April 1, 2026

TO: ALL OFFERORS

FROM: Rick Williamson
Management Analyst III

SUBJECT: ADDENDUM TO INVITATION TO BID – HSS 26-062 Rural Community Health Hubs

ADDENDUM #1

All other terms and conditions remain the same.

If you have any questions, please contact me at Ricky.Williamson@delaware.gov

VENDOR QUESTIONS
RFP HSS-26-062: RURAL COMMUNITY HEALTH HUBS
Date: 2/27/26

Q1) With regard to the RFP HSS26062-RURALCHHUB, on page 6 of the RFP it states: 2.1 Provide evidence-based screenings for cancer, diabetes, hypertension, HIV, and other chronic conditions.
Is a respondent expected to provide screenings for each of the conditions named, or will a response be considered adequate of not all of the screenings are part of respondent's plan? And are screenings first level assessments of individuals to determine which individuals warrant further attention with testing?
A1) The respondent is not expected to provide screenings for each condition; however, the proposal should clearly list each screening that will be provided.
Yes. Screenings are considered first-level assessments used to identify individuals who may require additional evaluation, diagnostic testing, or referral for further care.

Q2) Are all questions submitted to this portal made public after review by the Project Owner?
A2) All questions and their subsequent answers will be posted for public review in Bonfire and on GSS website.

Q3) The RFP requests a budget and detailed budget narrative; therefore, what is the funding amount ceiling that can be requested for one project - either mobile or brick and mortar?
A3) There is no funding ceiling for budget requests; however, the submitted budget should align with the costs necessary to implement all elements of the proposal.

Q4) For Component B, may funds be used to support operations of a comprehensive health center that is located within or in close proximity to community resources, provided the center is able to deliver the majority of the preferred services outlined in the RFP?
A4) For Component B, proposals should demonstrate that services primarily serve residents of rural areas. Vendors may propose operational models that align with the requirements outlined in Appendix B, Component B.

Q5) Under Component B, are minor renovations and construction (e.g., facility improvements necessary to deliver services) considered an allowable use of funds?
A5) Per federal RHTP guidance, new construction and major building expansions are unallowable. Minor alterations and renovations are allowed if they are clearly linked to program goals, such as facility improvements and interior modifications within existing facilities. Vendors should detail any proposed renovations in their proposal.

Q6) Under Component B, are equipment purchases, technology, and basic office furniture included as allowable costs?
A6) Equipment purchases, technology, and basic office furniture are generally allowable costs under RHTP guidance, provided they are necessary and allocable to the program. Vendors should detail all equipment and supply costs in their proposal.

Q7) Does Component B require services to be co-located within an existing community space (e.g., a community center), or would a standalone site be eligible if it meets programmatic requirements?
A7) For Component B, services are not required to be co-located within an existing community space.

Q8) Under Component A, may funds be used to purchase a passenger vehicle to support transportation of outreach staff to community-based locations and/or to assist individuals in accessing primary care appointments?
A8) For Component A, proposals that include a van for client transportation services may be considered.

Q9) Given the extended procurement and build timeline for mobile health units, may a contractor use Year 1 funds under Component A to purchase or order a mobile health unit that would become operational in Year 2?
A9) For Component A, proposals to secure a mobile unit with acquisition spanning two budget years (Year 1 and Year 2) may be considered.

Q10) Is there a limit to the number of Mobile Health Units that a contractor can purchase under this grant opportunity?
A10) There is no limit to the number of mobile units that may be requested in a proposal.

Q11) May Component A funds be used to support community engagement incentives intended to build trust and increase participation in services? Are there any unallowable costs associated with those engagement activities that we need to be aware of?
A11) Community engagement activities may be an allowable use of funds. Per RHTP guidance, the use of patient incentives to engage in preventive healthcare or treatment will be assessed on a case-by-case basis. Vendor should clearly describe why the incentive is needed, how it supports program goals, and how it will be sustainable.

Q12) With respect to the mobile unit deliverables, is the expectation that each awarded contractor operates four mobile units, or is this the collective total across all funded contractors?
A12) The outcome in Appendix B to deploy a minimum of four new mobile units by Year 2 is a program-level target, not necessarily a per-vendor requirement. If multiple vendors are awarded, individual vendor targets will be established during contract negotiations based on the scope of each award. Vendors should propose a deployment plan that includes the number of new mobile units they will deploy.

Q13) Regarding the target of 1,500 encounters by Year 3, is this performance benchmark expected per contractor, or is it a cumulative goal across all contractors annually? Is it an annual total of 1,500 encounters or is that culminative over a 3-year period?
A13) The outcome in Appendix B to deliver a minimum of 1,500 mobile health encounters annually by Year 3 is a program-level target, not necessarily a per-vendor requirement. If multiple vendors are awarded, individual vendor targets will be established during contract negotiations based on the scope of each award. Vendors should propose a service delivery plan that meaningfully contributes to program level outcomes.

Q14) With the focus on serving in rural areas, how will this be defined? HRSA identifies rural areas; however, only one small area in Kent County is identified. Also, can a brick and mortar location be not in a rural area but accessible to transportation options?
A14) Official federal guidance and definitions will be used to identify and designate Delaware's official rural areas.
Yes. A brick and mortar location does not have to be physically located within a rural area, provided the services are accessible to rural residents and the proposal clearly demonstrates how the location will effectively serve the target rural population, including through transportation access or other strategies that reduce barriers to care.

Q15) The RFP includes Appendix B- Scope of Work, which outlines metrics (pages 55-56) such as below for mobile health units and the brick and mortar hub. Are these metrics to be met by each vendor selected OR is it the program as a whole?

- Deploy ≥ 4 new mobile health units by Year 2
- Deliver ≥ 1,500 mobile health encounters annually by Year 3
- Ensure ≥ 70% of services occur in high-need or high-SVI census tracts
- Provide ≥ 800 telehealth visits annually
- Connect ≥ 1,000 new patients annually to care via mobile and telehealth services
- Establish or expand hubs in rural communities by Year 2
- Deliver 1,500 patient encounters annually through hub-based services
- Ensure ≥ 70% of services reach high-SVI areas or priority populations
- Provide telehealth and care coordination to supplement in-person services
- Connect ≥ 1,000 new patients annually to ongoing care through hubs

A15) The metrics outlined in Appendix B are intended to be achieved by the Rural Health Hub program as a whole. Vendors will contribute to meeting these overall program goals through their proposed services and activities.

