

DHS Responses to Public Comments Regarding Life 360 HOME Program

Amy Jo Grissom, HFA / PAT Coordinator

Inspired Communities Foundation

Comment: Thank you so much for our meeting this morning. This is something we've been looking forward to for some time. In talking over how realistic this is for our site, a few questions came up.

It was mentioned that there would be a payment of \$300 per family per month. Does this fluctuate month to month based on the current caseload for the month, or is it an amount that is set for each month based on the max caseload? Is the \$50,000 startup cost per hospital? per site the hospital contracts with? or per home visitor? And same with the mileage - per hospital? per site? or per home visitor?

Another thought that was discussed was the difference in programs (HFA vs. PAT). I am not sure how familiar you all are with the two, so I wanted to share a quick breakdown as maybe something to think about. An average full caseload for Healthy Families is 15 families seen weekly. An average full caseload for Parents as Teachers is 20 families seen twice monthly. So if we choose to use the HFA program (which is typically our choice with moms who have multiple risk factors), the total will be \$54,000 for a home visitor with a full caseload, who is completing 60 visits per month. On the other hand, if we choose to use the PAT program, the total will be \$72,000 for a home visitor with a full caseload, who is completing 40 visits per month. See the imbalance? It makes more sense for us financially to use only PAT, even though that really may not be the best option for the families. I'm wondering if there's a way to even this out? Just a thought?

Thanks again for your willingness to share today, and we are truly excited to see if this is an option for our organization.

Response:

DHS appreciates the interest in and enthusiasm for the development of the Life360 HOME program. To answer the commenter's questions, the program's per member per month payment rate will not change from month to month or based on changes in caseload. It will remain the same regardless of changes in the home visiting provider's staffing or caseloads. The start-up and transportation funding will be per Life360 HOME hospital.

DHS acknowledges that there are different costs for each home visiting model and that may make the use of some models more financially viable than others. We encourage hospitals to consider using a mix of models, where possible, to ensure the funding can best serve the diverse needs of the mothers and babies in their communities.

Child Care Aware of Northwest Arkansas

Comment: I wanted to give some insight/public comment on the proposed Life 360 program. I would like to voice concerns on how the money is being allocated and that there should be more thought and focus on staff salaries of the program and who it reaches on the ground level.

Response:

DHS appreciates the commenter's interest in the program. The funding structure of the program provides key areas of resources (e.g., technology, start-up funding), but allows—and expects—the funding to be to cover staffing costs. DHS recognizes that the most important cost of this program's success will be the people implementing it.

Bob and Kay Burton, Co-Founders

Inspired Communities Foundation

Comment: INSPIRED COMMUNITIES FOUNDATION - WHO WE ARE

Established in 2008, the Inspired Communities Foundation is a small 501(c) 3 evidence-based at-risk home visiting organization offering Parents as Teachers and Healthy Families America programs in four counties (Stone, Izard, Fulton, and Sharp) in north central Arkansas as part of the Arkansas Children's Hospital Home Visiting Network. Our organization has had consistently high marks in quality, participated in a number of pilot programs and has created a unique and successful program (Baby Bucks) to establish and maintain lifelong healthy habits and behaviors in children and adults.

THE NEED

None of the counties we serve have maternity care services, with the nearest maternal hospitals in Jonesboro, Mountain Home, Searcy, and Batesville. In addition, three counties to our east, (Lawrence, Clay, and Randolph), have no obstetrical and no home visiting services. This leaves a huge swath of our region (seven counties, 4,385 sq. miles) as secondary hospital markets without maternity care. Inspired communities foundation is uniquely positioned with the infrastructure, programs. expertise, quality and motivation to help solve this problem.

We live in a maternity care desert, meaning there are no obstetric hospitals or birth centers and no obstetric providers. According to Dr. Zsakeba Henderson, March of Dimes senior vice-president, "Many people don't know that we are in a maternal and infant health crisis in our country. Our country is currently the least safe to give birth and be born in among the industrialized countries, and ... part of that problem is not having access to high quality maternity care. We have failed moms and babies too long in our country, and we need to act now to improve this crisis."

One of the counties which Inspired Communities Foundation serves and in which we live, Stone County, has an infant death rate (14.7) that ranks 75th of 75 counties in a state that ranks 47th of 50 (Mortality in the United States-National Center for Health Statistics 2020). If Stone county were a country it would rank just behind Syria at 123rd in the world. (World Atlas). Two more of the counties the ICF serves have above the US average (5.42) in Infant mortality - Izard 8.9, Sharp 6.3 with Fulton at 3.6. (Mortality in the United States-National Center for Health Statistics 2020).

