title: Rural Health Transformation Grant Guide — Arizona version: 1.0 date: 2025-10-13 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary

Arizona can position its Rural Health Transformation (RHT) application to maximize both baseline and workload funding by aligning high-impact, evidence-supported initiatives with CMS's scoring framework and the State's existing managed-care and health IT assets. The Rural Health Transformation Collaborative (the Collaborative) brings interoperable technologies, tele-specialty services, value-based design, and program management that can support Arizona's priorities under the NOFO (CMS-RHT-26-001), including prevention and chronic disease, workforce development, innovative care models, and secure data infrastructure. The NOFO makes $50B available across FY26–FY30, with equal baseline distributions and competitive workload funds recalculated annually; application is due November 5, 2025. (files.simpler.grants.gov)

Arizona's starting point is strong: AHCCCS operates one of the nation's most mature Medicaid managed care models (since 1982) under a Section 1115 demonstration currently approved through September 30, 2027; a five-year renewal (2027–2032) is in development (2025). AHCCCS reports 1,971,674 members as of June 2025 and eight contracted managed care plans as of October 2024, with half of Arizona births covered by AHCCCS in CY2024. These features support population-scale implementations and value-based arrangements that the Collaborative can help actuarily model and operationalize. (azahcccs.gov)

For technical pillars, Arizona's statewide HIE (Contexture, formerly Health Current) reports more than 1,000 participating organizations and longitudinal data for 14M+ individuals (2025), while eClinicalWorks' PRISMANet became a TEFCA-designated QHIN in January 2025—enabling nationwide exchange. These assets can be combined with Arizona's BEAD broadband program ($993M) to extend secure telehealth and remote monitoring across rural and frontier areas. (azahcccs.gov)

Near-term, the Collaborative's capabilities that offer outsized impact for Arizona include: 1) a rural virtual-specialty network (tele-ER/ICU/behavioral) via Avel eCare; 2) continuous remote physiologic monitoring for high-risk chronic disease using FDA-cleared wearables; 3) pharmacy-anchored prevention and chronic care workflows with retail partners; and 4) cybersecurity uplift for rural hospitals through widely adopted programs such as Microsoft's rural hospital cybersecurity initiative. These map directly to NOFO allowed uses and caps, while addressing Arizona's workforce shortages and access gaps. (avelecare.com)

One-page printable summary

- Funding and timing (NOFO): $50B (FY26–FY30); LOI optional by Sep 30, 2025; application due Nov 5, 2025; award by Dec 31, 2025; baseline equals 50% of each period, workload equals 50% based on rural/technical factors; admin cap 10%. (files.simpler.grants.gov)
- High-leverage Arizona fit (2025): 1.97M AHCCCS members; eight MCOs; statewide HIE >1,000 orgs; TEFCA QHIN available; BEAD $993M to close rural broadband gaps. (azahcccs.gov)
- Priority initiatives the Collaborative can support:
  - Rural virtual-specialty and crisis response (Avel eCare) for emergency, ICU, behavioral, EMS. (avelecare.com)
  - Remote monitoring for heart failure/diabetes using BioButton (FDA 510(k) K241101). (accessdata.fda.gov)
  - Pharmacy-enabled prevention and chronic disease management; workforce upskilling.
  - Cybersecurity uplift for rural hospitals (550+ participants Feb 2025; 700+ by Jul 2025). (techtarget.com)
- Compliance anchors: provider-payment cap ≤15%; capital/infrastructure cap ≤20%; EMR replacement cap ≤5% in certain cases; special limits for "Rural Tech Catalyst Fund"-like initiatives (≤10% or $20M). (files.simpler.grants.gov)

2. Eligibility and RFP Fit

2.1 Summary of NOFO requirements (selected)

- Eligible applicants: only the 50 U.S. States; DC and territories ineligible. Governor designates lead agency; AOR signature required. One application per State; latest on-time submission prevails. (2025) (files.simpler.grants.gov)
- Key dates: optional LOI by Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; expected awards/earliest start Dec 31, 2025. (2025) (files.simpler.grants.gov)
- Funds distribution and scoring: 50% baseline (equal split) and 50% workload. Workload points include rural facility/population and technical factors; rural component set once using Q4 2025 data; technical recalculated each period from required reporting. (2025) (files.simpler.grants.gov)
- Conditional points for State policy actions (B-factors): conditional credit in Year 1; policies must be enacted by Dec 31, 2027 (Dec 31, 2028 for B.2 and B.4) or points drop to zero and CMS recovers associated funds. (2025) (files.simpler.grants.gov)