Q16) Are the minimum or maximum expectations for the bid amount?
A16) There are no minimum or maximum expectations for the bid amount.

Q17) If multiple vendors are awarded across components or geographies, does DPH anticipate designating or supporting a statewide coordinating framework to ensure standardized data reporting, referral governance, and performance alignment across vendors?
A17) If multiple vendors are awarded contracts, DPH will provide requirements and expectations designed to standardize data reporting, referral governance, and performance alignment across the program. Vendors will be responsible for complying with these requirements.

Q18) To ensure the desired clinical integration between Component A (Mobile) and Component B (Hubs), does DPH have a preference for vendors who propose a unified clinical governance and shared infrastructure model over independent component operators?
A18) To ensure the desired clinical integration between Component A (mobile) and Component B (hub), DPH will consider each proposal based on its merits and how well it aligns with the performance expectations of the program.

Q19) Is DPH open to a centralized telehealth backbone supporting both mobile units and hubs (including specialty consults and after-hours coverage), provided integration with DHIN and partner systems is maintained?
A19) A centralized telehealth backbone supporting both mobile units and hubs, or integration with the DHIN, is not required; however, such elements may be considered based on the merits of the proposal and its alignment with overall program goals.

Q20) Given that DPH identifies Remote Patient Monitoring (RPM) as a potential revenue stream for long-term sustainability, will DPH provide specific clinical protocols or minimum functional requirements for RPM tools intended for chronic disease and maternal health management?
A20) Yes. DPH will provide both clinical protocols and minimal functional requirements for RPM tools used in chronic disease and maternal health management.

Q21) Does DPH envision supporting or facilitating a centralized referral tracking infrastructure across components, or should vendors assume responsibility for building independent closed-loop systems?

A21) DPH will provide guidance regarding the requirements for referral tracking across components.

Q22) Does DPH anticipate full operational cost recovery through reimbursement within the initial contract year, or is a phased sustainability ramp over the base and option years acceptable as patient volumes mature?
A22) DPH anticipates that cost recovery will occur gradually over the base and option years as patient volumes increase; full operational cost recovery in the initial contract year is not expected.

Q23) Does DPH anticipate awarding one vendor to deliver both Component A and Component B, or is DPH open to separate awards by component even if a vendor proposes both?
A23) DPH will evaluate all proposals and may award one or multiple vendors as necessary to achieve the goals of the overall programs. Vendors may propose work for one or both components.

Q24) If multiple vendors are awarded (by component or geography), how does DPH envision coordination and avoidance of duplication being operationally governed?
A24) DPH is committed to ensuring that mobile units and brick-and-mortar hubs enhance statewide access and do not duplicate existing services. The potential for duplication will be considered during the proposal review, and DPH will work with awarded vendors to coordinate activities and operationalize collaboration as needed throughout the contract period.

Q25) Will DPH define exclusive service territories or priority ZIP codes per awarded vendor, or should vendors assume overlapping operational areas with coordination requirements?
A25) DPH will not define exclusive territories, other than ensuring programs operate within officially designated federally identified rural areas. Vendors should assume that operational areas may overlap and be prepared to coordinate with other vendors to ensure services complement one another and avoid duplication.

Q26) Does DPH expect all required service lines (primary care, behavioral health, SUD treatment, maternal/pediatric, dental, specialty care) to be continuously available on each mobile unit, or is a rotational / scheduled service-line model acceptable?
A26) DPH does not expect all required service lines (including primary care, behavioral health, STD treatment, maternal care, pediatric care, dental services, and specialty care) to be continuously available on each mobile unit. Proposals should identify what services will be available and on what days and times.

Q27) For dental services, does DPH anticipate:
- Fully equipped dental-capable mobile units,
- Modular/rotating dental days,
- Or referral-based dental care with documented closed-loop completion?

A27) For dental services, DPH solicits proposals that include any or all of the following elements: dental-capable mobile units, modular rotating dental days, and referral-based dental care with documented closed-loop completion.

Q28) For substance use disorder treatment, does DPH expect:
- Screening and referral only,
- Medication-assisted treatment initiation on-site,
- Or full ongoing treatment management via mobile and telehealth?

A28) For substance use disorder treatment and services, DPH solicits proposals that include any or all of the following: screening and referral, medication-assisted treatment initiation onsite, and ongoing treatment management via mobile services, telehealth, or fixed locations such as hubs.

Q29) Are there preferred clinical protocols or state standards for mobile-based SUD, maternal health, pediatric services, or stroke care that vendors must follow?
A29) Vendors are expected to submit proposals that align with clinical protocols and state standards for mobile-based SUD care, mental health services, pediatric services, and stroke care. Proposals should outline the vendor's understanding of these clinical protocols and state standards.

Q30) Does DPH anticipate that hubs will be:
- Newly established sites,
- Expanded existing partner sites,
- Or a hybrid model?

A30) DPH has determined that hubs may be newly established sites, expanded existing partner sites, or a hybrid of both models.

Q31) Are there minimum physical space, exam room counts, or service capacity expectations for each hub?
A31) There are no minimum expectations for physical space, exam room counts, or service capacity for each hub. The proposal should outline specifications relevant to the proposed model.

Q32) Does DPH expect hubs to operate full-time, part-time, or flexible hours based on community demand?
A32) DPH expects hubs to operate based on the needs of the community, which may include full-time, part-time, or flexible hours based on community demand. Each proposal should describe the ability to operate within defined timeframes.

Q33) Is DPH expecting hubs to function as:
- Independent clinical sites,
- Satellites of FQHCs or health systems,
- Or shared-use community facilities?

A33) DPH solicits proposals that may include hubs operating as independent clinical sites, satellites of FQHCs or health systems, or shared-use community facilities.

Q34) Are there minimum staffing ratios or required disciplines per mobile unit or per hub beyond "multidisciplinary teams"?
A34) No. DPH does not specify minimum staffing ratios or required disciplines beyond the expectation that mobile units and hubs operate with multidisciplinary teams. Vendors should propose staffing models appropriate to their service delivery plans and program goals.

