STATE OF OKLAHOMA

2nd Session of the 54th Legislature (2014)

HOUSE BILL 3385 By: Shannon

AS INTRODUCED

An Act relating to Medicaid; defining terms; establishing managed care program; requiring application for Medicaid waiver; providing for selection of managed care plans; requiring Medicaid recipients to be enrolled in certain plan; providing exceptions; providing services to be covered under managed care plan; establishing long-term care managed care program; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.12 of Title 56, unless there is created a duplication in numbering, reads as follows:

As used in this act, the following definitions apply:

1. "Authority" means the Oklahoma Health Care Authority;

2. "Managed care plan" means a health insurer, specialty plan, health maintenance organization authorized under the Oklahoma Insurance Code, or a Medicaid-authorized provider service network under contract with the Authority to provide services in the Medicaid program;

3. "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity or is an approved provider service network, and is paid a prospective per-member, per-month payment by the Authority;

4. "Provider service network" means an Authority-approved entity of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include state-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies;

5. "Specialty plan" means a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis;

6. "Comprehensive long-term care plan" means a managed care plan, provider-sponsored organization, health maintenance organization, or coordinated care plan, that provides long-term care services as outlined in this act;

7. "Long-term care plan" means a managed care plan that provides the services described in this act for the long-term care managed care program; and

8. "Long-term care provider service network" means a provider service network a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with

seventeen or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.13 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The Authority shall apply for and implement both a 1932(a) Medicaid State Plan Amendment and a 1915(b) Medicaid waiver as necessary to implement the program. Before submitting the waiver or state plan amendment, the Authority shall provide public notice and the opportunity for public comment and include public feedback to the U.S. Department of Health and Human Services.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.14 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Services in the Medicaid managed care program shall be provided by managed care plans that are capable of coordinating and/or delivering all covered services to enrollees.

B. The Authority shall select managed care plans to participate in the Medicaid program using invitations to negotiate. The procurement method must give the state the most flexibility and broadest power to negotiate value and provide potential bidder the most flexibility to innovate. Separate and simultaneous

procurements shall be conducted in each region to be established by the Authority.

C. The Authority shall consider quality factors in the selection of managed care plans, including:

1. Accreditation by a nationally recognized accrediting body;

2. Documentation of policies and procedures for preventing fraud and abuse;

3. Experience serving, and achieving quality standards for, similar populations;

4. Availability/accessibility of primary and specialty care physicians in the network; and

5. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

D. After negotiations are conducted, the Authority shall select the managed care plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to this act.

E. To ensure managed care plan participation in all regions, the Authority shall award an additional contract in a more populous region to each plan with a contract award in a more rural region. If a plan terminates its contract in a more rural region, the

additional contract in the more populous region is automatically terminated in one hundred eighty (180) days. The plan must also reimburse the Authority for the cost of enrollment changes and other transition activities.

F. The Authority may not execute contracts with managed care plans at payment rates not supported by the General Appropriations Act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.15 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall select managed care plans through the procurement process described in this act.

B. Participation by specialty plans is subject to the procurement requirements in this act. The enrollment of a specialty plan in a region may not exceed ten percent (10%) of the enrollees of that region. However, a specialty plan whose target population includes no more than ten percent (10%) of the enrollees of that region is not subject to the regional plan number limits of this section.

C. Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-Sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan is not subject to the procurement requirements if the plan's

Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.16 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall establish a five-year contract with each managed care plan selected through the procurement process described in this act. A plan contract may not be renewed; however, the Authority may extend the term of a plan contract to cover any delays during the transition to a new plan.

B. The Authority shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the Authority may deem necessary, the contract must require:

1. Physician compensation: Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians;

2. Hospital compensation: Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. Payment rates may be updated periodically;

3. Access:

a. The Authority shall establish specific, population-based standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Consistent with standards established by the Authority, provider networks may include providers located outside the region. Plans may limit the providers in their networks based on credentials, quality indicators, and price.

b. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, or specialty credentials and other certifications. The database must be available online to both the Authority and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients.

c. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within twenty-four (24) hours after

making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers;

4. Encounter data: The Authority shall maintain and operate a Medicaid encounter data system to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans. The Authority shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region;

5. Continuous improvement: The Authority shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

a. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

b. Each plan must collect and report Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the Authority. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance

of plans. The Authority shall use the HEDIS measures as a tool to monitor plan performance.

c. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within one (1) year after the contract is executed;

6. Program integrity: Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

a. a provider credentialing system and ongoing provider monitoring,

b. procedures for reporting instances of fraud and abuse, and

c. designation of a program integrity compliance officer;

7. Grievance resolution: Consistent with federal law, each managed care plan shall establish and the Authority shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees;

8. Penalties: Managed care plans will incur penalties for withdrawal and enrollment reduction, failure to comply with

encounter data reporting requirements, and/or termination of a regional contract due to noncompliance;

