RHODE ISLAND GOVERNMENT REGISTER

PUBLIC NOTICE OF PROPOSED RULEMAKING

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Title of Rule: Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Certification (214-RICR-40-00-6)

Rule Identifier: 214-RICR-40-00-6

Rulemaking Action: Proposed Amendment

Important Dates:

Date of Public Notice: February 16, 2026

Hearing Date: March 3, 2026

End of Public Comment: March 18, 2026

Rulemaking Authority:

R.I. Gen. Laws §§ 42-72-5

40.1-5-5. 40.1-5-6

40.1-5-8

42-72-5.2

42-72.1

R.I. Gen. Laws § R.I. Gen. Laws § 27-18-95

Summary of Rulemaking Action:

This revision updates and expands the existing Emergency Services (ES) regulations to incorporate licensure standards for Mobile Response and Stabilization Services (MRSS), consistent with recent statutory changes and statewide behavioral health system reforms. Key changes include:
•Expanded scope and purpose to implement R.I. Gen. Laws § 27-18-95 and 2025-H 5151 Substitute A, establishing MRSS as a licensed service and a Medicaid-covered benefit for children and youth ages two through twenty-one
•Creation of two distinct licensure levels: Emergency Services (ES) and Mobile Response and Stabilization Services (MRSS), with MRSS providers required to meet all ES standards plus additional MRSS-specific requirements.
•New definitions and clarified terminology, including detailed definitions related to behavioral health emergencies, child-family competency, MRSS service phases, warm handoffs, system of care, and designated collaborating organizations (DCOs).
•Detailed MRSS service delivery standards, including required response timeframes, staffing models, stabilization services, coordination with 988, and expectations for crisis de-escalation and follow-up care.
•Statewide service structure and accountability, establishing primary service areas aligned with CCBHC regions, mutual aid requirements across MRSS providers, and expectations for statewide coverage.
•Enhanced staffing, supervision, and training requirements, including QMHP staffing on mobile teams, supervision minimums, cultural and linguistic competency, and ongoing professional development.
•Expanded data collection, reporting, and quality improvement requirements, including fidelity measures, encounter data, and documentation standards.
•Updated licensure application, review, and enforcement provisions, clarifying application timelines, approval criteria, licensing actions, corrective action processes, and appeal rights.
•No substantive change to emergency hospitalization authority under R.I. Gen. Laws § 40.1-5-7, which remains excluded from these regulations.
Overall, the revisions modernize the regulatory framework to support a coordinated, community-based crisis response system for children and youth while maintaining existing emergency service requirements and protections.

Additional Information and Public Comments:

All interested parties are invited to request additional information or submit written or oral comments concerning the proposed amendment until March 18, 2026 by contacting the appropriate party at the address listed below:

Sarah St. Jacques
Department of Children, Youth, and Families
Department of Children, Youth and Families
101 Friendship Street
Providence, RI 02806
sarah.stjacques@dcyf.ri.gov

Public Hearing:

A public hearing, in accordance with R.I. Gen. Laws § 42-35-2.5, to consider the proposed amendment shall be held at which time and place all persons interested therein will be heard. This hearing is subject to R.I. Gen. Laws Chapter 42-46, Open Meetings.

Public Hearing Information:

Date: March 3, 2026
Time: 5:00 P.M.

Location: The Da Vinci Center
470 Charles Street
Providence, RI, 02904

The place of the public hearing is accessible to individuals with disabilities. If communication assistance (readers/interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call 401-272-7474 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting. For questions regarding available parking, please contact the agency staffperson listed above.

Regulatory Analysis Summary and Supporting Documentation:

Benefit-Cost Analysis

Mental Health Emergency Service Interventions for Children, Youth, and Families Regulations for Licensure

Prepared by:
Rhode Island Department of Children, Youth, and Families

Date of Publication:
February 2026

I.Introduction

The Department of Children, Youth, and Families (DCYF) is proposing revisions to the regulations for Mental Health Emergency Service Interventions for Children, Youth, and Families. The revisions are being undertaken in order to implement provisions of R.I. General Laws § 27-18-95 Acute Mental Health Crisis Mobile Response and Stabilization Services. In accordance with this law, DCYF is:
1.Making minor updates to the current Emergency Services (ES) certification – changing from certification to licensure and updating to reflect the current terminology and practice for ES services for children.
2.Adding a new level of licensure for Mobile Response and Stabilization Services (MRSS), required for the provision of mobile crisis response and stabilization services. MRSS providers will need to meet all of the standards of the ES licensure, in addition to satisfying MRSS-specific requirements.
These regulations also implement 2025-H 5151 Substitute A as amended, which directs the Executive Office of Health and Human Services (EOHHS) to establish MRSS as a Medicaid-covered benefit and the state-sanctioned crisis system for children's behavioral health, adhering to nationally recognized fidelity standards for children and youth ages 2-21.

These regulations also document how the MRSS services align with the requirements of the Certified Community Behavioral Health Clinic (CCBHC) demonstration, a joint initiative supported by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). As required by R.I. General Laws § 40.1-8.5-8, Rhode Island is participating in the CCBHC demonstration, and federal demonstration rules require 24/7 crisis teams, emergency crisis intervention services, and crisis stabilization for adults and children.

In accordance with the Administrative Procedures Act, as outlined in R.I. General Laws §42-35-2.9, DCYF has conducted a regulatory analysis of the revisions to these regulations. DCYF has identified all changes proposed to the regulations, and of those, which regulatory provisions were discretionary in the implementation of R.I. General Laws § 27-18-95, 2025-H 5151 Substitute A, and R.I. General Laws § 40.1-8.5-8. For those provisions that were discretionary, DCYF has described any benefits and costs of the proposed regulatory changes, using available data at the time of publication.

II.Purpose of Original Regulations

The Mental Health Emergency Service Interventions for Children, Youth, and Families regulations were first issued in 2006. The purpose of the regulations in 2006 was to comply with R.I. Gen. Laws § 40.1-5-6, which requires any child who is under the age of eighteen whose health insurance is publicly funded to have an emergency service intervention by a provider certified by DCYF as a condition for admission to an inpatient psychiatric facility. These regulations set the standards for certifying providers and included standards for child and family competent clinicians.

III.Summary of Proposed Regulatory Changes and Citations

A.General Overview

A full summary of all regulatory changes proposed in the ES and MRSS regulations — including a total of 65 discretionary and non-discretionary changes—is provided in Appendix 1. A subset of these changes is discretionary; of those discretionary changes, some have no cost impact, while others have quantifiable benefits and costs. Table 1 provides a summary of these regulatory change categories and how these changes are organized in this document.

Table 1. Summary of Regulatory Changes

Type of Regulatory Change	Information Provided	Number of Changes	Location
All Discretionary & Non-Discretionary Changes	Description and citation	75	Appendix 1
All Discretionary Changes	Description and citation	24	Section III, Table 2
Discretionary Changes with Negligible or Non-Quantifiable Cost Impact	Description, citation, and rationale for negligible or non-quantifiable cost impact	16	Section V, Table 3
Discretionary Changes with a Cost Impact	Explanation, citation, and detailed benefit-cost analysis	5	Section VI: Narrative Appendix B: Detailed Calculation Tables
Discretionary Changes for Clarification	Description and citation	3	Appendix 1 Section III, Table 2

The reference numbers (Ref #) for all regulatory changes in tables in this regulatory analysis correspond to the reference numbers in Appendix 1.

B.Provisions Overview

The discretionary regulatory changes are categorized into seven provision types as follows:

1.Provision 1: Revisions to Child-Family Competency standards for all ES providers to reflect best practices. Revisions to the existing ES regulations help to clarify and strengthen the Child-Family competency standards. DCYF also revised the language regarding skills to reflect current terms, including child development, family systems, DSM-based diagnostics, risk and family assessment, crisis intervention, and cultural competence. There are new requirements for training for ES providers, including training on RI Mental Health Laws and mandatory reporting.

2.Provision 2: Additional DCYF review of provider policies, procedures, and documentation to enhance accountability and monitoring. To enhance provider accountability, DCYF has included new requirements for submission of policies, procedures, and other supporting documentation for DCYF review in the licensure application process. Additionally, new MRSS-specific requirements for ongoing standardized reporting have been included to promote monitoring of quality service delivery and fidelity to the national MRSS model. These requirements align with best practices and agency-preferred administrative practices.

3.Provision 3: Specified Rhode Island stabilization services standards in accordance with the national MRSS model. The MRSS model includes stabilization services tailored to the needs of children/youth and their caregivers. The regulations describe the period of stabilization and services to be provided, including weekly meetings and assessments.

4.Provision 4: Addition of MRSS staffing-related requirements to align with best practices. The regulations specify staffing schedule submissions and review, supervision standards, and cultural and linguistic competency requirements.

5.Provision 5: Implementation of statewide service capacity using mutual aid agreements and proactive capacity monitoring. To enable proactive and real-time monitoring of MRSS capacity to provide services statewide, DCYF is requiring MRSS Provider agencies to provide notification of capacity constraints and establish reliable backup capacity to ensure 24/7/365 statewide crisis coverage.

6.Provision 6: Incorporated DCYF standard licensing processes and actions. To clarify licensing expectations and timelines for both providers and DCYF, additional licensing details have been incorporated in alignment with DCYF licensing laws under RI General Law §42-72.1, the Department's Licensing Division recommendations, and operational best practices.

7.Provision 7: Incorporated definitions and clarifications, regarding behavioral health emergencies and interventions and settings and the system of care.

C.Discretionary Changes Overview

Table 2 includes a summary of all discretionary regulatory changes proposed in the ES and MRSS regulations, organized by Provision type. The table summarizes the regulatory change, indicates whether a change was a revision or addition to existing regulation, provides the citation, and describes the cost impact. Cost impacts for each change are classified in three categories:

1.Cost Impact: Regulatory changes that have quantifiable costs and benefits.
2.No Cost Impact: Regulatory changes that codify the practices that align with the national MRSS model, which align with existing MRSS provider practices, and therefore impose no new costs on stakeholders.
3.Clarification: Regulatory changes that are exclusively clarifications to existing terms and definitions and have no impact on cost.

