



## Assisted Living: An Underused Community-Based Housing Option for People with Behavioral Health Needs

People with significant behavioral health needs — serious mental illness (SMI), substance use disorder (SUD), or both — require stability, structure, and access to treatment and interventions. Assisted living facilities (ALFs) can provide these things. ALFs are home-like residential settings that also offer additional services depending on a person's needs. These settings can serve as transitional housing — helping people step up or down from other levels of care — or as long-term homes for those with ongoing behavioral health and functional needs.

Unfortunately, assisted living is often underutilized for people with behavioral health and functional needs. As a result, the flow between housing/treatment settings across the care continuum remains inefficient, and vulnerable people can get “stuck” at a level of care or in a setting that doesn't serve their needs. The main reason for this underutilization? The players don't understand the delivery and payment systems for assisted living (Medi-Cal and county safety net programs) and the universe of what's available to support people with behavioral health needs.

This issue brief describes how using ALFs as a housing and care option for people with functional needs and behavioral health conditions could improve patient flow across the housing and care continuum and help deliver better outcomes. It focuses on ways that Medi-Cal and the safety net — including assisted living operators, managed care plans (MCPs), and county behavioral health plans (BHPs) — can increase

utilization, improve referral pathways, and create stability for people who can thrive in assisted living settings.

### Toby's Story

Toby, a 56-year-old man, has lived much of his adult life in Hollywood navigating schizophrenia, diabetes with neuropathy, and worsening vision. For years he bounced between hospitals, the streets, and friends' couches — never in one place long enough to stabilize.

Two years ago, a hospitalization for severe foot ulcers landed him in a skilled nursing facility. The medical care helped, but the institutional environment didn't: His mental health declined, he withdrew from treatment, and he told staff he wanted “a place that felt like home.”

When his Medi-Cal care team reassessed, they realized Toby didn't need a nursing facility — he needed support for both daily living and mental health. With Assisted Living Waiver slots full, his Medi-Cal managed care plan used the Assisted Living Facilities Transitions Community Support to move him to an adult residential facility that could meet both his medical and psychiatric needs.

In his new setting, Toby gets medication management, blood-sugar monitoring, help with daily activities, on-site therapy, and 24-hour support. He hasn't returned to the hospital in two years. He now cooks meals with other residents, rides his bike to volunteer at the local animal shelter, keeps up with therapy, and says he finally feels “part of something.”

# What Is Assisted Living?

ALFs provide support for adults who need assistance with their daily functioning, in a community-based, home-like setting. In California, there are two types of ALFs: adult residential facilities (ARFs) and residential care facilities for the elderly (RCFEs). Both are licensed by the California Department of Social Services.<sup>1</sup> The box below compares ARFs and RCFEs.

**Types of ALFs**

Adult Residential Facilities (ARFs)	Residential Care for the Elderly (RCFEs)
<ul style="list-style-type: none"> <li>▶ Ages served: 18 to 59*</li> <li>▶ Strong focus on behavioral and social support</li> <li>▶ Most residents live in small ARF settings</li> <li>▶ California has 6,400 licensed ARFs with 43,208 beds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Ages served: 60 and older</li> <li>▶ Strong focus on engagement and community</li> <li>▶ Most residents reside in larger RCFE settings</li> <li>▶ California has 7,701 licensed RCFEs with 211,939 beds</li> </ul>

Source: "Adult and Senior Care Program Total Number of Licensed Facilities and Capacity by Facility Type" [as of June 2024], [CCLD Facility and Capacity Data 2017-24](#), California Department of Social Services Community Care Licensing Division.

\* Age guidelines are not absolute: Residents of ARFs are not required to transition when they reach age 60. ARFs may have up to 50% of their residents over age 59 if their capacity is six or fewer residents, and up to 25% if their capacity is more than six residents (22 Cal. Code of Regs, § 85068.4).

ARFs and RCFEs provide a wide array of supportive services. With 24/7 staffing, ALFs help residents with their *functional needs*, assisting with bathing and eating, medications, laundry, transportation, or mobility assistance, among other services. These assisted living services are targeted at residents' Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). (See the box in the next column for a full list of ADLs and IADLs.)

