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THE ESCAPE ACT

Ending Systemic Collusion and Accountability Penalties Evasion Act

A Comprehensive California and Federal Framework

Revised and Consolidated Following the Death of Presley Gerber, September 20, 2026

Prepared by Wendy McEntyre, Founder, Jarrod's Law, with co-advocates Allen Nelson and Dr. Angela McMahon

September 26, 2026

I. EXECUTIVE SUMMARY: A THREE-PART FRAMEWORK

The ESCAPE Act is the third and most comprehensive iteration of Jarrod's Law — legislation born from the death of Wendy McEntyre's son Jarrod in 2004 at a sober living facility called "The Safe House." Two prior attempts failed: AB 920 was vetoed in 2019, and AB 2087 died in Appropriations in 2022. This revision incorporates a third case that has, within days, done more to prove the ESCAPE Act's central argument than years of testimony: the death of Presley Gerber, age 27, on September 20, 2026, less than twelve hours after he arrived at Resolutions Living in Santa Monica.

This document consolidates the California ESCAPE Act, the Federal ESCAPE Act package, and a third part: a formal call for

Congress to convene on the Americans with Disabilities Act (ADA) and Fair Housing Act (FHA) barriers that keep state and federal regulators from reaching "housing plus services" operators, and to tie federal recovery-housing funding — including funding used to start up Accessory Dwelling Unit (ADU) sober living conversions — directly to state licensure compliance. Together these three parts form a single, coordinated framework: close the loophole in Sacramento, close it in the federal agencies that fund and license behavioral health, and close it in Congress, where ADA/FHA ambiguity currently lets operators claim disability-housing protection for clinical services no state agency has ever inspected.

The throughline connecting all three parts is one sentence, repeated in every letter, every subpoena response, and every piece of correspondence documented below: housing plus services requires a license. Presley Gerber's death did not create this loophole. It exposed it, in the clearest and most public terms yet available.

This framework reflects direct collaboration with co-advocates Allen Nelson — co-sponsor of the ESCAPE Act and father of

Brandon Nelson, for whom Brandon's Law (SB 434) is named — and Dr. Angela McMahon, an independent DHCS, Joint Commission, and CARF licensing compliance consultant, both of whom reviewed and contributed to the findings documented throughout this record.

II. THE PRESLEY GERBER CASE STUDY

A. The Facts

Presley Gerber, 27 — son of Cindy Crawford and Rande Gerber — arrived at Resolutions Living, a residential facility at 1014 Berkeley Street, Santa Monica, on the evening of September 19, 2026. He was found unresponsive the following morning; Santa Monica Police responded to a report of a possible overdose at approximately 9:35 a.m. on September 20, less than twelve hours after intake. He was pronounced dead at the scene. The Santa Monica Police Department is investigating; the Los Angeles County Medical Examiner has deferred a determination of cause and manner of death pending toxicology. This document does not assert a specific cause of death. It asserts something separate and, for legislative purposes, more important: the regulatory structure that allowed this facility to operate without a DHCS license and without a DSS license.

B. The Corporate Structure — A Textbook Individual-Professional-License Shield

Resolutions Therapeutic Services operates out of 2001 Wilshire Boulevard, Suite 505, Santa Monica, as "Reza Nabavi, PhD, A Psychology Corporation" (California Entity No. 3595852). Dr.

Nabavi is its sole officer — CEO, Secretary, and CFO — and sole director. Its stated business type is simply "Therapy." It holds no DHCS license and no DHCS outpatient AOD certification under Health & Safety Code Sec. 11832.3, despite marketing Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), and Outpatient (OP) addiction and dual-diagnosis treatment at up to 30 hours per week.

