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April 14, 2026

The Honorable Louis P. DiPalma, Chairman
Honorable Members of the Senate Finance Committee on Human Services
Room 211-State House
Providence, RI 02903
RE: **HR7127- Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) Budget Article 10, Sections 1 and 2- Concerned**

Good afternoon Chairman DiPalma and members of the Committee:

Thank you for the opportunity to provide testimony on H7127 and the proposed FY2027 budget for the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) Article 10, Sections 1 and 2.

I am submitting testimony today to highlight critical gaps in Rhode Island's approach to adolescent behavioral health—specifically around Crisis Services and Substance Use Disorder (SUD)—and to urge a more intentional, transparent, and adequately funded strategy within BHDDH's role as the State Substance Abuse Authority.

At the outset, it is important to recognize that Rhode Island's children's behavioral health service array at DCYF has increased by nearly 50% since August 2024, largely driven by system transformation efforts, the Consent Decree, and expansion of community-based services through recent procurement.

At the same time, Rhode Island has made significant investments in Certified Community Behavioral Health Clinics (CCBHCs). However, available data suggests that youth—particularly those with high-acuity needs—are not the primary beneficiaries of these investments. According to the State's CCBHC Program Year 1 Impact Report, high-acuity children represent only approximately 4% of the population served.

This raises a fundamental question for the General Assembly: are current investments producing a system that is appropriately designed for children, or one that remains predominantly oriented toward adult care?

Children do not access services as individuals—they exist within families, schools, and communities. A system designed primarily around adult service delivery will not adequately meet their needs.

Broader structural changes reflected in the FY27 budget in Article 10 and related policy initiatives further heighten this concern. As outlined in the RICCF budget analysis, Rhode Island is experiencing a shift toward governance consolidation, centralized 988 authority, and increasing reliance on adult-oriented behavioral health infrastructure.

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While these changes may improve impact efficiency, they also create a real risk of assimilating children's behavioral health services into systems that are not designed to meet their developmental, clinical, or legal needs.

Rhode Island has made important progress with the implementation of the 988 Behavioral Health Crisis Line, which represents a critical national investment in improving access to crisis support through a simple and recognizable entry point.

However, as the State continues to build its crisis continuum, system design must ensure that access pathways do not unintentionally replace or restrict specialized services. RI is also operating under a Federal Consent Decree with the U.S. Department of Justice related to its children's behavioral health system. A central component of that agreement is the development and statewide implementation of Mobile Response and Stabilization Services (MRSS) as a core, community-based crisis intervention.

This places a clear obligation on the State not only to establish MRSS, but to ensure that it is accessible, timely, clinically appropriate, and sufficiently resourced to meet the needs of children and families—consistent with federal expectations around system capacity, service availability, and least restrictive care.

RI must avoid building duplicative crisis systems—but it must also avoid oversimplifying access in ways that reduce clinical appropriateness. A "single point of access" is not the same as a "no wrong door" approach. Individuals and families must be able to enter the system through multiple pathways and be connected to the most appropriate level of care.

MRSS is a specialized, developmentally specific service designed for children and families. It is complementary to—but not interchangeable with—adult-oriented crisis services. At present, proposed regulatory and system design changes—particularly those tying MRSS access or licensure to CCBHC structures—risk introducing additional layers of access, complexity, and structural dependency that may constrain provider participation and reduce overall system capacity.

RI must avoid building parallel systems but at the same time, it is equally important to recognize that a "single point of access" is fundamentally different than "no wrong door" approach, where individuals can enter the system through multiple pathways and be connected to the most clinically appropriate response.

Children in crisis require teams with specific competencies, including:

- Child and adolescent development
- Family dynamics and caregiver engagement
- School and community-based intervention
- Coordination with child welfare and juvenile justice systems

Without this level of specialization, there is a significant risk that system structure—rather than clinical need—will determine how and when children receive care.

