

ENNOBLE CARE
To care is an honor

2026 Quality and Outcomes Report

A Higher Standard of Home-Based Care for the Patients and Families Who Need It Most.

Home-Based Primary Care · Palliative Care · Hospice



Serving those who need it most

Early in our careers, we both saw the same failure from opposite ends of an ambulance ride. One as an EMS provider, bringing the same frail, elderly patients to the emergency room for problems that had been building for weeks. The ER was not the right place for them to get care, but by the time the ambulance arrived, the window for a better answer had closed. The other met those same patients when they came to the hospital – first as a hospital and rehabilitation facility nursing assistant and then as an ER nurse, admitting patients that needed a home visit, not a lengthy hospital stay.

That shared experience is what Ennoble Care is built around.

The frailest Medicare beneficiaries are some of the most expensive patients in the country and also some of the most neglected. The system is still organized around buildings – clinics, ERs, hospitals – rather than the places patients actually live. Many of our patients are homebound or close to it, so small problems become big ones, and big ones become crises.

We built Ennoble Care to be present, in the home, before the crisis. Our clinicians visit patients where they are many times a year and sometimes multiple times a month, building a long-term relationship with most patients and families. They know which medications were adjusted last month, which patients have been sleeping more than usual, and which families are struggling. That proximity – combined with care coordination, remote monitoring, behavioral health, and a team that follows patients across primary care, palliative care, and hospice – is how we catch problems while they're still manageable.

The data in this report shows our outcomes, and we are incredibly proud of that impact. Hospital admissions fall 25% in the first year under our care. We match or beat national quality benchmarks – and we do it with patients two to three times sicker than the Medicare average. Our Medicare hospital spend is approximately $500 per member per month by year 2, about half that of comparable homebound patients.

Coming into someone's home at the hardest moment of their life is not a job. It is an Honor. Our commitment is that this work always stays personal – a team that knows its patients by name and shows up because we want to be there.

Kush Das, JD, Chairman and CEO
Molly Viscardi, PhD, RN, Board Director and COO



Kush Das
Chairman & CEO



Molly Viscardi
Board Dir. & COO

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Who we are

Ennoble Care is a leading home-based primary, palliative, and hospice care provider for high-need Medicare patients. We meet patients wherever they live — private homes, senior communities, and long-term care. Our providers live in the communities they serve and stay close enough to build lasting relationships with their patients and their families. We are a team of **1,500+ dedicated employees**, and we're growing every year.

Our mission

Ennoble's mission is to provide **individualized care that goes beyond medical treatment**. We pride ourselves in being a support system for our patients and their loved ones during a vulnerable time in their lives. We believe in delivering exceptional care that encompasses physical, emotional, and spiritual well-being.



Our core values

01 To care is an honor

02 Act with urgency

03 Perform with excellence

04 Grow like an entrepreneur

05 Embrace change

Who we serve

Today we deliver multidisciplinary care to ~50,000 patients across 15 states and the District of Columbia. Our patients are primarily seniors for whom leaving home is difficult or unsafe.

Many live with multiple morbidities, cognitive impairment, and social isolation that most care systems never meaningfully reach.



