JARROD'S LAW

Behavioral Health Oversight & Patient Safety Reform

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THE ESCAPE ACT

Federal Policy Framework – Revised September 14, 2026

Companion to the California State Legislative Framework

Why Federal Action, Not Just State Action

California's state legislative process is currently blocked: the Senate Health Committee has declined to advance any treatment-facility bill until the Department of Health and Human Services (HHS) provides legal clarity on patient brokering, and HHS has indicated this is not an active priority. A single state's request carries limited weight; coordinated federal pressure—legal clarification, funding conditions, and enforcement priority—is the prerequisite for unblocking the state bill outlined in the companion State Legislative Framework. This document details administrative actions federal agencies can execute immediately under existing statutory authorities without waiting for congressional intervention.

Families continue to report daily harm and loss stemming from systemic misconduct inside this industry. This is not an abstract policy concern; it represents fraud, waste, and abuse committed against a highly vulnerable population, and every section below must be evaluated through that lens.

I. The Underlying Problem, Restated for a Federal Audience

California Health and Safety Code § 11834.01 grants the California Department of Health Care Services (DHCS) exclusive authority to license all 24-hour residential Substance Use Disorder (SUD) treatment facilities, irrespective of funding source. However, DHCS has failed to enforce this mandate against operators self-designating as “housing only”—a claim DHCS does not independently audit or verify. Compounding this enforcement deficit, three distinct mechanisms converging since June 2026—expanded federal and state recovery-housing funding, California's 30-to-60-day ministerial Accessory Dwelling Unit (ADU) approval mandate, and sustained non-enforcement by DHCS—allow an unlicensed facility to be established, financed, and fully occupied in six to nine months.

II. The Medication Administration Loophole – The Federal Enforcement Hook

Residents routinely arrive at these facilities prescribed up to sixteen concurrent medications within 72 hours of intake at an affiliated treatment center, driven partly by separately reimbursable evaluation and medication-management billing codes. Operators categorize subsequent distribution as mere “self-administration,” yet unlicensed personnel regularly pre-sort doses, manage dispensing on rigid schedules, and log entries into an active Medication Administration Record (MAR)—an instrument of administration rather than self-administration by definition. This establishes an objective, bright-line standard for federal oversight that avoids subjective debates over what constitutes clinical “treatment.”

III. Evidentiary Basis

Blue Cross of Oklahoma v. Asana Recovery (Case No. 8:25-cv-00735-DOC-DFM): Incurred $8.5M in fraudulent insurance billings from a facility operating without mandatory Title 9 licensure. Blue Cross

settled with facility owners for $7.5M but explicitly refused to settle with the clinical director, maintaining the unlicensed operation could not have functioned without his participation.

United States v. Tonmoy Sharma / Sovereign Health: An eight-count, $149M federal indictment involving wire fraud and EKRA violations, specifically tied to unnecessary urine drug screening schemes and kickbacks to patient brokers.

Alexander Soofer / LAHSA: Embezzlement exceeding $10M in public homelessness contracts resulted in the U.S. Department of Housing and Urban Development (HUD) suspending all Continuum of Care funding to the Los Angeles Homeless Services Authority (LAHSA). More than $300M of that suspended funding is currently being redirected into the same ADU-based recovery housing model.

DHCS Administrative Records: Official state licensing records indicate single clinical directors holding between fifteen and more than twenty concurrent medical director roles, demonstrating purely nominal licensure designed to avoid substantive clinical supervision.

IV. The ACA Medical Loss Ratio – A Structural Financial Incentive Gap

A structural piece of this puzzle, raised by Laurie Girand of Advocates for Responsible Treatment, helps explain why insurers so rarely fight back against inflated or fraudulent treatment-facility billing: the Affordable Care Act ties insurer profitability to the volume of claims paid out.

The relevant provision is the ACA's Medical Loss Ratio (MLR) rule, codified at Section 2718 of the Public Health Service Act and enforced by HHS. It requires insurers to spend at least 80 percent of premium revenue (individual and small-group markets) or 85 percent (large-group) on medical claims and quality

improvement, or issue rebates to policyholders. On its face this looks like consumer protection. In practice, because allowed profit and administrative spending are capped as a percentage of claims rather than a fixed dollar amount, an insurer's absolute profit rises whenever claims costs rise. There is no MLR penalty for paying out more—only for paying out too little relative to premium.

This bears directly on the fraud pattern underlying the ESCAPE Act. When a facility submits inflated, medically unnecessary, or fraudulent claims, the insurer that pays them is not purely a victim: the MLR formula means a higher claims total can support higher premiums and a larger profit base, so long as the ratio holds. Health-policy researchers, including Health Affairs Forefront, describe this as a “perverse incentive structure” that discourages insurers from containing costs. The effect compounds where an insurer is vertically integrated with its own pharmacy benefit manager or provider network, because payments to those affiliated entities count as “medical spending” for MLR purposes even when pricing is inflated—a mechanism currently at issue in litigation against UnitedHealthcare and Optum in Louisiana.