Table 2. Discretionary Regulatory Changes in ES and MRSS Regulations

Provision TypeRef # Revision TypeRegulatory Change DescriptionRegulatory CitationClassification
P1. Revisions to Child-Family Competency standards for all ES providers to reflect best practices.23
RevisionClarifies and strengthens Child-Family Competency standards for ES providers by updating terminology, refining skill descriptions, adding training requirements on RI Mental Health Laws and mandatory reporting, and requirement to use QMHP if emergency certification is required.214-RICR-40-00-6.2.F.1a-kNegligible Cost Impact
P2. Additional DCYF review of provider policies, procedures, and documentation to enhance accountability and monitoring.10AdditionRequires providers to verify and document child-family competency through personnel files, training records, and supervision logs to enhance accountability.214-RICR-40-00-6.1.C.5aCost Impact
24RevisionReplaces written confirmation of staff competency with policies and procedures for documenting clinical staff competency via resumes, licensure, and training records, including recruitment, orientation, supervision, and training.214-RICR-40-00-6.2.F.2a-dCost Impact
70AdditionRequires MRSS providers to submit policies and procedures for delivering stabilization services post-crisis, including clinical services, care coordination, peer support, and community-based services.214-RICR-40-00-6.4.D.4Cost Impact
68AdditionRequires MRSS provider applicants to demonstrate at least one year of experience providing MRSS or experience providing similar child-focused crisis services and participation in MRSS training to demonstrate expertise and ensure model fidelity.214-RICR-40-00-6.4.D.2Negligible Cost Impact
63AdditionIntroduces fidelity measure reporting for DCYF to track outcomes in alignment with national MRSS best practices.214-RICR-40-00-6.3.E.2Cost Impact
65AdditionProviders must regularly review all MRSS records for completeness and

clinical quality, implementing corrective action plans as needed to ensure adherence to documentation standards and continuous quality improvement.214-RICR-40-00-6.3.E.4Negligible Cost Impact
P3. Specified Rhode Island stabilization services standards in accordance with the national MRSS model43AdditionSpecifies stabilization services may be provided for 30 days unless the child transitions to appropriate services sooner, or longer if necessary. Includes collaboration and warm handoffs, consistent with MRSS best practices.214-RICR-40-00-6.3.B.1.cNegligible Cost Impact
44AdditionRequires weekly face-to-face stabilization meetings with evening and weekend availability for families in crisis.214-RICR-40-00-6.3.B.1.c.iiNegligible Cost Impact
46AdditionAdds biopsychosocial assessments during stabilization, including developmentally appropriate suicide screening.214-RICR-40-00-6.3.B.1.c.iNegligible Cost Impact
P4. Addition of MRSS staffing-related requirements to align with best practices.57AdditionRequires submission of staffing schedules every six months detailing credentials, roles, and on-call coverage.214-RICR-40-00-6.3.D.1.bCost Impact
59AdditionEstablishes routine supervision standards, including monthly individual and group sessions and 24/7 supervisor access.214-RICR-40-00-6.3.D.1.dNegligible Cost Impact
60AdditionEncourages recruitment of diverse staff to promote culturally humble and linguistically competent services.214-RICR-40-00-6.3.D.1.eNegligible Cost Impact
P5. Implementation of statewide service capacity using mutual aid agreements and proactive capacity monitoring.53AdditionRequires MRSS providers to apply for statewide licensure and designate one or more primary service areas aligned with CCBHC regions, for which they must maintain primary responsibility. Applicants must demonstrate alignment through documentation that the applicant is a CCBHC or a Letter of Intent with a CCBHC and formalize any DCO agreements upon licensure.214-RICR-40-00-6.3.C.1-2Negligible Cost Impact
54AdditionRequires MRSS providers to maintain mutual-aid agreements with all licensed MRSS providers, avoid routine reliance on mutual aid, provide temporary coverage for areas without a preferred MRSS provider, and establish care coordination agreements with all CCBHCs.214-RICR-40-00-6.3.C.3-4Negligible Cost Impact
66AdditionRequires MRSS providers to notify DCYF within 24 hours of anticipated or actual capacity constraints, including caseload and staffing details.214-RICR-40-00-6.3.D.2Negligible Cost Impact
69AdditionRequires MRSS providers to demonstrate reliable service capacity within their area and statewide through mutual aid arrangements, at the time of licensure.214-RICR-40-00-6.4.D.3Negligible Cost Impact
P6. Incorporated DCYF standard licensing processes and actions.66AdditionOutlines the licensure process for ES and MRSS providers, including application submission, review timelines, and requirements.214-RICR-40-00-6.4.A-CNegligible Cost Impact
72AdditionEstablishes a review process for ES and MRSS applications, including a 60-day timeline and optional site visits.214-RICR-40-00-6.4.F.1Negligible Cost Impact
74AdditionDefines grounds for denying, suspending, or revoking an ES or MRSS license, such as non-compliance or health and safety risks. Outlines requirements for agency closure or discontinuation of ES or MRSS services.214-RICR-40-00-6.5.A-GNon-Quantifiable Cost Impact
75AdditionClarifies license duration and renewal requirements for ES and MRSS providers.214-RICR-40-00-6.6.A.2-3Negligible Cost Impact
P7. Clarifications & Definitions5RevisionRenames “Mental health emergency” definition to “Behavioral health emergency” and revises definition to emphasize observable signs indicating urgent need for intervention.214-RICR-40-00-6.1.C.2Clarification
6RevisionRenames "Mental health emergency service interventions" definition to “Behavioral health emergency service interventions” and adds settings like family homes and CCBHCs to modernize terminology and enhance clarity and inclusivity.214-RICR-40-00-6.1.C.3Clarification
17RevisionRevises the definition of “System of Care” to emphasize cross-system collaboration (education, child welfare, juvenile justice, healthcare) and measurable

outcomes. Revision enhances clarity and aligns with best practices.214-RICR-40-00-6.1.C.19Clarification

IV.MRSS Context: Key Source Documents and Baseline Assumptions

This section provides context for MRSS in Rhode Island prior to R.I. Gen. Laws § 27-18-95, Acute Mental Health Crisis Mobile Response and Stabilization Services. This helps clarify the existing requirements for MRSS, where those requirements are documented, and how many MRSS and ES providers are operating in the state. In the regulatory analysis, we refer to these documents and base our analysis on the current number of MRSS providers and ES providers in the state.

How has MRSS been delivered in Rhode Island to date?

Prior to the CCBHC program, Rhode Island funded MRSS services statewide through the SAMHSA System of Care Expansion and Sustainability grant awarded to Rhode Island in 2022. In the State Fiscal Year 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS to establish CCBHCs in Rhode Island, in accordance with the federal model, and to set criteria for CCBHCs. In 2024, Rhode Island was selected to join the SAMHSA/CMS CCBHC Medicaid Demonstration Program and went live with eight CCBHCs on October 1, 2024. Once the CCBHC program went live, MRSS services were provided and funded through the CCBHC demonstration in nearly all of the state. Under the federal CCBHC Certification Criteria, 24/7 mobile crisis is a core CCBHC service, and CCBHCs must provide core services directly or have an agreement with a Designated Collaborating Organization (DCO) to provide these services. In addition to the federal criteria, Rhode Island CCBHC Criteria also specifies that (1) all CCBHCs meet the requirements of the DCYF emergency services regulations; and that (2) CCBHCs or their DCOs provide MRSS as the evidence-based practice for children's mobile crisis services.

How many ES providers and MRSS providers are in the state?

For the CCBHC Demonstration Year 1 (October 1, 2024-September 30, 2025) and Year 2 (October 1, 2025 – September 30, 2026) of the RI CCBHC program, eight CCBHCs had ES certifications through DCYF. Rhode Island anticipates adding another CCBHC in Demonstration Year 3, bringing the total to nine CCBHCs. The ES certification enables CCBHCs to provide crisis services to children on-site at their offices. There are currently three providers who provide MRSS in the state: two CCBHCs and one non-CCBHC that serves as a DCO. These MRSS providers provide mobile crisis services in the community for children and youth. One (1) of the CCBHC MRSS providers also serves as a DCO for MRSS services for other CCBHCs.

What are the current requirements for MRSS providers in Rhode Island?

Requirements for mobile crisis services provided by CCBHCs and DCOs are outlined in the Federal and RI CCBHC Certification Standards. Rhode Island has also developed a guidance document, "Best Practice Expectations for Mobile Response and Stabilization Services (MRSS) for CCBHC Demonstration Year 1 and Year 2" for CCBHCs and other MRSS providers in the state. This document, referred to as the MRSS Guidance Document, is based on the national MRSS model created by the Innovations Institute and was reviewed by the Innovations Institute. It also incorporates best and promising practices from MRSS programs in Connecticut, Ohio, New Jersey, Wisconsin, and Maryland. When the state issued the MRSS Guidance document, the state was already engaged in oversight and monitoring of the MRSS providers and MRSS service delivery, including monthly review of MRSS data submitted by MRSS providers and CCBHCs. Based on oversight and monitoring processes and data and in-depth follow-up engagement with MRSS providers, the state had strong confidence that providers were already in full compliance with the Guidance document requirements at the time of publication.

V.Analysis of Regulatory Impacts

Table 3 includes the list of regulatory changes with no financial impact and an accompanying rationale.

Table 3. Discretionary Regulatory Changes with Qualitative Rationale

Provision Ref #Regulatory ChangeRationale
P1. Revisions to Child-Family Competency standards for all ES providers to reflect best practices.23Revision to Child-Family Competency standards for all ES providers to reflect best practices.Description: The skills in this section mirror the language in the staff child/family competency section of the current RI MRSS guidance document (EOHHS, 2025, p. 12-13). The competencies in the guidance document were informed by existing RI regulations (214-RICR-40-00-6).

Impact: Given there is no change to current practice as verified by providers via biweekly MRSS provider meetings and CCBHC oversight, there are no additional costs for providers or the state for implementing the provision.
P2. Additional DCYF review of provider policies, procedures, and documentation to enhance accountability and monitoring.68Requires MRSS provider applicants to demonstrate at least one year of experience providing MRSS or experience providing similar child-focused crisis services and participation in MRSS training to demonstrate expertise and ensure model fidelity.Description: State law required MRSS services to be provided by licensed behavioral health organizations providing outpatient services, which have “demonstrated experience in delivering child-specific mobile response and stabilization services.” DCYF determined that 1 year of MRSS experience meets the requirement for “demonstrated experience” but added some flexibility for experience and training on MRSS to provide opportunity for new provider entrants. MRSS training is available free of charge from the Institute.