ALFs are not clinical providers. While they may sometimes have clinical services on-site, and frequently

coordinate with clinical care, they are fundamentally nonmedical residential environments.

For more information about ARFs and RCFEs, see CHCF's [What Is Assisted Living? Opportunities to Advance Community-Based Care for Medi-Cal Enrollees](#), and [How Assisted Living Fits in the Care Continuum](#).

**Types of Daily Living Support**

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
<ul style="list-style-type: none"> <li>▶ Bathing</li> <li>▶ Dressing/Grooming</li> <li>▶ Eating</li> <li>▶ Toileting/Incontinence Care</li> <li>▶ Transferring/Mobility</li> <li>▶ Wayfinding</li> </ul>	<ul style="list-style-type: none"> <li>▶ Medication Management</li> <li>▶ Housekeeping</li> <li>▶ Laundry</li> <li>▶ Transportation</li> <li>▶ Meal Preparation (including for special diets)</li> <li>▶ Scheduling/Care Coordination</li> </ul>

Source: Paula Hertel, [What is Assisted Living? Opportunities to Advance Community-Based Care for Medi-Cal Enrollees](#), California Health Care Foundation, August 2024.

Beyond their core functions, ARFs and RCFEs vary significantly. Some are very small, with six beds or fewer; others (more often RCFEs) are larger with up to several hundred beds. Some provide transitional housing, while others offer longer-term housing. They supply varying levels of service according to a resident's needs. Depending on their size, capacity, and service model, ARFs and RCFEs may employ their own staff to provide services and supports or may contract or partner with other agencies for those services.

Although eligibility for assisted living is based on functional need, not medical diagnosis, many people with SMI or SUD do have functional needs.<sup>2</sup> Some ARFs and RCFEs specialize in serving people with behavioral health conditions. They may have specially

trained staff, offer links to mental health services on-site, or coordinate closely with outpatient community providers of mental health and SUD services. They may also offer psychiatric medication management, case management, and recovery-oriented programs for residents.

Although the eligibility criteria for assisted living can vary based on the payer (e.g., Medi-Cal eligibility rules are different from county eligibility rules), there are generally two circumstances when someone with behavioral health needs may be assessed for assisted living eligibility:

► **Transition.** Assisted living may be considered when someone is living in a nursing facility and no longer needs medical rehabilitation or is ready to leave an acute or subacute facility (e.g., an inpatient psychiatric stay or Institution for Mental Diseases) but still

needs a higher level of care. Assisted living can provide a more home-like environment that supports overall wellness, while also freeing up a nursing facility or other institutional facility bed for someone with higher medical acuity.

► **Diversion.** Assisted living may be considered when someone is living in the community and wants to stay but needs a higher level of care. “Diverting” them to an ALF where their needs can still be met safely supports their wish to stay in the community and also prioritizes the nursing facility or other institutional facility bed for those with higher medical acuity.<sup>3</sup>

Table 1 highlights where ARFs and RCFEs fall on a continuum of treatment beds and housing for people with mental health and substance use conditions.

**Table 1. Where Assisted Living Facilities Fit in the Behavioral Health Treatment Beds and Housing Continuum**

		SETTING					
		FORENSIC/ CORRECTIONS	TREATMENT BEDS		TREATMENT BEDS/ HOUSING	HOUSING	
BEHAVIORAL HEALTH TYPE	MENTAL HEALTH CONTINUUM	Forensic/ Corrections	Acute	Subacute	Community and Residential Treatment	Interim	Housing with Supports
	ARF/RCFE						
	SUBSTANCE USE DISORDER CONTINUUM	Forensic/ Corrections	Withdrawal Management	Residential Treatment	Sober Living Housing	Interim	Housing with Supports
						ARF/RCFE	

Note: ARF = Adult Residential Facility; RCFE = Residential Care Facilities for the Elderly

Source: Adapted from [Behavioral Health Treatment Beds and Housing in California: An Explainer](#), which has more information about the range of bed and housing types for people with behavioral health needs. See also “[How Assisted Living Fits in the Care Continuum](#).”

