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| **NEMT Call Center Script Evaluation Tool** | |
| **Name of CCO** |  |

**Instructions**

**Delivery Method:**

1. NEMT Call Center Scripts should be submitted by December 15 to the CCO deliverables mailbox: [CCO.MCODeliverableReports@odhsoha.oregon.gov](mailto:CCO.MCODeliverableReports@odhsoha.oregon.gov).

**Formatting Requirements:**

1. Submit the original script and any resubmissions in Microsoft Word format.
2. Use the naming convention CCO ACRONYM\_NameOfDeliverable\_Version\_YYYYMMDD. The date must be the date the CCO submits the deliverable to OHA. (e.g.: EOCCO\_NEMTPhoneScript\_v01\_20211215).
3. If more than one script is submitted, identify the primary and supplementary scripts.
4. Every page should be numbered.
5. Every page should include the CCO logo or branding or the script must explicitly state the name of the CCO to which it applies.
6. Use script format (sequence of questions and criteria).
7. Use Track Changes in Microsoft Word to indicate any edits or revisions to the script.

**Readability:**

1. Call Center Scripts must read at a 6th-grade reading level (below a 6.9) on the Flesch-Kincaid Readability Scale.

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| **Script Content**  (Ex. B. Part 2, Sec. 5(e)-(f)) | **CCO Use Only:**  **Provide page(s) and section number where information is found** | **OHA Review** | | | |
| *Name of 1st Reviewer:* | | *Name of 2nd Reviewer:* | |
| *Review date(s):* | | *Review date(s):* | |
| **Eligibility** |  |  | **Comments** | |
| 1. Obtain the Member’s or Member’s representative name, Medicaid ID #, and preferred contact method (e.g., phone call, email, fax) when transportation arrangements are in place. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| 1. Verify member’s enrollment with CCO and eligibility for NEMT services. For all FBDE (Full-Benefit Dual Eligible) Members, verify eligibility for services with such Members’ MA (Medicare Advantage) or D-SNP(Dual Special Needs) Plans, or directly with such Members’ Medicare Provider. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| **Trip Purpose** |  |  |  | |
| 1. Verify whether the NEMT transportation request services are a Covered Service or Health-Related Service and whether it is within CCO’s Service Area, or in the case of FBDE (Full-Benefit Dual Eligible) Members, that such Members require NEMT to travel to a Medicaid or Medicare covered appointment within Contractor’s Service Area or outside the Service Area if NEMT Services are not available within CCO’s Service Area. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| **Appropriate Mode** |  |  |  | |
| 1. Determine the scheduled appointment time, the address of pick-up, and the name and address of the provider to whom the Member seeks transport to. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| 1. Determine if the Member needs a secured transport. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| **Other Information** |  |  |  | |
| 1. Determine whether the Member is ambulatory and current level of mobility and functional independence. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| 1. Determine whether an attendant will accompany the member. |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| 1. *For members with an attendant:* Determine whether the Member requires assistance, and whether the attendant meets the requirements per [OARs 410-141-3935 through 410-141-3960](https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265572). |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |
| 1. Verify Member’s age and ensure that Members 12 years of age and younger will be accompanied by an adult as per [OAR 410-141-3935](https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265572), and that child safety seats are provided for children defined under [ORS 811.210](https://oregon.public.law/statutes/ors_811.210). |  | 1st review  YES  NO  YES  NO |  | |
| 2nd review  YES  NO  YES  NO |

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| 1. Determine whether the Member has special conditions or needs including physical or behavioral health disabilities. |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| 1. Identify whether service modifications are needed to address the safety of passenger/s and drivers. |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| 1. Provide the name and telephone number of the NEMT driver to the Member and confirm the scheduled pick-up time and address with the Member no less than two (2) days prior to the scheduled pick-up time. If the ride is requested less than two (2) days prior to the scheduled pick-up time, Contractor or its subcontracted NEMT brokerage shall provide the Member with the brokerage’s phone number and may, but is not required, to provide the Member with the name and telephone number of the NEMT driver or NEMT Provider |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| 1. Identify any other pertinent information relating to the trip. |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| **General Structure** |  |  |  |
| 1. Does the script include a sequence of questions and criteria? |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| **Readability Assessment** |  |  |  |
| 1. Is the script written at 6th-grade reading level?   (TBD once all changes have been made to the call center script.) |  | 1st review  YES  NO  YES  NO |  |
| 2nd review  YES  NO  YES  NO |
| **Script Format** |  |  |  |
| 1. Is the CCO logo or brand letterhead visible on every page, or does the script explicitly state the name of the CCO to which it applies? |  |  |  |
| 1. Is there more than one script? If so, are the primary and supplementary scripts identified? |  |  |  |
| 1. Are pages numbered? |  |  |  |
| **Additional Comments or Feedback** | | | | |
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| **OHA USE ONLY** | |
| Total # Applicable Elements | **15** |
| Total # Compliant Elements |  |
| Total Percent Compliant | % |