title: Rural Health Transformation Grant Guide — Wisconsin version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary Wisconsin can leverage the Rural Health Transformation (RHT) Program to stabilize rural access, accelerate outcomes-focused care, and modernize digital infrastructure. RHT is a five-year, $50B CMS cooperative-agreement program for States (FY26–FY30) with one application window in 2025 and awards by December 31, 2025. Funds are split each year between an equal baseline share and a workload component based on State factors and technical performance; States must propose initiatives using at least three approved uses of funds. (cms.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Wisconsin with interoperable data platforms, statewide tele-emergency/ICU backstops, clinically validated remote monitoring, pharmacy-enabled chronic disease programs, and value-based payment analytics. These offerings map to RHT priorities on prevention, sustainable access, workforce, innovative care, and tech innovation (internal source: RHT Collaborative consensus brief).

Key high-leverage opportunities in Wisconsin include: (a) creating rural provider High Value Networks (HVNs) to pool resources and extend specialty access while maintaining local control; (b) deploying 24/7 tele-ER/tele-ICU and behavioral crisis coverage to protect essential services; (c) integrating retail pharmacy and community screening with remote physiologic monitoring for cardio-metabolic risk; and (d) implementing a TEFCA-enabled data fabric linked to WISHIN for outcomes reporting and program monitoring. These align to RHT's approved uses and the required evaluation framework. (sequoiaproject.org)

By combining Wisconsin's Medicaid managed-care footprint and permanent telehealth coverage policies (2025) with the Collaborative's technical stack and implementation support, the State is positioned to demonstrate measurable reductions in avoidable transfers, readmissions, and uncontrolled hypertension/diabetes among rural residents over 24–36 months, subject to contracting and integration. (dhs.wisconsin.gov)

One-page printable summary

- Program window (2025): Application due early November 2025; awards by December 31, 2025; $10B per year FY26–FY30; States only. (cms.gov)
- Highest-yield WI opportunities (examples):
  - Rural HVNs to coordinate service lines and value-based models (internal).
  - Tele-ER/ICU and behavioral crisis support statewide (internal).
  - Cardio-metabolic screening + RPM via pharmacies, community sites, and home (internal).
  - TEFCA-enabled exchange integrated with WISHIN; eClinicalWorks QHIN (Jan 2025). (sequoiaproject.org)
- Compliance anchors: ≥3 uses of funds; governor-designated lead; narrative + budget + attachments; reporting and evaluation per cooperative-agreement terms. (cms.gov)
- Illustrative 24-month impact targets (examples; to be finalized with WI data):
  - 20–30% reduction in low-acuity transfers from CAHs to distant tertiary centers using tele-ER/tele-ICU supports (internal evidence base + CMS program logic).
  - 10–15 mmHg average SBP reduction in enrolled uncontrolled hypertension cohort via pharmacist-led programs and RPM by month 18 (internal).
  - 15–25% improvement in 30-day transition-of-care follow-up using TEFCA-enabled alerts and pharmacy med-rec (internal + TEFCA QHIN designation).

2. Eligibility and RFP Fit 2.1 Program and eligibility summary

- Eligible applicant: One State agency/office designated by the Governor; DC/territories are ineligible. One official submission; latest on-time submission counts. (cms.gov)
- Timeline (2025): NOFO posted mid-September; application due early November; awards by December 31. Optional LOI recommended (not required). (cms.gov)
- Funding and distribution: $50B over FY26–FY30 ($10B/yr). 50% baseline equal split among approved States; 50% workload allocated by State factors and technical scoring per NOFO. (cms.gov)
- Approved uses: prevention/chronic disease; provider payments; consumer tech; training/TA for advanced tech; workforce recruitment/retention (≥5-year rural service); IT/cyber; right-sizing service lines; behavioral health/SUD; innovative/value-based models; other Administrator-approved uses. (cms.gov)

2.2 Application contents and checkpoints (per CMS overview/FAQ; details in NOFO)

- Required materials: State narrative with measurable outcomes, budget narrative, workplan/timeline, governor's endorsement, reporting commitments. (cms.gov)
- Cooperative-agreement oversight: regular reporting; strong CMS involvement; annual continuations. (cms.gov)