# How Does Assisted Living Work in Medi-Cal and the Safety Net for People with Behavioral Health Conditions?

## Medi-Cal and County Reimbursement Pathways

The two primary mechanisms for Medi-Cal enrollees to access assisted living today are the Assisted Living Waiver (ALW) and Assisted Living Facility Transitions, one of the optional Community Supports launched as part of CalAIM (California Advancing and Innovating Medi-Cal). Counties also support assisted living services for people with behavioral health conditions, typically through non-Medi-Cal funding sources like the Behavioral Health Services Act (BHSA; formerly Mental Health Services Act, or MHSA) or county general funds.

This section discusses the ways that Medi-Cal and county behavioral health — specifically, MCPs and BHPs — can support people with behavioral health needs in assisted living.

**Table 2. Public Reimbursement Pathways for Assisted Living**

DELIVERY SYSTEM	MEDI-CAL	COUNTY BEHAVIORAL HEALTH/ SAFETY NET
Payer	<ul style="list-style-type: none"> <li>▶ Assisted Living Waiver</li> <li>▶ Assisted Living Facility Transitions Community Support</li> </ul>	<ul style="list-style-type: none"> <li>▶ Behavioral health plan</li> <li>▶ County “patch”</li> </ul>

Source: Author analysis, 2025.

Importantly, Medi-Cal support for assisted living is limited to services; Medi-Cal does not pay for the housing portion (room and board) at ALFs. That portion is typically paid directly by the resident. For people who

receive Supplemental Security Income (SSI) or State Supplementary Payment (SSP), which many people with serious behavioral health conditions and/or functional needs do, these benefits are often the funding source for the housing portion of the ALF.

The **Assisted Living Waiver (ALW)** is a federal 1915(c) Medicaid Home and Community-Based Services waiver that has been in place in California since 2009. It offers an alternative to long-term nursing facility placement for eligible people aged 21 or older who have resided in a nursing facility for at least 60 days. The ALW program is currently available in 15 of 58 California counties and can enroll a maximum of 18,762 participants each year.<sup>4</sup> As of November 2025, ALW enrollment was 14,876.<sup>5</sup> To apply, applicants must work with local Care Coordination Agencies, organizations approved by the California Department of Health Care Services to administer the waiver program. In addition to being limited geographically, ALW has a capped number of slots and a significant waitlist that nearly matches that capped enrollment (17,513 on the waitlist in November 2025).<sup>6</sup>

The newer Medi-Cal pathway, **Assisted Living Facility Transitions**, is one of 15 **Community Supports** approved for optional use by MCPs. A foundational goal of Community Supports is to provide access to care in the least restrictive environment, allowing for choice while providing appropriate, cost-effective health care services that are alternatives to Medi-Cal State Plan services. The ALF Transitions Community Support is designed to facilitate appropriate transitions to licensed assisted living settings either as an alternative to skilled nursing care or when skilled nursing services are no longer required. As in the ALW program, the Community Support pays assisted living operators a negotiated rate for services through Medi-Cal, while the resident pays for room and board. For the ALF Transitions Community Support, MCPs pay for ALF services. ALF Transitions launched in January 2022; it is offered by MCPs in 42 counties, but enrollment continues to be low, with only 2,217 people statewide using ALF Transitions during the second

quarter of 2025, and more than 60% of those concentrated within four MCPs.<sup>7</sup>

**County “patch”** funding is used to support assisted living services — and sometimes room and board — for people with serious behavioral health conditions. Some BHPs are planning to use funding from the BHSA to support assisted living services, but other local programs in Housing and Homelessness, Departments of Aging, Human Services, Diversion and Reentry, etc., also support assisted living services for residents. The 2024 passage of Proposition 1 — the Behavioral Health Services Program and Bond Measure — puts an increased emphasis on housing services for people with SMI and SUD who experience homelessness, with a requirement that counties spend 30% of their BHSA funds for that purpose beginning in July 2026. It is unclear how many assisted living residents with behavioral health conditions are paid for through county patches. In the annual Data Notebook published by the California Association of Local Behavioral Health Boards and Commissions, BHPs estimated that over 8,000 people receiving specialty mental health services reside at ARFs — and that at least 1,400 beds are still needed across the state for BHP clients.<sup>8</sup> (This estimate of need doesn’t account for those who are eligible for, but not connected to, treatment services.)