9. Prompt payment: Managed care plans shall comply with the prompt payment requirements of the Oklahoma Insurance Code;

10. Electronic claims: Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards; and

11. Itemized payment: Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

C. The Authority is responsible for verifying the achieved savings rebate for all Medicaid prepaid plans. The achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income-sharing ratios:

1. One hundred percent (100%) of income, up to and including five percent (5%) of revenue, shall be retained by the plan;

2. Fifty percent (50%) of income above five percent (5%) and up to ten percent (10%) shall be retained by the plan, and the other fifty percent (50%) refunded to the state; and

3. One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the state.

D. Each managed care plan must accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for twelve (12) months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the Authority. The Authority shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for medically needy patients for services provided before enrollment in the plan. Medically needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least ninety (90) days before disenrolling recipients who fail to pay their shares of the premium.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.17 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in this act. Payments shall be risk-adjusted rates based on historical utilization and spending data, projected forward and adjusted to reflect the eligibility category, geographic area, and clinical risk

profile of the recipients. In negotiating rates with the plans, the Authority shall consider any adjustments necessary to encourage plans to use the most cost-effective modalities for treatment of chronic disease.

B. Provider service networks may be prepaid plans and receive per-member, per-month payments. The fee-for-service option shall be available to a provider service network only for the first two (2) years of its operation.

C. The Authority may not approve any plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.18 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this act. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have thirty (30) days in which to make a choice of plans.

B. The Authority shall implement a choice counseling system to ensure recipients have timely access to accurate information on the available plans. The counseling system shall include plan-to-plan comparative information on benefits, provider networks, drug

formularies, quality measures, and other data points as determined by the Authority. Choice counseling must be made available through face-to-face interaction, on the Internet, by telephone, and in writing and through other forms of relevant media. Materials must be provided in a culturally relevant manner, consistent with federal requirements. The Authority shall contract for any or all choice counseling functions.

C. After a recipient has enrolled in a managed care plan, the recipient shall have ninety (90) days to voluntarily disenroll and select another plan. After ninety (90) days, no further changes may be made except for good cause.

D. The Authority shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan. Except as otherwise outlined in this act, the Authority may not engage in practices that are designed to favor one managed care plan over another.

1. The Authority shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established in this act, and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards.

2. If a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the Authority shall assign the recipient to that plan.

3. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the Authority shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.

4. A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the managed care plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing Medicaid services to the newborn. The mother may choose another plan for the newborn within ninety (90) days after the child's birth.

5. Otherwise, the Authority shall automatically enroll based on the following criteria:

a. whether the plan has sufficient network capacity to meet the needs of the recipients,

b. whether the recipient has previously received services from one of the plan's primary care providers, and

c. whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

E. Recipients with access to private health care coverage shall opt out of all managed care plans and use Medicaid financial assistance to pay for his/her share of the cost in such coverage.

The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The Authority shall seek federal approval to require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.19 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. All Medicaid recipients shall receive covered services through the statewide managed care program except for exempt populations as outlined in Section 1932(a)(2) of the Social Security Act. These exempt populations may voluntarily enroll in the statewide managed care program. Populations who only receive limited services from Medicaid shall not be included in the statewide managed care program.

B. Participants in the medically needy program shall enroll in managed care plans. Medically needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.20 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Managed care plans shall cover, at a minimum, the following services:

1. Advanced registered nurse practitioner services;

2. Ambulatory surgical treatment center services;

3. Birthing center services;

4. Chiropractic services;

5. Dental services;

6. Early periodic screening diagnosis and treatment services for recipients under age twenty-one (21);

7. Emergency services;

8. Family planning services and supplies (plans may elect not to provide these services);

9. Healthy start services;

10. Hearing services;

11. Home health agency services;

12. Hospice services;

13. Hospital inpatient services;

14. Hospital outpatient services;

15. Laboratory and imaging services;

16. Medical supplies, equipment, prostheses, and orthoses;

17. Mental health services;

18. Nursing care;

19. Optical services and supplies;

20. Optometrist services;

21. Physical, occupational, respiratory, and speech therapy services;

22. Physician services, including physician assistant services;

23. Podiatric services;

24. Prescription drugs;

25. Renal dialysis services;

26. Respiratory equipment and supplies;

27. Rural health clinic services;

28. Substance abuse treatment services; and

29. Transportation to access covered services.

B. Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The Authority shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.

C. Each plan operating in the managed care program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program.

Each plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.21 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall make payments for long-term care, home- and community-based and residential services, and for primary and acute medical assistance and related services for recipients eligible for long-term care, using a managed care model.

B. The Aging Services Division of the Oklahoma Department of Human Services shall assist the Authority in developing specifications for the invitation to negotiate and the model contract; determine clinical eligibility for enrollment in managed long-term care plans; monitor plan performance and measure quality of service delivery; assist clients and families to address complaints with the plans; facilitate working relationships between plans and providers serving elders and disabled adults; and perform other functions specified in a memorandum of agreement.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.22 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

1. Sixty-five (65) years of age or older, or eighteen (18) years of age or older and eligible for Medicaid by reason of a disability; or

2. Determined to require nursing facility care.

B. Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in an existing long-term care Medicaid waiver program are eligible to participate in the long-term care managed care program for up to twelve (12) months without being reevaluated for their need for nursing facility care.