A higher-acuity panel

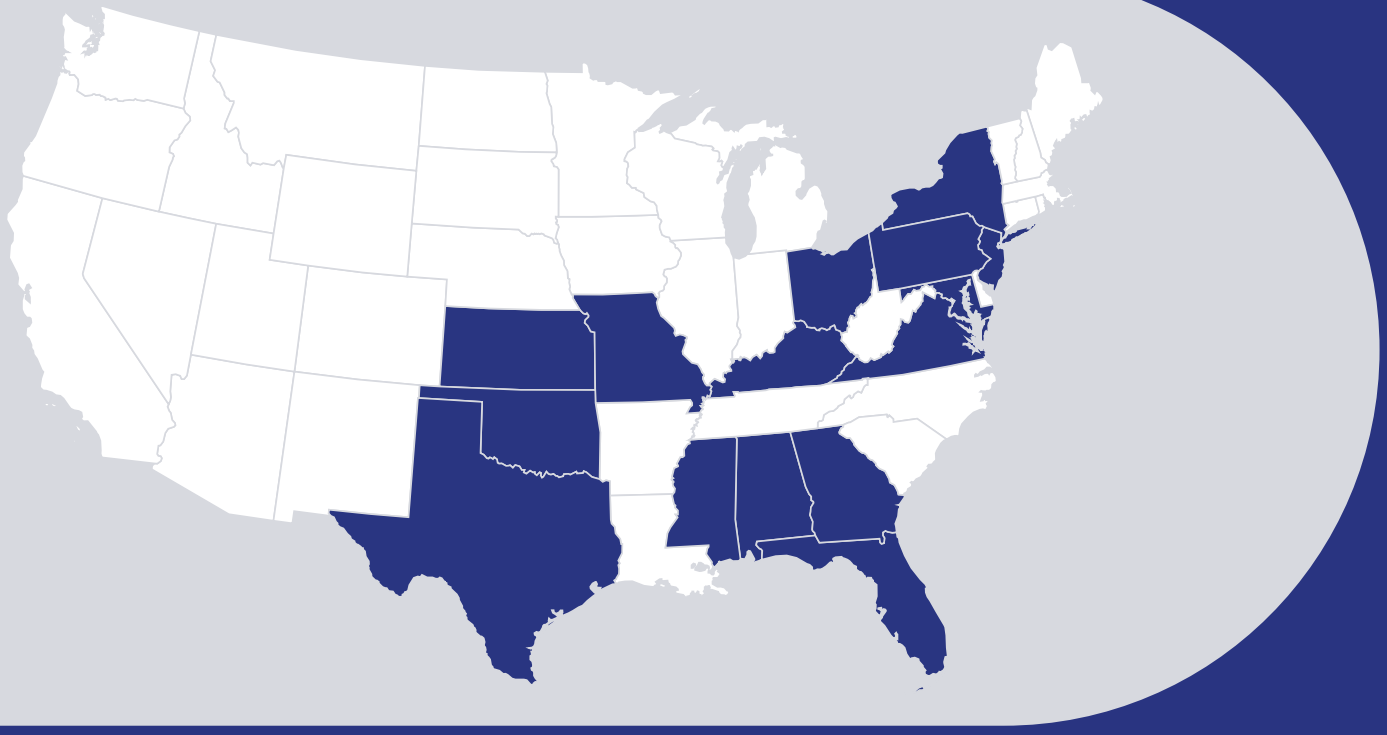
Twice as medically complex as the average Medicare beneficiary.

~25%

Of Medicare beneficiaries in value-based ACO programs

~30%

dually eligible with Medicaid, vs **~14%** nationally



~50,000

active patients, most of whom are frail, elderly Medicare patients that have trouble leaving home

800,000+

clinical visits per year (private homes, skilled nursing facility, assisted living facility, and long-term care facility)

95%+

Of clinical visits are delivered physically at home vs. via telemedicine

The Ennoble Care model

We put **the patient at the center of everything we do**. Our teams work seamlessly together so patients are supported across the continuum of care: primary care, chronic condition management, palliative care, hospice, and more. We support patients and families through behavioral health and end-of-life support, and our purpose-built EHR, Office Anywhere, powers remote patient monitoring and predictive analytics.



How we care for patients

4+ hrs
of one-on-one attention per patient, every month

9+
care touchpoints per patient, per month

1:1
provider-to-care-coordinator ratio

70
Patient Net Promoter Score

What each service delivers

Home-based primary care

Primary Care
In-home primary and chronic care management, with 4+ hours of clinician attention each month.

Behavioral Health
Integrated behavioral health support, diagnosis, and ongoing treatment within the care plan.

Remote Monitoring
Vitals tracked between visits through secure and compliant remote patient-monitoring.

Care Coordination
A dedicated coordinator for every provider — a 1:1 ratio that keeps care connected.



End-of-life services

Palliative Care
Whole-person comfort-focused care and advance care planning for serious illness.

Family Support
A support system for loved ones through end of life, including bereavement services.

Hospice
End-of-life care at home, including routine, respite, inpatient, and continuous care.

Predictive Analytics
Our Office Anywhere platform anticipates changes in a patient's condition so the team can act on time.

One coordinated team, from the first house call through hospice.

Our integrated home-based primary care, palliative care, and hospice care keeps patients at the center with continuity at every stage.

Built around value

Most healthcare providers struggle to reach frail, homebound seniors. Ennoble Care was built to serve them and is rewarded for taking better care of those patients.

At Ennoble, “value” means **clinical quality, total cost of care, and access.** We built our team around the conviction that providers should be accountable for their patients’ health and well-being. That accountability drives everything from how we staff our teams to how we measure success.



Clinical quality

Ennoble Care achieves comparable or better outcomes for blood-sugar control, blood-pressure control, and 30-day readmissions, on a panel **far sicker than average.**

Total cost of care

Hospital admissions fall about **25% in year one** and **63% by year two,** and ACO savings run well above program norms.

