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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

**RELATING TO STATE AFFAIRS AND GOVERNMENT -- CHILDREN'S MOBILE
RESPONSE AND STABILIZATION SERVICES**

Introduced By: Senators Lawson, Murray, Ciccone, Tikoian, and LaMountain

Date Introduced: March 12, 2026

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Legislative Findings and Purpose.

2 (a) The General Assembly finds that:

3 (1) Children and youth experiencing behavioral health crises require timely, community-
4 based interventions to prevent unnecessary emergency department utilization, inpatient
5 hospitalization, out-of-home placement, and involvement with law enforcement;

6 (2) Children's Mobile Response and Stabilization Services (MRSS) are a Substance Abuse
7 and Mental Health Services Administration (SAMHSA) best practice, trauma-informed
8 intervention that provides rapid crisis response and short-term stabilization for children and youth
9 in their natural environments;

10 (3) A statewide Children's MRSS system funded through a combination of commercial
11 insurance, Medicaid and state general revenue promotes equitable access to services regardless of
12 insurance status;

13 (4) Rhode Island has an interest in ensuring continuity of care, fiscal sustainability, and the
14 participation of experienced community-based providers in delivering children's behavioral health
15 crisis services.

16 (b) The purpose of this act is to establish Children's Mobile Response and Stabilization
17 Services as a standalone statewide behavioral health service in Rhode Island, funded through a
18 coordinated Medicaid and state funding model, and administered in a manner that ensures access

1 for all children and youth.

2 SECTION 2. Title 42 of the General Laws entitled "STATE AFFAIRS AND
3 GOVERNMENT" is hereby amended by adding thereto the following chapter:

4 CHAPTER 72.13

5 CHILDREN'S MOBILE RESPONSE AND STABILIZATION SERVICES

6 **42-72.13-1. Definitions.**

7 As used in this chapter:

8 (1) "Department" means the department of children, youth and families (DCYF).

9 (2) "Designated MRSS provider" means a community-based provider licensed or
10 contracted by the department to deliver MRSS.

11 (3) "Medicaid agency" means the Medicaid program administered within the executive
12 office of health and human services (EOHHS).

13 (4) "Mobile response and stabilization services" or "MRSS" means community-based
14 behavioral health crisis services for children and youth up to the age of twenty-one (21), including:

15 (i) Rapid mobile crisis response;

16 (ii) Crisis assessment and de-escalation;

17 (iii) Short-term stabilization and follow-up services; and

18 (iv) Care coordination with families, schools, healthcare providers, and community-based
19 organizations.

20 (5) "Natural environment" means homes, schools, childcare settings, and other community
21 locations in which children and youth typically live, learn, or receive care.

22 **42-72.13-2. Establishment of a statewide MRSS program.**

23 (a) The department, in coordination with the Medicaid agency, shall establish and
24 administer a statewide mobile response and stabilization services program, and shall ensure
25 alignment with the Children's Behavioral Health Consent Decree that was ordered in United States
26 v. State of Rhode Island, C.A. No. 24-cv-00531.

27 (b) The department shall establish standards for MRSS service fidelity.

28 (c) MRSS shall be available statewide, twenty-four (24) hours per day, seven (7) days per
29 week, to all children and youth regardless of insurance status or Medicaid eligibility.

30 (d) The department shall license a minimum of two MRSS providers and a maximum of
31 three (3) providers for the entire State of Rhode Island.

32 (1) Each licensed MRSS provider shall be responsible to provide MRSS to all children and
33 youth up to the age of twenty-one (21) to their agreed geographic region or catchment area as
34 established by the department.

1 (2) Licensed MRSS geographic catchment areas shall be through the assignment of the
2 specific cities and towns and ensure sustainability and community connection.

3 (3) Each MRSS licensed provider shall be responsible for a catchment area with a
4 minimum of a total of ninety thousand (90,000) or as established in regulations by the department,
5 and a maximum of one hundred forty thousand (140,000) or as established in regulations by the
6 department, children and youth up to the age of twenty-one (21).

7 (e) No prior authorization, referral, or clinical intake determination shall be required for
8 initiation of MRSS.

9 (f) Services pursuant to this chapter shall be delivered in the child's natural environment
10 whenever clinically appropriate.

