IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA

RICHMOND DIVISION

UNITED STATES OF AMERICA

v.

MIKIA ANTONEICE NOBLE,

Defendant.

Case No. 3:26-cr- 69

Count 1

Conspiracy to Commit Health Care Fraud
(18 U.S.C. § 1349)

Forfeiture Allegation

CRIMINAL INFORMATION

THE OFFICE OF THE UNITED STATES ATTORNEY CHARGES THAT:

GENERAL ALLEGATIONS

At all times relevant to this Criminal Information, in the Eastern District of Virginia and elsewhere:

1. Defendant MIKIA ANTONEICE NOBLE and Co-Conspirator 1 ("CC-1") established Advancing Communities Everywhere, LLC ("ACE") on or about August 29, 2018. ACE was a mental health agency based in Richmond, Virginia, and purported to provide mental health services to Medicaid recipients in the Eastern District of Virginia. NOBLE was ACE's Chief Operating Officer, owning 49% of the company, while CC-1 was ACE's Chief Executive Officer, owning 51% of the company.

2. NOBLE and CC-1 also established Community Culture for Virginia ("CC4VA") on or about January 12, 2021. CC4VA was created as a non-profit. NOBLE was listed in CC4VA's bylaws as its Vice President, with CC-1 listed as the President. CC4VA provided clothing, food and skill-building training to clients. However, it also was used to pay kickbacks, in the form of

hotel stays, to ACE's mental health clients in exchange for permitting ACE to bill Medicaid for mental health services on behalf of those clients.

3. Between January 2022 and January 2026, ACE falsely and fraudulently billed Medicaid more than $49.6 million for Community Stabilization and Mobile Crisis Response ("Mobile Crisis") services, which were designed to treat individuals in acute need of crisis mental health services. This includes more than $27.3 million in false claims for Community Stabilization services, involving more than 2,300 Medicaid recipients, and more than $18.1 million in false claims for Mobile Crisis services, involving more than 2,600 Medicaid recipients. Medicaid paid ACE approximately $38.6 million on these claims.

4. NOBLE and CC-1 targeted low-income, often homeless, Medicaid recipients by purporting to provide those recipients with mental health services that the recipients did not receive as billed and often did not need. NOBLE conspired with CC-1 to create and falsify medical records that NOBLE and CC-1 used to bill Medicaid for Crisis Stabilization and Mobile Crisis services. NOBLE and CC-1 falsely claimed in these medical records and in claims submitted to Medicaid that two mental health professionals simultaneously provided services to recipients, when in truth and in fact, at most one mental health professional provided the services. The false claims that two providers participated in treatment caused Medicaid to pay ACE tens of millions of dollars for services that the purported recipients of those services did not receive as billed. In addition, NOBLE and CC-1 at times billed Medicaid for Community Stabilization and Mobile Crisis services without regard to individualized medical need and offered kickbacks and bribes in the form of free hotel stays to induce recipients experiencing homelessness to utilize ACE's services, regardless of whether those recipients actually needed the care.

5. Through CC4VA, NOBLE and CC-1 paid more than $2 million dollars in kickbacks by renting hotel rooms for the Medicaid recipients during the times that ACE purportedly provided them with mental health services.

6. As a result of their schemes, NOBLE and CC-1 obtained millions of dollars in fraudulent proceeds from Medicaid, which they used to further their scheme and for their personal benefit.

A. Virginia Medicaid Mental Health Programs

7. The Virginia Medicaid Program ("Medicaid") provided medical assistance to low-income individuals in Virginia who met certain eligibility requirements. Medicaid was a "health care benefit program," as defined by 18 U.S.C. § 24, and a "Federal health care program," as defined by 42 U.S.C. § 1320a-7b(f). The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), and the Commonwealth of Virginia, Department of Medical Assistance Services ("DMAS"), administered and supervised the administration of the Medicaid program in Virginia. The United States contributed more than 50% of the cost to the Medicaid program.

8. Individuals who received mental health benefits under Medicaid were commonly referred to as "recipients." When a recipient initially enrolled in Medicaid, DMAS issued the recipient a unique Medicaid identification number ("Medicaid ID").

9. Medicaid provided for the delivery of health benefits through contracted arrangements between DMAS and Managed Care Organizations ("MCOs"). An MCO was a health plan that coordinated a group of doctors and other providers working together to deliver health services. MCOs covered all Medicaid services provided to Medicaid recipients, including mental health services. In Virginia, the MCOs included Anthem, Sentara/Optima Health ("Sentara"),

Magellan/Molina ("Molina"), United Behavioral Health (d/b/a "Optum"), Aetna, and Virginia Premier.