2.3 Requirement → Collaborative capability → Evidence (selected examples)

- Use of funds: prevention/chronic disease → Retail pharmacy outreach + RPM + AI-triage; BioIntelliSense wearables; community kiosks. Evidence: FDA-cleared BioButton; multi-language intake; pharmacy adherence programs.
- Workforce development → Tele-mentoring for rural clinicians, ambient documentation, CHW training modules. Evidence: Avel provider-to-provider telemedicine; Microsoft ambient AI; NACHC training.
- IT/cybersecurity → Azure-based security program for rural hospitals; data platforms; TEFCA connectivity via eClinicalWorks QHIN. Evidence: Microsoft rural hospital cybersecurity initiatives; eClinicalWorks QHIN (Jan 2025). (sequoiaproject.org)
- Service-line optimization/right-sizing → GrowthOS analytics, tele-specialty clinics, care-gap identification. Evidence: Accenture service-line modeling; Avel tele-specialty; Pangaea Data.

3. Wisconsin Context Snapshot Key metrics (latest available) and tie-ins:

- Rural/nonmetro population: 1,502,222 (25.5%) in nonmetro areas (ACS 2019–2023 5-year). 2023 update posted 9/11/2025. Implication: concentrate HVNs and pharmacy-RPM in Northern and Western counties. (ruralhealthinfo.org)
- Facilities: 58 CAHs; 143 RHCs; 47 FQHC organizations (rural-sited count); 25 short-term PPS hospitals in rural areas (2025). Implication: tailor tele-ER/ICU backstops to CAH clusters. (ruralhealthinfo.org)
- HPSA picture: HRSA dashboard (data as of 10/12/2025) shows widespread primary care/dental/mental health HPSAs across rural counties; March 31, 2025 quarterly summary indicates Great Lakes primary care shortfall persists (state-level examples show WI with ~165 primary care HPSAs; 1.33M residents in HPSAs). Implication: prioritize recruitment/retention pipeline and tele-behavioral supports. (data.hrsa.gov)
- Medicaid delivery: Most BadgerCare Plus members enroll in HMOs statewide (2025), enabling value-based arrangements with plan partners. (dhs.wisconsin.gov)
- Telehealth policy: Wisconsin transitioned from temporary to permanent Medicaid telehealth coverage effective June 1, 2023; ongoing policy updates maintain coverage for synchronous services and remote physiologic monitoring (2025). Implication: durable payment path for tele-enabled care. (forwardhealth.wi.gov)
- Maternal health: Wisconsin had 49 pregnancy-associated deaths in 2023 (state Maternal Mortality Review), similar to 2020–2022 levels. Wisconsin has not adopted the 12-month postpartum Medicaid extension as of 2025; policymakers continue to debate expansion beyond 60–90 days. Implication: target maternal-behavioral integration and community supports. (wpr.org)
- Behavioral health/SUD: 1,415 opioid overdose deaths in 2023 (state vital records), down from 1,459 in 2022; CDC shows age-adjusted drug overdose death rate ~30.6 per 100,000 in 2023 (no significant change vs. 2022). Implication: expand tele-behavioral and recovery supports statewide. (dhs.wisconsin.gov)
- Broadband: PSC goals include ≥97% of locations with ≥25/3 Mbps by 2025, and statewide BEAD deployment planning (2025). Gap pockets persist in rural counties; PSC projects near-universal coverage by ~2030. Implication: pair connectivity grants with RPM/telehealth rollouts. (psc.wi.gov)
- Rural hospital stress: HSHS Sacred Heart (Eau Claire) and St. Joseph's (Chippewa Falls) permanently closed March 22, 2024; a local cooperative is advancing interim reopening of St. Joseph's building (2025). Implication: prioritize right-sizing and networked emergency coverage. (hshs.org)
- Interoperability: eClinicalWorks designated as TEFCA QHIN (Jan 16, 2025), enabling statewide connectivity options for rural clinics; WISHIN participant base spans providers and public agencies. Implication: rapid path to exchange for RHT metrics. (sequoiaproject.org)

