data privacy and security protections
  - Understanding of how to store and analyze data
  - Responsible for obtaining any Institutional Review Board (IRB) procedures and approvals
- **Liability and/or malpractice insurance** (as appropriate)

Examples of eligible applicants*

- ✓ Private medical practices
- ✓ Health systems and ACOs
- ✓ Academic organizations
- ✓ Functional, lifestyle, preventive, and integrative medicine centers
- ✓ Community-based organizations
- ✓ Federally Qualified Health Centers (FQHCs)
- ✓ Rural Health Clinics (RHCs)
- ✓ Indian Health Service/Tribal Services/Urban Indian Programs
- ✓ Local and state governments

**Not an exhaustive list*

Funding and Disbursement Timeline

- **Funding paid out based on meeting milestones and targets:**
  - 60% distributed based on meeting ***operational milestones***
  - 40% tied to meeting ***minimum enrollment targets***

- Participants have up to six months for pre-implementation activities at start of award
  - After six months, should start enrolling patients
  - If haven't started enrolling patients by 12 months post-award, award may be terminated
  - Can request modifications to award timeline (e.g., intervention lasts more than 12 months)

- May only use cooperative agreement funds for portion of program that serves Original Medicare beneficiaries

Disbursements: Operational Milestones

Disbursement Timeline Based on *Operational Milestones* (60%)

Illustrative example of $3 million award

Disbursement	Milestones
Initial (40%) – e.g., $1.2 million	Receipt of Notice Award
14 months post-award (5%) – e.g., $150,000	• Submitted 90% or more of beneficiary rosters on time. • Participated in technical assistance (when applicable). • Secured CMS IT systems access within six months post-award. • Submitted TIN/NPI information in recipient portal within 6 months post-award • Submitted cooperative agreement progress and financial reports. • Enrolled at least 10% of beneficiary target.(Program completion is not required for this milestone.)
20 months post-award (5%) – e.g., $150,000	• Submitted clinical data on time. • Submitted 90% or more of beneficiary rosters on time. • Completed at least 20% of your minimum beneficiary target, meaning they have enrolled and completed the program.* • Submitted cooperative agreement progress and financial reports.
26 months post-award (5%) – e.g., $150,000	• Submitted clinical data on time. • Submitted 90% or more of beneficiary rosters on time. • Submitted information to the evaluation contractor. • Submitted cooperative agreement progress and financial reports.
32 months post-award (5%) – e.g., $150,000	• Submitted clinical data on time. • Submitted at least 90% of beneficiary rosters on time. • Submitted information to the evaluation contractor. • Submitted cooperative agreement progress and financial reports. • Completed at least 65% of the minimum beneficiary target.*
Total (60%) – e.g., $1.8 million	**$1.2 million pre-implementation funding** **$600,000 milestone funding**

Disbursements: Minimum Enrollment Targets

- CMS will set minimum beneficiary target based on intervention and size of expected effect
- To count toward beneficiary targets, beneficiaries must:
  - Enroll in program
  - Be confirmed by CMS as being eligible for Original Medicare
  - Complete entire program
- Funds will be disbursed as participant meets targets
  - Cannot receive disbursement if fail to meet previous operational milestones

Disbursement Based on *Minimum Enrollment Targets* (40%)

Illustrative example of $3 million award

Percent of beneficiary target	Percent of funding disbursed
25%	**7.5%** – e.g., $225,000
50%	**12.5%** – e.g., $375,000
75%	**7.5%** – e.g., $225,000
100%	**12.5%** – e.g., $375,000
Total	**40%** – e.g., $1.2 million

Limitations on Funding and Indirect Costs

- **Cooperative agreement funding has certain limitations –** including the following unallowable costs:
  - Services covered by Original Medicare
    - However, could fund service that is offered in excess of Original Medicare limits or outside current coverage determination (since those instances would not be considered covered services)
  - Meals or food, including vouchers
  - Services provided to persons not enrolled in Original Medicare
  - *See pages 28-29 of the NOFO for full listing of limitations on funding.*

- **Salary Rate Limitations** set at $228,000 for 2026 (*current salary cap for most health-related federal grants*)

- **Indirect Costs:** Option of two methods:
  - **Approved Rate** approved by cognizant federal agency
  - ***De minimis rate*** of 15% of modified total direct costs (if don't already have a negotiated indirect cost rate)

Quality Measures

- Recipients required to collect and report patient-level data to CMS for monitoring and evaluation

- **Required measures:**
  - **Nutrition OR physical activity measure**
  - **Behavioral health measure**
  - **At least two clinical measures** that are evidence-based, feasible to collect, and directly related to the intervention
  - **Patient satisfaction measure –** *CMS will develop and track*

- **Optional Measures:** Participant can also choose to track measures related to:
  - Sleep
  - Stress management
  - Avoidance of risk substances
  - Positive social connections