Families and women with high-risk pregnancies need high-risk care.

OUR APPROACH

The Healthy Families America program we offer begins with a comprehensive assessment of all the issues, support or lack of support, medical and economic issues impacting the family. In one case, a young family was living without electricity, transportation or water, and the father would hitch-hike each day to his job. The HFA program enabled us to work with the family to find ways they could solve their problems and enable the children to thrive. This story had a happy ending.

Dr. Henderson from the March of Dimes also stated, “We also know that improving the social and economic conditions and quality of healthcare at all stages in a woman’s life will help mitigate some of the issues of access to maternity care, because how healthy a woman is before pregnancy impacts how well she does and what complications she may have and the health of that baby from pregnancy.”

Our own Department of Health has concluded that the Healthy Families America program is very effective. We believe that a broad approach is the most effective and efficient helping families solve problems and creating a family that encourages the child to thrive. This is especially true for families with multiple risk factors. “In a retrospective case-control study that evaluated a project of intensive home visiting following the Nurse Family Partnership and Healthy Families America models, they found that infants whose families did not participate were 2.5 times more likely to die compared to those whose families participated” (from Data to Action, A Background Paper on Infant Mortality, Arkansas Department of Health, March 2012).

As noted earlier, the Inspired Communities Foundation offers the Parents as Teachers (PAT) and Healthy Families America programs (HFA). Both programs are proven and effective and have a lasting impact upon young lives. The approach of both programs, however, is different, The PAT program is geared to enhancing child development, while the HFA program is broader and encompasses the total environment of the family. HFA is a very comprehensive approach and is the best choice for families with multiple risk factors. In counties where only PAT is available, the population will benefit greatly from participation.

Our experience however, has been that the HFA model is better suited to deal with the many social and economic barriers, and broader family issues which contribute to high-risk pregnancies. However, the proposed Maternal 360 reimbursement system, would steer services toward PAT even though it may not be the best program for the baby and family. Our Director Amy Jo Grissom notes that under the guidelines we have been provided, the PAT program will also cost the state more, have fewer visits with families, and emphasize enhancing child development instead of assisting the family in broader issues that affect pregnancies and children’s health. Again, the PAT program is a wonderfully effective child development program that will benefit mothers and babies, but if HFA is available it is usually the best fit in high-risk families.

ISSUES

High Need Secondary Markets

All of the counties served by the Inspired Communities Foundation are secondary hospital markets. It is logical to assume that the hospitals will seek to establish services through Maternal 360 in their primary markets first. This may result in the secondary markets receiving inadequate resources in the face of compelling needs. Establishing staff at the hospital and offering services in the primary hospital market

will probably not leave enough resources for the secondary markets. The hospitals do not have guidelines of how much should be shared with the home visiting agencies. This can create disparities and inadequate resources, especially in secondary markets where the need is highest. The hospitals will want to serve their primary market first since that is their community base with the people they see at the supermarket and the country club.

The funding model proposed by Maternal 360 looks at the problem through the lens of the individual hospital and this is a very logical position. However it is easy to see that the Maternity Care Desert in North Central Arkansas and third world type infant death rates needs a regional approach.

Response:

DHS recognizes the troubling issues Arkansas has with maternal and infant morbidity and mortality. Our deep concern over the health problems that too many mothers and babies face in our state is at the core of the creation of Maternal Life360 HOMEs. We also admire the work of HFA and PAT and hope both models will be part of making Maternal Life360 HOMEs successful.

We are also concerned about the areas of the state that lack birthing hospitals and OB/GYNs. While DHS has limited ability to address those specific issues directly, we believe Life360 HOMEs can spread pre and postnatal home visiting to these “maternity care deserts.” We hope and anticipate that hospitals that choose to become Maternal Life360 HOMEs will provide home visiting services in counties beyond their typical service footprint. We fully agree with Dr. Henderson that “improving the social and economic conditions and quality of healthcare at all stages in a woman’s life will help mitigate some of the issues of access to maternity care,” We hope our Maternal Life360 HOME program contributes to making those improvements.

We understand the concern around the amount of funding Life360 HOMEs will share with their chosen partner organizations. While we have no requirements around that issue, we anticipate it will be negotiated between the hospital and its partner to the satisfaction of both parties.