Table 1. Wisconsin rural context and matching Collaborative capability

- Rural/nonmetro share (25.5%, 2023 ACS) → HVNs + pharmacy-RPM cohorts in high-need counties. (ruralhealthinfo.org)
- 58 CAHs (2025) → Tele-ER/ICU and transfer-avoidance protocols. (ruralhealthinfo.org)
- HPSA shortages (2025) → Ambient documentation + tele-mentoring + compacts to expand supply. (data.hrsa.gov)
- Permanent Medicaid telehealth (2023–2025) → Scale tele-behavioral and RPM. (forwardhealth.wi.gov)
- TEFCA QHIN + WISHIN (2025) → Program dashboards, cross-setting alerts, evaluation data feeds. (sequoiaproject.org)

4. Strategy Aligned to RFP 4.1 Model overview

- Organize rural providers into HVNs that coordinate service lines, shared staffing, and capital planning; link CAHs, RHCs, FQHCs, and retail sites to regional hubs for emergency and specialty access (internal).
- Deploy statewide tele-ER/ICU, tele-pharmacy, and behavioral crisis response to reduce avoidable transfers and ED boarding (internal).
- Establish a TEFCA-enabled data layer to integrate WISHIN feeds, claims, and device data for outcomes and workload scoring; leverage eClinicalWorks QHIN (2025) to de-risk HIE onboarding.

(sequoiaproject.org)
- Embed pharmacy-led chronic disease and maternal risk programs with consumer screening (kiosks/ophthalmic AI), RPM, and care navigation to close cardio-metabolic gaps (internal).

4.2 Mapping to RHT pillars and scoring dimensions

- Prevention/Chronic disease: Community screening (AHA/Higi/Topcon), RPM (BioIntelliSense), and tele-check-ins (Avel/Teladoc); track BP/A1c improvements for workload points. Evidence (internal).
- Sustainable access: Tele-ER/ICU coverage and right-sizing analysis reduce transfers and stabilize local services (internal).
- Workforce: Ambient AI documentation and tele-mentoring mitigate burnout; compact-enabled licensure accelerates recruitment (external compact references). (psypact.gov)
- Innovative care/payment: Value tracking tools, VBP analytics, and ACO-compatible reporting (internal).
- Tech innovation/cyber: Azure security services for rural hospitals and TEFCA connectivity (2025). (sequoiaproject.org)

4.3 Equity strategy (rural and Tribal) Partner with FQHCs and Tribal/IHS sites to expand access points; deploy multi-language triage apps and community CHWs; prioritize counties with high overdose mortality and low broadband, using PSC/HRSA data to target investments. (psc.wi.gov)

4.4 Data use and privacy Adopt TEFCA participation via QHINs for treatment exchange; integrate WISHIN; apply HIPAA Security Rule controls and Microsoft cyber hardening; restrict AI features to audited datasets with consent workflows. (sequoiaproject.org)

5. Program Design Options (tailored for Wisconsin; each can be phased or combined) Option A—Rural High Value Networks with global budgets for essential services

- Target: CAHs/RHCs in North, Northwest, and Driftless regions.
- Problem: CAH financial fragility, ER coverage gaps, transfer dependency (2024 closures in Chippewa Valley). (hshs.org)
- Collaborative services: HVN formation (governance, pooled procurement), tele-ER/ICU, shared specialty clinics, GrowthOS modeling (internal).
- Payment logic: Global budgets for defined services; quality withhold tied to transfers/readmissions; compatible with Medicaid managed-care contracts.
- Enablers: No statewide CON program; approval processes exist but not a CON—facilitates right-sizing. (ncsl.org)
- Risks: Payer alignment; talent; broadband pockets. Mitigations: phased contracts, compacts, BEAD targeting. (wpr.org)

Option B—Statewide Tele-Emergency/ICU and Behavioral Crisis Grid

- Target: 58 CAHs and rural EDs (2025). (ruralhealthinfo.org)
- Services: 24/7 tele-ER/ICU, 988-linked crisis response, tele-pharmacy. (internal).
- Payment: PMPM per facility plus case-rates for escalations; Medicaid pays parity per permanent policy. (forwardhealth.wi.gov)

Option C—Pharmacy-enabled Cardio-Metabolic Control with RPM

- Target: Hypertension/diabetes patients in rural counties; maternal hypertension risk.
- Services: Retail pharmacy programs, kiosk/retina-based screening, RPM (BioButton), tele-coaching; multi-language triage. (internal).
- Payment: Combination of provider-payment use-of-funds (subject to cap) and plan incentives; track SBP/A1c outcomes.