11 (g) All requests for MRSS shall be presumed eligible for response under a no wrong door
12 standard, and services shall not be denied or delayed due to:

13 (1) Payer status;

14 (2) Referral source; or

15 (3) Clinical screening thresholds inconsistent with a family-defined crisis.

16 **42-72.13-3. Service delivery standards.**

17 (a) Response time. Designated MRSS providers shall provide in-person mobile response
18 within sixty (60) minutes of initial contact, unless clinically contraindicated. Telephonic or virtual
19 response shall not substitute for in-person response except where clinically appropriate and
20 determined by MRSS staff.

21 (b) Service components. MRSS shall include, at a minimum:

22 (1) Crisis assessment and de-escalation;

23 (2) Family engagement and support;

24 (3) Short-term stabilization services of sufficient duration to support safe resolution of the
25 crisis; and

26 (4) Transition planning and linkage to ongoing behavioral health, educational, and
27 community supports.

28 (c) Designated provider MRSS teams shall consist of a minimum of two (2) staff, including
29 at least one licensed behavioral health clinician qualified to conduct clinical assessments and one
30 additional team member, which may include a peer support specialist, family partner, or other
31 trained paraprofessional. Providers shall ensure access to clinical supervision and psychiatric
32 consultation on a twenty-four (24) hour basis.

33 (d) Workforce composition. Designated MRSS provider teams shall include licensed
34 clinicians and may include peer support specialists, family navigators, and other trained staff with

1 demonstrated expertise in children's behavioral health.

2 (e) Cultural and linguistic competency. MRSS designated providers shall deliver services
3 in a culturally and linguistically responsive manner and shall ensure accessibility for individuals
4 with disabilities.

5 (f) Coordination with crisis lines. MRSS shall serve as the primary, mobile crisis response
6 system for children and youth experiencing behavioral health crises. MRSS shall operate in
7 coordination with, but remain clinically and operationally distinct from, the 988 Suicide and Crisis
8 Lifeline (988) and other telephonic triage or referral lines, including Kids' Link RI. Referrals to
9 designated MRSS providers shall originate from 988, Kids' Link RI, 911, schools, child welfare
10 agencies, healthcare providers, law enforcement, families, or self-referral; provided, however, that
11 988 and other telephonic triage or referral lines may receive, assess, de-escalate, and route crisis
12 contacts with applicable law, and designated MRSS providers shall retain clinical discretion in
13 accordance with nationally recognized fidelity standards regarding deployment, response modality,
14 and timing. Coordination with 988 and other crisis lines shall not result in unnecessary screening,
15 triage delays, or redirection that substitutes telephonic intervention for in-person mobile response
16 when MRSS is clinically appropriate. Nothing in this section shall permit 988 or any call center
17 entity to control dispatch or clinical decision-making for MRSS services once a referral has been
18 made. Nothing in this section shall be construed to require designated MRSS providers to operate
19 or staff a call center, crisis hotline, or telephonic triage service.

20 (g) Coordination with certified community behavioral health clinics (CCBHC). Designated
21 MRSS providers shall coordinate with CCBHCs and other behavioral health providers for purposes
22 of referral, care transitions, information-sharing, and continuity of care when clinically appropriate
23 and with appropriate consent.

24 (1) Designated MRSS providers may execute non-financial coordination agreements
25 and/or designated collaborating organization (DCO agreements) with coordinating entities such as
26 pediatricians, law enforcement, hospitals and other child and youth serving entities.

27 (2) Coordination shall not require MRSS to be operated by, embedded within,
28 subcontracted to, or financially dependent upon a CCBHC, nor shall it limit the department's
29 authority to contract directly with community-based designated MRSS providers. MRSS shall
30 remain a distinct mobile crisis response and stabilization service with independent clinical decision-
31 making authority.

32 (h) Child and family competency requirement. MRSS shall be delivered by designated
33 MRSS providers with demonstrated expertise in child and adolescent behavioral health and family
34 systems. Designated MRSS providers shall ensure that licensed clinical staff assigned to MRSS

1 possess training and experience specific to children, youth and families, including child
2 development, trauma-informed care, family engagement, and coordination with child-serving
3 systems. Providers that primarily serve adult populations shall not deliver MRSS unless they
4 demonstrate child-specific capacity, staffing, and supervision as required by this chapter.