Impact: Given all providers currently meet the requirement for 1 year experience or would be able to receive MRSS training free of charge, there is no additional cost associated with this provision.
65Providers must regularly review all MRSS records for completeness and clinical quality, implementing corrective action plans as needed to ensure adherence to documentation standards and continuous quality improvement.Description: The requirements in this section mirror the language in the data collection and documentation section of the current RI MRSS guidance document (EOHHS, 2025, p. 18-19).

Impact: Given there is no change to current practice as verified by providers via biweekly MRSS provider meetings and CCBHC oversight, there are no additional costs for providers or the state for implementing the provision.
P3. Specified Rhode Island stabilization services standards in accordance with core national MRSS model43Specifies stabilization services may be provided for 30 days unless the child transitions to appropriate services sooner, or longer if necessary to complete a warm handoff, consistent with MRSS best practices. Description: The materials for the MRSS model state that stabilization services should be available for “6 to 8 weeks” (Innovations Institute, 2022, p. 4) but acknowledge “shorter MRSS lengths of service can be desirable if, for example, a goal is to ensure that youth are connected as quickly as possible to clinically appropriate services and supports.” (CHDI, 2023, p.13)

The current RI MRSS guidance states “the stabilization phase can last up to 30 days. It may be shorter if the child or youth transitions to appropriate service or no longer requires stabilization” (EOHHS, 2025, p.16-17). RI based the 30-day length on: (1) the current MRSS stabilization period as of November 2025 under the CCBHC program which is 21.74 days (EOHHS, 2025), and (2) the fact that the CCBHCs had capacity for referrals for post-stabilization care before 6 weeks.

Impact: Given there is no change to current practice, providers have flexibility to

adjust the stabilization period to the client needs. Since the language is consistent with the national model, there are no additional costs for providers or the state for implementing the provision.
44During stabilization, providers must conduct weekly face-to-face meetings and ensure weekend and evening availability.
Description: The MRSS national model emphasizes regular home and community-based face-to-face responses for the stabilization services but does not specify the frequency. The National Best Practices document also says that the provider should continue to provide access to 24/7/365 in-person response as needed (Innovations Institute, 2022, p. 4). The current RI MRSS guidance states “Stabilization Services are provided through face-to-face meetings with the child or youth and/or their family or caregiver(s) at least once a week or more frequently as needed” (EOHHS, 2025, p. 8-9).

Impact: Given there is no change to current practice and the language is consistent with the national model, there are no additional costs for providers or the state for implementing the provision.
46Stabilization must include a biopsychosocial assessment to inform a comprehensive plan of care.
Description: The current RI MRSS guidance document requires clinicians to “complete a brief biopsychosocial assessment” and “utilize screening and assessment tools required by RI CCBHC Certification Standards to gather information for developing and implementing a plan of care” (EOHHS, 2025, p. 16).

Impact: Given this is current practice as verified by providers via biweekly MRSS provider meetings and CCBHC oversight, as well as consistent with the national model and CCBHC standards, there are no additional costs for providers or the state for implementing the provision.
P4. Addition of MRSS staffing-related requirements to align with best practices.59Conduct routine supervision with all licensed direct service staff at least 4 hours per month (1 hour of individual supervision, 3 hours of group supervision).
Description: This requirement aligns with supervision requirements for all behavioral health organizations (BHOs) certified by BHDDH, per BHDDH BHO rules and regulations, Services and Programs 1.6.b.3 (212-10-10-01), and the current RI MRSS guidance (EOHHS, 2025, p. 11).

Impact: Given this is consistent with current BHO rules and regulations there is no change in current practice, and no additional costs for providers or the state for implementing the provision.
60Staff should reflect the diversity of the communities served, whenever possible.Description: This requirement aligns with the current RI MRSS guidance (EOHHS, 2025, p. 11) and with the requirement for “culturally humble and linguistically competent” care necessary to provide high-quality MRSS services (Innovations Institute, 2022, p.1).

Impact: Given this is consistent with the national model and there is no change in current practice, there are no additional costs for providers or the state for implementing the provision.
P5. Implementation of statewide service capacity using mutual aid agreements and proactive capacity monitoring.53Requires MRSS providers to apply for statewide licensure and designate one or more primary service areas aligned with CCBHC regions, for which they must maintain primary responsibility. Applicants must demonstrate alignment through documentation that the applicant is a CCBHC or a Letter of Intent with a CCBHC and formalize any DCO agreements upon licensure.Description: 24/7 Mobile Crisis is a required core service for Rhode Island CCBHCs and CCBHCs must either provide or have a DCO arrangement for any core services. As CCBHCs can only have DCO arrangements with licensed providers, a letter of intent will indicate that a formal DCO agreement will be executed upon MRSS licensure (EOHHS, 2025 Criteria, p. 40-42, 85).

Impact: Given this is a current CCBHC requirement, and CCBHCs and MRSS providers are currently engaged in DCO arrangements for the provision of MRSS

services in service areas, there are no additional costs for providers or the state for implementing the provision.
54, 69Requires MRSS providers to maintain mutual-aid agreements with all DCYF-licensed MRSS providers, avoid routine reliance on mutual aid providers, provide temporary coverage for unassigned areas, and establish care coordination agreements with all CCBHCs. MRSS providers must also demonstrate reliable service capacity within their area and statewide through mutual aid arrangements, at the time of licensure.Description: During the licensure process, DCYF will review the MRSS licensure applications and ensure providers have the capacity to serve priority service areas. Mutual aid will be reserved for periods of exceptional demand or other capacity constraints. This is consistent with current practice.

Impact: DCYF will use existing volume data from CCBHC Demonstration Year 1 and 2 to evaluate whether provider staffing is adequate to serve anticipated MRSS volume in service areas. There is no expectation that providers should have additional staff on hand to prepare for the contingency to respond to service beyond their own service area. Providers would activate the staff they have, when called upon. Therefore, there is no additional cost to the provider. Costs associated with DCYF review of provider capacity are captured as part of the review of semi-annual staffing schedules submitted by providers, described in Section VII.
61MRSS providers must notify DCYF within 24 hours if they anticipate or experience a capacity constraint that may necessitate the use of mutual aid.Description: This requirement aligns with current MRSS guidance which states, “If an MRSS provider reaches capacity and cannot accept additional clients, the provider must notify the Department of Children, Youth, and Families (DCYF) within 24 hours…” (EOHHS, 2025, p.12). While updated regulatory language specifies notification when the use of mutual aid may be required, the capacity constraint experienced by the provider and the notification process and expectations remain the same for both providers and DCYF.

Impact: Given there is no change in current practice as verified by providers via biweekly MRSS provider meetings and CCBHC oversight, there are no additional costs for providers or the state for implementing the provision.
P6. Incorporated DCYF standard licensing processes and actions.
66Enhancements added to clarify ES and MRSS licensure processes, including application submission to DCYF, DCYF review timelines, and provider application requirements. Description: This update to application submission and review processes and requirements is based on the recommendation of the DCYF Licensing Division to enhance clarity of expectations and timelines for both providers and the department. Timelines and processes are agency enhancements and not otherwise legally mandated.

Impact: DCYF timelines to review applications for completeness and for providers to provide missing information upon notification of an incomplete application are aligned with current DCYF practices for licensing foster care providers, residential treatment and group care facilities for children, and agencies that place children, and therefore have no cost impact on DCYF or providers. Time and effort dedicated to licensure application by providers is considered non-discretionary as licensure is required by law and the DCYF licensing process is a typical application process. Discretionary components of licensure have been costed separately in Section VII below.
72DCYF must review ES and MRSS provider applications within 60 days and request additional documentation from providers within 15 business days. Description: This update to DCYF application review processes is based on the recommendation of the DCYF Licensing Division to enhance clarity of review expectations and timelines for both providers and the department. Timelines and processes are agency enhancements and not otherwise legally mandated.

Impact: DCYF timelines to review applications and request additional information are aligned with current DCYF practices for licensing foster care providers, residential treatment and group care facilities for children, and agencies that place children, and therefore have no cost impact on DCYF or providers.

74DCYF grounds for denying, suspending, or revoking an ES or MRSS provider license are now clearly defined to include non-compliance with regulations, false information, health/safety risks, or failure to address deficiencies. Outlines requirements for agency closure or discontinuation of ES or MRSS services.Description: Licensing actions now incorporated into regulations are largely aligned with DCYF licensing laws defined under RI General Law §42-72.1 to ensure compliance with regulations and appropriate accountability levers. Discretionary provisions primarily introduce procedural flexibility, such as offering informal resolutions or corrective action plans, and have been incorporated to align with best practices and DCYF Licensing Division recommendations.

Impact: These updates do not create new mandatory obligations for providers or DCYF. Because licensure is already required by law and these measures are applied at DCYF's discretion, they do not impose predictable or universal costs. Any associated expenses would be situational and therefore not quantifiable.
75Specified renewal application submission timelines and expectations.Description: Renewal application is due 90 days before licensure expiration.

Impact: The DCYF renewal application submission timeline of 90 days prior to licensure expiration is aligned with current DCYF practices for licensing foster care providers, residential treatment and group care facilities for children, and agencies that place children, and therefore has no cost impact on DCYF or providers.

VI.Scope of Analysis and Stakeholder Identification

This section establishes the parameters of the benefit-cost analysis and identifies the stakeholders impacted by the proposed regulatory changes. The geographic scope of this analysis is the State of Rhode Island, and the timeframe assessed is ten years unless otherwise stated. The analysis considers both direct and indirect effects on key stakeholders such as government agencies, provider organizations, and families. It is anticipated that initial implementation of regulatory changes will require additional resources—particularly for policy development and administrative processes—which are expected to decrease over time as systems and practices become standardized. By defining these boundaries and identifying affected groups, this section provides a foundation for evaluating costs, benefits, and distributional impacts across the regulatory landscape.