Option D—Maternal and Behavioral Health Integration leveraging CCBHCs

- Target: Counties with higher maternal morbidity and SUD burden (2022–2023). (dhs.wisconsin.gov)
- Services: CCBHC network coordination, perinatal tele-psych, pharmacy-based depression screening, peer supports; address postpartum coverage gaps via State policy dialogue. (samhsa.gov)

6. Governance and Collaborative Roles 6.1 Structure

- State Lead Agency (Governor-designated): accountable for grant, policy, and cross-agency alignment; convenes Rural Health Steering Committee. (cms.gov)
- HVN Boards (regional): provider-led fiduciary bodies for initiative execution (internal).
- Data Trust: TEFCA QHIN participation agreements; WISHIN interop; analytics vendor.

6.2 RACI (selected)

- Strategy and NOFO compliance: State (R), CMS (A), Collaborative advisors (C), HVNs (I). (cms.gov)
- Tele-ER/ICU deployment: HVNs (R), Avel (C), hospitals (R), State (I) (internal).
- RPM program: HVNs (R), BioIntelliSense (C), clinics/pharmacies (R), State (I) (internal).
- Data & evaluation: State (A), QHIN/HIE (R), SI partners (C), providers (I). (sequoiaproject.org)

7. Payment and Funding 7.1 Funding paths consistent with RHT

- Mix of prevention/RPM, provider payments (subject to provider-payment cap), workforce, IT/cyber, and capital "minor alterations/equipment" (subject to capital cap). Program reporting annually. (cms.gov) 7.2 Budget guardrails (drawn from the draft NOFO details in the compressed spec; confirm on final NOFO)
- Example caps referenced: administrative ≤10% of period allotment; provider-payments share capped; capital/equipment share capped; EMR replacement and "tech catalyst" initiatives limited. Assumption noted (see Section 9.3 box). (cms.gov)

7.3 Illustrative cost categories (per $200M planning placeholder/year)

- Tele-ER/ICU grid + crisis services: $40–60M/yr; deliverables: facility coverage, KPIs.
- RPM + pharmacy cardio-metabolic program: $35–45M/yr; devices, staffing, outcomes tracking.
- Workforce/compacts/onboarding: $15–25M/yr; recruiting incentives with ≥5-year rural service; training. (cms.gov)
- Data/TEFCA/HIE/cyber: $25–35M/yr; QHIN participation, dashboards, cyber uplift. (sequoiaproject.org)
- Service-line optimization and minor capital/equipment: $25–35M/yr; analytics, equipment.
- Program management and evaluation: ≤10% admin. Assumption as above.

8. Data, Measurement, and Evaluation

- Core measures: access (local admissions retained; transfer rates), quality (30-day TOC follow-up), chronic disease (BP, A1c), behavioral (PHQ-9 change), maternal (post-delivery follow-up), utilization (ED visits/1000), financial (operating margin for essential services), technology (cyber posture). (cms.gov)
- Data sources: Medicaid/MA claims; QHIN exchange payloads; WISHIN event notifications; EHR extracts; pharmacy systems; RPM device data; EMS; vital stats. (sequoiaproject.org)
- Evaluation cadence: quarterly dashboards; annual continuation applications; CMS third-party evaluation collaboration. (cms.gov)

9. Implementation Plan 9.1 24-month Gantt-style plan (illustrative)

- Workstream; Start; End; Owner; Outputs
  - Governance & PMO; M1; M3; State; Charter, meeting cadence. (cms.gov)
  - Data Trust & TEFCA onboarding; M1; M9; QHIN/HIE; DSA, FHIR road map, dashboards. (sequoiaproject.org)
  - HVN formation; M1; M6; Providers/Cibolo; bylaws, pooled services.
  - Tele-ER/ICU coverage; M4; M18; Avel/Hospitals; go-lives, KPIs.
  - RPM + pharmacy programs; M4; M24; BioIntelliSense/Retail; cohorts active, outcomes.
  - Workforce recruitment & training; M3; M24; State/SI/NACHC; compacts onboarding.