## Reimbursable Services

As discussed above, ARFs and RCFEs are not providers of mental health or substance use treatment. Their services focus on living skills, care coordination, and supporting stabilization in the community.<sup>9</sup> The services listed below are examples of what may be available at ALFs and reimbursable through Medi-Cal and county sources, but what is covered depends on who is paying. Additionally, availability of services varies by ALF depending on their staffing, agreements with county agencies, and partnerships with service providers. Some services are time-limited or based on specific activities. Here are examples of services:

- ▶ **Assessment and transition support.** Time-limited services that support the residents in transitioning to their new residence in the facility. These include an assessment of the person’s service needs, completion of required applications, and verification of supporting documentation to secure a bed.
- ▶ **Assisted living services:**
  - ▶ **Supervision.** 24/7 staff monitoring and assistance, including behavioral and emotional support or de-escalation
  - ▶ **Personal care.** Assistance with ADLs and IADLs (see Types of Daily Living Support box, above).
  - ▶ **Care coordination.** Appointment scheduling and transportation, and connections to clinical resources, conservators, county resources, and other supports
  - ▶ **Care plan management.** Individualized care plan where residents’ progress and goals are regularly assessed and updated.
  - ▶ **Habilitation, social supports, and life skills training.** Structured activities to build social skills; community engagement to reduce feelings of isolation and loneliness; and assistance with finances and employment, etc.
  - ▶ **“Enriched services” such as on-site therapy, counseling, or medical care.** Linkages and coordination with county or community behavioral health providers who visit the ALF regularly, as well as on-site support provided by a registered nurse.

For assisted living operators, it can be challenging to provide some of these services for people with behavioral health conditions because of the need to work across systems. For example, care coordination for people with serious behavioral health conditions living at an ALF can be extremely complex. Typically, it requires the ALF to work both with a resident’s MCP and with the county BHP. For someone with functional and behavioral health needs living at an ALF, the county BHP is likely to be responsible for most mental health and/or SUD treatment and services, while the

MCP is responsible for physical health care or medical needs. (See the Medi-Cal Behavioral Health Services Delivery System box.) For residents enrolled through the ALW, the Care Coordination Agency manages care coordination; however MCPs may also deliver this service via Enhanced Care Management [ECM].

### Medi-Cal Behavioral Health Services Delivery Systems

Several delivery systems administer mental health and substance use disorder services for Medi-Cal members. Medi-Cal managed care plans are responsible for the delivery of non-specialty mental health services to Medi-Cal members — things like psychotherapy and psychological testing — and limited SUD services, including alcohol and drug screening. County behavioral health plans administer or provide a more extensive set of mental health and substance use disorder services for Medi-Cal members who qualify based on their clinical need. For more information, see [The Crucial Role of Counties in the Behavioral Health of Californians](#).

## What Barriers to Assisted Living Exist for People with Behavioral Health Needs?

Underuse of assisted living for people with behavioral health needs is due to various barriers within the primary payment systems: the ALW, Medi-Cal managed care, and county programs through BHPs or other agencies.

### Access Is Limited by Referring Delivery System

People who are eligible for assisted living can be overlooked because of misunderstandings across delivery systems and gaps between MCPs and BHPs. Since serious behavioral health conditions are managed by BHPs and physical health conditions are managed by

MCPs, there are missed opportunities for referrals and improved coordination between the plans.

All parties may have incomplete information. MCPs may fail to screen members with behavioral health conditions for assisted living, wrongly assuming that ALF eligibility is limited to older adults or those with physical disabilities. Or MCPs may assume that members must go through the ALW first before receiving the ALF Transitions Community Support. Despite the state's commitment to renewing the ALW and maintaining the ALF Transitions Community Support, some MCPs continue to be skeptical about the long-term financial sustainability of these alternatives, creating barriers to access for eligible members.