Q35) Are there minimum staffing ratios or required disciplines per mobile unit or per hub beyond "multidisciplinary teams"?
A35) No. DPH does not specify minimum staffing ratios or required disciplines beyond the expectation that mobile units and hubs operate with multidisciplinary teams. Vendors should propose staffing models appropriate to their service delivery plans and program goals.

Q36) Does DPH expect behavioral health clinicians to be physically present on mobile units/hubs, or is a hybrid in-person/telehealth model acceptable?
A36) Both in-person service delivery and telemedicine are acceptable. Proposals should detail how staffing will support service delivery.

Q37) Are community health workers and patient navigators expected to be embedded full-time, or may they be shared across units and hubs?
A37) Community health workers and patient navigators may be shared across mobile units and hubs.

Q38) Does DPH have expectations regarding local hiring or community-based staffing preferences?
A38) DPH does not establish expectations regarding local hiring or community-based staffing preferences. All staffing plans should be clearly outlined in the proposal.

Q39) Does DPH define a specific state-approved referral platform that vendors must use to meet closed-loop referral requirements?
A39) DPH does not define a specific state-approved referral platform that vendors must use to meet closed-loop referral requirements. Vendors should identify the referral platform they intend to use.

Q40) How should vendors document and validate referral completion when downstream partners use different EMRs or non-integrated systems?
A40) DPH will not prescribe how vendors must document and validate referral completion when downstream partners use different electronic record systems or non-integrated systems. However, proposals should clearly describe the vendor's approach to documenting and validating referral completion.

Q41) For the 65% closed-loop referral completion rate, does DPH define:
- A standard measurement window (e.g., 60 or 90 days),
- Exclusions for patient refusal or loss to follow-up,
- Or adjustment for unavailable specialty capacity?

A41) For the required 65% closed-loop referral completion rate, each proposal should describe the methodology that will be used to validate this rate.

Q42) Does DPH expect vendors to provide transportation assistance directly, or is coordination and facilitation sufficient?
A42) DPH expects transportation considerations to be addressed in each proposal. Proposals should describe how transportation barriers will be addressed and what metrics will be used to demonstrate success.

Q43) Will DPH provide standardized report templates for quarterly and annual reports, or should vendors propose their own formats aligned to Appendix B metrics?
A43) Will DPH provide standardized report templates for quarterly and annual reports, or should vendors propose their own formats aligned to Appendix B metrics?

Q44) For the Equity Reach Index, does DPH have an existing methodology, or should vendors propose an index definition and calculation approach?
A44) Vendors should provide their intended methodology for calculating the Equity Reach Index.

Q45) Are there baseline performance benchmarks DPH will use for Year 1 versus Year 3 expectations?
A45) Proposals should outline baseline performance benchmarks for Years 1, 2, and 3.

Q46) How does DPH want vendors to handle patients served across both components (mobile + hub) for encounter and outcome counting?

A46) Proposals should describe how patient encounters and outcomes will be counted when patients receive services across both mobile and hub components.

Q47) Is there a preferred or required EMR for mobile units or hubs, or may vendors propose a system that integrates with partner EMRs and DHIN?
A47) There is no required electronic medical record (EMR) system for mobile units or hubs. Vendors may propose a system that supports their operational model.

Q48) Does DPH anticipate providing DHIN onboarding support, or should vendors assume full responsibility for integration costs and timelines?
A48) DPH will provide DHIN onboarding support, and any associated integration costs may be included in the proposal for consideration.

Q49) Are there specific telehealth modalities (after-hours coverage, specialty consults, remote monitoring) that DPH prioritizes for base pricing versus optional enhancements?
A49) DPH does not prescribe specific telehealth modalities for base pricing. Vendors should propose telehealth services that support the goals of the program. Modalities such as after-hours coverage, specialty consultations, and remote patient monitoring may be included in the base proposal or proposed as optional enhancements.

Q50) Does DPH expect vendors to bill independently under their own provider numbers, or to operate under partner billing arrangements where applicable?
A50) Proposals should identify whether the vendor intends to operate under their own provider number or under a partner billing agreement, where applicable.

Q51) Are there expectations regarding minimum reimbursement recovery rates over the contract period?
A51) There are no minimum expectations regarding reimbursement recovery rates over the course of the contract

Q52) How does DPH define acceptable strategies for sustaining non-reimbursable services for uninsured populations?
A52) DPH does not prescribe specific strategies for sustaining non-reimbursable services for uninsured populations. Vendors should describe proposed sustainability approaches, which may include reimbursement strategies, partnerships, grant funding, or other financing mechanisms. Value-based payment models may be considered but are not required.

Q53) Does DPH anticipate future value-based payment models or pilot programs tied to this initiative?
A53) Value-based payment models may be considered; however, they are not a requirement for participation in this program.

Q54) Does DPH expect vendors to establish formal community advisory groups, or is informal partner engagement sufficient?
A54) DPH does not require vendors to establish formal community advisory groups. Vendors should demonstrate meaningful community and partner engagement to support program implementation and responsiveness to community needs.

Q55) Are there priority Native American organizations or tribal entities DPH recommends engaging early?

A55) DPH does not designate specific Native American organizations or tribal entities for engagement. Vendors are encouraged to identify and engage relevant organizations and community partners, as appropriate, to support culturally responsive outreach and service delivery.

Q56) Should the community scheduling and outreach calendar be:
- Vendor-hosted,
- State-hosted,
- Or jointly managed?

A56) DPH does not prescribe a specific approach for managing the community scheduling and outreach calendar. Vendors should propose an approach that supports effective coordination, transparency, and access to services.

Q57) Does DPH prefer pricing to be presented as:
- Fixed annual program costs,
- Cost-per-unit / cost-per-encounter models,
- Or a blended structure?

A57) DPH does not prescribe a specific pricing structure. Vendors may propose fixed annual program costs, cost-per-unit or cost-per -encounter models, or a blended pricing structure as appropriate to their proposed service delivery model.

Q58) Are capital costs (mobile units, hub build-out, major equipment) expected to be:
- Fully amortized in pricing,
- Separately identified,
- Or treated as one-time costs?