9.2 Procurement/legal accelerators

- Utilize existing cooperative purchasing, standard BAAs/DPAs, and TEFCA Participant agreements to shorten onboarding; align with Medicaid managed-care contracts for value-based incentives. (sequoiaproject.org)

9.3 Assumptions and Open Questions (to validate against final NOFO)

- Scoring weights and specific caps (e.g., admin ≤10%, provider-payment %, capital %) are based on pre-release NOFO summaries; confirm final published terms. (cms.gov)
- CMS workload scoring formula and technical factor definitions will be confirmed at award; our workload targeting uses current CMS web guidance plus Wisconsin baselines. (cms.gov)
- CCBHC site list and Medicaid DSH hospital counts will be attached using WI DHS's most recent public lists as of Sep 1, 2025 and latest SPRY respectively (not included here due to length). (samhsa.gov)

10. Risk Register (selected)

- Broadband gaps impede RPM adoption (Owner: PSC/Providers). Mitigation: BEAD alignment; device caching; cellular fallbacks. (wpr.org)
- Tele-staffing shortages (Owner: HVNs). Mitigation: IMLC/eNLC/PsyPACT licensure pipelines; ambient documentation; stipends. (law.justia.com)
- Data-sharing delays (Owner: QHIN/HIE). Mitigation: TEFCA agreements; minimal-dataset pilots; phased onboarding. (sequoiaproject.org)

- Policy uncertainty (Owner: State). Mitigation: conditional scoring items sequenced; contingency budgets. (cms.gov)
- Rural facility closures (Owner: HVNs/State). Mitigation: tele-ER/ICU bridge capacity; EMS protocols. (hshs.org)
- Security incidents (Owner: Providers/IT). Mitigation: Azure cyber uplift; tabletop exercises; MFA. (internal).
- Postpartum coverage gaps (Owner: State/Medicaid). Mitigation: targeted maternal care bundles; explore SPA/waiver pathways. (wsaw.com)
- Program duplication with other funding (Owner: State PMO). Mitigation: duplication checks; SOPs; FFATA alignment. (cms.gov)
- RPM adherence variability (Owner: Clinics/Pharmacies). Mitigation: CHW follow-up; pharmacy touch-points. (internal).
- Value-based alignment with HMOs (Owner: Medicaid). Mitigation: actuarial modeling and shared measures. (dhs.wisconsin.gov)

11. Draft RFP Response Language (pasting scaffold; subject to State edits) 11.1 Project Summary (abstract) "Wisconsin proposes a Rural Health Transformation program that strengthens essential rural access through regional High Value Networks, a statewide tele-emergency and behavioral crisis grid, pharmacy-enabled cardio-metabolic control with remote monitoring, and a TEFCA-enabled data infrastructure integrated with WISHIN. The program addresses at least three approved uses of funds (prevention, workforce, IT/cyber; provider payments where appropriate), sets measurable outcomes (reductions in transfers/readmissions; improvements in BP/A1c and follow-up rates), and establishes a governance and evaluation framework under a State-led PMO." (cms.gov)

11.2 Rural Health Needs & Target Population (excerpt) "Approximately 25.5% of Wisconsinites live in nonmetro areas (ACS 2023), with 58 CAHs and 143 RHCs serving large rural geographies; HRSA designations indicate primary care, dental, and mental health HPSAs across many rural counties (2025). We prioritize Northern and Western counties with facility stress and broadband gaps, including communities affected by 2024 hospital closures." (ruralhealthinfo.org)

11.3 Goals & Strategies (excerpt) "Goals for FY26–FY31 include: reduce avoidable transfers from CAHs by ≥20%; improve 30-day TOC follow-up by ≥15%; reduce mean SBP by ≥10 mmHg among enrolled high-risk adults; improve postpartum follow-up within 12 weeks; deploy TEFCA-enabled exchange in ≥80% of participating sites. Strategies align to RHT pillars and leverage Collaborative partners for execution and analytics." (cms.gov)

11.4 Proposed Initiatives (excerpt; one initiative) "Statewide Tele-Emergency/ICU Network: Provide 24/7 tele-hospitalist/intensivist and behavioral crisis consults to 58 CAHs and affiliated EDs. Outcomes: 10% reduction in ED transfer rate; 15% decrease in 30-day readmissions for targeted DRGs; time-to-consult median <5 minutes by month 12." (internal evidence base).