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To ensure alignment with best practice, federal Medicaid requirements, and the State's obligations under the federal consent decree

BHDDH serves as the federal Mental Health Authority while DCYF has statutory authority for children's behavioral health for Federal Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment (SAPT) Block Grant funding and has the authority to allocate these funds across state agencies, community providers, and nonprofits serving children with serious emotional disturbance (SED).

However:

- There is no clear, publicly defined allocation process for youth-specific investments
- Funding appears embedded within broader adult service structures
- There is limited transparency or accountability regarding how much funding directly supports prevention, early intervention, or adolescent treatment

This lack of clarity makes it difficult for policymakers and providers to assess whether investments are aligned with need.

Rhode Island continues to underinvest in the overall child and family prevention infrastructure, despite clear evidence that early intervention reduces long-term system costs and improves outcomes. Community-based prevention efforts are critical components of a comprehensive system, but are not clearly or consistently funded within the overall Health and Human Services budget structure.

Rhode Island continues to face a crisis and significant gap in adolescent SUD treatment capacity, particularly across the full continuum. Former adolescent SUD programs in Rhode Island were financially fragile and have since closed, leaving a significant gap in the State's continuum of care.

As a result, adolescents are too often served in:

- Emergency departments
- Inpatient psychiatric settings
- Juvenile justice systems
- Out of State Placements

While planning grants have recently been awarded to develop two gender-specific programs we need a sustainable funding strategy as a Medicaid rate has not yet been established, and the system remains in a planning phase. In the interim, services are expected to be reimbursed using adult Medicaid billing codes, as the State must seek federal approval to establish a developmentally appropriate youth-specific rate—further underscoring the current misalignment between financing structures and the clinical needs of adolescents. They will need support from the General Assembly.

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Adolescents with SUD and co-occurring behavioral health conditions require developmentally specific, family-centered, and community-based care, not adaptations of adult treatment models. It is important to note that Medicaid reimbursement alone will not cover the true cost of adolescent SUD care, particularly when:

- Youth remain in care beyond strict medical necessity for safety. Will they return to a DCYF service within the children's service array outside of BHDDH placement.
- Discharge can be delayed due to a lack of appropriate step-down options
- Educational and placement needs must be addressed concurrently

Under both federal and Rhode Island law, determining the most appropriate educational arrangement for a youth in placement is a complex and highly individualized process. The Every Student Succeeds Act (ESSA) requires deliberate, structured decision-making with identified participants to ensure that children and youth receive a free and appropriate public education in a manner that reflects their best interests. This is not merely an administrative issue; it requires coordination across systems, thoughtful planning, and case-specific consideration of the child's educational, clinical, and placement needs. In prior years, when adolescent SUD programming existed, tutoring was at times used in lieu of a traditional school placement.

It remains unclear how Rhode Island intends to meet these obligations within any revived or expanded adolescent SUD treatment framework. This issue creates significant fiscal and operational complexity that is not clearly accounted for within BHDDH's current budget planning or statutory structure for adolescent SUD services. Any viable approach will require coordination with DCYF, RIDE, and other relevant entities to ensure that educational planning is legally compliant and, most importantly, in the best interest of the child and family.

Recommendation:

- Incorporate general revenue funding to supplement Medicaid for adolescent SUD services
- Clarify responsibility for education costs associated with treatment placements
- Invest in step-down, recovery, and community-based supports

Although the children's system is expanding, governance and financing remain divided and hospital and adult institutional services remain more visible and resourced. Additionally, community-based and youth-focused services are less clearly defined. This reinforces a system that is structurally oriented toward adult care rather than a balanced, lifespan approach.

Within H7127, BHDDH appropriations are presented in aggregate, with no clearly defined adolescent SUD strategy or youth-specific investment framework.

Without greater transparency, intentionality, and alignment with children's system design, Rhode Island risks continuing to invest in structures that do not adequately serve youth and families.

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I respectfully urge the Committee to examine not only the level of funding, but how that funding is structured, allocated, and held accountable to outcomes for children.

Thank you for your time and consideration. I would welcome the opportunity to provide additional data or recommendations.

Sincerely,

Beth A. Bixby

Beth A. Bixby, LICSW
Chief Executive Officer
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