The stakeholders for the proposed regulatory revisions to the Mental Health Emergency Service Interventions for Children, Youth, and Families are diverse and span across various sectors. Note, there are no anticipated impacts on small businesses, therefore we have not included an economic impact statement nor regulatory flexibility analysis within this benefit-cost analysis.

a.Government Agencies: DCYF will license providers and ensure implementation of and compliance with these regulations. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) is also directly involved, as it is responsible for the certification of Qualified Mental Health Professionals (QMHP) and Behavioral Health Organizations (BHOs). BHDDH also oversees the 988 contract and coordination of 988 with BHOs. The Executive Office of Health and Human Services (EOHHS)/Medicaid will seek state plan authority for MRSS, develop the payment structure for MRSS services, provide Medicaid certification, and ensure that providers meet Medicaid requirements through oversight and monitoring.

b.CCBHCs: There are currently eight CCBHCs operating in Rhode Island that are required to be licensed as ES providers for the delivery of both adult and children's mobile crisis services. The state anticipates adding another CCBHC in Demonstration Year 3, bringing the total to nine CCBHCs. The CCBHCs will be directly impacted by updates to the ES licensure process and the requirement to either be a licensed MRSS provider or have a DCO agreement with a licensed MRSS provider.

c.MRSS Providers: Three provider agencies currently provide MRSS services in Rhode Island. Two are also CCBHCs, and one of those CCBHCs also provides MRSS services as a DCO to other CCBHCs. The MRSS providers will be impacted by the new ES and MRSS licensure requirements.

d.988 Call Center Vendor: The 988 call system vendor will continue to respond to calls for children/youth in crisis and will refer these calls to licensed ES and MRSS providers.

e.Managed Care Organizations (MCOs): As MRSS will be a Medicaid in-plan benefit, MCOs will contract with licensed MRSS providers to deliver the service, monitor service utilization, and administer state-established reimbursement rates and payment models.

f.Private insurance companies: Rhode Island has a commercial coverage mandate for MRSS services, and commercial payers will need to provide reimbursement to licensed providers who may receive commercial reimbursement.

g.Families and Children: The ultimate beneficiaries are the families and children who receive these services. The ES and MRSS regulations will ensure the quality and effectiveness of the services families receive when they reach out for help for a child/youth in crisis.

VII.Analysis of Costs and Benefits

This section analyzes the quantifiable fiscal impacts of a subset of the proposed regulatory changes. The regulatory changes below are organized by provision and include a brief description of potential impact to stakeholders and a high-level analysis of forecasted costs in comparison to baseline practices if the regulatory changes were not implemented.

We have estimated costs associated with ES and MRSS license requirements for three providers, assuming there will continue to be three MRSS providers in the state. We have estimated costs associated with ES licenses for ten providers – including the nine CCBHCs for Demonstration Year 3 and the one MRSS provider that is not also a CCBHC.

Provision 2: Additional DCYF review of provider policies, procedures, and documentation to enhance accountability and monitoring.

D.ES Provider policies and procedures (P&Ps) for clinical staff competency (Ref # 24)

Regulatory Change: To be licensed to provide emergency service interventions, ES Provider Agencies must establish and submit policies and procedures for maintaining and verifying documentation that demonstrates all clinical staff meet the child-family competency requirements via resumes, licensure, and training records. These policies and procedures must address recruitment, orientation, supervision, and training.

Considered Alternatives: The State considered no submission requirement, requiring only on-file policies with no DCYF review, or mandating a specific minimum number of annual training hours without prescribing content.

Justification: Requiring ES Provider Agencies to establish and submit policies ensures that agencies systematically recruit, orient, supervise, and train staff to deliver high-quality, child- and family-centered crisis care. This approach supports accountability, promotes consistent service quality, and enables oversight entities to

verify that all clinical staff meet essential competency standards for effective emergency interventions. SAMHSA's 2025 National Guidelines for Child and Youth Behavioral Health Crisis Care emphasize the importance of establishing policies and procedures that are "aligned with SAMHSA's System of Care values, including family-driven, youth-driven, trauma-informed, and culturally and linguistically responsive care" in establishing a strong crisis response system (SAMHSA, 2025). This option was selected because lighter-touch alternatives—such as no submission requirement or policies kept solely on file—would not allow DCYF to verify competency or ensure consistent implementation across agencies.

Impacted Stakeholders:
•ES Providers: This regulatory update is expected to require an initial provider investment of administrative time to develop comprehensive P&Ps in advance of initial licensure under the new regulation and minor investments to make amendments every two years in advance of licensure renewal.
•DCYF: DCYF review of P&Ps will require additional administrative time by the department. As there is an existing full-time position within DCYF whose role historically has encompassed the licensure of ES providers, DCYF does not anticipate any new hires will be required to fulfill newly required licensure tasks. The estimated hourly cost associated with the new requirements has been incorporated into cost estimates. This new licensure requirement will enhance DCYF's ability to ensure provider compliance and maintain high standards for workforce competency.
•Families and Children: Families and children will benefit indirectly from improved service quality and safety, as providers will be held to clear standards for staff qualifications and ongoing professional development.
•Other Stakeholders (e.g., Medicaid, MCOs, Private Insurers): Payers may see improved assurance of provider quality and reduced risk of adverse events; supporting better outcomes and potentially lowering long-term costs.

Summary of Costs: The primary cost impacts of the new requirement for ES Provider policies and procedures (P&Ps) for clinical staff competency will be borne by ES Providers and DCYF. Over a 10-year period, ES Providers are expected to incur approximately $11,300 in administrative costs for the initial creation and biennial updates of competency-related policies and procedures. DCYF will incur an estimated $6,500 in costs associated with the initial and biennial review of these materials for all providers. The total projected cost for implementing this regulatory change across all stakeholders is $17,829 over ten years. For detailed cost calculations, including present value totals and assumptions, see Table 4, Appendix II.

E.ES Provider documentation of clinical staff competency (Ref # 10)

Regulatory Change: To be licensed to provide emergency service interventions, ES Provider Agencies must verify and document child-family competency through personnel files, training records, and supervision logs for submission to DCYF with licensure application and renewal.

Considered Alternatives: The state considered accepting a simple attestation of compliance, requiring documentation only at initial licensure, or limiting submission to a random sample of staff files.

Justification: Requiring providers to verify and document child-family competency aligns with MRSS best practice, which emphasizes a workforce model built on clearly defined core competencies, specialized training, and ongoing supervision for all staff. Documented verification ensures that direct care and supervisory staff possess the necessary skills in crisis de-escalation, safety and risk assessment, trauma-responsive care, and culturally humble practice, as outlined in the MRSS model (Quinn, S., Sulzbach, D., & Estep, K., 2024). This approach supports high-quality, consistent service delivery and enables oversight entities like DCYF to monitor fidelity to best practices and drive improved outcomes for children, youth, and families. Alternatives such as attestation-only or one-time documentation review were determined insufficient, as they would limit the State's ability to confirm

ongoing compliance with workforce competency requirements.

Impacted stakeholders:
•ES Providers: This regulatory update will require providers to compile resumes, training records, and other proof of staff competency to submit with their licensure application, which will require administrative resources for collection of documentation and file management. Following the initial compilation of competency documents, we anticipate that this collection and documentation will occur during staff onboarding and annually thereafter.
•DCYF: DCYF review of competency documentation in alignment with provider policies and procedures will require administrative time by the department. This will enhance DCYF's ability to provider compliance with competency standards and ensure that only qualified staff deliver emergency services.
•Families and Children: Families and children will benefit indirectly from increased assurance that clinical staff have verified qualifications and competencies, supporting safer and more effective emergency service interventions.
•Other Stakeholders (e.g., Medicaid, MCOs, Private Insurers): Payers may benefit from improved provider quality assurance, reducing the risk of adverse events and supporting better outcomes for covered populations.

Summary of Costs: The cost impact of the new requirement for ES Provider documentation of clinical staff competency will primarily affect ES Providers and DCYF. Over a 10-year period, ES Providers are projected to incur approximately $13,900 in administrative costs for the initial collection and annual updating of competency documentation for their clinical staff. DCYF will incur an estimated $2,400 in costs for the initial and biennial review of these materials as part of the licensure process. The total estimated cost for implementing this regulatory change across all stakeholders is $16,293 over ten years. For detailed cost calculations, including present value totals and assumptions, see Table 5, Appendix II.

F.MRSS Provider policies and procedures for stabilization services (Ref # 70)

Regulatory Change: To be licensed to provide Mobile Response and Stabilization Services, the MRSS Provider Agencies must establish and submit policies and procedures for delivering stabilization services post-crisis.

Considered Alternatives: The state considered requiring only an attestation that stabilization services are provided or mandating a separate full stabilization manual.

Justification: Requiring MRSS Provider Agencies to establish and submit policies and procedures for delivering stabilization services post-crisis promotes the implementation of MRSS best practice guidance, which identifies stabilization as an essential component of the MRSS care continuum. The guidance emphasizes that high-quality MRSS programs must provide structured, evidence-informed stabilization services following a crisis, with clear protocols for care coordination, skill building, and ongoing support. Documented policies ensure that providers deliver consistent, effective stabilization services, support positive outcomes for children and families, and enable oversight entities to verify fidelity to the MRSS model. This requirement offers a balanced approach between minimal attestation, which provides insufficient detail, and a full standalone manual, which would create unnecessary administrative burden.

Impacted Stakeholders:
•MRSS Providers: Most MRSS providers already have care coordination policies as part of their ES certification, so the incremental administrative burden will primarily involve reviewing, amending, and expanding existing policies to meet the technical requirements for stabilization services. While providers are not starting from scratch, the need to document their stabilization services and align with MRSS best practices will require administrative time similar to that needed for the initial creation and ongoing monitoring of staff competency policies (see above). Additional indirect impacts may include periodic staff training and updates to documentation systems

to ensure ongoing compliance. Establishing clear, evidence-informed stabilization protocols will improve consistency and fidelity to the MRSS model, strengthen operational clarity for providers, and support positive outcomes for children and families by reducing repeat crises and improving care continuity.
•DCYF: For DCYF, the review of stabilization services policies and procedures will result in a marginal increase in administrative time during licensure application and renewal cycles. This may also require periodic updates to review protocols and staff training to ensure that submitted policies meet regulatory and best practice standards. Enhanced oversight and accountability will allow DCYF to verify compliance with MRSS best practices, promote system alignment with national guidelines, and ensure high-quality stabilization services across providers.
•Families and Children: Families and children will benefit from improved consistency, quality, and continuity of stabilization services following a crisis, as providers will be held to clear standards and oversight. Structured, evidence-informed protocols will help maintain safety, provide skill-building and ongoing support, and foster trust in the behavioral health system.
•Other Stakeholders (BHDDH, EOHHS/Medicaid, MCOs, Private Insurers): This requirement will strengthen system-wide quality assurance by ensuring stabilization services adhere to MRSS best practices. BHDDH and EOHHS/Medicaid will benefit from improved oversight and alignment with national guidelines, supporting Medicaid certification and payment structures. MCOs and private insurers will have confidence in service quality and fidelity to evidence-based standards, reducing risk of adverse events and promoting cost-effectiveness.