- Caps and limits: provider payments ≤15% (category B), capital/infrastructure ≤20% (category J), EMR replacement ≤5% when a HITECH-certified EMR existed on 9/1/2025, and "Rural Tech Catalyst Fund"-like initiatives ≤10% or $20M per period. (2025) (files.simpler.grants.gov)
- Administrative expenses: ≤10% of award per budget period (includes indirects). (2025) (files.simpler.grants.gov)
- SF-424: check "No" for EO 12372 Item 19c. (2025) (files.simpler.grants.gov)

2.2 Requirements → Collaborative capabilities → Evidence

- Prevention & chronic disease (Use A): Consumer screening, RPM, and virtual consults supported by pharmacy and telehealth partners; BioIntelliSense device supports continuous vitals. Evidence: FDA 510(k) K241101 (2024); collaborative catalog. (accessdata.fda.gov)
- Innovative care/value-based models (Use I): Design of rural HVNs and ACO/shared-savings constructs with analytics (Cibolo Health + integrators). Evidence: collaborative governance/HVN model.
- Workforce (Use E): Tele-mentoring, ambient documentation, pharmacist-driven services/training. Evidence: collaborative workforce sections.
- Technology/cybersecurity (Use F): Cloud data platforms and hospital cyber uplift programs with broad rural adoption in 2025; TEFCA QHIN connectivity. Evidence: Microsoft rural hospital program, eClinicalWorks QHIN. (blogs.microsoft.com)
- Tele-ER/ICU/behavioral/EMS (Use F/G/H): Avel eCare service lines and crisis care model used by law enforcement; Joint Commission ambulatory accreditation (2024). (avelecare.com)
- Data interoperability: HIE participation statewide; PRISMANet QHIN; TEFCA exchange growth in 2025. Evidence: Contexture and Sequoia Project. (azahcccs.gov)

3. Arizona Context Snapshot (2024–2025)

Highlights

- Rural population share: 10.7% (2020 Census). This positions Arizona's rural share below many states, increasing the importance of right-sizing facilities and optimizing regional networks. (ncsl.org)
- Rural facilities: 17 Critical Access Hospitals (CAHs) and about 55 Rural Health Clinics; 26 health center systems and ~185 FQHC sites (2025). Collaborative tele-specialty and RPM can extend capacity and reduce transfers. (crh.arizona.edu)
- HIE/Interoperability: Contexture maintains EHR/HIE data for 14M+ individuals and >1,000 organizations (2025). TEFCA QHIN designation (eClinicalWorks) supports nationwide exchange. (azahcccs.gov)
- AHCCCS Medicaid: 1.97M covered (June 2025); eight MCOs; "1 in 2" births covered in CY2024—suggesting high leverage for chronic-disease and maternal initiatives. (azahcccs.gov)
- HPSA indicators (Mar 31, 2025): Primary Care HPSAs—215 designations, 2.29M residents in HPSAs, ~493 practitioners needed; Dental HPSAs—207 designations, 2.05M residents, ~339 dentists needed. These underscore the need for telehealth and pharmacist-enabled care models. (commentary.healthguideusa.org)
- Broadband: BEAD allocation $993.1M (state's largest broadband investment; 2024–2025 planning and 2025 Final Proposal submitted). (azcommerce.com)
- Cybersecurity readiness: Microsoft rural hospital program reported ~550 participants as of Feb 2025, rising to 700+ by mid-2025. This helps de-risk digital expansion in rural hospitals. (techtarget.com)