Resolutions Living LLC (California File No. 202119510763, formed August 18, 2021) is a separate entity registered as "Supportive Housing," with its principal office at 1014 Berkeley Street — a different address from the clinical practice — and its sole manager/member listed as Maryam Akbar, a licensed clinical psychologist (CA License PSY22794) who is, by the user's understanding, Dr. Nabavi's wife. On paper, Dr. Nabavi holds the clinical license and Ms. Akbar holds the housing. In practice, program materials and industry integrations credit the two as co-owners and co-operators of both the clinical suites and the residential housing. This is precisely the corporate-splitting mechanism the ESCAPE Act's Universal Oversight Standard is designed to close: a licensed clinical entity paired with a

separate, related-party residential LLC, insulating the housing arm from the licensure and liability that would attach if the two functions were recognized, together, as a single "housing plus services" program.

Dr. Nabavi's own disciplinary history sharpens the accountability gap. California Board of Psychology Case No. 1F200416132800 (effective February 16, 2006) reflects a license revoked and stayed, with five years' probation and conditions requiring abstention from alcohol and controlled substances — the Board's standard condition where the underlying misconduct involves the licensee's own substance use. His 2004 application had initially been denied over two prior misdemeanor drug-possession convictions; the license was ultimately approved in 2006 under probationary terms and remains current today (License No. 21276, renewed through June 30, 2028). That license, unrestricted since 2011, is now the sole state credential underlying a scaled outpatient addiction-treatment operation with no facility-level DHCS review ever conducted.

C. The Accreditation Gap

In place of state licensure, the program relies on Joint Commission accreditation (HCO ID 603206) for Outpatient Therapy, PHP, and IOP services. Joint Commission accreditation is a private, voluntary, fee-based credential carrying no Interim Suspension Order authority, no injunction power, no criminal referral pathway, and no unannounced-inspection regime of the kind that defines DHCS Audits & Investigations. Joint Commission surveys occur roughly every 36 months, and a sentinel event — including a resident death — does not trigger mandatory reporting to the Commission unless the facility's own policies and procedures require it. The clinical arm is accredited; the housing arm, by all available evidence, is not accredited by anyone and is not on the DHCS SUD Directory of licensed programs at all — an omission consistent with a program holding no SUD license, but highly unusual for a residence housing clients with primary substance use diagnoses.

D. The Diagnostic-Coding Escape Hatch

A related mechanism compounds the shield: an operator can obtain a Type 2 organizational NPI through NPPES — a self-

attested registration requiring no DHCS verification — and use DSM-5-TR diagnostic discretion to code a mental health condition as the primary diagnosis and a substance use disorder as secondary. Because DHCS's SUD-specific certification trigger depends on primary diagnosis, this coding choice alone can move an addiction-treatment operation outside DHCS's certification requirement entirely, regardless of the services actually delivered.

III. THE TRANSFORMATION OF SOBER LIVING: FROM OXFORD HOUSE TO "RECOVERY RESIDENCE"

Every part of this framework rests on a single fact that has never been properly explained to legislators, regulators, or the families making placement decisions: today's "sober living home" is not what the term used to mean, and it has not meant that since before the Affordable Care Act.

A. The Pre-ACA Model: Johns Hopkins and Oxford House

Before the Affordable Care Act expanded behavioral health parity and insurance reimbursement for addiction services, the American sober living home followed the model developed at Johns Hopkins and popularized nationally through Oxford House: unlicensed, peer-run, alcohol-and-drug-free housing in which residents governed themselves, paid their own rent, and worked full-time jobs while reintegrating into ordinary life. There was no clinical staff, no medication administration, and no mandatory programming beyond house chores and peer meetings. There was no reason for the state to license these homes, because nothing licensable was happening inside them. The entire premise of the model was that residents left the house each morning to go to work and came home each night to a drug-

free environment — that transition back into working society, inside a sober environment, was the point of the model, not an incidental benefit of it.

B. After the ACA: Recovery Residences as Tentacles of Treatment Facilities

The Affordable Care Act changed the economics of this model beyond recognition. Once insurers were required to reimburse behavioral health and substance use treatment at parity with medical care, the financial incentive shifted from "housing that happens to be drug-free" to "housing that also delivers billable clinical services." The industry responded by rebranding: the peer-run sober living home became the "recovery residence," a term that sounds like a modernization of the Oxford House model but functions, in practice, as a tentacle of a treatment facility rather than a standalone home. The clinical program and the housing are marketed and operated as one continuous client experience, even when — as documented throughout this framework — they are legally split into separate corporate entities specifically to avoid being regulated as one.