Comment: Reimbursement Issues

Start-up costs

Our understanding is that there will be two startup payments to the hospitals of \$50,000 each with a negotiated share going to the home visiting programs plus \$300.00 per month per family enrolled. Our cost to establish a home visitor is about \$45,000 per year. This does not include the necessary indirect costs of rent, utilities, affiliate fees, accounting fees, office supplies, internet cost, or postage. This means that about half of the startup payments going to the hospital would be need to be shared with the home visiting agency for one home visitor. Again, if the hospital establishes a relationship with a home visiting agency in their primary market and retains (as it should) funding to offset their own costs, little or nothing will be left for other Arkansas counties with third world infant death statistics.

Response:

We understand the concern around the amount of funding Life360 HOMEs will share with their chose partner organizations. While we have no requirements around that issue, we anticipate it will be negotiated between the hospital and its partner to the satisfaction of both parties.

We also expect start-up funding to be used to recruit and employ staffing for the Life360 HOME program, including home visitors. Our Life360 application process requires hospitals to pass a readiness review before they can begin serving clients. That means the first round of start-up funding must be used to employ staff to be ready to serve clients to pass the readiness review.

Comment: Billing Per Family Per Month

The start-up funding would be offset by the billing per family. However, it takes time (4-12 months) to build up a caseload. The home visitor would also need to leave enough room in their caseload for new families. What happens when the home visitor has reached capacity and cannot accept new patients or risk a violation of HFA or PAT program fidelity?

In a series of e-mails, our director received the following clarification of the proposed \$300 month payment and how it compares against the reimbursement for PAT and HFA.

The \$300 month. Payment is for enrolled families only. In the beginning, when the home visitor is building a caseload and they have 6 families, the reimbursement will only be \$1,800 for that month with a cost of \$4,100.

An average full caseload for Healthy Families America is 15 families seen weekly. An average full caseload for Parents as Teachers is 20 families seen twice monthly. If we choose to use the HFA program (which is the best program for families with risk factors), the total will be \$54,000 per year for a home visitor with a full caseload, who is completing 60 visits per month. On the other hand, if we choose to use the PAT program, the total will be \$72,000 for a home visitor with a full caseload, who is completing 40 visits per month.

Reimbursement at \$300 per month per family:

Maximum caseload

HFA 15 Families (60 visits month) \$54,000 yr.

PAT 20 Families (40 visits month) \$72,000 yr.

A more reasonable case load is 80 to 90 per cent. This is how the funding would work at an 80 per cent caseload.

80 per cent caseload

HFA 12 Families (60 visits mo.) \$43,200 yr.

PAT 16 Families (40 visits mo.) \$57,600 yr.

After the home visitors are established beyond the start-up period, the total cost to maintain a home visitor is about \$55,000 per year. The reimbursement for the best program for high-risk pregnancies and families (HFA) is inadequate.

Our understanding is that we can choose which program to use. From a financial and efficiency standpoint, the PAT program would seem to be the obvious choice, but perhaps not the best choice for all families where HFA is also offered. Assuming a cost of about \$50,000 per year to maintain a home visitor, and a caseload at 80 percent would not cover costs.

Travel

The budget of \$50,000 for travel is excessive. About \$40,000 could go to people and infrastructure and still be adequate.

Response:

DHS expect start-up funding to be used to recruit and employ staffing for the Life360 HOME program, including home visitors. Our Life360 application process requires hospitals to pass a readiness review before they can begin serving clients. That means the first round of start-up funding must be used to employ staff to be ready to serve clients to pass the readiness review. Passing readiness review will trigger a second round of start-up funding which can be used to support staff salaries while home visitors are building their caseloads.

DHS acknowledges that there are different costs for each home visiting model and that may make the use of some models more financially viable than others. We encourage hospitals to consider using a mix of models, where possible, to ensure the funding can best serve the diverse needs of the mothers and babies in their communities.

Comment: WHAT CAN BE DONE

Place Resources in Areas of Great Need

With the grievous state of infant health in some of our counties, the Maternal Care Deserts in Arkansas represent a compelling need. These high-need, under-resourced areas need more home visitors who bring positive changes. It is suggested that the Maternal Care Deserts be designated as under-resourced and receive additional funding for maternal services and home visitors.

It may be tempting to assume that a home visitor could be based in the hospitals primary market community but also serve the secondary markets of four other counties. We see several problems with this approach. The home visitor will fill their caseload with the families that are closer to home. Also, long distances tie up valuable time, and coordination of services over a five-county area is extremely difficult and time consuming.