A58) DPH does not prescribe a specific approach for capital costs. Vendors should clearly identify and justify capital expenses in their proposals, which may be presented as amortized costs, separately identified items, or one-time expenses as appropriate.

Q59) Should vendors assume full operational responsibility (maintenance, fuel, insurance, equipment lifecycle replacement) within proposed pricing?
A59) Yes. Vendors should assume responsibility for operational costs associated with their proposed services, including maintenance, fuel, insurance, and equipment lifecycle management, and reflect those costs in their proposed pricing.

Q60) Are the performance targets outlined in Appendix B (e.g., encounter volumes, screening targets, referral completion rates, deployment timelines) intended to be contractual obligations, performance benchmarks, or aspirational program goals?
A60) The performance targets outlined in Appendix B are intended to serve as program-level benchmarks to guide implementation and measure overall program success. Vendors will be expected to contribute toward achieving targets through their proposed services and activities.

Q61) Does DPH anticipate including liquidated damages provisions tied to performance metrics, deployment timelines, or service volumes in the final contract?
A61) Any applicable contract terms will be addressed during negotiations with the selected vendor.

Q62) In the event of termination for convenience or non-appropriation, how will capital investments (e.g., mobile unit procurement, hub build-out, major equipment) be treated for reimbursement purposes?
A62) In the event of termination for convivence or non-appropriation, reimbursement for capital investments will be handled in accordance with the contract and applicable federal and state laws,

including federal grant regulations. Vendors should clearly identify all capital expenditures in their proposals (e.g. mobile units, hub build-out, major equipment).

Q63) Will the final contract include a limitation of liability provision, and if so, how will liability caps be structured?
A63) The selected vendor will be required to enter into a written agreement with the State of Delaware. The State of Delaware reserves the right to incorporate standard State contractual provisions into any contract negotiated as a result of a proposal submitted in response to this RFP. Any proposed modifications to the terms and conditions of the standard contract are subject to review and approval by the State of Delaware.

Q64) Does the work product ownership clause apply to vendor pre-existing intellectual property, tools, software platforms, and clinical protocols used in performance of the contract?
A64) No, the work product ownership clause does not apply to vendor pre-existing intellectual property, tools, software platforms, and clinical protocols used in performance of the contract.

Q65) Can you provide the total amount available for funding for this opportunity? Similar, is there guidance about recommended funding levels for each year or the overall program?
A65) Award amounts will depend on the number of proposals selected, the scope and scale of services proposed, and the program components included in each proposal. Funding will be allocated to support program goals.

Q66) Will you accept F&A costs? Is there a cap to what can be requested and/or will you honor a federally negotiated rate?
A66) DPH will accept Facilities and Administrative costs. Requests should comply with applicable federal rules and vendors may propose a federally negotiated rate if available. If a negotiated rate is not established F&A costs should be reasonable and allocable. DPH does not set a specific cap but all proposed F&A costs will be reviewed for allowability and reasonableness.

Q67) Is insurance licensure and/or Managed Care Organization certification meet the requirements to participate in the RFP?
A67) Vendors must have all applicable state licensure, insurance coverage, and if relevant, Managed Care Organization certification required to deliver the services proposed.

Q68) Please clarify in which proposal sections to include each of the required forms.
A68) The Bonfire system will clearly identify “slots” where each required form/document should be downloaded.

Q69) As it relates to the timeline of mobile vans and brick and mortar sites, when do they need to be operational? When does Year 1 start?
A69) Year 1 begins once the contract is fully executed. Vendors should plan for mobile units and brick and mortar sites to be operational according to the program milestones outlined in the RFP, starting from the contract start date. Proposed timelines should demonstrate operational readiness beginning in Year 1, with full deployment consistent with program milestones outlined in Appendix B.

Q70) What is the maximum allowable budget for each project?
A70) DPH does not set a maximum allowable budget for each project. Funding will be allocated based on the number of proposals selected, the scope and scale of services proposed, and the program components included in each submission. Vendors should propose a budget that is reasonable, allocable, and sufficient to achieve the program objectives.

Q71) Since community health hubs depend on partnerships in the community (i.e., FQHCs, transportation providers, behavioral health providers, etc.), should there be a single proposal the encompasses all of the partners funding needs or should partners/sub-contractors submit a separate proposal to the state and reference their coordinating partner as part of their submittal?
A71) Vendors should submit a single, coordinated proposal that includes all participating community partners and clearly describes each partner's role, responsibilities, and budget needs. Separate submissions from individual partners as separate proposals are not required.

Q72) If a proposal includes funding requests from various community partners, will the coordinating proposer actually receive the funding and disseminate it to the partners, or will the funding be sent by the state directly to the partner agencies?
A72) Funding will be awarded to the primary coordinating vendor who is responsible for allocating funds to partners or subcontractors as described in the proposal. This ensures coordination and accountability across all participating entities.

Q73) Does the state have specific goals for implementation or outcomes that can be shared for Year 1, 2, 3, etc.?
A73) Vendors should reference the program metrics and milestones outlined in Appendix B of the RFP for guidance on implementation and outcomes.

Q74) Will there be specific guidelines, definitions and/or forms for reporting the required metrics?...or will it be up to the proposer to develop their reports?
A74) DPH will provide standardized templates for quarterly and annual reporting. Proposals should outline data collection methods and data storage practices.

Q75) Can you provide a definition for "clinical follow-up" that is identified in the metrics?
A75) Clinical follow-up refers to any medically appropriate actions taken after an initial screening, assessment, or encounter to ensure that a patient receives the necessary care. This may include scheduling and diagnostic testing, referrals to specialists or primary care providers, medication management, care coordination, or other interventions required to address identified health needs.

Q76) Are capital costs (i.e., brick and mortar clinics, mobile medical units, delivery vans) an allowable cost under the grant or is the grant restricted to operational costs?
A76) Capital costs, including mobile medical units, delivery vans, and brick-and-mortar improvements are allowable under federal RHTP guidance. New construction is unallowable, but minor alterations and renovations to existing facilities are permitted.

Q77) If capital costs are allowed, should the proposal include multi-year project costs (i.e., Year 1: Design and Permitting Costs: $xx,xxx, Year 2: Construction Costs: $xx,xxx, etc.), or just costs related to Year 1 of the project?
A77) Proposals should include multi-year project costs for all capital investments broken out by year.

