

The Hidden Cost of Undetected Cognitive Decline

What MA plan leaders don't know about cognitive impairment is costing them twice.

Executive Summary

Undetected cognitive decline represents a double loss for Medicare Advantage plans.

The vast majority of mild cognitive impairment cases in the Medicare population never receive a formal diagnosis, which means plans absorb the elevated costs of a high-acuity population across every care setting, including diminished performance in the diabetes, COPD, and heart failure programs they already fund.

At the same time, because these conditions never appear in the medical record, plans forgo the risk adjustment revenue that accurate documentation would capture under CMS-HCC Model V28. The financial exposure compounds from both directions: excess claims cost on one side, structural underpayment on the other.

Neurotrack was built to address both problems at once. As the cognitive care enablement platform that equips providers to assess, diagnose, and care for people living with MCI and dementia, earlier and with greater accuracy, Neurotrack gives plans population-level visibility, accurate documentation, and the lead time to intervene before costs accelerate. Clinically validated, self-administered assessments fit existing workflows without adding burden to provider networks.

This white paper quantifies the scale of the undetected population, the full cost of leaving it unaddressed, and the Neurotrack approach that organizations are already using to close the gap.



The Scale of the Problem

Dementia and its precursor, mild cognitive impairment (MCI), represent one of the largest unmanaged cost drivers in Medicare Advantage today.

In 2024, the U.S. spent an estimated \$360 billion on dementia-related care, a figure projected to surpass \$1 trillion annually by 2050. For MA plans, this is not a distant threat. It is embedded in your member population right now, and it is largely invisible.

\$22,562

Average annual Medicare spending per member with dementia

Source: Alzheimer's Association / Caring Senior Service, 2024

3x higher

Healthcare costs for dementia patients vs. members without dementia

Source: AJMC, Economic Burden of Alzheimer Disease

- Members with dementia are hospitalized at three times the rate of cognitively healthy peers
- As many as 26% of Alzheimer's patients experience a fall-related hospitalization each year
- Emergency department, skilled nursing, and long-term care costs compound annually without intervention
- Excess cost burden per affected member ranges from \$15,000 to \$30,000 annually above baseline

The Diagnosis Gap: 92% Go Undetected

The financial exposure would be significant even if plans had full visibility into their affected populations. But most plans do not. The true scale of the problem is far larger than what appears in claims data.

A 2023 peer-reviewed analysis published in Alzheimer's Research & Therapy examined 100% of Medicare fee-for-service and Medicare Advantage beneficiaries from 2015 to 2019. The finding was striking: of the estimated 8 million Medicare beneficiaries expected to have MCI, 92% remained undiagnosed. Only 1 in 12 cases ever received a formal diagnosis in the medical record.



A separate 2025 study from Brown University examining nationally representative Medicare data confirmed similar rates: of 2.7 million continuously enrolled Medicare beneficiaries with symptoms consistent with MCI, only 10.6% had a formal diagnosis in their claims record.

This matters for several reasons. Plans cannot manage costs they cannot see. And without a diagnosis in the medical record, these members generate no risk adjustment revenue despite requiring substantially more care.

The Double Loss Hiding in Your Member Panel

Undetected cognitive impairment does not create a single financial problem for MA plans. It creates two simultaneous ones.

Loss 1: Excess Cost Burden

Members with undiagnosed MCI or early dementia generate significantly higher utilization across every care setting. Studies consistently show elevated rates of inpatient admissions, emergency department visits, and outpatient encounters compared to cognitively healthy peers of the same age. Members who go on to progress from MCI to full dementia incur mean annual total costs of \$34,599, compared to \$24,541 for those whose cognition remains stable, a 41% cost premium driven primarily by inpatient utilization.

Left unaddressed, MCI progresses. And the financial trajectory accelerates with it.

For every member who progresses from MCI to dementia, the estimated annual cost premium is more than \$10,000. Intervening before that progression changes the entire cost equation.