Table — Arizona metrics and matched Collaborative capabilities

- Rural share (2020): 10.7% → Tele-specialty and RPM to reach sparse geographies. (ncsl.org)
- CAHs (2025): 17 → Avel eCare tele-ER/ICU and EMS support. (crh.arizona.edu)
- RHCs (2025): ~55 → Contexture HIE fee waivers for CAHs/RHCs; Collaborative analytics. (contexture.org)
- FQHC sites (2025): ~185 → Pharmacy/FQHC chronic care and RPM integration. (crh.arizona.edu)
- HPSA primary care need (3/31/2025): ~493 clinicians → Tele-mentoring; ambient documentation; pharmacist scope optimization. (commentary.healthguideusa.org)
- AHCCCS enrollment (Jun 2025): 1.97M; eight MCOs → Value-based models and claims analytics support. (azahcccs.gov)
- Interop: TEFCA QHIN (2025) and Contexture statewide network → Data exchange for reporting and evaluation. (sequoiaproject.org)
- Broadband (2025): BEAD $993.1M; State Navigator Map and Final Proposal under review → Telehealth footprint expansion and device connectivity. (azcommerce.com)

Assumptions and Open Questions

- Frontier designations: Arizona includes frontier census tracts across multiple northern and western counties; specific 2025 FAR tract counts should be confirmed with HRSA/USDA prior to final targeting. (hrsa.gov)

- Maternal mortality: most recent Arizona-specific 2024/2025 MMRC rates should be pulled from ADHS dashboards before submission; statewide “1 in 2 births covered by AHCCCS in CY2024” is confirmed. (azahcccs.gov)
- Telehealth statute details (e.g., HB2454) and licensure compacts (IMLC, NLC, PSYPACT) should be verified with State counsel for 2025 statuses prior to claiming related technical points.

4. Strategy Aligned to RFP

4.1 Program theory of change for Arizona

- Stabilize rural access and outcomes through: 1) statewide virtual specialty coverage (ER/ICU/behavioral/EMS) to reduce avoidable transfers; 2) longitudinal chronic-disease monitoring for high-risk Medicaid and duals populations; 3) pharmacy-enabled prevention and medication management; and 4) secure data infrastructure to drive measurement and value-based contracts. The model maps to NOFO uses A, D, F, G, H, I, J and technical scoring factors across B–F. (files.simpler.grants.gov)

4.2 Evidence links to NOFO pillars and points

- Tele-ER/ICU/behavioral: Avel eCare provides 24/7 services and law-enforcement crisis response used across multiple counties; ambulatory accreditation (2024). Supports C.2 (EMS), H (behavioral/SUD), F.1 (remote care). (avelecare.com)
- RPM for chronic disease: BioButton System (K241101, 2024) supports continuous biometrics for home-to-hospital care; Collaborative provides implementation toolkits. Supports B.1/B.2 (population health/health & lifestyle), F.1/F.2/F.3 (remote/data/consumer tech). (accessdata.fda.gov)
- Pharmacy/retail activation: Walgreens/CVS programs for adherence, MTM, and virtual engagements; workforce pipelines. Supports D.1 (talent), E.1 (Medicaid payment incentives via team-based care), and prevention goals.
- Interoperability and TEFCA: PRISMANet QHIN designation (Jan 2025) enables cross-network exchange to power evaluation reporting and care coordination. (sequoiaproject.org)
- Cybersecurity uplift: Microsoft rural hospital program reports ~550 participating hospitals by Feb 2025, 700+ by July 2025—supports resilient telehealth rollout and NOFO’s cybersecurity emphasis. (techtarget.com)

4.3 Equity strategy for rural and Tribal communities

- Combine virtual-specialty coverage, CHW/tribal liaison workflows, language-capable intake and engagement tools, and pharmacy access in rural towns. The Collaborative’s consumer-facing and multilingual triage tools can support culturally relevant navigation and reduce digital barriers.

4.4 Data use and privacy

- Use Arizona HIE and TEFCA QHIN exchange for clinical, claims, and EMS data; apply role-based access, audit logging, and 2-CFR/HHS GPS requirements; implement a cybersecurity plan when accessing HHS systems/PII/PHI (required post-award). (files.simpler.grants.gov)