10. Agencies became approved providers of Medicaid mental health services by enrolling as a provider with DMAS and obtaining licenses from the Virginia Department of Behavioral Health and Developmental Services ("DBHDS"). Once enrolled with DMAS and licensed by DBHDS, providers entered contracts with MCOs known as Provider Agreements. Provider Agreements required agencies to (a) comply with the DMAS provider manuals setting requirements for Medicaid mental health services; (b) follow applicable laws and policies, including federal laws prohibiting health care fraud and illegal kickbacks; and (c) train employees and contractors on the applicable laws and policies, including compliance with the relevant DMAS manuals and anti-kickback laws, among other requirements.

11. ACE enrolled as a Medicaid provider with DMAS and obtained a license from DBHDS to provide Community Stabilization and Mobile Crisis services no later than December 2021. Between 2020 and 2023, CC-1, acting on behalf of ACE, entered into Provider Agreements with Anthem, Sentara, Molina, Optum, Aetna, and Virginia Premier.

12. ACE received payments from Medicaid by filing claims with the MCOs. A Medicaid claim contained certain important information, including (a) the recipient's name and Medicaid ID; (b) the type of Medicaid mental health service that was provided to the recipient; (c) the billing codes for the service; (d) the date or date range upon which the service was provided; and (e) the length of time the service was provided to the recipient.

13. NOBLE and CC-1, acting on behalf of ACE, submitted claim forms electronically for reimbursement.

B. Community Stabilization and Mobile Crisis

14. On or about December 1, 2021, DMAS launched Community Stabilization and Mobile Crisis mental health programs.

15. Community Stabilization services were designed to help recipients experiencing a short-term crisis to transition from a high level of care, such as Mobile Crisis, to a relatively lower level of care. Community Stabilization services were available 24 hours a day, seven days a week, to individuals who recently experienced an acute or significant behavioral health crisis. Given the goal of transitioning clients to lower levels of care, Community Stabilization services were designed to last typically no longer than one or two weeks.

16. Providers were typically authorized to render up to 28 hours of Community Stabilization services during the initial seven-day period, to be followed by additional service hours if approved by an MCO.

17. Mobile Crisis was a higher level of care than Community Stabilization. The purpose of Mobile Crisis was to provide rapid response and early intervention to individuals actively experiencing a behavioral health crisis. To be eligible to receive Mobile Crisis services, a recipient must have been experiencing an active behavioral health crisis, need urgent intervention to stabilize the crisis, and report one of several conditions (such as suicidal, assaultive, or destructive ideas, or an acute loss of control over thoughts that could result in harm to self or others), among other criteria. Mobile Crisis allowed a provider to render up to eight hours of services within a 72-hour period to an eligible recipient.

18. Providers of Community Stabilization and Mobile Crisis were generally prohibited from paying for housing for the recipients of those services, including for the recipients' hotel

stays. Community Stabilization and Mobile Crisis were mental health services and were not designed to provide temporary housing while the recipients received mental health services.

19. Providers were required to provide Community Stabilization and Mobile Crisis services face-to-face to a single recipient at a given time. Neither program allowed providers to treat multiple recipients simultaneously.

C. Qualified Mental Health Professionals ("QMHPs") and Licensed Mental Health Professionals ("LMHPs")

20. Community Stabilization and Mobile Crisis were required to be provided by mental health professionals such as a Qualified Mental Health Professional ("QMHP") and/or a Licensed Mental Health Professional ("LMHP").

21. The Virginia Department of Health Professions ("DHP") was responsible for issuing licenses and credentials to mental health providers who served as QMHPs and LMHPs.

22. To qualify as a QMHP, an individual must have met the following criteria: (i) have completed, at a minimum, a bachelor's degree; (ii) have registered with the Virginia Board of Counseling to practice; and (iii) possess a combination of work, training, or experience in providing collaborative behavioral health services for youth or adults.

23. To qualify as an LMHP, an individual must be a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

24. Relative to each other, LMHPs were required to have a higher level of education, training, and experience than QMHPs.

D. Team Treatment and Reimbursement Rates

25. Community Stabilization services could be provided to a recipient by an LMHP, by a QMHP, or by both types of providers simultaneously.