Loss 2: RAF Revenue Gap

Under CMS-HCC Model V28, which reached full implementation in 2026, dementia carries a Risk Adjustment Factor (RAF) value of 0.341 across its expanded HCC categories (HCC 125, 126, and 127). When a member's cognitive impairment goes undiagnosed and undocumented, that RAF value is never captured. The plan absorbs the costs of a high-acuity member while being paid at a lower-acuity rate.

With an estimated 60% of dementia cases undocumented in primary care settings, the aggregate RAF revenue gap across an MA plan's population is not a rounding error. It is a structural underpayment embedded in every plan year.

0.341

RAF value per member with documented dementia under CMS-HCC V28

Source: CMS (2023). Announcement of Calendar Year 2024 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. CMS-HCC Model V28 risk adjustment coefficients, HCC 125, 126, and 127.

~60%

Estimated share of dementia cases undocumented in primary care

Source: Alzheimer's Research & Therapy / NCBI

The Health Affairs journal documented a related dynamic: when CMS reintroduced dementia to its risk adjustment payment model in 2020, incident dementia diagnosis rates in MA plans increased by 11.5% relative to traditional Medicare, concentrated among populations most likely to have had undiagnosed conditions.

The implication is that the population is there. The documentation is not.

The Comorbidity Multiplier: Why Your Chronic Condition Programs Are Underperforming

The excess costs described above understate the problem, because dementia rarely travels alone. Medicare beneficiaries with Alzheimer's or other dementias are significantly more likely than their peers to also live with heart disease, diabetes, and kidney disease. And undetected cognitive impairment quietly inflates the cost of managing every one of those conditions.

The clearest evidence comes from diabetes. An analysis of 100% traditional Medicare claims found that average annual medical costs for members with both dementia and diabetes reached \$46,772, more than double the \$21,140 for members with diabetes alone. Diabetes is also more common in this population: 38.3% of people living with dementia carry a diabetes diagnosis, compared with 27.6% of those who never develop dementia.

\$46,772 vs. \$21,140

Average annual medical costs for Medicare members with diabetes, with and without comorbid dementia

Source: Alzheimer's & Dementia / AAIC, 2024

22.8%

Share of total healthcare costs generated by the 9.4% of Medicare members with dementia

Source: AJMC, Impact of Dementia on Costs of Modifiable Comorbid Conditions

The pattern holds across the chronic conditions MA plans invest most heavily in managing.

A cross-sectional analysis of more than one million Medicare beneficiaries found that members with Alzheimer's disease and other dementias represented 9.4% of the population but generated 22.8% of total healthcare costs. The same study quantified the population cost multiplier by comorbid condition: fractures (5.7x), urinary tract infections (5.6x), diabetes without complications (2.4x), congestive heart failure (1.4x), and COPD (1.1x). In COPD specifically, the Global Initiative for Chronic Obstructive Lung Disease estimates that 32% of patients have cognitive impairment, and COPD patients with comorbid dementia experience longer hospital stays and higher hospital costs.

The mechanism is not mysterious. Chronic condition management depends on member self-management: medication adherence, glucose monitoring, inhaler technique, dietary discipline, and appointment follow-through. Cognitive impairment erodes each of these capabilities, often years before a dementia diagnosis appears in the record. The result is preventable exacerbations, avoidable emergency department visits, and admissions that surface in the claims of the diabetes program, the COPD program, and the heart failure program, while the true root cause remains undocumented.

For plan leaders, the implication is uncomfortable but actionable. A meaningful share of the underperformance in existing chronic condition programs is not a care management failure. It is a visibility failure. Until cognitive status is assessed at the population level, every disease management program in the portfolio is operating with a blind spot that compounds annually.

Why Traditional Screening Falls Short

Annual Wellness Visits are the primary mechanism for cognitive screening in primary care. Yet despite the regulatory opportunity, up to 60% of dementia cases still go undiagnosed in those settings.