Summary of Costs: The estimated cost impact of the new requirement for MRSS Provider policies and procedures (P&Ps) for stabilization services will primarily affect MRSS Providers and DCYF. Over a 10-year period, MRSS Providers are projected to incur approximately $3,700 in administrative costs for the initial creation and biennial updates of policies and procedures for stabilization services. DCYF will incur an estimated $2,000 in costs for the initial and biennial review of these materials as part of the licensure process. The total projected cost for implementing this regulatory change across all stakeholders is $5,619 over ten years. For detailed cost calculations, including present value totals and assumptions see Table 6, Appendix II.

G.MRSS Provider fidelity reporting requirement (Ref # 63)

Regulatory Change: To be licensed to provide Mobile Response and Stabilization Services, the MRSS Provider Agencies must track and report on a set of fidelity measures designed to assess adherence to the core components of the MRSS model. Measures must be submitted using a DCYF-prescribed template.

Considered alternatives: The state also considered accepting each provider’s existing fidelity tools with no state template, or reliance on self-attestation without data submission.

Justification: Requiring MRSS Provider Agencies to consistently track and report on fidelity measures is directly supported by MRSS best practice guidance, which emphasizes the importance of ongoing evaluation and oversight to ensure adherence to the core components of the MRSS model. Fidelity tracking enables providers and oversight agencies to monitor service quality, identify areas for improvement, and demonstrate that MRSS interventions are delivered as intended. This approach promotes accountability, supports continuous quality improvement, and helps ensure positive outcomes for children, youth, and families receiving crisis and stabilization services. A uniform state template was selected because alternatives—such as accepting provider-developed tools or relying solely on self-attestation—would lead to inconsistent data and limit DCYF’s ability to compare performance statewide.

Impacted Stakeholders
•MRSS Providers: MRSS providers are already tracking fidelity measures using provider-preferred tools as of the start of DY2, so the foundational mechanisms for

fidelity monitoring are in place. The primary cost impact of the new regulation will be marginal, stemming from the need to transition to the DCYF-prescribed fidelity measure set and reporting template, as well as the administrative effort required for regular (e.g., quarterly) submission of reports. These costs are expected to be limited to initial adjustments and ongoing reporting, rather than the creation of entirely new tracking systems.
•DCYF: An initial administrative effort will be required to compile and come to consensus on the state-defined fidelity measure set and template. DCYF will incur additional administrative effort to review, aggregate, and act on fidelity reports submitted by providers. This will enhance their ability to monitor provider performance, ensure adherence to the MRSS model, and target technical assistance or corrective action where needed.
•Families and Children: While not directly affected by reporting requirements, families and children will benefit from improved service quality and accountability, as fidelity monitoring helps ensure that MRSS interventions are delivered as intended and lead to better outcomes.
•Other Stakeholders (e.g., Medicaid, MCOs, Private Insurers): Payers may see improved assurance of service quality and alignment with evidence-based practices, potentially reducing adverse events and improving cost-effectiveness over time.

Summary of Costs: The cost impact of the MRSS Provider fidelity reporting requirement will primarily affect MRSS Providers and DCYF. Over a 10-year period, MRSS Providers are projected to incur $42,800 in administrative costs for initial adjustments to their fidelity tracking systems and ongoing quarterly reporting. DCYF will incur an estimated $26,300 in costs for the initial development of the fidelity measure set and reporting template, as well as ongoing review of submitted reports. The total projected cost for implementing this regulatory change across all stakeholders is $69,120 over ten years. For detailed cost calculations, including present value totals and assumptions see Table 7, Appendix II.

Provision 4: Addition of MRSS staffing-related requirements to align with best practices

H.MRSS Provider semiannual staffing schedule submission (Ref # 55)

Regulatory Change: To be licensed to provide Mobile Response and Stabilization Services, the MRSS Provider Agencies must submit staffing schedules as part of their initial licensure application and every six months thereafter, detailing credentials, roles and on-call coverage. DCYF will review and approve initial submissions of staffing schedules during review of licensure applications to ensure providers demonstrate capacity to serve their designated primary service area(s). DCYF will review and approve staffing schedules biannually to ensure that providers maintain adequate staffing levels and can provide appropriate coverage to meet service demands.

Considered Alternatives: The state considered monthly submission of staffing schedules (the current CCBHC practice), annual submission, submission only at initial licensure and upon material changes, or an attestation of adequate coverage with no schedule review.

Justification: MRSS best practice guidance emphasizes the importance of maintaining adequate staffing levels, appropriate coverage, and qualified personnel to meet service demands. The MRSS model calls for clear documentation of staff credentials, roles, and on-call coverage to ensure that mobile response teams are available 24/7/365 and that supervision and clinical consultation are consistently accessible. Regular review and approval of staffing schedules by DCYF helps ensure fidelity to the MRSS model, supports service quality, and safeguards timely, effective crisis response for children, youth, and families. Biannual submission provides more reliable oversight than annual or attestation-only approaches, while avoiding the administrative burden associated with monthly submissions.
Impacted Stakeholders:
•MRSS Providers: Under current practice, staffing schedules for MRSS providers

(as DCOs under CCBHCs) are submitted monthly by the CCBHCs using a standardized template. The proposed regulatory update would reduce the submission frequency to every six months, representing a less frequent requirement than the current baseline. If a similar reporting template is permitted, the additional administrative workload for MRSS providers would be marginal. There will likely be a one-time investment of 10–30 hours, depending on the extent of changes as compared to current process. Subsequent updates throughout the year to reflect staffing changes would likely require only a few hours per submission.
•DCYF: Department review and approval of staffing schedules in alignment with provider policies and procedures will require administrative time and coordination. This process enhances the DCYF's ability to confirm provider compliance with staffing and competency standards, ensuring that only qualified staff deliver emergency and crisis services. It also supports system oversight and continuous quality improvement.
•Families and Children: Families and children will benefit indirectly from increased assurance of staff qualifications and coverage, supporting safer and more effective crisis interventions, as a result of the staffing schedule submission and review process.
•Other stakeholders (e.g., Medicaid, MCOs, private insurers, 988 call center): Payers and referral partners may benefit from improved provider quality assurance, reducing the risk of adverse events and supporting better outcomes for covered populations. Clear staffing standards and oversight can facilitate more reliable referrals and predictable service delivery.

Summary of Costs: The primary cost impacts of the new requirement for MRSS Provider semiannual staffing schedule submission will be borne by MRSS Providers and DCYF. Over a 10-year period, MRSS Providers are expected to incur approximately $13,300 in administrative costs. This includes a one-time investment of 15 hours for the initial build and submission process, as well as ongoing costs to update and submit staffing schedules twice per year. The ongoing administrative burden is expected to be minimal, as the submission frequency is reduced compared to current practice and providers may continue to use existing templates.

DCYF will incur an estimated $5,400 in costs associated with the initial and ongoing review of staffing schedules for all MRSS providers. This includes a one-time investment for initial review and ongoing costs for semiannual review over the 10-year period. The total projected cost for implementing this regulatory change across all stakeholders is $18,613 over ten years. For detailed cost calculations, including present value totals and assumptions, see Table 8, Appendix II.

VIII.Regulatory Benefits

States that have adopted MRSS programs have seen a wide range of benefits for children, families, and the behavioral health system. The MRSS model delivers immediate and tailored crisis support to young people and their families, reducing families' reliance on emergency departments, law enforcement, or 911 for crisis services. MRSS provides the support to stabilize children and youth in their homes and communities, resulting in a decreased chance of inpatient hospitalization or removal from home settings. Other states implementing MRSS have reported the following results (Innovations Institute, 2023, p. 2):
•Connecticut:
oReported a 20–25% drop in youth ED visits within 18 months of launching MRSS.
oOver a four-year period, found that MRSS diverted 2,212 children from inpatient hospital stays, and 61% of those children were enrolled in Medicaid. The avoided Medicaid costs for these hospitalizations in this period valued over $15 million.
•New Jersey:
oReported that 98% of children who received MRSS were able to stay at home.
•Oklahoma:
o83% of MRSS participants experienced no change in placement or their living arrangements.
oOf the 5,218 students at risk for school disruption who received MRSS, 81% were able to return to school.

While the exact benefits of the proposed regulatory changes cannot be estimated, evidence from other states delivering MRSS to fidelity can be leveraged to generate an order of magnitude impact via estimated reductions in youth emergency department (ED) use. The proposed licensure and fidelity provisions are expected to increase consumer confidence in MRSS services and providers, which should, in turn, raise MRSS utilization and further reduce ED use. Because benefits cannot be estimated with precision, we present potential benefits using two complementary methods that reflect the available evidence.

Benefit threshold (breakeven).
For this analysis, we define breakeven as the point at which the present value discounted at 3% (PV at 3%) of total benefits across all payers equals or exceeds the PV at 3% of total implementation costs of $111,178. Using a $500 per avoided youthspecific ED visit benchmark (Moore & Stocks, 2021), all payer benefits would exceed costs if approximately 275 youth ED visits are avoided over ten years. Under this scenario, allpayer savings resulting from 275 avoided ED visits are estimated to be $112,435 PV at 3% which is slightly greater than PV costs. For context, this threshold corresponds to Medicaid savings of $70,834 PV at 3% using a 63% Medicaid attribution rate; the state share of those Medicaid savings is approx. $30,000, applying a state share of 42.27% through SFY 2026 and 42.19% thereafter (EOHHS, 2026).
Highlevel benefits range (illustrative).
Drawing on Connecticut's MRSS utilization experience, a plausible utilization increase of 2–5% per year due to the regulations would translate to approximately 1,000 to 2,600 avoided ED visits over ten years. Applying the $500 per visit benchmark yields orderofmagnitude allpayer savings of about $0.4M to $1.1M PV at 3%, over ten years. These ranges are directionally consistent with outcomes observed in other MRSS implementations, indicating that Rhode Island is likely to exceed the break even point of 275 avoided ED visits (Innovations Institute, 2023).
Appendix I. Comprehensive List of Regulatory Changes

Table 9. All Regulatory Changes in ES and MRSS Regulations (Discretionary & Non-Discretionary)