11.5 Implementation & Timeline (excerpt) "Phased approach (Months 1–24): governance (M1–M3), data trust and TEFCA onboarding (M1–M9), first 20 CAHs live on tele-ER/ICU (by M12), RPM cohorts initiated in 25 counties (by M12), statewide scale (M24)." (sequoiaproject.org)

11.6 Stakeholder Engagement (excerpt) "Engage WHA, WPHCA, WISHIN, EMS councils, Tribal/IHS partners, health plans, and local governments; formalize HVN boards and consumer advisory panels." (wishin.org)

11.7 Metrics & Evaluation (excerpt) "Data sources: Medicaid claims, TEFCA exchange events, WISHIN alerts, EHR/RPM feeds. Quarterly dashboards; independent evaluation partner; compliance with CMS evaluation requirements." (cms.gov)

12. Checklists 12.1 Application completeness (grants.gov)

- SF-424, SF-424A, Project/Performance Site, SF-LLL (if applicable). (cms.gov)
- Narratives: Project (≤60 pp), Budget (≤20 pp), Summary (1 p), Business assessment, Program duplication assessment, Governor's letter. (cms.gov)
- Attachments: Indirect rate (if any), support letters, policy commitments (if pursued). (cms.gov)

12.2 Technical deployment readiness

- TEFCA participation path confirmed (QHIN + WISHIN agreements). (sequoiaproject.org)
- Security controls and audit plan. (internal).
- Tele-ER/ICU clinical protocols and privileging workflows. (internal).

13. References [1] Rural Health Transformation (RHT) Program — Overview, CMS, https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview, accessed 2025-10-14. (cms.gov) [2] RHT Program — Frequently Asked Questions, CMS, PDF, accessed 2025-10-14. (cms.gov) [3] RHT Program Overview Presentation (Aug 2025), CMS, PDF, accessed 2025-10-14.

(cms.gov) [4] eClinicalWorks designated as TEFCA QHIN (Jan 16, 2025), The Sequoia Project (RCE) news, accessed 2025-10-14. (sequoiaproject.org) [5] RHIhub Wisconsin State Profile (updated 9/11/2025), Rural Health Information Hub, accessed 2025-10-14. (ruralhealthinfo.org) [6] Wisconsin Medicaid BadgerCare Plus HMO information, DHS, accessed 2025-10-14. (dhs.wisconsin.gov) [7] Wisconsin Medicaid telehealth policy resources (permanent policy and 2025 updates), ForwardHealth/DHS, accessed 2025-10-14. (forwardhealth.wi.gov) [8] Wisconsin Maternal Mortality and morbidity resources; WPR coverage of 2023 pregnancy-associated deaths; DHS/MMRT pages, accessed 2025-10-14. (wpr.org) [9] Wisconsin drug overdose mortality (state WISH dashboard; CDC Health E-Stat 2022–2023 changes), accessed 2025-10-14. (dhs.wisconsin.gov) [10] PSC State Broadband Plan and news (2025), Wisconsin PSC; WPR reporting on 2030 broadband outlook, accessed 2025-10-14. (psc.wi.gov) [11] HSHS closures in Eau Claire and Chippewa Falls (closure information page; chamber releases 2025), accessed 2025-10-14. (hshs.org) [12] HPSA resources (HRSA Shortage Areas dashboard; state PCO pages), accessed 2025-10-14. (data.hrsa.gov) [13] Certificate of Need state status — Wisconsin (no CON; related moratoria/approvals), NCSL brief (updated Apr 29, 2025), accessed 2025-10-14. (ncsl.org) [14] WISHIN participant map, Wisconsin Statewide HIE, accessed 2025-10-14. (wishin.org) [15] Interstate compacts status — PsyPACT (Wisconsin enacted 2022), PSYPACT, accessed 2025-10-14; Nurse Licensure Compact overview, NCSBN. (psypact.gov) [16] Internal source: Rural Health Transformation Collaborative. R1. 10-11-25 (capabilities, members, roles), provided by the Collaborative (Oct 2025).

AI Generation Notice This guide was generated by the gpt-5 model on 2025-10-14. It incorporates internal materials (the Rural Health Transformation Collaborative consensus document) and public sources. All facts, figures, and citations should be independently validated against the final CMS Notice of Funding Opportunity (NOFO), State policy, and current data systems before use in any official submission.