5. Program Design Options (Arizona-tuned)

5.1 Option A: Rural Virtual Specialty Network (primary recommendation)

- Target population: Rural residents served by 17 CAHs and ~55 RHCs; EMS and law enforcement in rural counties (2025). (crh.arizona.edu)
- Problem: High transfer rates and limited on-call specialty coverage.
- Services/partners: Avel eCare tele-ER/ICU/behavioral; crisis care for law enforcement; EMS tele-support; HIE integration; Viz-enabled stroke triage if pursued. (avelecare.com)
- Payment logic: Shared-savings tied to reduced transfers/LOS; facility stabilization via Medicaid incentives (E.1); adherence to NOFO caps (e.g., ≤20% capital for tele-ICU rooms; ≤15% for any direct provider payments). (files.simpler.grants.gov)
- Pros/risks: Rapid access gains; dependency on broadband/cyber readiness (mitigated via Microsoft program; BEAD deployments). (blogs.microsoft.com)

5.2 Option B: Statewide RPM for High-Risk Chronic Disease (backup priority)

- Target population: AHCCCS high-risk cohorts (e.g., CHF/COPD/diabetes) and duals.
- Services: BioButton-based RPM + pharmacist MTM; TEFCA-enabled data flow. (accessdata.fda.gov)
- Payment: Per-member-per-month for device/monitoring; quality incentives for BP/A1c control; analytics for ROI and readmission reduction.
- Pros/risks: Preventive impact; device logistics and patient engagement—mitigated via retail pickup and CHW support.

5.3 Option C: Rural Maternal and Behavioral Integration

- Target: Perinatal and behavioral health needs in rural and tribal communities; leverages AHCCCS "1 in 2 births" coverage. (azahcccs.gov)
- Services: Tele-MFM consults, pharmacy BP management, crisis care routing via Avel, and postpartum RPM pathways.
- Payment: Value-based bundles with postpartum metrics and depression screening.

5.4 Option D: Data Modernization and Cyber Resiliency

- Target: Rural hospitals and clinics participating in HIE and TEFCA.
- Services: Cloud data platform build, HIE connectors, quality dashboards, and cybersecurity uplift.
- Payment: Capital ≤20% for minor renovations/equipment; training/TA; no construction; compliance with 2 CFR 200.216. (files.simpler.grants.gov)

6. Governance and Collaborative Roles

6.1 Governance diagram (text)

- State (Lead Agency designated by Governor): strategy, policy, award management, subrecipient oversight, reporting to CMS.
- AHCCCS: alignment with managed care and 1115 authorities; SPA/contractual levers for incentives.
- Contexture (HIE): data exchange, interfaces, and analytics feeds.
- Provider networks (CAHs/FQHCs/RHCs) and payers: initiative execution and value-based participation.
- The Collaborative: technical integration, tele-specialty coverage, RPM, pharmacy activation, analytics, workforce training, and economic modeling.

6.2 RACI (illustrative)

- R (Responsible): Collaborative partners for tele-care operations, RPM deployment, analytics build; State PMO for grants management.
- A (Accountable): State lead agency; AHCCCS for Medicaid alignment.
- C (Consulted): Hospital association, AZ Center for Rural Health, Contexture, payers, Tribes.
- I (Informed): Local health departments, EMS, community organizations.

7. Payment and Funding

- Funding model must honor NOFO caps: provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5% when criteria met; Rural Tech Catalyst-like initiatives ≤10% or $20M. Administrative ≤10% overall. (All 2025.) (files.simpler.grants.gov)
- Medicaid alignment: AHCCCS operates under 1115 authority (through 9/30/2027) with integrated managed care; renewal underway for 2027–2032. The Collaborative can support actuarial impact modeling, SPA language drafting where needed for incentives, and payer engagement. (azahcccs.gov)

Illustrative cost categories and sources (ROM, to be refined in budget narrative)

- Tele-ER/ICU buildout and service fees: Use F/G; funding source RHT (≤20% capital for room retrofits). Deliverable: coverage schedule and quality metrics. (files.simpler.grants.gov)
- RPM devices and monitoring: Use A/F; deliverables: enrollment, alert volumes, outcomes.
- Pharmacy-enabled prevention: Use A/E; deliverables: MTM volumes, adherence improvements.
- Cybersecurity uplift: Use F; deliverables: assessments, MFA rollout, training completions. (blogs.microsoft.com)
- Data platform/HIE connectors: Use F; deliverables: interfaces live, reporting suite.