Fixed Ref #Reg Citation 214-RICR-40-00-Change TypeDiscretionary / Non-DiscretionaryDescription of Regulatory Change
16.1.A.24Addition Non-DiscretionaryAdded R.I. Gen. Laws § 27-18-95 (2026), effective January 1, 2026, requiring licensure for MRSS providers. Establishes two licensure levels: Emergency Services (ES) for immediate crisis intervention and MRSS for immediate crisis response and stabilization services. MRSS providers must meet ES standards plus MRSS-specific requirements. Non-discretionary because it implements statutory requirements from R.I. Gen. Laws § 27-18-95 (2026).
26.1.A.3AdditionNon-DiscretionaryAdded 2025-H 5151 Substitute A as amended, Article 8, § 10(e), which directs EOHHS to establish MRSS as a Medicaid-covered benefit and the state-sanctioned crisis system for children's behavioral health, adhering to nationally recognized fidelity standards, for children and youth ages 2-21. Non-discretionary because it implements 2025-H 5151 Substitute A (not yet codified in RI law).
36.1.B.1.d,fAdditionNon-DiscretionaryAdded R.I. Gen. Laws § 27-18-95 (2026) and 2025-H 5151 Substitute A as amended, Article 8, § 10(e) to the legal basis, reflecting the new MRSS licensure and Medicaid covered benefit (ages 2-21) requirements. Non-discretionary because they are mandated by statute.
46.1.C.1,6,7,21-22AdditionNon-DiscretionaryAdded definition for "Adolescent", "Child", "Children and Youth", "Young Adult" and "Youth". Aligns with BHDDH regulations where applicable. Non-discretionary as MRSS providers are required to serve populations ages 2-21.
56.1.C.2RevisionDiscretionaryRevised definition (previously 6.1.D.7). Renamed "Mental health emergency" to "Behavioral health emergency" and revised definition to emphasize observable signs, behaviors, or expressions indicating urgent need for

intervention. Discretionary because the terminology update aligns with modern behavioral health standards, not a legal mandate.
66.1.C.3RevisionDiscretionaryRevised definition (previously 6.1.D.8). Renamed "Mental health emergency service interventions" to "Behavioral health emergency service interventions" and added settings like family's home and Certified Community Behavioral Health Clinics (CCBHCs). Discretionary because the addition of settings and terminology update enhances clarity and inclusivity, not required by law.
76.1.C.4AdditionNon-DiscretionaryAdded definition for "Behavioral Healthcare" in alignment with BHDDH regulations.
86.1.C.5AdditionNon-DiscretionaryAdded definition for "Certified Community Behavioral Health Clinic (CCBHC)," aligning with BHDDH standards for coordinated mental health and substance use services. Non-discretionary because CCBHCs are tied to federal and state standards.
96.1.C.9RevisionNon-DiscretionaryRevised definition (previously 6.1.D.2) for "Child-family competent clinician" definition to include specific roles (e.g., Psychiatrists, Licensed Psychologists, LICSW, LCSW, LMFT, LMHC, LMFT-A, LMHC-A) and reduced clinical experience requirement from two years to one year to align with CCBHC certification standards for experience required. Non-discretionary because it aligns with Medicaid requirements for approved clinician roles.
106.1.C.9aAdditionDiscretionaryAdded requirement that providers verify and document child-family competency through personnel files, training records, and supervision logs. Discretionary because this enhances accountability through agency-preferred administrative processes, not mandated by law.
116.1.C.11RevisionNon-DiscretionaryRevised definition (previously 6.1.D.4) for "Cultural and linguistic competency" to include fluency in common languages, translation/interpretation services within one hour (reduced from two hours), TTY/auxiliary aids for deaf/hearing-impaired, and accessible formats for blind/vision-impaired individuals. Non-discretionary because it aligns with SAMHSA standards required for CCBHC certification and MRSS is a core CCBHC required service (e.g., same standards apply to MRSS providers through DCO)
126.1.C.12-14AdditionNon-DiscretionaryAdded definitions for "Current accreditation from the Joint Commission," "Current certificate from CARF," and "Current certification from COA" to clarify accreditation standards for licensure. Non-discretionary because these accreditation standards are required under existing regulations and definitions are only added for clarification.
136.1.C.15AdditionNon-DiscretionaryAdded definition for "DCO Agreement," for MRSS providers to have agreements with CCBHCs for care coordination and service integration within the CCBHC's service areas. Non-Discretionary because MRSS is a core CCBHC required services and a DCO is required to be in place per the federal CCBHC certification standards in order for services to be provided by MRSS providers.
146.1.C.16AdditionNon-DiscretionaryAdded definition for "Mental Health Professional" in alignment with BHDDH regulations.
156.1.C.17AdditionNon-DiscretionaryAdded definition for "Mobile Response and Stabilization Services (MRSS)," outlining crisis intervention, de-escalation, and stabilization services.
166.1.C.18AdditionNon-DiscretionaryAdded definition for "Qualified Mental Health Professional (QMHP)," authorized for emergency psychiatric assessments and involuntary hospitalizations per BHDDH regulations. Non-discretionary because QMHPs are required by BHDDH for hospitalization processes.
176.1.C.19RevisionDiscretionaryRevised definition (previously 6.1.D.10) "System of Care (SOC)" definition to emphasize cross-system collaboration (education, child welfare, juvenile justice, healthcare) and measurable outcomes. Discretionary because the revision enhances clarity and aligns with best practices, not a legal mandate.
186.1.C.20AdditionNon-DiscretionaryAdded definition for "Warm Handoff" which is a core requirement to deliver MRSS to fidelity per R.I. Gen. Laws § 27-18-95.
196.1.DAdditionNon-DiscretionaryAdded clarification as to BHDDH authorities over substance use disorder services, including for individuals 18-21 and the shared BHDDH/DCYF authority for reporting and investigation of abuse, neglect and exploitation of those 18-21. Non-discretionary, in alignment with R.I. Gen. Laws Chapters 40.1-5 and 40.1-8.5 and §§ 40.1-1-13, 40.1-1-16, 40.1-5.4-4, 40.1-5.4-11, 40.1-24-3, 40.1-24-7, 40.1-24-9, 40.1-24-17.

206.1.EAdditionNon-DiscretionaryAdded parental notification and consent requirements for MRSS, based on R.I. Gen. Laws § 23-4.6-1 and R.I. Gen. Laws § 40.1-5-7. Language mirrors existing guidance for current MRSS providers (EOHHS, p. 5)
216.2.ARevisionNon-DiscretionaryChanged "certified" to "licensed" for Emergency Service Providers.
226.2.D.5AdditionNon-DiscretionaryAdded overdose response protocols. Non-discretionary as aligns with federal CCBHC certification standards for crisis.
236.2.F.1a-kRevision DiscretionaryRevised to clarify and strengthen Child-Family Competency standards for ES Providers, better reflecting best practices. Updated “certified” to “licensed” and “emergency service staff” to “clinical staff.” Reworded existing skills for clarity, including child development, family systems, DSM-based diagnostics, risk and family assessments, crisis intervention, and cultural competence. Added new requirements for training on RI Mental Health Laws, and mandatory reporting. Added requirement to use QMHP if emergency certification is required.
246.2.F.2a-dRevisionDiscretionaryReplaced requirement for written confirmation of staff knowledge in age-appropriate behavior, parental roles, psychiatric medications, legal status, cultural views, family supports, and SOC-based service with requirement for Providers to establish policies for documenting clinical staff competency (per 6.2.F.1.a-k) via resumes, licensure, and training records. Includes policies for recruitment, orientation, supervision, and training. Discretionary change to enhance accountability and align with best practices.
256.3AdditionNon-DiscretionaryAdded new section for MRSS licensure standards. Non-discretionary because it implements the requirement of licensed or certified MRSS providers from the R.I. Gen. Laws § 27-18-95 (2026).
266.3.A.1AdditionNon-DiscretionaryAdded requirement for MRSS providers to meet Emergency Services standards.
276.3.A.2AdditionNon-DiscretionaryAdded requirement for MRSS providers to be licensed to deliver mobile crisis intervention per R.I. Gen. Laws § 27-18-95 (2026). Non-discretionary due to licensure mandate.
286.3.A.3AdditionNon-DiscretionaryAdded requirement for MRSS providers to deliver services to all populations, regardless of ability to pay or insurance status, consistent with current practice and aligned with MRSS and CCBHC requirements. This change is non-discretionary because it aligns with national MRSS organizing principles stating that MRSS is “a whole population intervention universally available to any child, youth, young adult, or family that can benefit” (Innovations Institute, 2024, p. 3). It is also required for MRSS providers acting as DCOs delivering a core CCBHC service. RI CCBHC Certification Standards state: “DCOs are required to serve all individuals referred by the CCBHC…in compliance with CCBHC standards on access, regardless of ability to pay or insurance status” (EOHHS, 2025). Additionally, the MRSS model specifies that “In addition to Medicaid, funding is identified to ensure that MRSS is universally available to children, young people, and families, including those who are uninsured and commercially insured and for whom MRSS may not be a covered service” (Innovations Institute, 2024, p. 7). Rhode Island has secured funding to ensure statewide access, irrespective of insurance coverage, meeting the funding requirements of the model.
296.3.A.4AdditionNon-DiscretionaryAdded clarification that MRSS services are available to children ages 2-21. Non-discretionary per 2025-H 5076 Substitute A as amended.
306.3.A.5AdditionNon-DiscretionaryAdded reporting and investigation requirements per R.I. Gen. Laws §§ 11-5-10.2, 11-5-11, 11-5-12, 23-17.8-2, 23-17.8-3 40-8.5-2, 40.1-5-3, 40.1-26-10, and 40.1-27-2.
316.3.A.6AdditionNon-DiscretionaryAdded requirement for MRSS providers to maintain RI Suicide & Crisis Lifeline/ 988 coordination protocols. Aligns with national model for MRSS that requires use of “a single point of access that is or includes 988” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2022, p. 3). No deviations, core to MRSS model.
326.3.B.1.aAdditionNon-DiscretionaryAdded 24/7/365 live-voice telephone triage system to assess child needs, risks, and family capacity, considering cultural/linguistic needs. Aligns with “offers in-person responses 24/7/365” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2022, p. 2). No deviations, core to MRSS model.
336.3.B.1.a.iAdditionNon-DiscretionaryAdded Immediate response triage, deploying

