

Closing the Cognitive Care Gap

How cognitive decline goes unidentified and unmanaged in primary care, what late-stage care costs, and what it takes to close the gap.



Section 1: The problem

More than 7 million Americans age 65 and older are living with Alzheimer's dementia today, a number projected to reach 13.8 million by 2060. ^[5]

Cognitive decline is one of the most underdetected conditions in primary care. Most people living with MCI and early-stage dementia go unidentified until well after the point where earlier intervention could have changed the course. ^[1]

Health systems and health plans recognize this gap. The challenge has never been awareness or intent. It has been having the right tools to act on it. Most cognitive assessments used in primary care today are paper-based, subjectively scored, and too slow for a standard visit. ^{[2][4]} The result is a cognitive care gap that opens at detection and widens through diagnosis and care, so patients are identified late, when the cost of care is highest and the window for meaningful intervention has already narrowed.



THE BOTTOM LINE

- Over half of dementia cases go undetected in primary care. ^[1]
- Legacy cognitive tests are too slow and too subjective for a 15 to 20 minute visit. ^{[2][4]}
- Late diagnosis concentrates cost in the most expensive phase of care. ^{[5][6]}
- Closing the gap is now both clinically validated and financially supported. ^{[5][7]}

Section 2: A system that acts late

>50%

of dementia cases are missed or undiagnosed in primary care. ^[1]

1.1%

of Medicare Annual Wellness Visits were followed by a new cognitive diagnosis at a later visit. ^[3]

287 days

median lag between an Annual Wellness Visit and a coded dementia-related diagnosis. ^[3]

55%

of primary care physicians say there are not enough dementia specialists in their community. ^[5]

34 to 59%

of adults 65+ live in areas with a potential dementia specialist shortfall. ^[5]

10+ min

to administer and score a low accuracy legacy test like the MMSE or MoCA, inside a 15 to 20 minute visit. ^{[2][4]}

Section 3: Where the cognitive care gap opens

Every primary care visit with an older adult is an opportunity to detect cognitive decline before it's too late. The current system loses them at each step of the arc from assessment to diagnosis to care.

The Medicare Annual Wellness Visit already requires measures to detect cognitive impairment, but structured assessment remains the exception, and patients at higher risk are no more likely to be assessed than anyone else. ^[2] When a concern is noted, there is often no clear, reimbursable path from a positive signal to a diagnosis and care plan, and the default next step is a specialist referral into a workforce most primary care physicians already describe as too thin to meet demand. ^[5]

Primary care physicians often recognize the early signs. They hesitate because of diagnostic uncertainty, limited specialist access, and unclear next steps. The barrier is not data quality or lack of effort. It is the absence of tools and a pathway built for the visit.



Redesign the workflow, and the leaks close.

Section 4: Better tools, built for the visit

The cognitive care gap is not a clinical effort problem. It is an instrumentation problem. The paper-based tests most primary care still relies on, the MMSE, Mini-Cog, and MoCA, were designed decades ago for a different kind of visit. They are slow to administer and score inside a 15 to 20 minute appointment, their results vary with the scorer, and they are less accurate than what is available today.

Neurotrack's assessments were built for the modern visit. Symbol Match, Path Points, and Word Wise are each built on a clinically validated paradigm backed by decades of independent research, and together they measure processing speed, executive function, and verbal memory. ^[12] Because they can be self-administered and consistently scored, removing variability of paper tools, and extend reach beyond the walls of a traditional clinical setting, integrating directly into an existing EHRs, Neurotrack tools add no clinician time or referral burden.

Test	Sensitivity	Specificity
Neurotrack: Symbol Match + Path Points	94%	90%
MoCA	84%	74%
Mini-Cog	76%	73%
MMSE	37%	98%

Sensitivity is the share of impaired patients correctly identified; specificity is the share of healthy patients correctly cleared. The MMSE's high specificity paired with 37% sensitivity means it clears the well but misses most early cases, the ones a cognitive care platform most needs to catch.



5x more patients reached a care plan.

In a real-world evaluation, Neurotrack's digital screener produced a care plan recommendation rate five times higher than the Mini-Cog, 3.1% versus 0.6%. ^[15] Standardized, consistent scoring surfaces impairment the paper tool misses and connects that finding to a care pathway.

Better than blood biomarkers.

In a 2024 study in Alzheimer's & Dementia, digital versions of the tests behind Neurotrack's Symbol Match and Path Points predicted Alzheimer's disease status better than blood plasma biomarkers, bettered only by a 30-plus minute assessment unsuitable for primary care. ^[13]



Section 5: The cost of acting late

\$384B

Projected 2025 U.S. cost of care for people 65+ with dementia. ^[5]

41% higher

Total annual health care costs for patients who progress from MCI to dementia versus those with stable MCI (\$34,599 vs \$24,541 per patient per year). ^[6]

~3x

Medicare per-person spending for a beneficiary with dementia versus one without, and more than 22x for Medicaid. ^[5]



Dementia is among the most expensive conditions in the Medicare population, and the cost concentrates in the late stages the current system is built to reach. Closing the gap earlier changes the economics in three ways that matter to health systems and health plans.