5 (i) MRSS shall be designed and delivered as a child- and family-centered service, distinct
6 from adult behavioral health crisis systems. Program design, staffing, and service delivery models
7 shall not be modified in a manner that:

8 (1) Aligns MRSS with adult crisis response frameworks; or

9 (2) Diminishes specialization in child and adolescent behavioral health.

10 (j) Designated MRSS providers shall retain exclusive authority over dispatch, triage, and
11 clinical response decisions for MRSS encounters, and such authority shall not be delegated to
12 external call centers or third-party entities.

13 **42-72.13-4. Funding and reimbursement.**

14 (a) MRSS shall be funded through a funding model consisting of:

15 (1) Medicaid reimbursement for services provided to Medicaid-eligible children and youth
16 and shall be developed utilizing a methodology that reflects the full cost of delivering twenty-four
17 (24) hour MRSS service;

18 (2) State general revenue appropriated to the department for services provided to children
19 and youth who are not Medicaid-eligible; and

20 (3) State general revenue funding shall function as a guaranteed access backstop, ensuring
21 that MRSS services are available to all children and youth regardless of payer source,
22 reimbursement status, or coverage limitations.

23 (b) On or before October 1, 2027, the Medicaid agency shall submit to the legislature a
24 report outlining the necessary steps and activities required to complete an alternative funding
25 methodology for Medicaid MRSS payments including any costs associated with implementation.
26 Implementation of the alternative methodology shall occur no later than October 1, 2028 in
27 accordance with federal approval.

28 (c) No child or family shall be denied MRSS based on inability to pay, insurance status or
29 failure to satisfy cost-sharing obligations. Designated MRSS providers shall not balance bill
30 families for services not reimbursed in whole or in part by Medicaid, commercial insurance, or
31 state appropriations.

32 (d) State funds appropriated pursuant to this section may be used to draw down available
33 federal matching funds to the maximum extent permitted by law.

34 (e) In the event of state budget reductions, MRSS shall be classified as an essential child

1 behavioral health service. No reduction in MRSS funding shall occur without a public impact
2 analysis and thirty (30) day notice to the general assembly, with explanation of how statutory
3 response time and coverage standards will be maintained.

4 (f) The department, in consultation with the state Medicaid agency, shall annually certify
5 to the general assembly the total funding level necessary to maintain compliance with this chapter
6 and the consent decree. The certification shall specify: the portion supported by Medicaid and the
7 portion requiring state general revenue.

8 (g) Appropriation and minimum state funding requirement.

9 (1) The general assembly declares MRSS to be a core child-serving safety net service, and
10 funding shall be sufficient to ensure no waitlists, service denials, or geographic gaps in access.

11 (2) For the fiscal year ending June 30, 2027, there is hereby appropriated nine hundred
12 thousand dollars (\$900,000) in general revenue to the executive office of health and human services
13 to support mobile response and stabilization services for uninsured and underinsured children and
14 youth and to cover services and costs not otherwise reimbursed by Medicaid or commercial
15 insurance.

16 (3) Beginning in fiscal year 2028, and annually thereafter, the department, in coordination
17 with the Medicaid agency, shall include in its annual budget request and the governor shall include
18 in the budget submitted pursuant to § 35-3-7, a general revenue appropriation sufficient to ensure
19 statewide access to mobile response and stabilization services for uninsured and underinsured
20 children and youth consistent with the requirements of this chapter and the Children's Behavioral
21 Health Consent Decree.

22 (4) For the fiscal year ending June 30, 2028, and for each fiscal year thereafter, the general
23 revenue appropriation for mobile response and stabilization services pursuant to this section shall
24 not be less than one million dollars (\$1,000,000), unless modified by act of the general assembly.

25 (h) For children and youth covered by commercial insurance, the state shall ensure access
26 to MRSS services without delay or denial based on coverage limitations, reimbursement disputes,
27 or network restrictions.

28 (i) The department shall ensure that state general revenue is available as a payer of last
29 resort to guarantee uninterrupted access to MRSS services when commercial coverage is
30 unavailable, insufficient, or delayed.

31 **42-72.13-5. Medicaid coverage.**

32 (a) The Medicaid agency shall designate MRSS as a covered Medicaid service for eligible
33 children and youth up to the age of twenty-one (21), including coverage pursuant to the early and
34 periodic screening, diagnostic, and treatment (EPSDT) benefit.