Monitoring Activities and Data Collection

- Starting in Q1 of Model Year 1, will be **required to participate in monitoring activities**, including (but not limited to):
  - Submitting quarterly progress reports
  - Engaging with appropriate partners as necessary to develop strategies and draft agreements to link and share data
  - Communicating regularly with a CMS project officer
  - Regularly attending and participating in learning system events
  - Participating fully in technical assistance activities

- **Data Collection:** Must collect and report following data elements* to monitor progress:
  - **Identifiers of beneficiaries and providers** participating in intervention and control/comparison group
  - **Documentation of intervention,** including duration of enrollment and intervention, nutrition and/or physical activity data, referrals to partners or other providers
  - **Clinical data reporting** for two selected measures
- **Qualitative and additional survey data:** Must assist CMS and contractors with survey and qualitative data collection (e.g., interviews, site visit, focus groups)
- **Other site-level health, utilization, and referral data**
- **Program documentation,** such as training materials, recruitment and educational materials, and other documents developed by participant

**Full listing of data elements, including frequency of data reporting, detailed in the Appendix.*

Model Overlap

- MSSP ACOs are eligible to apply
- Organizations participating in other CMS Innovation Center models may apply and will be assessed on a case-by-case basis

Applying

- Letter of Intent (LOI) due April 10, 2026
  - Submit through LOI Portal Submission Form
  - Must identify intervention pillars and chronic conditions that intervention will address

- Applications due by May 15, 2026 at 11:59 PM (ET)

- To apply must have:
  - SAM.gov registration --> **can take several weeks**
  - Grants.gov registration --> **can take several days**

Selection Criteria

CMS will select recipients based on five criteria:

1. Whole-person FLM intervention design, including cost savings
2. Beneficiary recruitment and study design
3. Organizational and administrative capacity
4. Data management capabilities
5. Budget

Competitive candidates must demonstrate:

- Strong evidence for proposed intervention
- Proof of organizations own success in implementing the intervention and cost savings
- Ability to recruit large number of participants with clear randomization plan and advanced data management capabilities

NOTE: Candidates who do not directly provide clinical care are strongly encouraged to partner with entities that do

Application Narratives

- Applicants will be required to submit the following narratives:
  - **Project summary** (1 page)
    - Describes purpose and outcomes of proposed project, including project goals, budget amount, and description of how funds will be used
    - Includes organization name and any subrecipients/sub-awardees
    - *Use Project abstract Summary form*
  - **Project narrative** (limited to 15 pages)
    - "Most important part" of the application
    - CMS recommends applicants use *Project Narrative templates* (See Appendix B of NOFO)
  - **Budget narrative** (limited to 10 pages)
    - *Use Budget Narrative Attachment form*

- Applicants must also submit several attachment forms and other required forms

See pages 35-36 of the NOFO for a full application checklist and details on formatting.

MAHA ELEVATE Application Scoring Rubric

Whole-person FLM intervention design (45 pts)

- Intervention and outcomes (*10 pts*)
- Approach (*10 pts*)
- Cost savings plan (*10 pts*)
- Description of evidence base (*15 pts*)
    - Strength and quality of study design (*6 pts*)
    - Sample size (*5 pts*)
    - Direction and magnitude of effect (*4 pts*)

Beneficiary recruitment/retention plan (20 pts)

- Beneficiary recruitment plan (*10 pts*)
- Study design (randomization) (*10 pts*)

Organization, administration, and capacity (15 pts)

- Key personnel (*5 pts*)
- Prior experience and capabilities (*10 pts*)

Data management plan (10 pts)

- Capability (*6 pts*)
- Patient safety plan (*3 pts*)
- CEHRT (*1 pt*)

Budget narrative (10 pts)

- Funds for activities (*6 pts*)
- Funds for personnel (*2 pts*)
- No funds for prohibited costs (*2 pts*)

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Data management plan (10 pts)
- Capability (*6 pts*)
- Patient safety plan (*3 pts*)
- CEHRT (*1 pt*)

Budget narrative (10 pts)
- Funds for activities (*6 pts*)
- Funds for personnel (*2 pts*)
- No funds for prohibited costs (*2 pts*)

✓ **Interventions and outcomes.** Clear link between the intervention, population/condition, and expected outcomes

✓ **Approach.** Intervention takes whole-person FLM approach and includes nutrition and/or physical activity

✓ **Cost savings plan.** Savings plan demonstrates reasonable expectation of generating savings in Original Medicare over time
- Do not need to prove cost savings within cooperative agreement period, but must show time period over which would expect to see reduced Medicare spending if intervention was covered

✓ **Description of evidence base.**
- Evidence demonstrates intervention's patient safety and effectiveness
- Randomized designs will receive the highest scores
- Preference given to studies with more than 1,000 individuals and demographics similar to Medicare
- Larger, clinically meaningful effects are preferred over statistically significant effects
- Cited articles must be attached to application

