S-4678.3

SECOND SUBSTITUTE SENATE BILL 6228

State of Washington 68th Legislature 2024 Regular Session

By Senate Ways & Means (originally sponsored by Senators Dhingra, Hasegawa, Kuderer, Lovelett, Nobles, Randall, Shewmake, Valdez, and C. Wilson)

READ FIRST TIME 02/05/24.

AN ACT Relating to treatment of substance use disorders; amending RCW 41.05.526, 48.43.761, 71.24.618, 18.225.145, and 43.70.250; reenacting and amending RCW 18.205.095; adding new sections to chapter 71.24 RCW; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 71.24 RCW to read as follows:

(1) The single standard set of criteria to define medical necessity for substance use disorder treatment and define substance use disorder levels of care in Washington is the most recent version of the ASAM Criteria as published by the American society of addiction medicine.

(2) When updated versions of the ASAM Criteria, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the authority and the office of the insurance commissioner shall jointly determine the date upon which the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies must post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care

organizations and carriers must begin to use the updated criteria no later than January 1, 2026.

Sec. 2. RCW 41.05.526 and 2020 c 345 s 2 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, a health plan offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2021, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2021, must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection. ((~~Once~~))

(ii)(A) Except as provided in (b)(ii)(B) of this subsection, once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section.

(B)(I) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, after the times specified in (a) of this subsection have passed, if a health plan authorizes services pursuant to the initial medical necessity review process permitted under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the

health plan approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization.

(II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a health plan from requesting information to assist with a transfer as permitted under this subsection (2)(b)(ii).

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration or hospitalization, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time

at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, the health plan may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for

adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Sec. 3. RCW 48.43.761 and 2020 c 345 s 3 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, a health plan issued or renewed on or after January 1, 2021, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan issued or renewed on or after January 1, 2021, must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection. ((~~Once~~))

(ii)(A) Except as provided in (b)(ii)(B) of this subsection, once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section.

(B)(I) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, after the times specified in (a) of this subsection have passed, if a health plan authorizes services pursuant to the initial medical necessity review process permitted under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the health plan approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization.

(II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a health plan from requesting information to assist with a transfer as permitted under this subsection (2)(b)(ii).

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration or hospitalization, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, the health plan may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Sec. 4. RCW 71.24.618 and 2020 c 345 s 4 are each amended to read as follows:

(1) Beginning January 1, 2021, a managed care organization may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) Beginning January 1, 2021, a managed care organization must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The managed care organization may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection. ((~~Once~~))

(ii)(A) Except as provided in (b)(ii)(B) of this subsection, once the times specified in (a) of this subsection have passed, the managed care organization may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section.

(B)(I) Beginning January 1, 2025, for inpatient or residential substance use disorder treatment services, after the times specified in (a) of this subsection have passed, if a managed care organization authorizes services pursuant to the initial medical necessity review process permitted under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the managed care organization approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization.

(II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a managed care organization from requesting information to assist with a transfer as permitted under this subsection (2)(b)(ii).

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's managed care organization as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the managed care organization with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the managed care organization may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a managed care organization may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration or hospitalization, a managed care organization may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the managed care organization must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the managed care organization the patient's need for continuing care and

justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) Beginning January 1, 2025, for inpatient or residential substance use disorder treatment services, the managed care organization may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The managed care organization is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the managed care organization involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the managed care organization shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The managed care organization shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the managed care organization's network is not available, the managed care organization shall pay the current agency at the service level until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Sec. 5. RCW 18.205.095 and 2021 c 165 s 1 and 2021 c 57 s 1 are each reenacted and amended to read as follows:

(1) The secretary shall issue a trainee certificate to any applicant who demonstrates to the satisfaction of the secretary that he or she is working toward the education and experience requirements in RCW 18.205.090.

(2) A trainee certified under this section shall submit to the secretary for approval a declaration, in accordance with rules adopted by the department, which shall be updated with the trainee's annual renewal, that he or she is actively pursuing the experience requirements under RCW 18.205.090 and is enrolled in:

(a) An approved education program; or

(b) An apprenticeship program reviewed by the substance use disorder certification advisory committee, approved by the secretary, and registered and approved under chapter 49.04 RCW.

(3) A trainee certified under this section may practice only under the supervision of a certified substance use disorder professional. The first 50 hours of any face-to-face client contact must be under direct observation. All remaining experience must be under supervision in accordance with rules adopted by the department. A certified substance use disorder professional trainee may not provide independent substance use disorder counseling or clinical services for a fee.

(4) A certified substance use disorder professional trainee provides substance use disorder assessments, counseling, and case management ((~~with a state regulated agency~~)) and can provide clinical services to patients consistent with his or her education, training, and experience as approved by his or her supervisor.

(5) ((~~A trainee certification may only be renewed four times, unless the secretary finds that a waiver to allow additional renewals is justified due to barriers to testing or training resulting from a governor-declared emergency.~~

~~(6)~~)) Applicants are subject to denial of a certificate or issuance of a conditional certificate for the reasons set forth in chapter 18.130 RCW.