Also, the HFA program is geared for county level activities. For instance, Group Meetings (required by HFA) simply will not be attended if the distance is more than a few dozen miles (assuming the families have transportation). Over distances that could be over 100 miles between visits and with all the

activities that surround each visit, the more geographically spread out the caseload, the smaller the caseload will be. Time spent traveling is time not spent with a family. It is not just a question of travel money, it is the complications, complexity and time that would accompany the effort to get the family to the resources and the resources to the family.

We propose enough HFA home visitor funding to provide:

Two additional HFA home visitors in Stone County.

Two HFA home visitors in each of Clay, Randolph, and Lawrence Counties (currently with no home visiting infrastructure).

One additional HFA home visitor in Izard County.

One additional HFA home visitor in Sharp County.

A registered nurse to oversee the relationship with the hospital/providers and integrate the healthy habits and behaviors program and HFA health issues into the fabric of our communities.

Another important issue is to provide funding for small hospitals for maternal services. Stone County has a good hospital as part of the White River Hospital System. The problem is that there are economic barriers for small hospitals to offer maternity services or to become birthing hospitals. Perhaps there are ways in which some additional services could be offered through better reimbursement and strategic relationships with high-risk pregnancy resources.

Expand Medicaid Postpartum Coverage

The state of Arkansas can expand the Medicaid postpartum coverage period from 60 days to 12 months, an option made available by the American rescue Plan Act of 2021. Two dozen states and Washington, D.C., have done this as of August.

The fact that a county in Arkansas has three times the national average of infant deaths, is a stain on the health of our children.

But, it is a problem that can be solved. If the Maternal 360 Program places resources in areas of great need instead of taking a “One size fits all” approach, we can begin to slowly address the issues creating poor outcome for our most vulnerable babies and families.

Arkansas has some of the best minds, best technology and the most passionate and caring people in the world. We can solve this problem. It is a matter of finding the best way to match high-risk resources with the needs of high-risk families.

Inspired Communities Foundation is uniquely positioned with the infrastructure, knowledge, experience, geographic presence, and passion to serve and let the babies live.

Response:

DHS is similarly concerned about the areas of the state considered maternity care deserts, and while we have limited ability to address those specific issues directly, we believe Life360 HOMEs can spread pre- and postnatal home visiting to these regions. The Life360 HOME provider manual does not limit the number of counties around the hospital's home county

that can be included in the Life360 service area. As part of the application process, DHS will assess whether the applicant hospital can serve the selected service area adequately or it needs to be adjusted. We will encourage hospitals that choose to become Maternal Life360 HOMEs to provide home visiting services in counties beyond their typical service footprint.

While the Maternal Life360 HOMEs are statutorily required to be birthing hospitals, we do not require that home visitors themselves must be based in the hospitals. In fact, we hope and anticipate home visitors will be based in their home counties, so they understand the needs and available resources of their community.

We also hope that the Maternal Life360 HOMEs will see the value and financial viability of serving counties considered maternity care deserts. Because Maternal Life360 HOMEs can serve both ARHOME enrollees and women enrolled in other Medicaid programs, we believe there will be enough families to serve in these traditionally underserved areas to support events (like group meetings) locally.

DHS understands the interest in expanding Medicaid eligibility to women from 60 days postpartum to 12 months. Although that provision is outside the parameters of the Life360 program, it should be noted that the Maternal Life360 HOME will allow ARHOME enrollees to continue receiving the Life360 home visiting services even if they lose Medicaid eligibility.

Bo Ryall, President & CEO

Arkansas Hospital Association

Comment: The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred healthcare facilities and their more than 50,000 employees as they care for all residents of our rural state. Hospital doors are always open, and during the pandemic our hospitals have provided health services to the thousands of Arkansans seeking care for COVID-19, while also acting as essential partners in public health's pandemic response effort. The Association works to support, safeguard, and assist our members in providing safe, high-quality, patientcentered care in a rapidly evolving – and highly regulated – healthcare environment.

The AHA sincerely appreciates the opportunity to comment on Arkansas's Life360 HOME Program proposed rule. Arkansas hospitals are not only the backbone of the Arkansas healthcare system through the delivery of emergency services, inpatient care, and outpatient care – hospitals are also already key components to the health of the communities where they serve. Hospitals fully recognize the importance of social, environmental, and behavioral factors as well as genetic and health care factors that impact a person's health. The AHA applauds the State for developing an innovative approach to fostering community health. Funding hospitals that volunteer to serve as "Life360 HOMEs" to identify and connect beneficiaries to social services, including integrating these services into their care delivery models, encouraging partnerships with community-based organizations, tracking social needs, and incentivizing a more holistic approach, has the potential to truly benefit those most in need in our state.