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- CEHRT (*1 pt*)

Budget narrative (10 pts)
- Funds for activities (*6 pts*)
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- No funds for prohibited costs (*2 pts*)

- ✓ **Specify target population and how many beneficiaries expect to screen, find eligible, and enroll**
  - CMS will use information to set minimum beneficiary target for program
- ✓ **Provide information on recruitment plan**, including service area, providers who will refer patients, how organization will assess patient need, specific dates for reaching enrollment goals (and backup plan), plans for patient outreach, strategies for patient engagement, patient incentives, etc.
- ✓ **Describe method for randomized design or creation of comparison group**

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- Key personnel (*5 pts*)
- Prior experience and capabilities (*10 pts*)

Data management plan (10 pts)
- Capability (*6 pts*)
- Patient safety plan (*3 pts*)*
- CEHRT (*1 pt*)*

Budget narrative (10 pts)
- Funds for activities (*6 pts*)
- Funds for personnel (*2 pts*)
- No funds for prohibited costs (*2 pts*)

*NOTE: The NOFO contains a discrepancy: one section assigns 3 points to patient safety and 1 to CEHRT, while another assigns 2 points to each

- ✓ **Describe organization and list individuals responsible for ensuring compliance**
  - Must attach organizational chart and CVs/resumes for key personnel
- ✓ **Describe work with partner organizations** (if applicable)
- ✓ **Describe prior experience implementing intervention**, including resources required to deliver intervention
  - Could be a pilot study, less rigorous study design, or non-Medicare population

- ✓ **Describe data collection plan,** including:
  - Experience collecting and reporting beneficiary-level data to CMS, including collecting and storing protected health information/personally identifiable information
  - Plans to collect and report patient and provider information
- ✓ **Describe plans to monitor for and mitigate potential patient harm from intervention**
- ✓ **Indicate whether organization has CEHRT**

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Data management plan (10 pts)
- Capability (*6 pts*)
- Patient safety plan (*3 pts*)
- CEHRT (*1 pt*)

Budget narrative (10 pts)
- Funds for activities (*6 pts*)
- Funds for personnel (*2 pts*)
- No funds for prohibited costs (*2 pts*)

✓ **Budget narrative supports information provided in Standard Form 424-A** – added detailed and justifies costs including:
- Designate a Principal Investigator/Project Director (PI/PD) with sufficient time and oversight responsibility for the grant
- Provide a yearly cost breakdown by line item (SF-424A)
- Describe and justify costs for each activity, including calculation methods
- Specify the proportion of funding allocated to each activity
- Clearly distinguish lead agency vs. subcontracted costs
- Articulate how costs align with each activity and program goal
- Include per-patient cost estimates for each intervention

Additional details, including instructions and template, are available on the CMS website

Questions?

Upcoming Events

Register Today! Spring 2026 Conference

Broadening Reach, Deepening Value

April 22-24 in Baltimore

Registration Open

Keynotes from CMS and health system leaders

Plus 16 breakouts on how to

- Partner across CMMI models
- Revolutionize home-based primary care
- Boost your bottom line with risk taking
- Elevate high-value providers
- Engage community health centers
- Structure successful contracts with payers
- Maximize shadow bundles

Fall Conference October 14–16, Marriott Marquis Washington, D.C.

Upcoming Events

Title	Date(s) and Times	Location	More information
NAACOS ACO REACH/LEAD Roundtable Meeting **MSSP vs LEAD**	April 2: noon ET	Virtual	Register
CMS LEAD Model Webinar	April 9: 2pm ET	Virtual	Register
NAACOS LEAD Model Webinar	April 27: 1pm ET	Virtual	Registration coming soon
NAACOS ACO REACH/LEAD Roundtable Meeting **With CMMI LEAD Team**	April 30: noon ET	Virtual	Register
Monthly ACO REACH/LEAD Roundtable Meeting **Series**	4th Thursday each month: noon ET	Virtual	Register
Other Deep Dive Roundtable Series	Schedules Vary	Virtual	Register
NAACOS Spring Conference	April 22-24	Baltimore, MD	Agenda and registration