C. The State's Blind Spot: DHCS Licenses Detox, Not Housing

California's licensing scheme has not caught up to this transformation. DHCS licenses detoxification and residential treatment facilities. It does not license housing, and it has no framework for a category in between. Regulators, families, and even legislators continue to operate on an assumption the industry has quietly made false: that a "sober living home" is a place where residents foolishly believe — and where the state has been content to let them believe — that people simply sleep there. That assumption made sense under the Oxford House model, where sleeping there, in a drug-free house, was in fact all that was happening. It does not describe what is happening inside the typical recovery residence today, where the resident is also subject to:

- Medication administration, frequently mischaracterized as self-administration through cup-dispensing rather than resident-controlled pop-packs (see Part V);**
- Mandatory drug and alcohol testing well beyond any reasonable move-in screening — routine, recurring,**

clinically supervised urinalysis or oral-fluid testing that is itself a diagnostic act, not a housing amenity; and

- Mandatory program-attendance requirements — structured IOP or PHP hours, mandatory meetings, and curfews built around programming schedules — that, combined with testing and medication check-ins, occupy the majority of a resident's waking hours.**

D. Why This Betrays the Entire Purpose of Sober Living

That third point is the one legislators and regulators have been slowest to grasp, and it is the one that most directly inverts the original purpose of sober living. The entire premise of the Oxford House model was that residents would hold full-time jobs and reintegrate into working society while living in a drug-free environment. A resident who is required to attend programming for a substantial portion of the day, several days a week, on top of drug testing and medication check-ins, cannot hold full-time employment. The recovery-residence model does not merely fail to reintegrate people into working society — it structurally forecloses that reintegration, replacing a transitional home with a captive, billable population. This is not sober living. It is

treatment, delivered inside a building the state has decided not to look at, because no one updated the legal definition of "housing" after the money changed what housing had become.

IV. LOOPHOLE FOUR: THE INDIVIDUAL-PROFESSIONAL-LICENSE SHIELD

The Title 9 exclusive-authority argument at the core of the ESCAPE Act framework addresses 24-hour residential substance use disorder facilities. That argument does not reach a second, distinct class of evasion operating in the outpatient tier — programs delivering PHP, IOP, and OP levels of addiction and dual-diagnosis treatment while carrying no DHCS license and no DHCS outpatient AOD certification under Health & Safety Code Sec. 11832.3.

DHCS's outpatient AOD certification requirement is written to reach any program offering treatment, recovery, detoxification, or Medication for Addiction Treatment services. In practice, that requirement is treated as inapplicable whenever the program is structured as an individually licensed clinician's private practice or professional corporation rather than as a standalone AOD program entity — regardless of the volume, intensity, or clinical content of the services actually delivered. The license belongs to the individual, not to the facility, so the facility itself is never licensed, never certified, and never subject to DHCS inspection,

however large the operation grows or however many clients pass through it.

Where Title 9 non-enforcement lets 24-hour residential operators evade licensure by mischaracterizing services as "housing only," the individual-professional-license shield lets outpatient operators evade certification by mischaracterizing the business itself — as a single clinician's practice rather than a treatment program. Both produce the same result: a facility delivering clinical addiction treatment at scale with zero state oversight. Both must be closed, through distinct statutory language, since conflating an outpatient case with the residential Title 9 argument would weaken both.

Proposed Statutory Language

Any outpatient program — regardless of corporate structure, including a program organized as an individual licensee's professional corporation — that provides substance use disorder treatment, recovery, detoxification, or dual-diagnosis clinical services at a cumulative intensity meeting or exceeding IOP-level care (nine or more hours weekly) shall be presumptively classified as an outpatient AOD program subject to DHCS

certification under Health & Safety Code Sec. 11832.3, without regard to whether the treating clinicians are individually licensed. Private accreditation by a non-governmental body, including Joint Commission or CARF accreditation, shall not substitute for, or create a presumption against, the certification requirement.