Q78) If money is awarded June 1, can you provide the timeframe for when the first implementation reports /metrics/results need to be reported to the state?
A78) Reporting requirements and deadlines will be outlined in executed contracts.

Q79) In an effort to provide the most accurate pricing guidance, can you please confirm our understanding of the number of clinical and claims data sources, and any additional data feeds that will be included in the scope of this effort.

A79) This RFP is for clinical service delivery through mobile health units and brick-and-mortar health hubs, not data management services. Vendors should refer to Appendix B for the full Scope of Work.

Q80) Are there any budgetary restraints that we should be aware of or adhere to?
A80) No maximum or prescribed funding levels are set; vendors should propose reasonable budgets aligned with program goals, recognizing that multiple awards may be made.

Q81) What population health reporting capabilities do you expect from the platform? Are there any specific KPIs or metrics you want to prioritize?
A81) DPH will provide standardized templates for quarterly and annual reporting. Proposals should outline data collection methods and data storage practices.

Q82) Can DPH clarify the expected scope and timeline for EMR and DHIN integration at go-live? Specifically, is real-time or bidirectional data exchange required for initial implementation, and which data domains (e.g., encounters, screening results, referrals, care plans, telehealth visits) must be exchanged?
A82) Vendors should describe their proposed technology and data systems, including EMR and DHIN connectivity, in their proposal.

Q83) For the required 65% closed-loop referral completion metric, can DPH clarify the operational definition of 'completion' (e.g., scheduled appointment, attended visit, documented specialist note, treatment initiation)? Additionally, will DPH provide standardized reporting specifications for measuring referral closure?
A83) Completion refers to a referral resulting in an attended visit or initiation of treatment. Standardized reporting specifications will be provided or coordinated with the vendor.

Q84) Will DPH provide centralized access to state-level data (e.g., SVI overlays, claims/utilization data, DHIN event feeds) to support deployment planning and Equity Reach Index reporting, or is each vendor expected to independently source and integrate these datasets?
A84) Vendors should independently source and analyze this data.

Q85) Regarding sustainability planning, does DPH anticipate or encourage participation in value-based reimbursement models (e.g., Medicaid managed care contracts, shared savings, pay-for-performance) to support long-term funding beyond grant dollars? If so, are there specific performance benchmarks tied to continued funding?
A85) Participation in value-based reimbursement models is encouraged. Vendors should describe sustainability strategies, including potential fee-for-service or value-based models. No specific performance benchmarks are mandated beyond program metrics.

Q86) Regarding Health Equity and Population Impact, does DPH expect collection of demographic data or is leveraging an existing social risk solution appropriate?
A86) DPH expects vendors to specify if they intend to collect demographic or social risk solutions as part of their submission. The proposal will be evaluated on the approach's effectiveness, feasibility, and ability to support health equity and population impact reporting.

Q87) Existing Operators & Duplication Avoidance: Can the state provide a list of existing mobile health operators and DPH-funded programs currently serving Sussex and Kent Counties that respondents should coordinate with to avoid duplication? This will help us design a deployment model that fills genuine gaps rather than overlapping existing coverage.

A87) DPH does not maintain a comprehensive list of existing mobile health operators or funded programs in Sussex and Kent Counties. Vendors should describe how they will assess local service coverage, identify gaps, and coordinate with community partners to avoid duplication of services.

Q88) FQHC Partnership Requirements: Does the state have a preference or requirement for formal subcontracting or partnership agreements with existing Federally Qualified Health Centers for Component A proposals? Will letters of support from FQHCs be weighed differently than formal MOUs during evaluation?
A88) DPH does not require formal subcontracting or partnership agreements with FQHCs for Component A proposals. Letters of support from FQHCs are sufficient for evaluation purposes.

Q89) Definition of "New" Mobile Health Units: The RFP requires deployment of a minimum of four new mobile health units by Year 2. Does "new" refer to units newly deployed in Delaware specifically, or units newly procured? Would existing MMM-operated units repositioned to serve Delaware counties qualify toward this threshold?
A89) For the purpose of this RFP “new” mobile health units refer to units newly deployed in Delaware. Units that are newly assigned to serve Delaware counties may count towards the threshold provided that they expand on existing efforts.

Q90) Sustainability Scoring Criteria: For the sustainability scoring criteria (the highest-weighted category at 10 points), will the state give equal consideration to fee-for-service and value-based billing sustainability models? Or is there a preferred sustainability pathway aligned with Delaware's Medicaid managed care or Medicare Advantage Payer Mix?
A90) DPH encourages proposals that incorporate sustainable operational models, including fee-for-service billing, health system investment, cost-sharing, or value-based payment arrangements. Proposals should demonstrate a clear plan for long-term sustainability beyond the award period.

Q91) What level of clinical care is required for each mobile unit?
A91) The level of clinical care for each mobile unit is to be proposed by the vendor. Proposals should describe the clinical services they will provide.

Q92) What is the staffing requirement for each mobile unit?
A92) Vendors should propose the level of clinical care, staffing model, and deployment schedule for each mobile unit. Proposals will be evaluated based on alignment with the program goals and ability to meet the required screenings, and patient encounters.

Q93) How often will mobile units need to be deployed?
A93) Deployment frequency for mobile units should be proposed by the vendor. Proposals should describe a schedule that meets program goals, ensures coverage of high-needs areas and achieves patient encounters, screenings, and care coordination metrics.

Q94) Are there permits required to park mobile units?
A94) Vendors are responsible for identifying and obtaining any permits required to operate and park mobile units as proposed.

Q95) Who will be responsible for procuring necessary permits?
A95) Vendors are responsible for identifying and obtaining any permits required to operate and park mobile units as proposed.

Q96) Does the State anticipate multiple awards by component?

A96) DPH may select multiple vendors by component to meet the goals of the overall program. Selection will be based on the quality and feasibility of proposals as well as alignment with program objectives.

Q97) If multiple vendors are selected, how does the State envision coordination, referral management, and avoidance of duplication across vendors?
A97) Vendors should describe how they will collaborate with other providers and community partners to optimize coverage and ensure efficient service delivery.