26. The chart below reflects the service reimbursement rates that DMAS authorized for Community Stabilization depending on the qualifications of the provider(s) conducting the service. As indicated below, the service rates increased on January 1, 2024.

Crisis Stabilization Service Rates			
Provider	**Billing Code Modifier**	**Rate (per 15 minutes) Dec. 1, 2021–Dec. 31, 2023**	**Rate (per 15 minutes) Jan. 1, 2024–present**
QMHP only	HN	$40.23	$44.25
LMHP **and** QMHP	HT	$85.83	$94.41

27. Providers billing for services using an "HT" billing code modifier represented to Medicaid that the services were rendered by both a QMHP and an LMHP, comprising a multi-disciplinary team, and that the services rendered therefore qualified as "Team Treatment."

28. Mobile Crisis, by contrast, was required to be provided by either (a) an LMHP acting alone, or (b) a multi-disciplinary team comprised of at least two specified mental health service providers. Medicaid did not cover Mobile Crisis services provided by a QMHP acting alone.

29. The chart below reflects the service reimbursement rates that DMAS authorized for Mobile Crisis depending on the qualifications of the provider(s) conducting the service. Again, the rates increased on January 1, 2024.

Mobile Crisis Service Rates			
Provider	**Billing Code Modifier**	**Rate (per 15 minutes) Dec. 1, 2021–Dec. 31, 2023**	**Rate (per 15 minutes) Jan. 1, 2024– present**
LMHP only	HO	$71.08	$78.19
LMHP **and** QMHP	HT	$131.93	$145.12

30. For both Community Stabilization and Mobile Crisis, providers were permitted to bill for "Team Treatment" only if two providers were actively engaged in delivering the services for the duration of the claimed services. DMAS generally required both providers to be physically present with the recipient when rendering Team Treatment services. The only exceptions to the physical presence requirement were (a) an LMHP could conduct an assessment via telemedicine when permitted by the DMAS Manual; and (b) when one of the two professionals separated from the recipient to conduct "care coordination" for that recipient. Care coordination included activities such as engaging with the recipient's family members, arranging for housing or medical treatment for the recipient, and coordinating with emergency responders or law enforcement on behalf of the recipient. When a provider conducted assessments via telemedicine or separated from a client to provide care coordination, the provider was required to document in the progress note for the covered service the nature and modality (*e.g.*, via telemedicine or in person) of the services that both providers rendered for the billed claims.

E. Progress Notes

31. DMAS required the providers involved in Community Stabilization and Mobile Crisis services to draft a progress note for each session. The progress note was required to reflect individual-specific information regarding the recipient's treatment and progress. DMAS required progress notes to include, among other information: (a) the name of the service rendered (*e.g.*, Community Stabilization or Mobile Crisis); (b) the date and time that the service was rendered;

(c) the dated signature and credentials of the qualified and/or licensed professional(s) who rendered the service; (d) the setting in which the service was rendered; (e) the amount of time spent delivering the service; and (f) an accurate description of the mental health services provided.

32. Providers were required to maintain and store progress notes associated with claims the provider submitted to MCOs for payment. MCOs and DMAS could request copies of progress notes—for example, when conducting an audit of a provider—but in the normal course of business, MCOs and DMAS did not regularly receive or review progress notes for claims billed by a provider.

33. When a provider billed for Team Treatment (a service rendered by an LMHP and a QMHP simultaneously), the progress note associated with the claim was required to contain the signatures of both the LMHP and the QMHP who participated in providing the service. DMAS further required that the progress note be written, signed, and dated within one business day from the time the services were rendered.

COUNT ONE
(Conspiracy to Commit Health Care Fraud)

34. The preceding paragraphs are incorporated herein.

35. Beginning in or around January 2022 and continuing through at least in or around January 2026, in the Eastern District of Virginia and elsewhere, defendant MIKIA ANTONEICE NOBLE, and others, unlawfully and knowingly conspired with each other, as well as others known and unknown, to commit an offense contained within Chapter 63 of Title 18 of the United States Code, that is: to knowingly and willfully execute and attempt to execute a scheme and artifice to defraud a health care benefit program and to obtain, by means of false and fraudulent pretenses, representations, and promises, any of the money owned by, and under the custody and control of, a health care benefit program, as defined by Title 18, United States Code, Section 24(b), in

connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

Purpose of the Conspiracy

36. The purpose of the conspiracy was for NOBLE and CC-1 to unlawfully enrich themselves by, among other actions: (a) submitting and causing the submission of false and fraudulent claims to Medicaid for Community Stabilization and Mobile Crisis services that were (i) not rendered as billed, (ii) ineligible for reimbursement, (iii) medically unnecessary, and (iv) procured through kickbacks; (b) concealing the submission of false and fraudulent claims to Medicaid; and (c) diverting the proceeds of the fraud for the personal use and benefit of NOBLE and CC-1, and to further the fraud.