V. HOW THE SHIELD OPERATES IN PRACTICE: TECHNICAL FINDINGS

The following mechanics were confirmed through direct consultation with Dr. Angela McMahon — co-advocate on this framework and an independent DHCS, Joint Commission, and CARF licensing compliance consultant — working alongside co-advocate Allen Nelson.

A. Medication Administration Is Being Mischaracterized as Self-Administration

Recovery residences claiming "housing-only" status routinely dispense medication via cup-dispensing — pouring a resident's medications into a cup and handing it to them. DHCS's own rules do not treat this as self-administration; "self-administration" requires the resident to retrieve and take the medication from a secured, individually assigned location (such as a lockbox) without staff handling it. Programs that use pop-packs (pre-sorted, resident-accessed blister packs) may satisfy the self-administration standard; programs that use cup-dispensing do not, whether or not the operator understands the distinction. This is a licensable clinical act mischaracterized as a housing amenity.

B. PHP Is Not a DHCS-Recognized Level of Care

Partial Hospitalization Program (PHP) is not a level of care DHCS licensing analysts are trained to recognize or that can be listed on a DHCS licensing application; the term does not appear in the state's regulatory vocabulary even though private insurance payers routinely reimburse it under outpatient certification. This creates a communication gap in which an operator can market and bill "PHP" services while the licensing side of DHCS has no framework for evaluating the claim — a gap the ESCAPE Act closes by defining PHP-level intensity (nine or more hours weekly) as the certification trigger regardless of DHCS's internal terminology.

C. Sister-Agency Corporate Splitting Insulates the Housing Arm

As documented in the Resolutions matter, the clinical entity and the housing entity are structured as legally and financially separate businesses — a professional corporation for the clinical practice and an LLC, controlled by a related party, for the housing. This corporate split shields real estate and housing assets from clinical malpractice liability and, more importantly for this record, allows the housing arm to claim it holds no

clinical function and therefore requires no clinical license, even where the two operate, in practice, as a single coordinated program. The ESCAPE Act's Universal Oversight Standard treats affiliated entities under common ownership or control providing coordinated housing and clinical services as a single program for licensure purposes.

D. No Public, Centralized Death or Clinical-Outcome Tracking Exists

There is currently no centralized, public system tracking patient deaths or clinical outcomes from behavioral health facilities in California. HIPAA permits de-identified centralized tracking; it is simply not being done. The ESCAPE Act mandates centralized, de-identified death and outcome reporting with annual public facility-level reporting.

E. The Licensing/Medi-Cal Coordination Gap

DHCS's Licensing Division and its Drug Medi-Cal (DMC) authorization division operate as completely separate systems with no cross-communication. A facility can be revoked in one system while continuing to operate, and bill, in the other. The ESCAPE Act mandates daily, mandatory data-sharing between

DHCS's licensing and Medi-Cal authorization divisions, and between DHCS and county behavioral health billing systems.

VI. DHCS'S OWN ADMISSION: THE LEGISLATIVE SUBPOENA RESPONSE

On August 26, 2026, Wendy McEntyre, founder of Jarrod's Law, submitted a legislative subpoena for records to DHCS (Reference #R008031-082626), seeking facility-level licensing, complaint, and enforcement records segmented by funding source. DHCS's written response, received in September 2026, states in relevant part that "the Department does not track Substance Use Disorder (SUD) facilities by funding source," and that producing the requested records for all currently licensed and certified SUD facilities "would require a substantial amount of time, likely several years, due to the volume of licensing files, complaint investigations, enforcement actions, and related materials that must be retrieved, reviewed, and appropriately redacted prior to release." DHCS then asked Ms. McEntyre to help prioritize which facilities, regions, or years to search first.