C. The Authority shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before enrollment offers, the Authority shall determine that sufficient funds exist to support additional enrollment into plans.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.23 of Title 56, unless there is created a duplication in numbering, reads as follows:

Long-term care plans shall, at a minimum, cover the following:

1. Nursing facility care;

2. Services provided in assisted living facilities;

3. Hospice;

4. Adult day care;

5. Medical equipment and supplies, including incontinence supplies;

6. Personal care;

7. Home accessibility adaptation;

8. Behavior management;

9. Home-delivered meals;

10. Case management;

11. Therapies, including occupational, speech, respiratory, and physical;

12. Intermittent and skilled nursing;

13. Medication administration;

14. Medication management;

15. Nutritional assessment and risk reduction;

16. Caregiver training;

17. Respite care;

18. Transportation; and

19. Personal emergency response system.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.24 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Provider service networks must be long-term care provider service networks. Other eligible plans may be long-term care plans or comprehensive long-term care plans.

B. The Authority shall select managed care plans through the procurement process described in this act.

C. In addition to the criteria established in this act, the Authority shall consider the following factors in the selection of long-term care managed care plans:

1. Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care;

2. Whether a plan has established a network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by the Authority for specialty services for persons receiving home- and community-based care;

3. Whether a plan is proposing to establish a comprehensive long-term care plan and whether the plan has a contract to provide managed medical assistance services in the same region;

4. Whether a plan offers consumer-directed care services to enrollees; and

5. Whether a plan is proposing to provide home- and community-based services in addition to the minimum benefits required by this act.

D. Participation by a Medicare Advantage Special Needs Plan is not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.25 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. In addition to the requirements earlier in this act, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

B. Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. Each selected plan must offer a network contract to all the following providers in the region:

1. Nursing homes;

2. Hospices; and

3. Aging network service providers that have previously participated in home- and community-based waivers serving elders or community-service programs administered by the Aging Services Division of the Department of Human Services.

C. Except as provided in this section, providers may limit the managed care plans they join. Nursing homes and hospices that are enrolled Medicaid providers must participate in all managed care

plans selected by the Authority in the region in which the provider is located.

D. Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the Authority and any additional measures mutually agreed upon by the provider and the plan.

E. The Authority shall establish and each managed care plan must comply with specific standards for the number, type, and regional distribution of providers in the plan's network.

F. Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing-facility-specific payment rates set by the Authority; however, mutually acceptable higher rates may be negotiated for medically complex care. Plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within ten (10) business days after receipt.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.26 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. In addition to the payment provisions in this act, the Authority shall provide payment to plans in the long-term care managed care program pursuant to this section.

B. Payment rates to plans shall be blended for some long-term care services.

C. Payment rates for plans must reflect historic utilization and spending for covered services projected forward and adjusted to reflect the level-of-care profile for enrollees in each plan. The Authority shall periodically adjust payment rates to account for changes in the level-of-care profile for each managed care plan based on encounter data.

1. Level-of-care 1 consists of recipients residing in or who must be placed in a nursing home.

2. Level-of-care 2 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who require extensive health-related care and services because of mental or physical incapacitation.

3. Level-of-care 3 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly medically or physically incapacitated.

D. The Authority shall make an incentive adjustment in payment rates to encourage the increased utilization of home- and community-based services and a commensurate reduction of institutional placement. The incentive adjustment shall continue until no more

than thirty-five percent (35%) of the plan's enrollees are placed in institutional settings. The Authority shall annually report to the Legislature the actual change in the utilization mix of home- and community-based services compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.27 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan. Except as otherwise provided in this act, the Authority may not engage in practices designed to favor one managed care plan over another.

B. The Authority shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established in this act, or by the Authority through contract, and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards.

1. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-Sponsored Organization, or Medicare Advantage Special Needs Plan, the Authority shall automatically enroll the

recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program.

2. Otherwise, the Authority shall automatically enroll based on the following criteria:

a. whether the plan has sufficient network capacity to meet the needs of the recipients,

b. whether the recipient has previously received services from one of the plan's home- and community-based service providers, and

c. whether the home- and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

C. If a recipient is referred for hospice services, the recipient has thirty (30) days during which the recipient may select to enroll in another managed care plan to access the hospice provider of the recipient's choice.

D. If a recipient is referred for placement in a nursing home or assisted living facility, the plan must inform the recipient of any facilities within the plan that have specific cultural or religious affiliations and, if requested by the recipient, make a reasonable effort to place the recipient in the facility of the recipient's choice.

SECTION 17. This act shall become effective November 1, 2014.

54-2-8534 AM 12/09/13