Ways, Manner, and Means of the Conspiracy

37. The manner and means used by NOBLE and others to affect the object of the conspiracy and scheme to defraud included the following actions.

A. Fraudulent Team Treatment

38. From in or around 2020 through in or around 2023, CC-1 certified, by entering Provider Agreements with MCOs on behalf of ACE, that ACE would comply with all of Medicaid's applicable laws and policies and that ACE would not knowingly present or cause to be presented a false or fraudulent claim for payment to Medicaid.

39. NOBLE, CC-1, and others, however, agreed to submit and cause the submission of fraudulent claims to Medicaid, falsely claiming Team Treatment was performed for both Community Stabilization and Mobile Crises services when, in fact, it was not.

40. At the direction of NOBLE and CC-1, ACE routinely billed Medicaid for Team Treatment services using the HT billing modifier, which represented that both a QMHP and an

LMHP jointly provided in-person crisis services to recipients. In truth, ACE typically dispatched only a single QMHP to provide Community Stabilization and Mobile Crisis services, while no LMHP was physically present during treatment sessions as required for Team Treatment reimbursement.

41. With CC-1's knowledge, NOBLE sent emails instructing QMHPs to provide crisis services alone, or in groups of two QHMPs. ACE billed Medicaid as though LMHPs participated in treatment, thereby fraudulently obtaining reimbursement at approximately double the lawful reimbursement rate.

42. At NOBLE's direction, ACE staff—including NOBLE—routinely altered progress notes to falsely claim an LMHP had participated in Crisis Stabilization and Mobile Crisis services in order to support false claims submitted to Medicaid that indicated an LMHP provided the services.

43. NOBLE and CC-1 also instructed ACE staff to alter billing and treatment practices to circumvent MCO scrutiny, including directing staff to place certain Medicaid recipients into repeated Mobile Crisis services to maximize reimbursement and avoid audits of Community Stabilization billing. As a result, Medicaid recipients were often cycled through crisis services or repeatedly re-admitted, not because of individualized clinical need, but to generate Medicaid reimbursements tied to Team Treatment billing.

44. ACE billed Team Treatment modifiers on at least 93% of Community Stabilization claims and at least 98% of Mobile Crisis claims despite the absence of LMHP participation. Through the submission of false Team Treatment claims, NOBLE and CC-1 fraudulently obtained millions of dollars in Medicaid reimbursements to which they were not entitled.

B. Falsified Medical Records and Progress Notes

45. As part of the conspiracy to defraud Medicaid, NOBLE and CC-1 agreed to and did knowingly cause false and fraudulent progress notes and medical records to be created, maintained, altered, and submitted in support of ACE's claims for Mobile Crisis and Community Stabilization services.

46. NOBLE personally signed progress notes as the supervising or participating LMHP even when she did not attend the sessions, including on dates and times when she was traveling internationally. For example, on September 14, 2023, NOBLE signed a progress note representing that she physically participated in a Mobile Crisis session with a Medicaid recipient, when in fact, NOBLE was on an international flight from the Grand Cayman Islands to Atlanta, Georgia, on September 14, 2023.

47. NOBLE also personally signed progress notes as the supervising or participating LMHP for multiple sessions involving different patients at different locations at the same time. For example, on August 13, 2023, NOBLE signed progress notes for approximately ten separate Community Stabilization sessions, all billed to Medicaid using the HT Team Treatment modifier, representing that an LMHP participated alongside a QMHP. Several of the sessions overlapped in time, including multiple sessions purportedly occurring simultaneously between approximately 8:00 a.m. and 12:00 p.m., making it impossible for NOBLE to have participated in the purported treatment sessions as documented.