Cost follows progression. Patients who move from MCI to dementia incur 41% higher total health care costs in the year that follows than those whose MCI stays stable. ^[6] Identifying decline earlier is what makes slowing that progression possible.

Accurate documentation supports appropriate risk adjustment. A documented dementia diagnosis is reflected in a member's RAF score under the CMS-HCC Model V28, and dementia remains significantly undercoded across the Medicare population. ^{[7][9]} Risk adjustment attaches to a dementia diagnosis, not to MCI.

Coordinated care lowers total cost of care. Care management programs for diagnosed patients have been shown to reduce total cost of care, not just improve outcomes. ^[8]

THE GUIDE TAILWIND

The CMS GUIDE program, launched July 1, 2024, is an eight-year, nationwide payment model with roughly 390 participating organizations across 46 states.

It pays for comprehensive dementia care management and ties payment to total cost of care and reduced long-term nursing home placement.

Closing the cognitive care gap earlier is the entry point to a model built to reward it. Source: CMS. ^[14]

Section 6: Earlier action changes the trajectory

40%

of dementia cases could be prevented or delayed by addressing modifiable risk factors across the lifespan. ^[10]

25%

greater overall improvement in cognitive function from a structured multidomain lifestyle intervention. ^[11]

+83%

improvement in executive function in the same intervention group. ^[11]

+150%

improvement in processing speed, with benefits seen even in carriers of the APOE4 risk gene. ^[11]

Detection matters because it is actionable. Finding cognitive change early is only valuable when it connects to a plan, and the evidence that intervention works is strong. The 2024 Lancet Commission attributes up to 40% of dementia cases to modifiable risk. ^[10] The FINGER trial showed a structured multidomain program can move cognitive function measurably in the right direction. ^[11] Neither result reaches a patient the system never identified. Closing the gap earlier is what turns this evidence into care.

Section 7: Cognitive care enablement



Neurotrack is the cognitive care enablement platform that integrates into existing EHR workflows to equip clinicians with clinically validated assessments, Smart Logic-powered diagnostic pathways, and dynamic patient-specific care plans that enable earlier dementia detection and reduce the cost of late-stage care.

Assess. Clinically validated, self-administered digital assessments delivered on any device and completed inside the Annual Wellness Visit rather than bolted onto it, extending reach beyond the walls of a traditional clinical setting.

Diagnose. Smart Logic-powered diagnostic pathways turn a positive signal into a defined next step inside the EHR, supporting confident clinical decision-making rather than replacing it.

Care. Dynamic, patient-specific care plans link detection to reimbursable action and to audit-ready clinical documentation that supports reimbursement, including under models like GUIDE.



Identify the population that is currently invisible, close the documentation gap, and begin intervening with the patients most likely to drive cost growth in the next 12 to 24 months.

Let's talk about what cognitive care enablement looks like inside your system.



References

1. Nature Medicine, 2024. Over half of dementia cases are missed in primary care (5-Cog paradigm trial).
2. Alzheimer's & Dementia, Liu et al., 2025. Usage patterns of cognitive assessments during Medicare's Annual Wellness Visit.
3. Alzheimer's & Dementia, Zigman Suchsland et al., 2025. MCI and dementia diagnoses after an Annual Wellness Visit in a large primary care network.
4. U.S. Government Accountability Office, 2023. Medicare Cognitive Assessments (GAO-24-106328).
5. Alzheimer's Association, 2025 Alzheimer's Disease Facts and Figures.
6. Journal of Prevention of Alzheimer's Disease, Frech et al., 2024. Economic Impact of Progression from MCI to Alzheimer Disease in the United States. DOI: 10.14283/jpad.2024.68.
7. Health Affairs, 2025. After Risk-Adjustment Change, Dementia Diagnoses Increased in Medicare Advantage Relative to Traditional Medicare. DOI: 10.1377/hlthaff.2024.00723.
8. AJMC, 2024. Care Management Improves Total Cost of Care for Patients with Dementia (Ochsner Care Ecosystem Program).
9. Alzheimer's Research & Therapy, 2023. Expected and diagnosed rates of MCI and dementia in the U.S. Medicare population. DOI: 10.1186/s13195-023-01272-z.
10. Livingston et al., 2024 Lancet Commission on dementia prevention, intervention, and care. (Primer source.)
11. FINGER (Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability). (Primer source.)
12. Neurotrack Clinical and Data Science; comparator values from published validation studies (Glenn et al., 2023; Smith et al., 2007; Seitz et al., 2021). (Primer source; confirm currency of proprietary figures before publication.)
13. Toniolo et al., Alzheimer's & Dementia, 2024. Relationship of plasma biomarkers to digital cognitive tests. (Primer source.)
14. Centers for Medicare & Medicaid Services. GUIDE Model overview.
15. Signify Health. Schwarzwald H., 2026. Why the Home is an Ideal Setting for Dementia Detection and Care Planning. (3.1% vs 0.6% care plan recommendation rate; 5x improvement.)