8. Data, Measurement, and Evaluation

- Core measures: hospital transfer rates, ED utilization, readmissions, chronic-disease control (A1c/BP), maternal outcomes, behavioral crisis diversions, and technology adoption/cyber readiness. The NOFO's annual recalculation of technical score requires timely reporting tied to cooperative-agreement milestones. (2025) (files.simpler.grants.gov)
- Data sources: Contexture HIE feeds, TEFCA exchange via PRISMANet, AHCCCS claims, EMS and law-enforcement integrations (for crisis care), pharmacy systems, and provider EHRs. (azahcccs.gov)
- Privacy/security: HHS GPS, 2 CFR parts 200/300, and cybersecurity plan requirement if using HHS systems/PII/PHI. (2025) (files.simpler.grants.gov)
- Independent evaluation readiness: CMS may conduct third-party evaluations; the Collaborative's analytics partners can generate initiative-level "Full Score Potential" (FSP) artifacts for merit review, tying to Table 2 categories. (2025) (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; illustrative)

Gantt-style table (dates relative to award date Dec 31, 2025)

- Workstream | Start | End | Owner | Outputs
- PMO stand-up and compliance (NOFO terms) | Jan 2026 | Feb 2026 | State PMO | Workplan, reporting calendar. (files.simpler.grants.gov)
- HIE/TEFCA integration sprints | Jan 2026 | Jun 2026 | Contexture + eClinicalWorks | Interfaces live; data QA. (azahcccs.gov)
- Tele-ER/ICU and crisis care rollout (wave 1 CAHs) | Feb 2026 | Sep 2026 | Avel eCare + CAHs | Coverage schedules; clinical protocols. (avelecare.com)
- RPM cohort onboarding (CHF/diabetes) | Mar 2026 | Dec 2026 | BioIntelliSense + FQHCs/RHCs | Enrollment; dashboarding. (accessdata.fda.gov)
- Pharmacy-enabled prevention pilots | Mar 2026 | Nov 2026 | Retail partners + FQHCs | MTM volumes; BP/A1c control.
- Cybersecurity assessments/training | Jan 2026 | Oct 2026 | Microsoft + hospitals | Assessment reports; MFA, E5 security. (blogs.microsoft.com)
- Policy action tracking (B-factors) | Jan 2026 | Dec 2027/2028 | State policy team | Enactments to secure points. (files.simpler.grants.gov)
- Evaluation and FSP updates | Jun 2026 | Nov 2026 | State + Collaborative | NCC package; workload recalculation. (files.simpler.grants.gov)

10. Risk Register (selected)

- Broadband/cyber gaps delay telehealth scale; Mitigation: align with BEAD deployments; use Microsoft program for rapid uplift; Owner: State Broadband Office + hospitals. (azcommerce.com)
- Workforce shortages persist; Mitigation: tele-mentoring, ambient documentation, pharmacist teams; Owner: Providers + Collaborative.
- Data-sharing delays; Mitigation: TEFCA QHIN participation; Owner: HIE + EHR vendors. (sequoiaproject.org)
- Failure to finalize State policy actions by deadlines reduces points and triggers recoveries; Mitigation: policy workplan with 2027/2028 checkpoints; Owner: State policy leads. (files.simpler.grants.gov)
- Provider-payment and capital spend exceed caps; Mitigation: budget guardrails and pre-award reviews; Owner: PMO; Reference: NOFO caps. (files.simpler.grants.gov)
- Construction scope creep; Mitigation: strict adherence to “no new construction” and minor renovations only; Owner: Facilities; Reference: NOFO unallowables. (files.simpler.grants.gov)
- Reporting slippage affecting workload recalculation; Mitigation: automated dashboards; Owner: PMO + analytics. (files.simpler.grants.gov)
- Privacy/security incidents; Mitigation: cybersecurity plan; Owner: State + covered entities. (files.simpler.grants.gov)
- Vendor onboarding delays; Mitigation: pre-negotiated statewide vehicles; Owner: Procurement.
- Community adoption barriers; Mitigation: CHW support, multilingual tools; Owner: Providers + community orgs.