This is not a records-request problem. This is the state agency responsible for licensing and overseeing every SUD facility in California admitting, in writing, that it cannot answer the single most basic accountability question in this entire framework: which facilities are operating under which oversight regime, and

how are their outcomes different. A department that cannot separate its own reported total of 2,285-plus facilities into publicly funded and private-pay categories — after previously having produced exactly this breakdown in Excel format for the same requester — cannot meaningfully oversee either category. This admission is the single strongest piece of evidence in this record for the ESCAPE Act's Foundational Principle: identical regulatory oversight standards for facilities receiving government funding and facilities receiving private insurance reimbursement, because the source of payment shall not determine the level of clinical accountability, patient protection, or enforcement authority.

VII. DOCUMENTED SERIOUS VIOLATIONS: THE CONSOLIDATED OVERSIGHT RECORD

All complaint letters referenced in this Part were drafted by Wendy McEntyre on behalf of Jarrod's Law. The initial six letters — to DHCS, The Joint Commission, the Los Angeles County District Attorney, the California Attorney General, the Los Angeles City Council, and Governor Newsom — were drafted and dated September 24, 2026. Two additional letters, to the City of Santa Monica's City Council and City Attorney, were drafted and dated September 26, 2026, and are summarized rather than reproduced in full below. Each letter follows Jarrod's Law's standard format and is available in full on request; the core allegations and requests are consolidated in the table below.

Recipient	Date Drafted	Core Allegations / Request Documented
DHCS Licensing & Certification Division	Sept. 24, 2026	Unlicensed 'housing plus services' operation; no DHCS AOD license/SUD certification for Resolutions Therapeutic Services; no DSS Community Care license for Resolutions Living; possible Brandon's Law (SB 434) and B&P Code Sec. 17500 marketing violations.
The Joint Commission	Sept. 24, 2026	Accreditation granted to

		a program with no DHCS license or SUD certification; TJC standards defer to state licensing law, creating a verification gap; sentinel-event reporting (a resident death) not mandatory absent internal policy requiring it.
LA County DA Nathan Hochman	Sept. 24, 2026	Corporate-splitting structure (licensed clinical PC vs. related-party housing LLC) built to insulate the residential arm from licensure and liability; potential insurance fraud, patient brokering, and B&P Sec. 17500 violations.
CA Attorney General Rob Bonta	Sept. 24, 2026	Statewide licensing-avoidance pattern (clinician PC + spouse-controlled housing LLC); DHCS's own admission it cannot segment its 2,285+ facility list by funding source; UCL Sec. 17200 and Brandon's Law referral requested.
LA City Council (CF 25-1484)	Sept. 24, 2026	Density/spacing regulation cannot reach unlicensed clinical or quasi-medical services delivered inside a home; case submitted as evidence that oversight must extend to service delivery, not just facility siting.

Governor Newsom	Sept. 24, 2026	Direct request that DHCS investigate; parallel drawn to Prop 1/BHSA accountability infrastructure for publicly funded providers, asked to be extended to private-pay 'housing plus services' operators; federal ADA/FHA shield concern flagged.
Santa Monica City Council	Sept. 26, 2026	Requests confirmation of current business licenses for both entities, a zoning-compliance review of the Berkeley Street residence given its clinical coordination with the Wilshire Boulevard practice, and coordination with DHCS, the Attorney General, and the LA County DA.
Santa Monica City Attorney	Sept. 26, 2026	Requests review of marketing practices and the corporate-splitting structure under Business & Professions Code Sec. 17500 and the Unfair Competition Law (Sec. 17200), independent of and in parallel to the pending DHCS licensing determination.

In every letter, the same principle anchors the requested action: Mr. Gerber's death is not a tragic coincidence separate from the facts described — it is the direct, foreseeable consequence of a

regulatory structure that allows a residential "housing plus services" program to operate for an unknown period without the licenses that would subject it to health and safety oversight.

VIII. THE CALIFORNIA ESCAPE ACT: REVISED STATUTORY FRAMEWORK

Foundational Principle: The Universal Oversight Standard

Facilities receiving government funding (Medicare, Medicaid, Medi-Cal, HUD, SAMHSA, BHCIP, Proposition 1, CalAIM PATH) and facilities receiving private insurance or private-pay reimbursement shall be held to identical regulatory oversight standards. The source of payment shall not determine the level of clinical accountability, patient protection, or enforcement authority. DHCS's own admission that it cannot segment its facility data by funding source is offered as Exhibit A for why this principle must be codified rather than left to agency discretion.