48. NOBLE and others altered, falsified, and supplemented progress notes and records after the fact, including records produced to investigators and auditors, to conceal the fraudulent scheme and create the appearance of compliance with Medicaid requirements. For example, in

response to a February 2024 request from a Virginia investigator, ACE produced progress notes accompanied by a certification signed by NOBLE, which were materially different than the original electronic records obtained directly from ACE's electronic medical records system. The discrepancies show that NOBLE changed records after the fact to falsely reflect that an LMHP was involved in rendering the services for which ACE billed Medicaid.

C. Misleading Auditors and MCOs

49. As part of the conspiracy to defraud Medicaid, NOBLE and CC-1 knowingly made false and misleading statements to MCOs and auditors during compliance reviews of ACE's crisis-service billing practices.

50. NOBLE and CC-1 were repeatedly placed on notice through audits that Team Treatment billing under the HT modifier required the in-person participation of both an LMHP and a QMHP, and that documentation had to reflect actual contemporaneous clinical participation.

51. Despite this notice and in response to inquiries from MCOs conducting audits of ACE's billing for Community Stabilization and Mobile Crisis services, NOBLE and CC-1 falsely stated, and submitted progress notes that falsely stated, that LMHPs were routinely present in the field and actively participated in the provision of crisis services as part of a Team Treatment model, even though ACE's actual practice was for QMHPs to provide services alone.

52. Through these repeated false statements and submission of misleading documentation during audits, NOBLE and CC-1 concealed the true nature of ACE's billing practices, causing MCOs to continue paying claims based on those false certifications of compliance, and enabling and perpetuating the ongoing fraudulent scheme.

D. Kickbacks to Recipients to Enable Medically Unnecessary Billing for Crisis Services

53. As part of the conspiracy to fraudulently bill Medicaid for crisis services, NOBLE and CC-1 targeted recipients experiencing homelessness and knowingly used hotel placements and temporary lodging to recruit, retain, and recycle those Medicaid recipients through ACE's Mobile Crisis and Community Stabilization programs, often without regard to the recipient's individualized medical needs and for the purpose of maximizing Medicaid reimbursements.

54. NOBLE and CC-1 knew that many recipients receiving hotel placements through ACE and CC4VA were seeking temporary lodging rather than crisis intervention services. NOBLE and CC-1 further knew that recipients were frequently admitted, retained, and readmitted to Mobile Crisis and Community Stabilization services because of their housing needs and desire for hotel accommodations rather than because they met the clinical criteria for those crisis services.

55. NOBLE and CC-1 caused ACE to bill Medicaid for Mobile Crisis and Community Stabilization services without regard to whether recipients were experiencing an active behavioral-health crisis, required urgent intervention, or otherwise met the eligibility criteria for the level of care billed. Instead, recipients were routinely cycled through crisis services in connection with the provision of hotel rooms and temporary lodging.

56. NOBLE and CC-1 knew that Medicaid rules prohibited conditioning temporary housing on the receipt of crisis services and prohibited providers from offering incentives to induce Medicaid recipients to receive services, including the provision of hotels and lodging.

57. Using hotel placements conditioned on participation in ACE services, NOBLE and CC-1 advanced, sustained, and concealed the broader conspiracy to fraudulently obtain Medicaid reimbursements for services that were not provided as billed and were often medically unnecessary.

E. Use of Fraud Proceeds

58. In total, and at NOBLE and CC-1's direction, ACE billed Virginia Medicaid over $49.6 million and was paid over $38.6 million for Community Stabilization and Mobile Crisis services that were not rendered as billed, ineligible for reimbursement, medically unnecessary, and procured through kickbacks.

59. ACE, acting through CC4VA and other related accounts, used at least approximately $2 million in fraud proceeds to pay kickbacks, in the form of free hotel stays, for Medicaid recipients.

60. For her role in the fraud scheme, NOBLE personally profited at least approximately $2 million from the Medicaid reimbursements derived from ACE's submission of false and fraudulent claims. NOBLE used the fraud proceeds for her personal benefit, including expenditures on travel and luxury clothing, shoes, and jewelry.

(In violation of Title 18 U.S.C. § 1349.)

FORFEITURE ALLEGATION

Pursuant to Rule 32.2(a) Fed. R. Crim. P., the defendant is hereby notified that upon the conviction of the offense listed in Count One of this Information, the defendant shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

TODD W. BLANCHE
ACTING ATTORNEY GENERAL

By: _____
Robert S. Day
Assistant United States Attorney

LORINDA I. LARYEA
Chief, Fraud Section

By: _____
Zachary H. Ray
Lauren Randell
Trial Attorneys