The MLR rule offers a partial, structural answer to a question that recurs in nearly every meeting on this issue: if insurers are being defrauded, why is enforcement against treatment facilities so rare, and why do insurers so often settle quietly for a fraction of what was billed—as with Blue Cross of Oklahoma and Asana Recovery—rather than pursue operators aggressively? It does not excuse the operators committing the fraud, but it explains why the party best positioned to detect and stop it does not always have the incentive to do so.

V. Seven Specific Federal Requests

1. DOJ/HHS Joint Guidance: Clarify that protections under the Fair Housing Act apply to housing occupancy status, not to unlicensed clinical or medical services delivered within a residence.

2. CMS MAR Definition: Issue formal guidance defining MAR-documented, staff-timed medication distribution as clinical administration for state licensure determinations, conditioning California's pending CalAIM Section 1115 demonstration renewal on the strict enforcement of this standard.

3. HUD Grant Conditions: Condition Recovery Housing Program disbursements and related grant streams on verified, active state clinical licensure prior to releasing funds.

4. DEA/DOJ Target Enforcement: Prioritize enforcement actions under 21 U.S.C. § 333 regarding unlicensed controlled-substance administration within recovery residences, coordinating with RICO referrals where patient brokering and insurance fraud are identified.

5. HHS OIG Compliance Guidance: Issue interpretive guidance establishing that kickback arrangements and financially incentivized referral networks between treatment centers and sober living operations constitute actionable federal fraud under EKRA.

6. HHS/CMS MLR Methodology Review: Direct HHS and CMS to examine whether Medical Loss Ratio methodology should exclude claims tied to facilities under active investigation or unlicensed under Title 9, so that fraudulent billing cannot continue to count toward an insurer's MLR compliance ratio.

7. HHS Preemption Clarification: Affirm that states preserve full statutory authority to regulate and oversee addiction treatment operations without triggering federal preemption constraints.

VI. The State's Record Since 2021

This systemic failure is well-documented. On December 13, 2021, the California Assembly Committee on Accountability and Administrative Review conducted an oversight hearing focused on these facility operations. Testimony revealed that DHCS maintains an internal structural divide between investigators with statutory enforcement power and administrative analysts restricted solely to issuing corrective action plans.

Additional testimony from that hearing confirmed:

DHCS's Licensing & Certification Chief acknowledged that the department had not filed a single injunction against an illicit facility throughout the preceding calendar year.

Healthcare fraud investigators testified that DHCS provides advance notice to operators prior to conducting on-site compliance visits, enabling operators to conceal regulatory violations.

DHCS's 2017 mortality investigation concerning the Above It All facility in Lake Arrowhead identified forged prescriptions and falsified records surrounding the death of 20-year-old Matthew Maniace—reportedly the seventh fatal incident at that specific site.

Five years of documented state notice without federal leverage have failed to remediate these abuses.

VII. Transparency and Regulatory Records

On August 18, 2026, Jarrod's Law issued a legislative subpoena (#L120514-081726) to DHCS seeking unredacted regulatory files to facilitate rigorous, independent research by California academic institutions and the Substance Use Task Force founded by Assemblywoman Cottie Petrie-Norris.

Independent investigation into illicit treatment operations in California has not produced a comprehensive state-level report since 2012—fourteen years ago. This predates the structural consolidation, funding expansion, and ADU deployment models utilized by today's operators. The continued withholding of unredacted state agency records impedes regulatory reform and obscures critical operational data.

VIII. Legislative and Advocacy Background

Co-created California Overdose Awareness Week via Assembly House Resolution 121 (2022) alongside Assemblywoman Cottie Petrie-Norris.

Authored John's Law (AB 1356, enacted 2025) with Assemblywoman Diane Dixon.

Authored AB 919 (enacted, effective January 1, 2020), introducing foundational patient-protection mandates under Jarrod's Law.

Investigative contributions featured in Shoshana Walter's Rehab: An American Scandal, HBO's Last Week Tonight with John Oliver, and the documentary The Business of Recovery.

Coordination on The Shuffle, a documentary directed by Ben Flaherty examining patient brokering and regulatory evasion; private screenings are available to regulatory and legislative bodies committed to oversight reform.

IX. Timeline and Implementation

Assemblywoman Laurie Davies' office is preparing to meet directly with HHS leadership in Washington to address this administrative impasse. Continued delay allows unlicensed, ADU-based facilities to expand

and embed their operations ahead of prospective oversight. Because each of the seven requested actions relies entirely on existing administrative and statutory authority, federal agencies possess the immediate capacity to act without waiting for new congressional mandates.

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