1. Title 9 Exclusive Authority — Mandatory Enforcement

Health & Safety Code Sec. 11834.01 already grants DHCS exclusive authority to license all 24-hour residential substance use disorder treatment facilities, regardless of funding source. The problem is not a gap between Title 9 and Title 22 — it is DHCS's non-enforcement of Title 9's exclusive authority against private-pay operators. The ESCAPE Act mandates affirmative DHCS enforcement of Title 9 against every facility providing 24-hour residential SUD treatment, with a rebuttable presumption

of coverage triggered by the delivery of clinical or quasi-clinical services, including medication administration, regardless of how the operator characterizes the housing.

2. Closing the Individual-Professional-License Shield (Loophole Four)

As set out in Part IV above: any outpatient program delivering SUD, recovery, detoxification, or dual-diagnosis clinical services at nine or more hours weekly is presumptively an outpatient AOD program subject to DHCS certification under Sec. 11832.3, regardless of whether it is structured as an individual licensee's professional corporation, and regardless of private accreditation.

3. Closing the Medication Administration Loophole

Any facility where medications are administered — including cup-dispensing, which does not meet the self-administration standard — requires licensure regardless of whether the facility is classified as "housing" or "treatment." Medication administration is a licensable clinical act in every state and country; California's current framework creates a loophole in which it occurs in "sober living" facilities with zero state

oversight. The Act codifies pop-pack, resident-controlled self-administration as the only configuration exempt from this trigger.

4. Closing the Void-Investigation Loophole

Facilities currently remain open and operational while their licenses enter void or investigation status. The Act mandates facility closure during the investigation period, ending the practice of continued operation under a lapsed or contested license.

5. Corporate-Splitting and Affiliated-Entity Standard

Affiliated entities under common ownership, control, or coordinated operation — including a licensed clinical practice and a related-party housing LLC operating in coordination, as documented in the Resolutions matter — shall be evaluated as a single program for licensure purposes, regardless of separate corporate registration or separate business addresses.

6. Centralized Death and Outcome Reporting

DHCS shall implement a centralized, HIPAA-compliant, de-identified system for tracking patient deaths and significant

clinical outcomes at behavioral health facilities, with mandatory annual public reporting of facility-level death rates.

7. Licensing/Medi-Cal/Managed-Care Data Coordination

DHCS's Licensing Division, its Drug Medi-Cal authorization division, county Mental Health Managed Care billing systems, and The Joint Commission's sentinel-event reporting shall be subject to mandatory, no-later-than-daily cross-notification requirements, closing the gap that currently allows a facility revoked in one system to continue operating, and billing, in another.

8. Recognition of Drug Testing and Program-Attendance Hours as Treatment Indicators

As documented in Part III, the transformation of sober living into "recovery residences" has added mandatory drug and alcohol testing beyond any reasonable move-in screening, and mandatory program-attendance requirements that occupy hours materially interfering with a resident's capacity to maintain full-time employment. Either indicator, standing alone, shall create a rebuttable presumption that a facility is delivering treatment-

level services subject to DHCS licensure, regardless of whether the facility calls itself housing.

9. ADU-Specific IBHS Licensure Trigger

Any Accessory Dwelling Unit deployed for integrated recovery housing services — including medication coordination, referral arrangements with treatment centers, or paid clinical or peer-support staffing — is presumptively an Integrated Behavioral Health Services (IBHS) program requiring DHCS licensure. Receipt of government housing or behavioral health funding (HUD Recovery Housing Program, SAMHSA STREETS/CCBHC/BCOR, BHCIP, Proposition 1, CalAIM PATH) for the acquisition, rehabilitation, or start-up of such a unit creates an irrebuttable presumption of IBHS status. Fair Housing Act protections attach to housing occupancy status only, not to the clinical or quasi-clinical services delivered inside the unit.