1 **(b) The Medicaid agency shall submit any necessary state plan amendments or waiver**
2 **applications to the Centers for Medicare and Medicaid Services to implement this section.**

3 **(c) The Medicaid agency shall ensure compliance with all applicable EPSDT requirements**
4 **for Medicaid eligible children and youth accessing MRSS.**

5 **(d) Nothing in this section shall prevent the Medicaid agency from implementing**
6 **utilization management or prior authorization to ensure program integrity and compliance with**
7 **federal Medicaid requirements.**

8 **42-72.13-6. Provider designation and contracting.**

9 **(a) The department shall license and oversee community-based designated MRSS**
10 **providers. The department may enter into contracts as necessary for payment and administrative**
11 **purposes; however, designation as an MRSS provider shall be based on licensure, not procurement**
12 **status.**

13 **(b) In designating MRSS providers, the department shall prioritize:**

14 **(1) MRSS providers with demonstrated experience in children's behavioral health crisis**
15 **services;**

16 **(2) Existing community-based providers currently delivering mobile crisis or stabilization**
17 **services; and**

18 **(3) Geographic coverage sufficient to ensure statewide access.**

19 **(c) Designated MRSS provider contracts shall establish reimbursement rates, performance**
20 **standards, reporting requirements, and care coordination expectations.**

21 **(d) The department shall establish a licensure category specific to children's mobile**
22 **response and stabilization services, including standards for clinical staffing, child and family**
23 **expertise, and service delivery requirements. Each designated MRSS provider shall be responsible**
24 **to provide MRSS to all children and youth up to the age of twenty-one (21) and demonstrate a**
25 **willingness to provide services for the purposes of mutual aid to other licensed MRSS providers**
26 **when needed.**

27 **(e) No provider shall deliver MRSS unless licensed pursuant to this chapter.**

28 **42-72.13-7. Oversight and reporting.**

29 **(a) The department shall collect data on MRSS utilization, response times, outcomes, and**
30 **cost avoidance.**

31 **(b) No later than January 1 of each year, the department shall submit a report to the**
32 **governor and the general assembly detailing:**

33 **(1) Program utilization and geographic coverage;**

34 **(2) Funding sources and expenditures;**

1 (3) Outcomes related to emergency department and inpatient diversion; and

2 (4) Recommendations for statutory or budgetary changes.

3 **42-72.13-8. Rulemaking authority.**

4 (a) The department shall promulgate rules and regulations necessary to implement this
5 chapter. The rules and regulations shall establish a statewide MRSS mutual aid framework to ensure
6 coverage during periods of high demand, workforce shortages, or regional capacity constraints.

7 (b) The department rules and regulations shall include the following:

8 (1) "Family-defined crisis" means a situation identified by a child or youth, their parent,
9 caregiver, or another individual responsible for the welfare of the child or youth as causing
10 emotional, behavioral, or relational distress that exceeds the family's ability to manage safely
11 without support.

12 (2) "Screen-in standard" means an access standard under which all requests for MRSS are
13 presumed eligible for response unless clinical judgment determines that the situation presents a
14 level of imminent risk that requires emergency services beyond the scope of MRSS.

15 (3) "Stabilization services" means time-limited, post-crisis supports provided following the
16 initial mobile response to assist the child or youth and their family in maintaining safety,
17 strengthening coping strategies, and connecting to ongoing services and natural supports.

18 (4) "Crisis episode" means the period of care beginning with the initial request for MRSS
19 and continuing through crisis response, stabilization, and transition or discharge.

20 (5) "Mutual aid" means a coordinated, temporary arrangement among designated MRSS
21 providers to ensure statewide coverage during periods of high demand, workforce shortages, or
22 localized capacity constraints.

23 (c) Designated MRSS providers shall participate in coordinated coverage protocols to
24 prevent service gaps and ensure statewide response time requirements are met. Participation in
25 mutual aid shall not be used to supplant existing designated MRSS providers or reallocate base
26 funding.

27 **42-72.13-9. Severability.**

28 If any provision of this act is held invalid, such invalidity shall not affect other provisions
29 of the act which can be given effect without the invalid provision.

30 SECTION 3. This act shall take effect upon passage.

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- CHILDREN'S MOBILE
RESPONSE AND STABILIZATION SERVICES

1 This act would establish a statewide mobile response and stabilization services program to
2 provide rapid crisis response and short-term stabilization for children and youth in their natural
3 environments.

4 This act would take effect upon passage.

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LC006098/SUB A/3
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