NAACOS Regional Map

Northwest

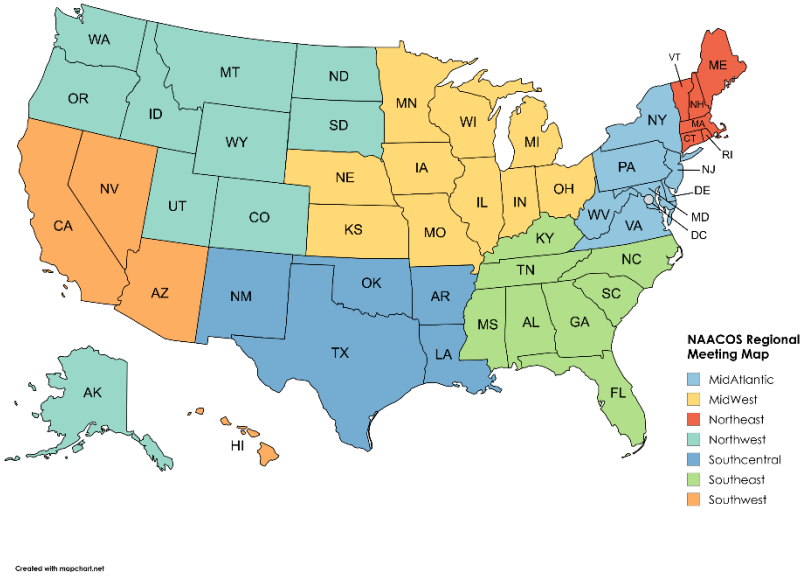
- August 13, 2026 - Boise Idaho
- March 2027 - TBA

Southwest

- November 2026 - TBA
- May 19, 2026 - Virtual

South Central

- January 2027 - TBA
- August 25, 2026 - Virtual



Northeast

- July 28, 2026 - Providence, RI
- March 2027 - Virtual

Mid-Atlantic

- June - TBA
- December 2, 2026 - Virtual

Midwest

- July 16, 2026 - Milwaukee, WI
- February 2027 - TBA

Southeast

- February 2027 - TBA
- September 14, 2026 - Virtual

THANK YOU!

Please submit additional questions to

advocacy@naacos.com

Appendix

Required Data Elements and Reporting Frequency

Data Elements	Unit of Analysis	Frequency of Data Reporting*
Identifiers of beneficiaries and providers involved in the intervention		
Medicare identifiers linkable to CMS claims and enrollment data for beneficiaries (screened and enrolled for the intervention, and for the control/comparison group).	Patient level	• Baseline (if available). • Pre-implementation (quarterly). • **Implementation (quarterly).***
Medicare identifiers (like TINs or NPIs) linkable to CMS claims data for providers participating in the intervention and control/comparison group (if applicable).	Provider level	• Baseline (if available) • Pre-implementation (quarterly). • **Year 1 (quarterly).*** • **After Year 1 (semiannual).***
Documentation of the intervention		
Duration of beneficiary enrollment in intervention (start and stop dates; frequency of contact).	Patient level	• Baseline (if available). • Pre-implementation (quarterly). • **Implementation (quarterly).***
Nutrition and/or physical activity data and results on beneficiaries screened and follow-up data on those enrolled in the intervention as well as beneficiaries assigned to the control or comparison group.	Patient level	• Baseline (if available). • Pre-implementation (quarterly). • **Year 1 (quarterly).*** • **After Year 1 (semiannual).***
Referrals to partners (such as CBOs, fitness centers, nutritionists) or other providers (primary care, specialists) based on screening and assessment data, if applicable.	Patient level	• Year 1 (quarterly). • After Year 1 (semi-annual)
Clinical Data Reporting		
Data on two different clinical measures (e.g., blood pressure, weight and height, waist circumference, HbA1c levels, cholesterol levels) expected to change due to the intervention for all beneficiaries enrolled in the intervention and for beneficiaries in a control or comparison group.	Patient level	• Baseline (if available). • Pre-implementation (quarterly). • **Year 1 (quarterly).*** • **After Year 1 (semiannual).***

*** Required data elements bolded and marked with asterisk.**

Cooperative Agreement Terms

Participant Responsibilities

- Comply fully with CMS and any CMS contractors' efforts to monitor and evaluate your project.
- Comply with the terms and conditions of the award.
- Work closely with CMS project staff to implement and monitor the project and track its progress.
- Submit the performance measures requested.
- Submit all required performance assessments, evaluations, and financial reports included in the terms and conditions.
- Attend monthly calls with the CMS project or grants management specialist to discuss your project's progress and challenges. The meetings will include key personnel and the project officer.
- Participate in any virtual meetings.

Cooperative Agreement Terms

CMS Responsibilities

- Monitor the project's performance and progress through data collection and reporting.
- Collaborate with you and provide substantial project planning and implementation input.
- Provide substantial input in evaluation activities.
- Provide feedback on your implementation to comply with the award terms and conditions.
- Monitor your performance based on the disbursement milestones and terms and conditions.
- Make recommendations for continuing the project.
- Review and approve marketing and website content before launch and updates.
- Review and approve all key personnel.
- Maintain regular communication with you through at least monthly conference calls along with technical assistance and consultation.
- Review and provide feedback on all required performance assessment reports.
- Review and approve all required submitted data.
- Provide a structured approach to sharing, integrating, and actively applying improvement concepts, tactics, and lessons learned.