((~~(7) A person certified under this chapter holding the title of chemical dependency professional trainee is considered to hold the title of substance use disorder professional trainee until such time as the person's present certification expires or is renewed.~~))

Sec. 6. RCW 18.225.145 and 2021 c 57 s 2 are each amended to read as follows:

(1) The secretary shall issue an associate license to any applicant who demonstrates to the satisfaction of the secretary that the applicant meets the following requirements for the applicant's practice area and submits a declaration that the applicant is working toward full licensure in that category:

(a) Licensed social worker associate—advanced or licensed social worker associate—independent clinical: Graduation from a master's degree or doctoral degree educational program in social work accredited by the council on social work education and approved by the secretary based upon nationally recognized standards.

(b) Licensed mental health counselor associate: Graduation from a master's degree or doctoral degree educational program in mental health counseling or a related discipline from a college or university approved by the secretary based upon nationally recognized standards.

(c) Licensed marriage and family therapist associate: Graduation from a master's degree or doctoral degree educational program in marriage and family therapy or graduation from an educational program in an allied field equivalent to a master's degree or doctoral degree in marriage and family therapy approved by the secretary based upon nationally recognized standards.

(2) Associates may not provide independent social work, mental health counseling, or marriage and family therapy for a fee, monetary or otherwise. Associates must work under the supervision of an approved supervisor.

(3) Associates shall provide each client or patient, during the first professional contact, with a disclosure form according to RCW 18.225.100, disclosing that he or she is an associate under the supervision of an approved supervisor.

(4) The department shall adopt by rule what constitutes adequate proof of compliance with the requirements of this section.

(5) Applicants are subject to the denial of a license or issuance of a conditional license for the reasons set forth in chapter 18.130 RCW.

(6)((~~(a) Except as provided in (b) of this subsection, an~~)) An associate license may be renewed ((~~no more than six times, provided that~~)) if the applicant for renewal has successfully completed eighteen hours of continuing education in the preceding year.

Beginning with the second renewal, at least six of the continuing education hours in the preceding two years must be in professional ethics.

((~~(b) If the secretary finds that a waiver to allow additional renewals is justified due to barriers to testing or training resulting from a governor-declared emergency, additional renewals may be approved.~~))

Sec. 7. RCW 43.70.250 and 2023 c 469 s 21 are each amended to read as follows:

(1) It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business.

(2) The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. Any and all fees or assessments, or both, levied on the state to cover the costs of the operations and activities of the interstate health professions licensure compacts with participating authorities listed under chapter 18.130 RCW shall be borne by the persons who hold licenses issued pursuant to the authority and procedures established under the compacts. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the cost of regulating licensed volunteer medical workers in accordance with RCW 18.130.360, except as provided in RCW 18.79.202. In no case may the secretary impose any certification, examination, or renewal fee upon a person seeking certification as a certified peer specialist trainee under chapter 18.420 RCW or, between July 1, 2025, and July 1, 2030, impose a certification, examination, or renewal fee of more than $100 upon any person seeking certification as a certified peer specialist under chapter 18.420 RCW. Subject to amounts appropriated for this specific purpose, between July 1, 2024, and July 1, 2029, the secretary may not impose any certification or certification renewal fee on a person seeking certification as a substance use disorder professional or substance use disorder professional trainee under chapter 18.205 RCW of more than $100.

(3) All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW.

NEW SECTION. **Sec. 8.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The single standard set of criteria to define medical necessity for substance use disorder treatment and define substance use disorder levels of care in Washington is the most recent version of the ASAM Criteria as published by the American society of addiction medicine.

(2) When updated versions of the ASAM Criteria, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the authority and the office of the insurance commissioner shall jointly determine the date upon which the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies must post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care organizations and carriers must begin to use the updated criteria no later than January 1, 2026.

NEW SECTION. **Sec. 9.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The single standard set of criteria to define medical necessity for substance use disorder treatment and define substance use disorder levels of care in Washington is the most recent version of the ASAM Criteria as published by the American society of addiction medicine.

(2) When updated versions of the ASAM Criteria, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the health care authority and the office of the insurance commissioner shall jointly determine the date upon which the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies must post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care organizations and carriers must begin to use the updated criteria no later than January 1, 2026.

NEW SECTION. **Sec. 10.** A new section is added to chapter 71.24 RCW to read as follows:

(1) The authority, in collaboration with the office of the insurance commissioner and in consultation with medicaid managed care organizations, health carriers, and substance use disorder inpatient and residential treatment providers, shall undertake development of standardized clinical documentation requirements for initial authorization and concurrent utilization review for residential treatment of substance use disorders. Medicaid managed care organizations and health carriers shall begin to use the standardized requirements by July 1, 2025.

(2) Any standardized documentation and associated process requirements must align with the centers for medicare and medicaid services interoperability and prior authorization final rule issued on January 17, 2024.

NEW SECTION. **Sec. 11.** The health care authority shall provide a gap analysis of nonemergency transportation benefits provided to medicaid enrollees in Washington, Oregon, and other comparison states selected by the health care authority and provide an analysis of the costs and benefits of available alternatives to the governor and appropriate committees of the legislature by December 1, 2024, including the option of an enhanced nonemergency transportation benefit for persons being discharged from a behavioral health emergency services provider to the next level of care in circumstances when a prudent layperson acting reasonably would believe such transportation is necessary to protect the enrollee from relapse or other discontinuity in care that would jeopardize the health or safety of the enrollee.

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