

What the EHR did for the hospital, Cura does for care in the community.

For decades, EHRs have given clinicians real-time intelligence in hospitals and clinics. AI is now making that capability dramatically more powerful. The established solutions offered to HCBS programs adapted that clinical architecture for community settings, importing medical practice assumptions into a space defined by non-licensed direct support professionals, non-clinical settings, and person-centered care plans. **Cura was built from the HCBS reality outward.** The authorized care plan is the operational document. Plain-language guidance is the delivery mechanism. The DSP is the primary user. Cura OS is the infrastructure the community-based system has been waiting for, minimizing medical utilization in independent community living.

EVV confirms a caregiver arrived. **Plan-Driven Service Validation (PDSV)** confirms the authorized care was delivered — against the individual's Plan of Care, at the moment of service, before payment.

FEDERAL POLICY ALIGNMENT

CMS CRUSH Initiative	CMS Access Rule	Rebalancing Mandates
CMS-6098-NC: CMS has shifted strategy from retrospective claims recovery to real-time point-of-care validation. Cura is that infrastructure.	2028/2030 compliance deadlines require states to document that HCBS services are delivered as authorized. EVV cannot satisfy this requirement. PDSV can.	Every state's Olmstead compliance depends on a commitment states cannot currently make with confidence: that community placement is as reliable as institutional care.

TWO MARKETS. ONE PLATFORM.

Aging & Adult HCBS / Long-Term Services

The largest and fastest-growing HCBS population. States cannot fulfill the Olmstead rebalancing commitment without confirmation that community placement is as reliable as institutional care. Access Rule 2028/2030 deadlines make quality documentation mandatory — not aspirational. States cannot quantify progress toward independence without data that captures what actually happens at each shift.

IDD & Developmental Disabilities

Where Cura was built and validated. The highest-acuity, most federally scrutinized cohort in HCBS. The accountability obligation created by actuarial rate studies cannot be satisfied by retrospective claims data. Cura answers it in real time.



INFRASTRUCTURE & EXECUTION AT SCALE

Cloud-Native. Secure. Government-Grade.

Institutional deployments available as FedRAMP aligned dedicated private cloud instances — no shared tenancy, customer-controlled data residency, isolated security perimeter. End-to-end encryption, zero-trust access control, role-based permissions, and 7-year audit log retention. The architecture security reviews expect, delivered the way government data governance requires.

Open Interoperability.

FHIR R4, HL7, and Direct Protocol integration available for existing MMIS, MCO authorization systems, and EHRs. Bi-directional data exchange bridges HCBS service records and clinical systems. Care coordination across settings through a single unified view, not parallel silos. No rip-and-replace. Cura operates alongside existing EVV infrastructure.

Enterprise Deployment Competency.

The Cura leadership team carries direct experience leading large-scale health system deployments — multi-year programs, enterprise governance structures, clinical and technical peer review, and formal benefits realization frameworks that produced documented, auditable outcomes at the level of shareholder and public reporting. Organizational change management at state program scale is not a planning assumption here. It is prior experience.

Deployment-Efficient by Design.

Structured, scoped, and sequenced for progressive value acceleration — not a high-risk infrastructure cutover. No EVV displacement. No structural or legislative dependencies.

Cura connects existing roles and structures, surfacing wellness signals upstream for effective support coordination each waiver level requires. Deployment can be operational, with state oversight dashboards active within 90–180 days.

WHAT VALIDATION MAKES POSSIBLE

When service delivery is confirmed against the Plan of Care in real time, states gain something claims data and EVV cannot produce: measurable progress toward independence. Employment readiness, community integration milestones, behavioral health stability, and waiver-level population resilience become quantifiable at the individual and program level. The infrastructure that satisfies PERM and CRUSH is the same infrastructure that tracks whether people are actually moving forward.

STAGED DEPLOYMENT. STRUCTURED VALUE AT EVERY PHASE.

Activate — Service validation and structured documentation at the point of care. Baseline data and wellness signal visibility established across the target population. Enrich — Wellness signals surface upstream to support coordination. Coordination advances from informed review to active real-time oversight. Optimize — Measurable outcomes demonstrated against program goals. Value-based payment readiness achieved. Statewide commitment justified by evidence.