11. Draft RFP Response Language (Arizona-tailored; paste-ready)

11.1 Rural health needs and target population (excerpt) “Arizona’s rural population was 10.7% in 2020, with critical access concentrated across 17 CAHs and ~55 Rural Health Clinics. As of June 2025, AHCCCS covers 1,971,674 residents, including approximately one-half of births in CY2024. The State faces documented primary care and dental HPSA shortfalls (Mar 31, 2025), reinforcing the need for tele-enabled care, pharmacist-supported chronic disease management, and virtual specialty coverage.” (ncsl.org)

11.2 Goals, strategies, and State policy actions (excerpt) “Arizona proposes a Rural Virtual Specialty Network (tele-ER/ICU/behavioral/EMS) and a scalable RPM program for heart failure and diabetes, leveraging Contexture HIE and TEFCA exchange for measurement. The State will evaluate legislative/regulatory updates aligned to NOFO technical factors, with a plan to finalize by Dec 31, 2027 (Dec 31, 2028 for factors B.2/B.4), consistent with the conditional points framework.” (files.simpler.grants.gov)

11.3 Proposed initiatives and uses of funds (excerpt) “Initial uses span A, D, F, G, H, I, and J, with budget guardrails meeting NOFO caps: provider payments ≤15% of the annual award; capital/infrastructure ≤20%; EMR replacement ≤5% when criteria met; administrative costs ≤10%.” (files.simpler.grants.gov)

11.4 Implementation plan and timeline (excerpt) “Wave 1 (first 9 months) activates tele-ER/ICU in five CAHs and crisis care in three rural law-enforcement jurisdictions, enrolls 2,000 high-risk members in RPM, and executes cybersecurity assessments across 10 hospitals, with NCC reporting aligned ~60 days before period end.” (files.simpler.grants.gov)

11.5 Metrics & evaluation (excerpt) “We will report quarterly on access, utilization, and outcomes (e.g., transfer

rates, A1c/BP control, behavioral crisis diversions, readmissions), using HIE and TEFCA exchange to ensure completeness and timeliness. We will cooperate with CMS and any third-party evaluators." (sequoiaproject.org)

12. References

1. Rural Health Transformation (RHT) Program — Notice of Funding Opportunity CMS-RHT-26-001 (PDF), CMS, posted Sep 15, 2025. https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (accessed Oct 14, 2025). (files.simpler.grants.gov)

2. Rural Health Transformation (RHT) Program overview page, CMS, last modified Sep 26, 2025. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (accessed Oct 14, 2025). (cms.gov)

3. AHCCCS 1115 Demonstration Waiver (current approval and 2027–2032 renewal materials), AHCCCS, updated 2022–2025. https://www.azahcccs.gov/Resources/Federal/waiver.html and /waiverrenewalrequest.html (accessed Oct 14, 2025). (azahcccs.gov)

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10. Contexture HIE — Arizona HIE program pages (participants; history), 2023–2025. https://contexture.org/... and AHCCCS HIT/HIE page. (accessed Oct 14, 2025). (azahcccs.gov)

11. TEFCA QHIN designation — eClinicalWorks PRISMANet, Jan 16, 2025; Sequoia Project RCE news. (accessed Oct 14, 2025). (sequoiaproject.org)

12. Arizona BEAD Program — State Broadband Office, 2025 Final Proposal pages. https://www.azcommerce.com/broadband/initiatives/bead/ (accessed Oct 14, 2025). (azcommerce.com)

13. Microsoft Cybersecurity for Rural Hospitals updates (2025), Microsoft On The Issues and third-party summaries. (accessed Oct 14, 2025). (blogs.microsoft.com)

14. Avel eCare services and crisis care model; Joint Commission ambulatory accreditation (2024). https://www.avelecare.com (accessed Oct 14, 2025). (avelecare.com)

15. BioIntelliSense BioButton FDA 510(k) K241101 (Sep 26, 2024), FDA. https://www.accessdata.fda.gov/.../K241101 (accessed Oct 14, 2025). (accessdata.fda.gov)

16. Rural Health Transformation Collaborative consensus document (internal catalog of capabilities and roles), R1, dated Oct 11, 2025 (accessed Oct 14, 2025).

13. AI Generation Notice

This guide was generated by the gpt-5 model on 2025-10-13 using a combination of Arizona-specific public sources and the Rural Health Transformation Collaborative's internal catalog. It is intended as analytical guidance only. All facts, figures, and citations must be independently validated against primary sources (including the CMS NOFO, AHCCCS documentation, HRSA datasets, and Arizona statutes) before use in any official submission.