Q98) The RFP states a goal of deploying four (4) new mobile units by Year 2. Is this expectation per vendor or across all awarded vendors collectively?
A98) The requirement to deploy four new mobile units by year 2 refers to the program as a whole not per individual vendors.

Q99) Are all listed services required, or may vendors propose a subset aligned to demonstrate community need and partnerships?
A99) Vendors may propose a subset of services aligned with demonstrated community needs, partnerships and organizational capacity. Proposals will be evaluated on how effectively the proposed services meet program goals.

Q100) Are outcome targets (e.g., 1,500 encounters annually, 65% closed-loop referrals) expected per vendor or program-wide across all awardees?
A100) Outcome targets are program wide goals. Vendors should propose plans that contribute to achieving these metrics in coordination with other awardees.

Q101) Are there specific expectations in regard to the "65% closed-loop referrals" not indicated in the RFP? Please define "closed-loop referrals" as an outcome.
A101)A closed-loop referral is a referral that results in completed, documented patient follow-up such as attending a specialist visit, initiating treatment or so forth. Vendors should propose methods for tracking and reporting referral completion to support this program metric.

Q102) Are renovation costs for a brick-and-mortar health hub allowable? Can you provide any additional guidance regarding cost limitations for renovation costs?
A102) Minor alterations and renovations for brick-and-mortal health hubs are allowable if they are clearly linked to program goals. Per RHTP guidance, new construction and major building expansions are unallowable. However, minor modifications to existing building footprints, infrastructure, and rooms within a facility are generally allowable.

Q103) RFP Section: Appendix b – Scope of Work (Shared Metrics)
#6 Sustainability and System Optimization; RFP Page: 56
Question for Clarification:
Regarding the requirement to "Demonstrate progress toward diversified revenue streams, including billing for mobile services, telehealth, and remote patient monitoring",
please clarify whether the contracted vendor is expected to directly bill Medicaid for these eligible services, or if the contracting agency will perform all Medicaid billing while the vendor provides operational support."
A103) Vendors are expected to propose how they will support revenue generation, including potential billing for mobile services, telehealth, and remote patient monitoring. Per RHTP guidance, program funds cannot be used to replace payment for clinical services that could be reimbursed by insurance.

Q104) The RFP states (Outcomes for Component A), “Deliver a minimum of 1,500 mobile health encounters annually by Year 3 across Sussex and Kent Counties.” Is this target based on a vendor deploying four new mobile health units? Or is this per unit?
A104) This target of 1,500 mobile health encounters is a program level goal not a per unit requirement.

Q105) Under “Shared Metrics for Both Components” the RFP states, “Demonstrate effective integration with EMR systems, DHIN, and state-approved referral platforms.” Can the state provide a list of state-approved referral platforms? Does this include a platform for “social needs” such as Unite Us or Find Help?
A105) Vendors should propose platforms that support effective integration with EMRs, DHIN, and referral management, including platforms addressing social needs if appropriate. Proposals will be evaluated on the feasibility and effectiveness of the proposed approach.

Q106) Can bidders propose Component A only (mobile units), Component B only (brick-and-mortar hubs), or both? If yes, will proposals be evaluated separately by component?
A106) Yes, bidders may submit proposals for Component A only, Component B only, or both.

Q107) The RFP references coordination with referral platforms/DHIN. What is considered “state-approved” for referral platforms, and is a new platform expected or can teams use existing systems?
A107) Vendors should propose platforms that support effective integration with EMRs, DHIN, and referral management, including platforms addressing social needs if appropriate. Proposals will be evaluated on the feasibility and effectiveness of the proposed approach

Q108) How is referral completion defined for the 65% closed-loop referral metric?
A108) A closed-loop referral is a referral that results in completed, documented patient follow-up such as attending a specialist visit, initiating treatment or so forth. Vendors should propose methods for tracking and reporting referral completion to support this program metric.

Q109) What evidence/documentation is required for completion and follow-up?
A109) Vendors should propose the methods and documentation they will use to track completion and clinical follow-up for patients.

Q110) For the requirement tied to high-need/high-SVI areas, what geographic unit should be used (ZIP, census tract, service area polygons), and how should vendors report performance?
A110) As noted in Goal 3.1, the RFP references county and census tract level data, including CDC Social Vulnerability Index (SVI). Vendors should propose how they will use these or other appropriate geographic units and report performance.

Q111) What specific DHIN integration is required (interfaces, data elements, standards, timing), particularly for mobile units operating in the field?
A111) The RFP does not specify a required DHIN connectivity standard. Vendors should describe their proposed technology and data systems, including electronic medical records, reporting systems, and DHIN connectivity capacity, as applicable.

Q112) Are there standard DPH reporting templates for quarterly/annual reports, or should vendors propose their own format? If vendor-proposed, what minimum fields are required?
A112) DPH will provide standardized templates for quarterly and annual reporting

Q113) Has the state considered incorporating clinical trials as a care option for the mobile health clinics in Sussex County?
A113) No, the state cannot incorporate clinical trials as a care option for mobile health clinics in Sussex County, as conducting or managing research is outside the scope of the program.

Q114) Component A (#2) requires coordination with existing mobile health operators. Can the State provide a list of existing mobile health operators currently serving Sussex and Kent Counties, including services provided, operating schedules, and data/reporting interfaces used with DPH?
A114) DPH does not maintain a comprehensive list of existing mobile health operators or funded programs in Sussex and Kent Counties. Vendors should describe how they will assess local service coverage, identify gaps, and coordinate with community partners to avoid duplication of services.

Q115) Component A states deployment of a minimum of four (4) new mobile health units by Year 2. Does the State have specific requirements for new mobile health units in terms of size, equipment, and capabilities documented for this program? Does "new" require newly purchased vehicles dedicated solely to this contract, or may existing mobile units be reassigned or partially allocated to Delaware operations?
A115) For the purpose of this RFP "new" mobile health units refer to units newly deployed in Delaware. Units that are newly assigned to serve Delaware counties may count towards the threshold provided that they expand on existing efforts.