There is no consistent statewide mechanism for matching members to the most clinically and functionally appropriate assisted living setting. As a result, people with behavioral health needs, especially if newly diagnosed and not connected to services through the county BHP, may not be identified as eligible for assisted living and may end up stuck at higher levels of institutional care or inadequately supported in independent living settings.

BHPs, for their part, are often unaware of MCP covered services like ECM and Community Supports that could offer support at a lower level of care such as assisted living.

Assisted living operators are generally more familiar with the ALW (and in some cases BHPs) as reimbursement options, but do not often work closely with MCPs. Lack of awareness means that residents may not be referred to and connected to MCP services such as ECM or Community Supports, or that the assisted living operator pays out of pocket for things like medical supplies or home health services that are reimbursable through MCPs.

## Lack of Coordination and Care Continuity After Assisted Living Placement

The referring entity or the assisted living operator may not know what is available to support a resident, which can lead to gaps in coordination and a failure to fully support people's needs. Delivery systems remain siloed between health plans, counties, and providers, limiting visibility into resident outcomes, care coordination, and facility performance.

While the transition from MHSA to BHSA now requires counties to integrate mental health and substance use services under shared population health goals, alignment with Medi-Cal managed care remains inconsistent.

Although a member's assisted living services are the responsibility of one payer, the MCP and BHP still need to coordinate how they cofund the many other services that person will need — from treatment to case management to housing supports. Without this coordination, assisted living operators frequently lack access to behavioral health consultation and crisis response support, which can contribute to failed placements and avoidable hospitalizations.

## Insufficient Reimbursement

A major factor in the financial sustainability for ALFs is that Medi-Cal pays only for services, not for housing (room and board). SSI and State Supplementary Payment rates cover only a fraction of operating costs, creating structural deficits for operators serving low-income or Medi-Cal residents.

Not all ARFs or RCFEs are equipped to care for people with serious behavioral health conditions — some are specialized for other populations, such as older adults or people with intellectual and developmental disabilities. Staffing, skills, and capacities need to be aligned so that ALFs can provide appropriate care for these residents. And, regardless of the payment pathway,

some operators feel that Medi-Cal reimbursement rates don't cover the full cost of supporting people with higher needs, especially those who need more help managing behavioral health problems. For residents with higher needs, operators bear unreimbursed costs for behavioral supports, staffing, transportation, and coordination required under CalAIM and BHSA's integrated-care model.

While new capital funding streams (e.g., BHSA, Behavioral Health Continuum Infrastructure Program, Community Care Expansion Program) support construction and modernization of ALFs, dedicated funding to ensure ongoing operations and workforce sustainability continues to be a challenge.

## Opportunities and Best Practices

Increasing awareness of the landscape for assisted living across all systems can help prevent the bottlenecks that keep people with behavioral health conditions out of assisted living. Such awareness helps referral partners know about additional options for their patients, facilitates the identification of eligible members enrolled at MCPs, and encourages better coordination between BHPs and MCPs to optimize Medi-Cal funding.

Here are some key opportunities to increase assisted living use for people with serious behavioral health conditions:

- ▶ Encourage MCPs to use ALW waitlists to identify eligible members for assisted living and expand their assisted living network capacity by contracting directly with ALFs, hubs or other service providers for the ALF Transitions Community Support.
- ▶ Encourage BHPs to refer members to MCPs for the ALF Transitions Community Support before using local funds, especially for members who meet criteria for the Community Support and have SSI or SSP income to cover room and board. For residents who

don't have this income, BHPs can use BHSA funding to pay for the room and board portion — and the BHP can count these costs toward the requirement that 30% of county BHSA funds be used for housing interventions.<sup>10</sup>