The reasons are practical and systemic: screening tools like the Mini-Cog and MMSE require trained clinical administration, are time-constrained in a typical PCP encounter, and depend on provider judgment about when to screen and how to document findings. The gap extends beyond screening itself. Chronic condition management programs are built on the assumption that members can self-manage, an assumption that undetected cognitive impairment breaks invisibly.

Specialist access compounds the problem. Neurologist and geriatrician waitlists can extend six months or longer in many markets. For a member with early-stage cognitive changes, that delay is not a scheduling inconvenience. It is a clinical and financial inflection point.

The result is a system that identifies cognitive impairment late, documents it inconsistently, and connects affected members to care rarely and slowly.

What Early Intervention Changes

The case for earlier detection and diagnosis is both clinical and financial. Interventions that delay cognitive decline by even six months produce measurable downstream savings.

Estimates of avoided costs from delayed progression run from \$7,500 to \$15,000 per member per six months of decline delayed, driven by reduced hospitalizations, deferred long-term care placement, and lower acute utilization.

A 2022 study published in AJMC examined a structured dementia care management program in a Medicare managed care population and found mean cost savings of \$475.80 per member per month, or approximately \$5,700 annually, after program costs. Return on investment was measured at 5.85x.

The window for high-impact intervention is earlier in the disease course, before progression accelerates costs and before members become difficult to engage and manage.

Earlier detection changes the financial trajectory. Identifying cognitive impairment before it progresses to a dementia diagnosis gives plans the lead time to intervene, manage utilization, and document conditions accurately.

A Scalable Approach to Cognitive Care Enablement

Neurotrack is a cognitive care enablement platform purpose-built for MA plans, health systems, and value-based care organizations. The platform enables population-level cognitive assessment, early identification of at-risk members, and care coordination at a scale that specialist networks and traditional screening workflows cannot match.

A key differentiator is Neurotrack's self-administered cognitive screeners. Members can complete assessments independently, without requiring a clinician to administer the test, a specialist referral, or a dedicated appointment. This removes the primary bottleneck in traditional screening workflows and makes it possible to reach members across a plan population rather than only those who happen to be flagged during a PCP encounter. For plans, that means broader coverage, faster identification, and no additional burden on already-strained provider networks.

This approach is already delivering measurable results. Desert Oasis Healthcare, a primary care medical group serving more than 60,000 members in Southern California, integrated Neurotrack's digital screening into routine Annual Wellness Visits and increased dementia diagnosis rates by 29% in four months. Results flow directly into the EHR, positive screens trigger warm handoffs to a dedicated Dementia Care Clinic, and providers save up to 10 minutes per patient compared with traditional pen-and-paper tools.

The same model scales to in-home settings: Signify Health, the nation's largest provider of in-home health evaluations, relies on Neurotrack's cognitive screening technology to reach members where they live, including in rural markets that traditional screening infrastructure cannot serve. In a separate three-month pilot, a national Medicare Advantage plan deployed Neurotrack's assessments within its home-based Annual Wellness Visit program, administered by trained nurse practitioners, with statistically significant results across all key comparisons.

29%

increase in dementia diagnosis rates in four months at Desert Oasis Healthcare

Source: Desert Oasis Healthcare / Neurotrack partner announcement, 2025

~5%

of US seniors receive care from organizations using Neurotrack, across health systems, primary care networks, and in-home care settings

Source: Neurotrack, 2025

Cognitive data also sharpens the programs plans already run. Knowing which members with diabetes, COPD, or heart failure have emerging cognitive impairment allows care teams to simplify regimens, activate caregivers, and adjust engagement strategies before adherence failures become admissions.

The platform integrates into existing care pathways and delivers structured cognitive data that supports accurate RAF documentation, care plan activation, and longitudinal member monitoring. Plans gain visibility into a population that previously did not appear in claims data until costs were already elevated.

For MA plan executives evaluating cognitive care as a strategic priority, Neurotrack offers a practical starting point: surface the hidden population, close the documentation gap, and begin intervening with the members most likely to drive cost growth in the next 12 to 24 months.

Sources & Citations

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