IX. THE FEDERAL ESCAPE ACT: LEGISLATIVE AND EXECUTIVE PACKAGE

State-level passage of the ESCAPE Act has stalled behind a single procedural chokepoint: the Senate Health Committee consultant handling this policy area will not move a treatment-facility bill until the U.S. Department of Health and Human Services provides legal clarity on patient brokering, medication administration, and the ADA/FHA housing-versus-services distinction. A single state legislator's request to HHS will not move that clarification. Coordinated federal pressure — from congressional offices, tribal nations, gubernatorial campaigns, media, and organized advocacy — is the prerequisite for unblocking the state bill. The following six requests constitute the Federal ESCAPE Act package.

Request One: DOJ Guidance on FHA Scope

The Department of Justice should issue formal guidance clarifying that the Fair Housing Act, 42 U.S.C. Sec. 3604, protects housing occupancy status for individuals with disabilities — including those in recovery from substance use disorder — but does not exempt the clinical services delivered

inside that housing, including medication administration, from state health-and-safety licensure.

Request Two: HUD Funding Conditioned on State Oversight Compliance

HUD should condition Recovery Housing Program funding, and any other federal housing dollars used to acquire, rehabilitate, or start up recovery residences, on the recipient operator obtaining and maintaining the applicable state license (DHCS or DSS, as appropriate) before disbursement and continuously thereafter. This directly closes the mechanism by which operators secure \$250,000 to \$1 million-plus in federal grants without any DHCS inspection or licensure vetting.

Request Three: DEA/DOJ Enforcement Priority Under the Controlled Substances Act

DOJ and DEA should treat unlicensed medication administration inside recovery residences as a 21 U.S.C. Sec. 333 enforcement priority, coordinated with RICO referral where patient brokering or interstate patient movement is documented.

Request Four: HHS OIG Interpretation of EKRA

HHS's Office of Inspector General should formally interpret referral arrangements between recovery residences and

treatment centers involving financial incentives as federal fraud under the Eliminating Kickbacks in Recovery Act (EKRA), removing ambiguity that currently allows operators to structure per-bed referral fees as ordinary business arrangements.

Request Five: HHS Authorization Affirming State Legislative Authority

HHS should affirmatively state that states retain authority to legislate on addiction-treatment facility licensure, including facilities that combine housing with clinical services, without federal preemption under the ADA or FHA — removing the specific legal uncertainty currently blocking the California Senate Health Committee from moving the ESCAPE Act forward.

Request Six: Congressional Convening — see Part X

The fifth request above asks HHS to confirm what states may already do. It does not resolve the underlying federal ambiguity itself, and it does not reach the federal funding streams that HHS does not control (HUD, SAMHSA appropriations riders, DEA enforcement priorities). That requires Congress. Part X sets out this request in full.

X. A CONGRESSIONAL CONVENING ON ADA/FHA BARRIERS TO OVERSIGHT

This is the newest and most consequential ask in this framework. Every mechanism documented here — the individual-professional-license shield, the corporate-splitting structure at Resolutions, the transformation of sober living into recovery residences described in Part III, the ADU deployment playbook used by operators like Andrew Lamb, the medication-administration loophole — survives because operators can invoke the ADA and the FHA as a shield against basic health-and-safety licensure, and because no federal body has ever been asked to draw the line between protecting housing occupancy for people with disabilities (which these laws were written to do) and exempting clinical service delivery from oversight (which they were never intended to do).

The Ask

- Congress should convene hearings — through the House Energy and Commerce Committee's Health Subcommittee and the Senate HELP Committee, in coordination with the Judiciary Committees given the ADA/FHA civil-rights dimension — specifically on the question of whether current**

ADA Title II/III and FHA Sec. 3604 protections for housing occupancy are being misapplied to shield clinical and quasi-clinical service delivery, including medication administration, from state licensure.