a team within 60 minutes with telephonic support. Aligns with “in-person response assessments are available within one hour of call” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2022, p. 2). No deviations, core to MRSS model.
346.3.B.1.a.iiAdditionNon-DiscretionaryAdded non-immediate response triage, deploying a team within 1-23 hours at family request, unless delayed response increases risk. Aligns with “deferred in person response… within 24 hours” in Mobile Response and Stabilization Services (MRSS): National Best Practices (Innovations Institute, 2022, p. 3). No deviations, core to model.
356.3.B.1.a.iiiAdditionNon-DiscretionaryAdded Emergency response triage, transferring calls to 911 with 24-hour MRSS follow-up. Aligns with “partnerships with… Emergency Departments/Hospitals” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2022, p. 2). No deviations, core to model.
366.3.B.1.bAdditionNon-DiscretionaryAdded 24-hour two-person mobile crisis teams (QMHP plus clinical/paraprofessional) for assessments. QMHP requirement is non-discretionary as it is mandated by RI CCBHC Certification Standards for Crisis Behavioral Services (EOHHS, 2025, p. 40). MRSS providers will be delivering these core CCBHC services as CCBHCs or via non-financial DCO arrangements with CCBHCs.
376.3.B.1.b.iAdditionNon-DiscretionaryAdded requirement for mobile crisis teams to conduct safety/risk assessments, including mental status exams and evaluations (suicide, violence, abuse/neglect). Aligns with “identification of… needs and strengths, risk factors” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). No deviations, core to MRSS model.
386.3.B.1.b.iiAdditionNon-DiscretionaryAdded requirement for mobile crisis teams to provide age-appropriate de-escalation and stabilization. Aligns with “prioritizes de-escalation and stabilization within the home and community” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2). No deviations, core to MRSS model.
396.3.B.1.b.iiiAdditionNon-DiscretionaryAdded requirement for mobile crisis teams to develop crisis/safety plans with child/family input. Aligns with “develops and implements an initial crisis and safety plan” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 3). No deviations, core to MRSS model.
406.3.B.1.b.ivAdditionNon-DiscretionaryAdded requirement to minimize law enforcement involvement unless safety requires it. Aligns with “responds without law enforcement, unless essential for safety reasons and as a last resort” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 3). No deviations, core to MRSS model.
416.3.B.1.b.vAdditionNon-DiscretionaryAdded requirement for mobile crisis teams to obtain releases and permissions from guardians to contact collateral contacts (e.g., behavioral health providers, schools). Aligns with standard behavioral health practice
426.3.B.1.b.viAdditionNon-DiscretionaryAdded requirement for mobile crisis teams to have the ability to link to higher care levels. Aligns with “connecting with current and needed service providers,” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 4). No deviations, core to MRSS model.
436.3.B.1.cAdditionDiscretionaryAdded clarification that stabilization services must be tailored to the needs of children and youth in crisis. Stabilization services may be provided for a period of 30 days unless the child transitions to appropriate services sooner, or longer if necessary to complete a warm handoff, consistent with current RI stabilization period data documented during demonstration years. A period of stabilization services is core to model. Aligns with “stabilization services…” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 4), which recommends 6-8 weeks of stabilization services. The shorter 30-day period is discretionary but aligns with current practice.
446.3.B.1.c.iiAdditionDiscretionaryAdded weekly face-to-face stabilization meetings, with evening/weekend availability. Aligns with “services… to families experiencing crises” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). Evening/weekend availability is discretionary.

456.3.B.1.c.iiiAdditionNon-DiscretionaryAdded telephone support and coordination with external providers during stabilization. Aligns with “partnerships with… School Systems” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2). No deviations, core to MRSS model.
466.3.B.1.c.iAdditionDiscretionaryAdded biopsychosocial assessments during stabilization. Aligns with “identification of… needs and strengths” as well as “administers a child- and family-specific assessment tool with developmentally appropriate suicide screening protocol” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). No deviations, core to MRSS model.
476.3.B.1.c.ivAdditionNon-DiscretionaryAdded collaboration with child/family to set short-term goals and connect to supports. Aligns with “family-driven” services and “facilitates connection to natural/informal supports” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). No deviations, core to MRSS model.
486.3.B.1.c.vAdditionNon-DiscretionaryAdded warm handoffs to service providers for ongoing needs. Aligns with “continuum of… stabilization” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). No deviations, core to MRSS model.
496.3.B.1.c.viAdditionNon-DiscretionaryAdded assessment of immediate basic needs (food, housing, transportation) and linkage to resources. Aligns with “assesses immediate basic needs the family may have such as food, income…” services in in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 3). No deviations, core to MRSS model.
506.3.B.1.c.viiAdditionNon-DiscretionaryAdded 24/7/365 on-call clinical support during stabilization. Aligns with “mobile responses… available 24/7/365” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2). No deviations, core to MRSS model.
516.3.B.1.dAdditionNon-DiscretionaryAdded provision for crisis response and warm handoffs for children already engaged with services, providing stabilization only if needed. Aligns with “continuum of… stabilization” in Mobile Response and Stabilization Services (MRSS): Best Practice Installation (Innovations Institute, 2024, p. 3). No deviations, core to MRSS model.
526.3.B.1.eAdditionNon-DiscretionaryAdded collaboration with child-serving systems (schools, courts, child welfare, juvenile justice). Aligns with “develops concrete collaborative agreements (e.g., MOUs)” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2). Formal MOUs not required, consistent with current guidance.
536.3.C.1-2AdditionDiscretionaryRequires MRSS providers to apply for statewide licensure and designate one or more primary service areas, aligned with CCBHC catchment areas, for which they must maintain priority responsibility for availability, accessibility, and timely response. Alignment with services areas can be demonstrated either by showing the applicant is the CCBHC for that area or by submitting a Letter of Intent from the CCBHC(s) confirming plans to execute a non-financial DCO agreement upon licensure. Once licensed, providers must formalize any DCO arrangements through a DCO contract with the relevant CCBHC(s).
546.3.C.3-4AdditionDiscretionaryAdded requirement that all MRSS providers must maintain mutual aid agreements with all other DCYF-licensed MRSS providers, ensure family notification and clinical appropriateness when mutual aid is used in exceptional circumstances, avoid routine reliance, provide temporary coverage for unassigned areas, and establish care coordination agreements with all CCBHCs statewide.
By virtue of maintaining a network of mutual aid and care coordination agreements, all MRSS providers are considered to have the capacity to respond to a crisis anywhere in the state when activated through the mutual aid process.
556.3.D.1.aAdditionNon-DiscretionaryAdded QMHP requirement for every two-person mobile crisis team. Required per RI CCBHC Certification Standards for Crisis Behavioral Services (p. 40). Non-discretionary, RI CCBHC Certification standards.
566.3.D.1.bAdditionNon-DiscretionaryAdded requirement that functions performed by QMHPs must be in accordance with R.I. Gen. Laws § 40.1-5-7 and applicable BHDDH regulations.
576.3.D.1.cAdditionDiscretionaryAdded submission of staffing schedules every six months, detailing credentials, roles, and on-call coverage. Discretionary, as

template-specific process is an agency enhancement.
586.3.D.1.dAdditionNon-DiscretionaryAdded 24/7/365 access to a child/adolescent psychiatrist or APRN for consultation, per original regulations 214-RICR-40-00-6.2.D.1, requiring access to a “child-trained psychiatrist” for Mental Health Emergency Service Intervention Teams. Non-discretionary, in original regulations.
596.3.D.1.eAdditionDiscretionaryAdded routine supervision (1 hour individual, 3 hours group monthly, pro-rated for part-time) with 24/7 supervisor access. Supervision hours are discretionary, reflecting agency preference.
606.3.D.1.fAdditionDiscretionaryAdded encouragement for diverse staff (racial, ethnic, linguistic, gender). Aligns with “culturally humble and linguistically competent” services in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 1). Discretionary, as encouragement is an agency preference.
616.3.D.2AdditionDiscretionaryAdded requirement for MRSS providers to notify DCYF within 24 hours when capacity is reached. Discretionary, as notification is an agency enhancement.
626.3.E.1AdditionNon-DiscretionaryAdded requirement to comply with ES data collection standards (214-RICR-40-00-6.2.G). Aligns with “establishes benchmarks and tracks data” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2). No deviations, core to MRSS model.
636.3.E.2AdditionDiscretionaryAdded fidelity measure reporting to DCYF. Aligns with “tracks data including… outcomes” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2023, p. 2) Non-discretionary, core to MRSS model.
646.3.E.3AdditionNon-DiscretionaryAdded documentation requirements for assessments, plans, and notes in compliance with protected health information (PHI) regulations. Non-discretionary, under the Health Insurance Portability and Accountability Act of 1996.
656.3.E.4AdditionDiscretionaryAdded requirement for providers to regularly review all MRSS records for completeness, and clinical quality, with use of corrective action plans as needed. This requirement aligns directly with current MRSS practice and guidance which states that “active and terminated records must be regularly reviewed for completeness, quality, and adherence to documentation deadlines, with a corrective action or quality improvement plan implemented as needed. (EOHHS, 2025, p.18).” Additionally, this requirement aligns with “continuous quality improvement” in Mobile Response and Stabilization Services: National Best Practices (Innovations Institute, 2022, p. 2).
666.4.A-CAdditionDiscretionaryAdded new section outlining the licensure process for Emergency Services (ES) and Mobile Response and Stabilization Services (MRSS) providers more clearly, including application submission to DCYF, review timelines, and specific requirements for providers
676.4.D.1AdditionNon-DiscretionaryAdded requirement for MRSS provider applicants to meet all Emergency Services (ES) provider application requirements per Section 6.4(B) and provide additional documentation to demonstrate expertise in child-specific mobile response and stabilization services, as mandated by R.I. Gen. Laws § 27-18-95 (2026). Non-discretionary due to statutory requirement.
686.4.D.2AdditionDiscretionaryAdded requirement for MRSS provider applicants to submit evidence of at least one year of organizational experience providing MRSS services or prior delivery of mobile crisis and stabilization services for children and participation in recognized MRSS training or technical assistance to ensure consistency and model fidelity. Non-discretionary due to alignment with R.I. Gen. Laws § 27-18-95 (2026) which requires "demonstrated expertise in child specific MRSS". Specific definition of "demonstrated" experience included in regulation is discretionary and was chosen to remove concerns regarding how demonstrated expertise would be measured.
696.4.D.3AdditionDiscretionaryAdded requirement for MRSS providers to demonstrate the capacity to reliably provide MRSS services for children and families within their designated service area and to participate in statewide coverage through mutual aid arrangements. Discretionary as the statewide requirement is to ensure universal access for all children across the state. DCYF lacks statutory authority to develop regional catchment areas, justifying the statewide scope.
706.4.D.4AdditionDiscretionaryAdded requirement for MRSS providers to submit policies and procedures for delivering stabilization services post-crisis, including clinical services, care coordination, peer support, and community-based services.