The success of the Life360 program depends on its ability to enroll interested hospitals and to support the provision of the enhanced services unique to the model. AHA has serious concerns that the proposed fee structure is insufficient to fulfill either. For example, the largest of the Life360

programs, the Maternal Life360 HOME, has evidence-based home visiting as an essential component of the model. However, an analysis from one such program suggests that start up funds should be at least 50% higher (\$150,000 versus \$100,000) and per-member-per-month rates double those proposed (\$600 vs. \$300), based on known program expenses. While some hospitals may take a chance on the model, most will be very hesitant to participate in a program that does not cover their costs – especially at a time when reimbursements for traditional, acute-care hospital services are not keeping pace with increased costs of labor and supplies. We encourage the State to invest more financial resources into the program to promote its success.

Thank you, again, for the opportunity to comment on the Arkansas Life360 HOME Program proposed rule. The Arkansas Hospital Association and its members are offering these comments in a spirit of collaboration with the goal of successful and timely implementation of this innovative program. We stand ready to work with the State and other stakeholders to address the issue raised in our letter and to ensure the program's overall success for Arkansas's hospitals and, most importantly, the patients and families that our hospitals are so honored to serve.

Response:

DHS appreciates the interest in and enthusiasm for the development of the Life360 HOME program and values the partnership with the state's hospitals and the Arkansas Hospital Association in this endeavor.

DHS acknowledges the different costs for each home visiting model that may make the use of some models more financially viable than others. We encourage hospitals to consider using a mix of models, where possible, to ensure the funding can best serve the diverse needs of the mothers and babies in their communities.

DHS continues to gather information on what would be an appropriate per member per month payment rate for Maternal Life360 HOMES. We will publish a final rate sheet prior to program implementation.

Brittany McAllister

National Service Office for Nurse, Family, Partnership and Child First

Public hearing held remotely on October 20, 2022, at 10:00 a.m.

Comment: Thank you and good morning. My name is Brittany McAllister. I'm with National Service Office for Nurse, Family, Partnership and Child First. I would like to thank the Department and the Administration for recognizing value at home based visiting models, especially evidence-based models like nurse, family partnership is an evidence-based home visiting models with over forty-five years of research, showing that it produces improvements in maternal and child health and development both over the short and long term. N.F.P. utilize registered nurses work with low-income moms from as early in their pregnancy as possible until their first child turns two years old. The nurses provide the trusted expertise. The moms need to have a healthy pregnancy to become a nurturing mother and parent a healthy child. We're grateful for the opportunity to provide comments and support of the effort to cover evidence based on visiting services through maternal life. We do, however, have concerns about implementation, and ultimately, then the success of the program. If the startup funding and per member per month rate are insufficient for working hospitals to provide services to the women in their

community. Evidence based models remain the gold standard and the home visiting field because they have staff providing on going technical assistance to ensure that the program is implemented with fidelity. That is in the way that will produce the same outcomes that the research has shown. This requires both upfront and ongoing training fees. Additionally, models like N.F.P., that utilize registered nurses must offer market-based salaries in order to compete in today's health care workforce landscape. Recently Alabama Medicaid began offering a seven hundred and twenty dollar per member per month rate to ensure adequate cost coverage for this programming and the seen tremendous interest and rapid by partners in various areas of the State. We suggest that in Arkansas per member per month rate of between six hundred and seven hundred and twenty per month, dependent on birthing hospital budgets, area cost of living and evidence-based model requirement would be an appropriate target range for this program. We also know that is may be beyond the purview of this particular set of rules that we encourage DMS to explore ways to provide a full two-years postpartum and funding for women on all categories and Medicaid assistance. N.F.P, provided services for those first two years because the evidence has shown that this timing is what is needed the most robust long-term positive outcomes. We're also thankful for the recognition that telehealth should be an accepted modality for these models when necessary. During the COVID 19 pandemic F.T.P. provided shifted to providing telehealth services to keep our clients and their baby safe, while we're now able to see family safely in person when taking the appropriate precautions, telehealth may still be appropriate in some situations and unfortunately, there's no guarantee that a client will have an internet connection or device that support video-based telehealth. N.F.P. nurse recognize the value of in person services, and when not possible, video-based telehealth services that there will be instances where client simply cannot connect to a video-based modality. We would like to request that video-based telehealth be a recommendation rather than a requirement for service delivery reimbursed through Medicaid. We appreciate the continued opportunities to work with DMS and this tremendous effort and are looking forward to ongoing conversations with DMS. For everything, hospitals, and other stakeholders about how we can best serve low-income Arkansas moms within our family partnership. Thank you so much.