- ▶ Develop bed registries (at local, regional or state-wide levels) for licensed ARFs/RCFEs and other residential care types, listing capabilities of each ARF and RCFE that are contracted for Medi-Cal or county patch funds: their admitting criteria, staffing model (e.g., 24/7 nursing, nurse on call, no nursing), policies around medication administration assistance, Americans with Disabilities Act (ADA) compliance, and their comfort and training on mental health, SUD, dementia, etc.)
- ▶ Standardize MCP and BHP payment methodologies across payment systems, with consistent tiering and clarity about what is reimbursable and not. Payment standardization would simplify reimbursement complexity for assisted living operators and reduce hesitancy from small and midsize facilities to contract under Medi-Cal.
- ▶ Standardize assessment and care-planning tools statewide to capture behavioral, medical, and functional needs consistently across ALW, CalAIM, BHP, and other county-funded placements.
- ▶ Promote use of administrative hubs or intermediaries to manage multi-payer contracting. Assisted living operators should leverage administrative hubs that can streamline processes and requirements across all payers. (See the “Community Care Hubs” box.)

### Community Care Hubs as a Model for Streamlining Administrative Activities

In Los Angeles, over 400 assisted living facilities with residents who rely on public benefits and/or live with serious mental illness engage as members of the nonprofit [Licensed Adult Residential Care Association \(LARCA\)](#). Many LARCA members contract with the Los Angeles County Department of Mental Health or with one or more managed care plans, but they continue to struggle with the complexity of Medi-Cal requirements and reimbursement processes. As a result, many LARCA assisted living facilities are reluctant to take potential residents with higher behavioral health needs, leaving beds empty and people unhoused, all for lack of coordination and proper matching of residents to the right level of care. To address these gaps, LARCA is developing a Community Care Hub model to support its members. The vision is that LARCA will serve as a centralized infrastructure that supports referrals and matching to optimize placements and that acts as a liaison between payers and facilities, streamlining payment and reimbursement processes.

## Conclusion

Assisted living can be a safe, recovery-focused, empowering housing and care resource for people with behavioral health and functional needs. Maximizing the use of ALFs as a resource across all systems can benefit the overall system and its parts — by substituting lower-acuity settings for higher-cost institutional care — and, more important, can benefit those Medi-Cal members who can thrive in community-based assisted living settings.

Payers and partners serving people with behavioral health needs must increase their understanding of the complexity of assisted living, such as who is eligible and how services are paid for. This understanding will support:

- ▶ Better patient flow across the mental health and SUD continuums so that more people can reside at the right level of care for their needs
- ▶ Long-term retention and stability for residents who can be better supported by assisted living operators through other payers based on availability and need
- ▶ Stretching local dollars further to serve the safety net when the ALF Transitions Community Support is prioritized for Medi-Cal members before county programs
- ▶ Prioritization of beds and housing that are the least restrictive and most appropriate setting, which can lead to better health outcomes.

## About the Authors

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## About the Foundation

The [California Health Care Foundation](#) (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

## Endnotes

1. [“Residential Regulations,”](#) California Department of Social Services (DSS), accessed October 2025.
2. [Community Supports Policy Guide Volume 1](#) (PDF), California Department of Health Care Services (DHCS), April 2025; [“Assisted Living Waiver,”](#) DHCS, accessed April 2025.
3. [Community Supports Policy Guide Volume 1.](#)
4. [1915\(c\) Renewal Approval Letter](#)
5. [Assisted Living Waiver \(ALW\) Year to Date Enrollment and Waitlist January 2019 through October 2025,](#) California Department of Health Care Services (DHCS), accessed February 2026.
6. [Assisted Living Waiver Year to Date Enrollment and Waitlist January 2019 through October 2025,](#) California Department of Health Care Services (DHCS), accessed February 2026.
7. Chart 3.5.2 and Chart 3.9.3, [“Community Supports Members Data: A Section of the ECM and Community Supports Quarterly Implementation Report,”](#) accessed February 2026.
8. [Executive Summary: Overview Report of the 2023 Data Notebook Project on California Behavioral Health](#) (PDF), California Behavioral Health Planning Council, December 2024.
9. [Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications](#) (PDF), California Department of Health Care Services (DHCS), January 2022.
10. Behavioral Health Services Act County Policy Manual, California Department of Health Care Services, [7. BHSA Components and Requirements,](#) accessed February 2026.