Requirement of policies and procedures are discretionary to ensure appropriate implementation of the MRSS model mandated by R.I. Gen. Laws § 27-18-95 (2026).
716.4.D.4.a-fAdditionNon-DiscretionaryAdded requirements for MRSS providers to submit policies and procedures summarizing MRSS model elements for the application process.
726.4.F.1AdditionDiscretionaryAdded review process for ES and MRSS provider applications, requiring DCYF to review within 60 days with additional documentation requests within 15 business days. Discretionary as the specific timeline and process are agency enhancements, not legally mandated.
736.4.F.2AdditionNon-DiscretionaryAdded determination process for DCYF to issue full licensure for ES or MRSS providers, or denial with written explanation and appeal rights per DCYF Department Operating Procedure 100.0040. Non-discretionary as it aligns with statutory and regulatory licensing requirements under R.I. Gen. Laws § 27-18-95.
746.5.A-GAdditionDiscretionaryAdded new section outlining grounds for denying, suspending, or revoking an ES or MRSS provider license, including non-compliance with regulations, false information, health/safety risks, or failure to address deficiencies. Outlines requirements for agency closure or discontinuation of ES or MRSS services. Discretionary as the specific timeline and process are agency enhancements, not legally mandated.
756.6.A.2-3AdditionDiscretionaryAdded new language clarifying additional detail and license duration and renewal.
Appendix II. Detailed Cost Calculations and Assumptions

Table 4. ES Provider policies and procedures (P&Ps) for clinical staff competency
Assumptions:
•No. Impacted Providers: 10 ES Providers
•Time Horizon: 10 Years
Calculation: Providers X Hours X Rate X Years
StakeholderTask DescriptionTime PeriodHours Per ProviderAdmin RateUnit CalculationTotal CostNotes
ES ProvidersInitial creation of P&PsInitial: Y110$63 10 x 10 x $63 x 1$6,300
Biennial update/ management of P&PsBiennial: Y3, Y5, Y7, Y92$63 10 x 2 x $63 x 4$5,040 Biennial due to licensure period of 2 years
DCYFInitial review of P&PsInitial: Y14$81 10 x 4 x $81 x 1$3,244
Biennial review of P&PsBiennial: Y3, Y5, Y7, Y91$81 10 x 1 x $81 x 4$3,244 “”
Total: ES Providers$11,340
Total: DCYF$6,489
10-Year Grand Total$17,829
10-Year Grand Total (Present Value Discounted @ 3%) $15,550

Table 5. ES Provider documentation of clinical staff competency
Assumptions:
•No. Impacted Providers: 10 ES Providers
•Time Horizon: 10 Years
Calculation: Providers X Hours X Rate X Years
StakeholderTask DescriptionTime PeriodHours Per ProviderAdmin RateUnit CalculationTotal CostNotes
ES ProvidersInitial collection/ documentation of competencyInitial: Y14$63 10 x 4 x $63 x 1$2,520
Annual updateAnnual: Y2-Y102$63 10 x 2 x $63 x 9$11,340 Assumes new documentation occurs with each new hire (annually)
DCYFInitial review of competency docsInitial: Y11$81 10 x 1 x $81 x 1$811
Biennial review of competency docsBiennial: Y3, Y5, Y7, Y90.5$81 10 x 0.5 x $81 x 4$1,622 Biennial due to licensure period of 2 years
Total: ES Providers$13,860
Total: DCYF$2,433
10-Year Grand Total$16,293
10-Year Grand Total (Present Value Discounted @ 3%) $14,210

Table 6. MRSS Provider policies and procedures (P&Ps) for stabilization services
Assumptions:
•No. Impacted Providers: 3 MRSS Providers
•Time Horizon: 10 Years
Calculation: Providers X Hours X Rate X Years
StakeholderTask DescriptionTime PeriodHours Per ProviderAdmin RateUnit CalculationTotal CostNotes
MRSS ProvidersInitial adjustments and additions to existing care coordination P&PsInitial: Y110$683 x 10 x $68 x 1$2,040Initial time estimate reduced by ~30% to account for existing P&Ps to use as starting point
Biennial update/ management of P&PsBiennial: Y3, Y5, Y7, Y92$683 x 2 x $68 x 4$1,632Biennial due to licensure period of 2 years
DCYFInitial review of P&PsInitial: Y14$81 3 x 4 x $81 x 1$973
Biennial review of P&PsBiennial: Y3, Y5, Y7, Y91$81 3 x 1 x $81 x 4$973 " "
Total: MRSS Providers$3,672
Total: DCYF$1,947
10-Year Grand Total$5,619
10-Year Grand Total (Present Value Discounted @ 3%) $4,900

Table 7. MRSS Provider fidelity reporting requirement
Assumptions:
•No. Impacted Providers: 3 MRSS Providers
•Time Horizon: 10 Years
Calculation: Providers X Hours X Rate X Years
StakeholderTask DescriptionTime PeriodHours Per ProviderAdmin RateUnit CalculationTotal CostNotes
MRSS ProvidersInitial adjustments to existing fidelity tracking/ monitoring systemsInitial: Y110$68 3 x 10 x $68 x 1$2,040 Time estimates account for existing fidelity tracking and monitoring
Ongoing fidelity reportingAnnual: Y1-Y1020$68 3 x (5x4) x $68 x 10$40,800
Assumptions: Quarterly reporting (4 reports / year);
5 hours of admin time per report
DCYFDevelopment of measure set and templateInitial: Y124$81 24 x $81 x 1$1,947
One time investment for initial creation, not required for each provider
Ongoing report reviewAnnual: Y1-Y1010$81 3 x (2.5x4) x $81 x 10$24,333
Assumptions: Quarterly reporting (4 reports / year);
2.5 hours of admin time per report
Total: MRSS Providers$42,840
Total: DCYF$26,280
10-Year Grand Total$69,120
10-Year Grand Total (Present Value Discounted @ 3%)$60,284

Table 8. MRSS Provider semiannual staffing schedule submission
Assumptions:
•No. Impacted Providers: 3 MRSS Providers
•Time Horizon: 10 Years
Calculation: Providers X Hours X Rate X Years
StakeholderTask DescriptionTime PeriodHours Per ProviderAdmin RateUnit CalculationTotal CostNotes
MRSS ProvidersInitial build for independent providerInitial: Y115$68 3 x 15 x $68 x 1$3,060 Initial build of staffing schedule estimated to require 15 hours for each provider
Ongoing staffing schedule submissionAnnual: Y1-Y105$68 3 x (2.5x2) x $68 x 10$10,200 Assumes 2.5 hrs per provider per update, twice per year (every 6 months)
DCYFInitial review of staffing scheduleInitial: Y14$81 3 x 3 x $81 x 1$973 Assumes 3 hrs per provider for intial review, plus 1 hour for Y1 semi annual submission
Ongoing reviewAnnual: Y2-Y102$81 3 x 2 x $81 x 9$4,380 Assumes 1 hr per provider per review, twice per year
Total: MRSS Providers$13,260
Total: DCYF$5,353
10-Year Grand Total$18,613

10-Year Grand Total (Present Value Discounted @ 3%)$16,234
Sources

Core MRSS Model Sources

Child Health and Development Institute of Connecticut (2023). Mobile Response for Children, Youth, and Families: Best Practice Data Elements and Quality Improvement Approaches. In Partnership with the Innovations Institute at the University of Connecticut School of Social Work. https://www.chdi.org/application/files/3417/2675/9704/MRSS_Data_and_Quality_Paper_2023_FINAL-compressed.pdf

Innovations Institute, University of Connecticut School of Social Work (2022). Mobile Response & Stabilization Services National Best Practices. In Partnership with Child Health and Development Institute. https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2023/03/Mobile-Response-Best-Practices.January-2023.pdf

Innovations Institute, University of Connecticut School of Social Work (2024). Mobile Response and Stabilization Services (MRSS): Best Practice Model Installation. https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2024/07/MRSS-Best-Practice-Readiness-Companion.pdf

MRSS State & National Outcomes

Innovations Institute, University of Connecticut School of Social Work (2023). A Guide for MRSS Leaders: Articulating the “Why.” In Partnership with Child Health and Development Institute. https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2024/03/MRSS-Guide-for-Leaders-V-1.0.pdf

Mobile Crisis Performance Improvement Center. (2022). Mobile Crisis annual report: Fiscal year 2022. Child Health and Development Institute. https://www.mobilecrisisempsct.org/wp-content/uploads/2022/09/Mobile_Crisis_Annual_FY2022_Report.pdf

Rhode Island Behavioral Health Organization Rules

Rhode Island Department of State. Rules and Regulations for Behavioral Healthcare Organizations - Rhode Island Department of State. (n.d.). Rules.sos.ri.gov. https://rules.sos.ri.gov/regulations/Part/212-10-10-01

Rhode Island CCBHC Certification Requirements

Rhode Island EOHHS, “Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria” Revised January 28, 2025. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-01/RI%20CCBHC%20Certification%20Standards%20for%20Program%20Year%202_01.28.2025.pdf

Rhode Island MRSS Guidance Document/Current Practice

Rhode Island EOHHS, “Best Practice Expectations for Mobile Response and Stabilization Services in Rhode Island for Demonstration Year 1 and 2.” https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-09/DY1%20%26%20DY2_Best%20Practices%20Expectations%20for%20MRSS%20in%20Rhode%20Island.pdf

Rhode Island CCBHC Data Dashboard & Savings Evidence

Moore, B. J., & Stocks, C. (2021). Cost of treat-and-release emergency department visits in the United States, 2021 (HCUP Statistical Brief #311). Agency for Healthcare Research and Quality. https://hcup-us.ahrq.gov/reports/statbriefs/sb311-ED-visit-costs-2021.pdf

Rhode Island EOHHS (2025), “CCBHC Dashboard”
Rhode Island EOHHS Medicaid Finance (February 2026)

Additional SAMHSA Crisis Care Guidance
Substance Abuse and Mental Health Services Administration: 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. PEP24-01-037: Substance Abuse and Mental Health Services Administration, 2025. https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf

For full regulatory analysis or supporting documentation contact the agency staffperson listed above.