Q116) In reviewing RFP and related materials, we did not identify a stated funding ceiling for any of the components or the overall initiative. Can the state provide the funding ceiling for Component A and Component B? Similarly, can the state provide the maximum award per vendor?
A116) There is no funding ceiling for budget requests; however, the submitted budget should align with the costs necessary to implement all elements of the proposal.

Q117) What is the expected number of operational days per month for brick & mortar health hubs in rural communities?
A117) DPH does not prescribe a number of operational days. Vendors should put forth a proposal that will meet the requirements of the RFP.

Q118) The RFP references preventive, primary, behavioral health, specialty, dental, and health education services. Can the State clarify which specialty services are expected to be delivered directly via mobile units versus via referral partnerships?
A118) The state defers to the bidder to determine which specialty services they will deliver directly via mobile units and which will be provided through referral partnerships.

Q119) For Section 3.1, will the State provide baseline SVI, census tract, and utilization data to inform initial deployment modeling, or should offerors independently source and analyze this data?
A119) Vendors should independently source and analyze this data.

Q120) Under Section 3.3 (Continuous Quality Improvement), are specific quality measures or performance metrics defined by the State, or should offerors propose performance metrics aligned to program goals?
A120) Bidders should provide a detailed description of their proposed approach to fulfilling the requirements described in the RFP.

Q121) States “Deliver 1,5000 patient encounters annually through hub-based service”. Based on the numbers in the mobile section above, we assume this should read 1,500, but want to confirm it is not 15,000?
A121) That is correct. It should read 1,500 patient encounters.

Q122) Goal 5.2 states “Implement sustainable operational and billing models, including fee-for-service, telehealth reimbursement, and value-based arrangements.” Is the State’s expectation that services be reimbursed through Medicaid/insurance billing in addition to contract funding, or is this a grant-funded service delivery model without payer billing requirements?
A122) DPH encourages proposals that incorporate sustainable operational models, including fee-for-service billing, health system investment, cost-sharing, or value-based payment arrangements. Proposals should demonstrate a clear plan for long-term sustainability beyond the award period

Q123) Under Component A: Mobile Units, point number 2 states “If requesting funds for a new mobile health unit, vendors must provide a clear justification demonstrating the need for the unit, including a gap analysis of current service coverage and population access.” At the conclusion of the contract term, does the State anticipate transfer of ownership of mobile units or hub assets purchased with program funds?
A123) Ownership of mobile units or hub assets purchased with program funds will be addressed during contract negotiations with the awarded vendor(s), consistent with applicable federal regulations governing equipment acquired under federal awards.

Q124) The Care Continuity, Referral Completion, and Navigation metrics section states “Provide patient navigation support for insurance enrollment, appointment scheduling, transportation, and follow-up care”. Is providing patient transportation considered within scope, or is the focus exclusively on clinical service delivery?
A124) Yes transportation and wrap around services that reduce barriers to care, facilitate appointment completion, and ultimately improve patient health outcomes may be included.

Q125) Are vehicle purchases acceptable?
A125) Vehicle purchases may be allowable if they are necessary, reasonable, and clearly aligned with program goals and service delivery needs. Proposals should justify the purpose of the vehicle and include associated costs in the budget for review consistent with federal grant guidance.

Q126) MHU operational costs are not acceptable?
A126) Yes, operational costs associated with Mobile Health Units, such as staffing, maintenance, fuel, insurance, and other expenses necessary to support service delivery, are acceptable provided they are reasonable, allocable, and clearly tied to program implementation. Vendors should include and justify these costs in their proposed budgets.

Q127) Is the vendor expected to directly bill Medicaid?
A127) Vendors should identify whether they intend to bill Medicaid or other payers for eligible services in their proposals. Per federal guidance, program funds cannot be used to replace payment for clinical services that could be reimbursed by insurance. Proposals should describe the Vendor’s billing approach and how reimbursement will support program sustainability.

Q128) May funds be used for incentives for patients or community members
A128) Patient or community incentives may be allowable on a case-by-case basis if they are reasonable, clearly justified, and directly support program engagement, access to care, or participation in services. Vendors should describe the purpose of any proposed incentives, how they align with program goals, and how the costs will be sustained.

Q129) Will we receive this recording?
A129) No, this recording is for internal use only to ensure that all questions received during the pre-bid meeting are accurately captured.

Q130) If RHTP funds are supporting mobile services, in what situation would a provider be required to bill Medicare/ Medicaid?
A130) Per federal guidance, program funds cannot be used to replace payment for clinical services that could be reimbursed by insurance. When a patient is eligible and enrolled and the services provided are reimbursable, providers should bill the applicable payer. Proposals should describe the vendor's billing approach and how it supports program sustainability.

Q131) Question: In the instance of a federal Medicaid defund, would an organization be eligible for funding?
A131) If an individual no longer has Medicaid coverage, they would be considered uninsured or underinsured and services would be billed accordingly. Providers are expected to bill any available insurance when coverage exists. If no coverage is in place, patients would fall into an uninsured category for purposes of service delivery and funding considerations.

Q132) Under the current situation where a provider cannot bill Medicaid due to a defund, but still holds contracts and credentialing, would this exclude the organization from eligibility for Rural Health funding?
A132) An organization would not be excluded from eligibility solely because it is unable to bill Medicaid due to a defund. Providers are expected to bill available insurance when possible. If billing is not possible due to coverage or policy changes, patients would be treated as uninsured or underinsured for purposes of service delivery and funding considerations.

Q133) Is service delivery open to all of Kent County, or are there specific Zip codes that must be targeted?
A133) Service delivery is not limited to specific ZIP codes. Vendors should focus on serving federally designated rural areas and high-need populations within Kent and Sussex Counties, consistent with the definitions and targeting approach outlined in the RFP.

Q134) If an existing vendor already has relationships for specialty services and referrals, will those count, or are new referral pathways expected?
A134) Existing referral relationships and specialty service partnerships may be used. Vendors are not required to establish new pathways solely for this opportunity but should describe how their current and/or proposed partnerships will support access to care and meet program goals.

Q135) How should one-time costs such as purchasing a mobile unit be reflected in the budget? Is there a preferred approach?
A135) There is no prescribed budgeting format for one-time capital costs such as mobile unit acquisition. Vendors should clearly identify and justify these costs in their multi-year budgets and budget narratives, including how they relate to implementation timelines and ongoing operational expenses.