Access

Care in-residence for **~50,000** frail seniors across **fifteen states**, without any Ennoble imposed narrow networks or prior authorization requirements.

The idea behind value-based care (VBC) is simple: focus on patient health outcomes, not on volume. It rewards providers who prevent the crises that drive most Medicare spending. For frail and homebound seniors carrying two to three times the clinical risk of the average beneficiary, that shift is the difference between care that reaches them and care that never arrives.

Reaching people in their homes turns that idea into reality. Among patients in Ennoble’s care, hospital admissions fall by about a quarter in the first year and by nearly two-thirds by the second. Our patient panel is far sicker than average, but we still perform highly on benchmarks for blood-sugar control, blood-pressure control, and 30-day readmissions.

Ennoble Care implements this model in collaboration with Medicare. Through ACO REACH, the model designed for the frailest, homebound beneficiaries, Ennoble Care has delivered savings well ahead of benchmarks while improving care. As ACO REACH concludes at the end of 2026, Ennoble Care will transition to other value-based care models, while maintaining our same high quality of care.

As a member of the Complex Care Alliance, Ennoble Care is working to expand these programs so they reach more of the seniors who depend on them. CMS has demonstrated a sustained commitment to moving Traditional Medicare toward accountable care for more seniors across the country. We are committed to supporting that goal.



25%

fewer hospitalizations, year one

63%

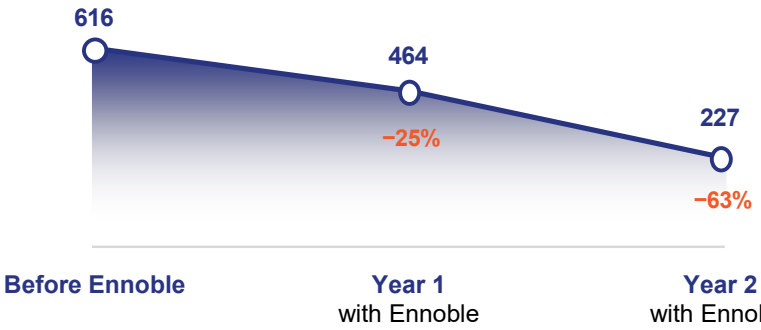
fewer hospitalizations, year two

The Ennoble difference

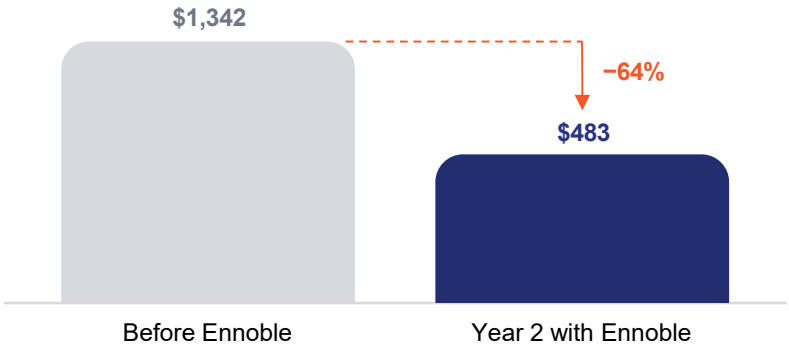
When a clinician is in the home eight to twelve plus times a year, small problems stay small. A medication gets adjusted. An infection gets treated at the kitchen table. The early sign of decline becomes a care plan update rather than an emergency call.

Hospital admissions with Ennoble Care

per 1,000 patients



Hospital spend with Ennoble Care (Part A, PMPM)



***Patient outcomes improve over time**: hospital admissions fall in the first year and fall again in the second.*

What's behind the numbers

The typical Medicare patient sees a primary care provider once or twice a year. Our clinicians are in the home eight to twelve plus times a year. That regularity is what creates the opportunity to notice — a subtle change in energy, a new symptom the patient didn't think to mention, a caregiver who's starting to struggle. Paired with daily care coordination and remote monitoring, that kind of proximity does something an annual office visit simply cannot.

The downstream effects compound. By year two, the average Ennoble Care patient sees dramatically fewer hospitalizations and post-acute care needs. Home-based primary care prevents the crisis and substitutes the services that typically follow a hospitalization.

Note: The multi-year trend tracks ACO-aligned beneficiaries across three 12-month windows (Medicare Part A + B).

Better outcomes. Lower cost.