- Congress should enact legislation, or direct DOJ/HUD to issue binding joint guidance, establishing the principle at the center of this entire framework as federal law: housing plus services requires a state license. The ADA and FHA protect where someone may live; they do not protect what may be delivered to them there without oversight.**
- Congress should require, as a condition of any federal funding used to acquire, rehabilitate, or start up a recovery residence — explicitly including Accessory Dwelling Unit conversions funded in whole or in part by HUD's Recovery Housing Program, SAMHSA's STREETS Program, CCBHC Expansion grants, BCOR grants, or any successor program — that the receiving operator hold the applicable state license before any funds are disbursed, and maintain that license as a continuing condition of the award, subject to clawback for lapse or revocation.**

- **Congress should direct HHS OIG and DOJ to report annually on EKRA and Controlled Substances Act enforcement actions involving recovery residences receiving federal funding, so that the scale of this problem — currently invisible, as DHCS's own subpoena response demonstrates at the state level — becomes visible at the federal level as well.**

Precedent: The Drinking Age and Federal Highway Funds

Congress already has a proven model for this exact mechanism, and it did not require inventing new constitutional authority: the National Minimum Drinking Age Act of 1984. Facing a patchwork of state drinking ages that created cross-border "blood borders" and rising alcohol-related traffic deaths among young people, Congress did not attempt to directly mandate a national drinking age — an area traditionally reserved to the states. Instead, it conditioned a state's receipt of federal highway funding under 23 U.S.C. Sec. 158 on that state raising its drinking age to 21, withholding a percentage of federal highway dollars from any state that refused. Every state complied within a few years. When South Dakota challenged the law as coercive,

the U.S. Supreme Court upheld it in *South Dakota v. Dole* (1987), holding that Congress may condition federal funds on state policy choices so long as the condition is reasonably related to the purpose of the funding and the amount withheld is not so large as to be coercive.

The parallel to this framework is direct. Congress does not need to federalize addiction-treatment licensure, any more than it needed to federalize the drinking age. It needs only to condition the federal dollars it already sends toward recovery housing — through HUD's Recovery Housing Program, SAMHSA's STREETS Program, CCBHC Expansion grants, and BCOR grants — on the receiving state, and the receiving operator, maintaining the applicable licensure this framework describes. If Congress could persuade every state to raise its drinking age within a few years by withholding a single-digit percentage of highway funds, it can persuade every state to close the housing-plus-services loophole by withholding the housing and behavioral health dollars operators are currently using to build it.

Why Federal Funding Conditioning Is the Mechanism, Not State Law

California cannot solve this at the state level alone. State law cannot override California Government Code Sec. 65852.2's mandatory 30-day ministerial ADU approval process, and cities cannot impose discretionary delays on ADU-based recovery housing without triggering FHA/ADA liability of their own, because recovering individuals are a protected disability class. That means the ADU deployment pipeline — federal funding secured in as little as weeks, followed by a mandatory 30-to-60-day ministerial approval, followed by construction — will keep operating at its current speed no matter what Sacramento does, unless the federal funding itself carries a licensure condition, exactly as federal highway funding once carried a drinking-age condition. Conditioning federal dollars is the only lever positioned to reach the ADU mechanism directly, because it operates upstream of the state approval process that federal law itself protects from state interference.

Timing

Assemblywoman Laurie Davies' office has secured a meeting with the HHS Secretary in October 2026 — the next milestone in

this effort. This framework, updated with the Presley Gerber case study and the full record of complaints filed in the days since his death, is the document intended to anchor that meeting and every subsequent congressional and federal-agency conversation. The window is real: government funding for recovery housing opened in June 2026, and the same federal dollars this framework asks Congress to condition are, right now, being used to deploy the ADU pipeline this framework is trying to stop. Every month of delay locks in more facilities that will be politically and financially difficult to unwind later.

Closing

For Wendy McEntyre and her co-advocates, Allen Nelson and Dr. Angela McMahon, this is the third attempt at this legislation, and the stakes of getting it right have never been clearer. Housing plus services requires a license. That is the whole of the argument, and it is the argument Presley Gerber's death now makes on its own.

Respectfully,

Wendy McEntyre

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