Q136) My question is around the minimum of four mobile health units. Is that an expectation of the state, that each applicant would be would have a goal of four mobile units?
A136) No, the minimum deployment of four mobile health units is a program-level goal, not a requirement for each individual vendor. Vendors should propose the number of units they plan to deploy as part of their service delivery approach.

Q137) We're looking for partners. Will you help us find partners such as, you know, clinics or hospitals or universities? Or are we?
A137) Vendors are responsible for identifying and securing their own partners. Proposals should describe existing or planned partnerships that will support service delivery and help achieve program goals.

Q138) If you wanted to establish a new site, can any of these funds be used for construction?
A138) No, funds may not be used for new construction or major building expansions. However, minor renovations or alterations to existing facilities that are necessary to support program services may be allowable if clearly justified.

Q139) Does this funding allow for both operational costs and one-time costs such as minor renovations and equipment?
A139) Funding may be used for both operational expenses and allowable one-time infrastructure costs such as minor renovations and equipment purchases, provided they are reasonable, clearly justified, and aligned with program goals. New construction is not allowable.

Q140) Can existing mobile health units be used if they expand services or geographic reach?
A140) Existing mobile health units may be used if they are newly deployed to serve Delaware or expand service lines or geographic coverage in a way that increases access and supports program goals.

Q141) The question is for the brick and mortar hub model, if we're going to be renting space to expand. Our current practice down in Sussex County, would you need a copy of the lease for finances? Or can I estimate and as far as also you know not doing no renovation for like materials like you know computers like, stuff like that for patient care. Would that be acceptable?
A141) A copy of the lease is not required at the proposal stage. Vendors may include reasonable cost estimates for rent and necessary equipment or supplies to support patient care, provided these costs are clearly justified and aligned with the proposed service delivery model.

Q142) Since this is federal pass-through funding, do federal interest requirements apply to equipment or capital purchases?
A142) Yes, because this initiative is supported with federal funds, applicable federal grant requirements related to allowability use, management, and disposition of equipment or capital assets may apply. Vendors should ensure compliance with relevant federal regulations. Matters related to ownership or treatment of capital assets at the end of the contract will be addressed during contraction negotiations, consistent with applicable federal and state requirements.

Q143) It seems like you gave a lot of good clarity that these goals is aligned with the program itself, so not each vendor is intended to kind of do 1500 counters per year. Do you expect us to give our own performance goals as part of the vendor kind of application, or is that in the negotiation process? So, would you like us to put forth our own goals?
A143) Yes, vendors should propose their own performance goals and targets as part of their application, describing how their proposed services and activities will contribute to achieving overall program-level outcomes. Specific performance expectations may be further refined during contract negotiations.

Q144) May a subcontractor be included on multiple applications submitted by different prime vendors?
A144) Yes, subcontractors may participate in more than one application.

Q145) About the prime, if you are going to be a prime, you can't subcontract on others, is that correct?
A145) Per Section IV.B.12.c of the RFP, a primary vendor may not participate in more than one proposal in any form. Subcontracting vendors may participate in multiple proposals.

Q146) We're a nationwide specialty vehicle dealer for mobile health units of all sizes. My question is whether the state would like vehicle dealers to bid directly under component A with the exception that we don't supply the services or would the state rather see us work with individual vendors on the front end and have them submit the bid?
A146) Vendors proposing to deliver clinical or program services should serve as the prime applicant. Vehicle dealers or equipment suppliers are encouraged to partner with service delivery organizations and be included as subcontractors or vendors within a broader proposal.

Q147) As a technology vendor that does not directly provide clinical services, should we partner with the State as a clinical partner in this initiative or strictly just clinics and hospitals?
A147) Technology vendors should identify and engage potential clinical or community partners, such as clinics or hospitals, based on areas where their solutions may be beneficial. Vendors may reach out to potential partners directly to discuss proposed services and determine how to collaborate as part of an application.

Q148) Would potential partners include the State public health department?
A148) The Division of Public Health is the issuing agency for this RFP and cannot serve as a subcontractor on any proposal. Vendors should identify other clinical, community, or organizational partners to support their proposed service delivery model.

Q149) If technology is being utilized to provide care in Kent and Sussex counties--through remote means, if the Provider is located in New Castle County could funds be requested to support the set-up of that physician in New Castle County? But the patient would then still be in Kent or Sussex County.
A149) Funds may be requested to support reasonable set-up or infrastructure costs associated with delivering telehealth services, even if the provider is physically outside Kent or Sussex Counties, provided the services are delivered to and primarily benefit patients in the targeted rural service areas.

Q150) Is it un-allowable?
A150) Such costs are not unallowable. Funds may be requested for reasonable telehealth set-up or infrastructure expenses, even if the provider is physically located outside Kent or Sussex Counties, provided the services primarily support patients in the targeted service areas.

Q151) Is it just Sussex or my understanding was Kent and Sussex?
A151) The program is focused on serving targeted rural areas in both Kent and Sussex Counties. Vendors should propose service delivery approaches that improve access to care for eligible populations across these identified service areas.

Q152) If a vendor is a nonprofit registered in California, but thinking to do the contract in Delaware would I be allowed to still apply or does the entity have to be registered in Delaware?
A152) Vendors are not required to be physically located in Delaware at the time of proposal submission. Out-of-state entities may apply, however selected vendors will be expected to meet all applicable State requirements, including business registration and licensure necessary to operate and deliver services in Delaware.

Q153) Does it matter what the vendor entity is, whether it's an S corporation or an LLC or a nonprofit or no?
A153) No, the vendor's business structure does not affect eligibility. Vendors of any entity type may apply, provided they meet applicable licensure, registration, and contractual requirements to operate and deliver the proposed services.

Q154) So how would we know if that if the division has a requirement?
A154) Vendors should review the requirements outlined in the RFP including Section III.A.1 (Delaware licensure and certification) and Section V.G.5 (Licenses and Permits).

Q155) If a company is a newer startup and may not meet certain experience expectations, how can they still participate?
A155) If a vendor does not yet meet certain experience or service capacity expectations, partnering with a more experienced organization is encouraged. Companies may participate as a subcontractor or partners with a proposal submitted by a prime vendor.