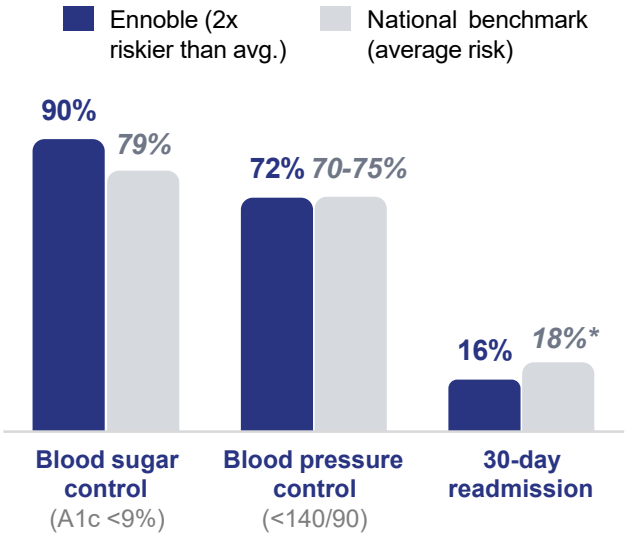
We achieve comparable or better quality outcomes against national standards — on a panel **carrying two to three times the clinical risk** of the average Medicare beneficiary. Then, we measure cost against the frail, homebound population that is our true peer group. On both sets of metrics, our outcomes are consistent with or exceed benchmarks.

Quality of life

90% Maintain blood sugar control (A1c <9%)

72% Avoid high blood pressure (<140/90)

16% Hospital discharges readmitted in 30-days



Our patients experience quality of life similar to patients with half the risk (measured in hospitalization rate and blood-pressure readings).

Our 72% blood-pressure control rate is comparable to the national fee-for-service average (70-75%) on a panel carrying two to three times the baseline risk. Our blood sugar control metrics outperform the national benchmark, and our 30-day readmission rate outperforms the benchmark for frail patient populations.

Quality at the end of life

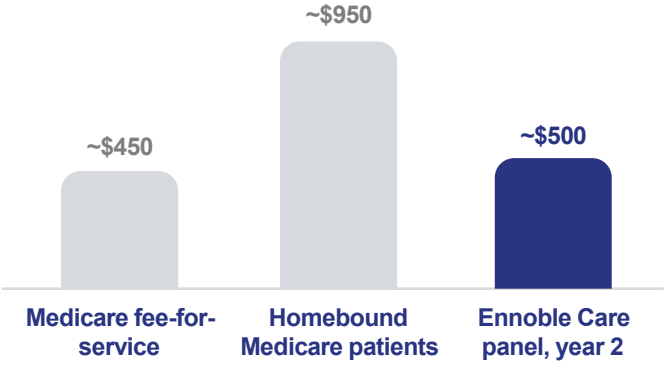
49 days Median hospice stay vs. 18 nationally

16% Crisis enrollment (<7 days) vs. ~25% nationally

Years of advance-care-planning conversations mean patients elect hospice earlier and on their own terms, making them far more likely to have an extended, peaceful stay and far less likely to enter in crisis. For these patients, quality is also about how their final months are spent.

Value - Cost

~$500 Medicare hospital cost in the second year post-enrollment, vs. ~$950 for the average homebound patient (Part A, PMPM)



*Sources: Ennoble patient panel, NCQA, MedPAC, CMS, HHS, third-party research. * Comparison based on frail patient populations.*



Our patients' stories

Caught twice

During a routine home visit, one of our nurse practitioners noticed a change in her patient. It turned out to be an infection, which she treated on the spot and directed the family to seek emergency care. The patient was hospitalized but recovered thanks to the early treatment. Weeks later, the same nurse practitioner noticed dangerously high blood pressure, prompting a second round of treatment. The patient's family credits the provider's vigilance with keeping him alive.

She is absolutely the best

For our patients, small care decisions can carry big consequences – a fall risk here, a sedation concern there, an interaction with every new prescription. For one 93-year-old assisted living resident, her Ennoble Care provider has been the steady voice through every adjustment. After a recent visit, the patient told facility wellness staff: "She is absolutely the best! Tell her I said thank you!" That trust carries through the harder decisions, too. Even as she has added specialists to her care team, she brings her symptoms first to her Ennoble Care provider, counting on her to coordinate what each new recommendation means alongside everything else. The partnership shows up most in what hasn't happened: over two years with Ennoble Care, zero hospitalizations.

Drawn from real Ennoble Care patient stories. Patient details de-identified.

> "It's a privilege to be there at the moment a patient needs us most"
>
> *- Ennoble Care Clinician, New Jersey*



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