Response:

We admire the work of NFP and hope the model will be part of making the Maternal Life360 HOME program successful.

DHS continues to gather information about what an appropriate per member per month payment rate for Maternal Life360 HOMEs would be. We will publish a final rate sheet prior to program implementation.

We also understand the value in ensuring the home visitors serving Maternal Life360 HOME clients have all appropriate training necessary, and we continue to work with our hospital and home visiting partners to determine the best way to fund and deliver it.

DHS also recognizes the value of delivering Maternal Life360 HOME services in person in clients' homes. We also appreciate the commenter's support of our proposed rules allowing for services to be delivered through other means, including video-supported telehealth visits, when necessary. We also recognize many of our clients have limited internet access, and we do not have any plans to require clients to use telehealth services

DHS appreciates commenters' suggestion that Arkansas Medicaid expand postpartum coverage. We continue to explore all available policy options to best serve pregnant women in Arkansas and their families.

Audrey Zavaleta, Executive Director

Family Network NWA

Comment: Our home visitors became almost unable to accomplish what was required by HFA because of families being in such an intense crisis without food, losing their housing, etc.

Our intention with the case manager was to alleviate some of those tasks so our home visitors can focus on the parent-child relationship, child development, goal setting, etc. Our case manager is currently funded by UAMS through their Community Health Worker funding that is a 2 year funding process. I think it would be interesting to talk with the hospitals about the need for this kind of service. It also brought to mind our frequent need for doula services, which ties into maternal care. We often have mothers that have zero support during their labor process, either because they're a single parent, recently immigrated here, or because they don't speak English. We know having a doula present for labor and available postpartum can greatly boost maternal and infant health outcomes around birth.

And finally I'm attaching here a quick breakdown of the home visitor position costs that we at Family Network have on average. (See table below response) I broke it down for the first year (with initial training costs, equipment costs) and then following years. I also included a supervisor position. Again, these are costs that we have here at Family Network, so it might vary per agency.

Response:

DHS appreciates the challenging work currently being done by the state's home-visitors to serve families in crisis. We hope to leverage and expand the existing work being done. We also appreciate the partnership of other health professionals in the continuum of care for pregnancy and postpartum care.

We also appreciate the information on home visitation staff positions needed, their salaries and other costs of providing services.

Staff position costs:**Home Visitor: 1 FTE Start up Year**

Categories:	Calculated From:	Total Cost:
Annual Salary:	\$16.50 X hour	\$34,320
Benefits (Fringe and Health Insurance Stipend)	\$2,699	\$2,699
Travel Cost Annually 6,500 miles per IRS rate	\$.625	\$4,062
Computer Software		\$750
HV expenses within site (affiliation fees, curriculum fees)		\$923
Training		\$700
		Total Cost: \$43,454

Home Visitor: 1 FTE

Categories:	Calculated From:	Total Cost:
Annual Salary:	\$16.50 X hour	\$34,320
Benefits (Fringe and Health Insurance Stipend)	\$3,899	\$3,899
Travel Cost Annually 6,500 miles per IRS rate	\$.625	\$4,062
Computer Software		\$0
HV expenses within site (affiliation fees, curriculum fees)		\$923
Training		\$0
		Total Cost: \$42,004

Supervisor: 1 FTE First Year

Categories:	Calculated From:	Total Cost:
Annual Salary:	\$18.00 X hour	\$37,440
Benefits (Fringe and Health Insurance Stipend)	\$2,936	\$2,936
Travel Cost Annually 1,000 miles per IRS rate	\$.625	\$625
Computer Software		\$750
HV expenses within site (affiliation fees)		\$524
Training		\$950
		Total Cost: \$43,225

Supervisor : 1 FTE

Categories:	Calculated From:	Total Cost:
Annual Salary:	\$18.00 X hour	\$37,440
Benefits (Fringe and Health Insurance Stipend)	\$2,936	\$2,936
Travel Cost Annually 6,500 miles per IRS rate	\$.625	\$625
Computer Software		\$
HV expenses within site (affiliation fees)		\$524
Training		\$
		Total Cost: \$41,525
