

Mergers and Acquisitions: A Practical Guide for Community Health Centers

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Introduction

“If you want to go fast, go alone. If you want to go far, go together.”

— African proverb

California has experienced a dramatic rise in the number of federally qualified health centers (FQHCs) over the past several decades. Significant expansion was originally fueled by President George W. Bush’s 2001 Health Center Growth Initiative, which sought to add 1,200 new community health center (health center)¹ sites nationwide. Growth continued to accelerate due to funding provisions included in the Patient Protection and Affordable Care Act (ACA) of 2010. Thanks in large part to ACA investments, the number of FQHC sites statewide increased by 27% between 2013 and 2017, to 1,716, and patient visits rose by 42% to 22.6 million over the same period.²

Although ACA expansion grants have ended, strategic investments from the US Department of Health and Human Services’ Health Resources and Services Administration (HRSA) have provided ongoing support to health centers in recognition of the key role that centers play in expanding access to health care for individuals with low incomes. At the same time, the coverage mechanisms established by the ACA have allowed health centers to do even more to address unmet health care needs in underserved areas. These combined investments have enabled California to reach patients who might otherwise go without care and provide them with a viable alternative to costly emergency room and late-stage specialty care.

Even with this continued growth, however, FQHCs — like most provider organizations — are grappling with an array of external pressures, including systemic changes unleashed by value-based care, shifting demographics in the communities they serve, and the ongoing impact of the COVID-19 pandemic. Because these factors have exacerbated existing pressures on public health reimbursement, many health centers are exploring acquisitions and mergers as a means of ensuring sustainability, expanding services, and maintaining patient access to basic health care services in underserved areas.

Given that the trend toward consolidation will likely continue, the California Health Care Foundation (CHCF) has created this manual to provide support and guidance for health centers contemplating a consolidation with another provider entity.

Beyond the challenges noted above, interest in mergers and acquisitions also is being driven by the long-standing political and regulatory uncertainty surrounding health care. Joining forces with a well-matched health center partner can enhance staffing expertise and help create valuable buffers against rapid regulatory, policy, and reimbursement changes. Acquiring existing provider entities or assets likewise can help smaller, independent health centers more effectively manage health care’s growing administrative burden while achieving charitable goals.

FQHCs additionally have become attractive affiliation candidates for hospitals and health systems due to health centers’ ability to deliver integrated, broad-based primary care. Connecting with health centers can help larger systems extend their capacity to provide a wider range of health care services in ways that are consistent with community needs.

Regardless of the underlying catalyst, health center consolidations can be complex to navigate, particularly for those without experience in this area. It therefore is the authors’ hope that organizations considering the journey will use this guide to walk through the process thoughtfully and intentionally, from the point of initial strategic inception through finalization and integration. By taking this approach, common pitfalls can be avoided and the likelihood of a successful outcome will be increased.

That said, the authors recognize — from a combined 80 years’ experience in advising health care mergers, acquisitions, and expansions — that organizations do not always enjoy the luxuries of time or resources when pursuing a new business approach or structure. If you’re facing a tight deadline, don’t be concerned if you’re unable to fully follow or adopt the guidance provided here. The chapters may be referenced individually to address specific areas or

challenges. Consult the sections as you are able and take from them what you can.

Conversely, if your organization is not facing an immediate need to consolidate or otherwise act, you may still benefit from this guide. Planning ahead will help ensure that potential partners have been identified and the necessary processes are fully understood. Thinking through the steps associated with various scenarios will help you be fully prepared when the time for action comes.

Ultimately, the decision about whether a merger or acquisition makes sense must be based on the unique circumstances surrounding the organizations involved and the

communities they serve. It is also important to remember that even with the best of planning, few unions are executed perfectly.

This guide should help you navigate the process to consummate an effective merger or expansion so you and your new partner can get back to the essential job of providing high-quality health care and enhanced access to the communities you serve. To further increase your knowledge in this area, we also recommend consulting CHCF's October 2019 publication *Building to a Sum Greater Than Its Parts: A Hands-On Guide to Cultural Integration in Community Health Partnerships and Alliances*.³

1. Defining Goals and Exploring Options



When health centers contemplate consolidation, it is essential that they take time to clearly identify the objectives they seek to achieve. It is also important to remember that while consolidation can be an effective approach to growing your practice or dealing with specific challenges, it may not always represent the best course of action.

For example, unilateral expansion through the addition of new fixed or mobile sites, adding new servicing lines, spurring organic patient growth, or engaging in alliances and partnerships also represent viable paths to growth. These approaches may be less dramatic than a practice acquisition. But they may be accomplished more quickly, with less of an investment of time and money, and without the inherent risks and challenges of integrating previously independent providers. Because gradual growth can still produce a substantial return on investment and do so with less risk, alternative strategies should not be overlooked when considering the best path forward.

Understanding the Options

While the terms *merger* and *acquisition* frequently are used interchangeably, they have quite different meanings. It is important that health center leaders understand these distinctions so that they can appropriately evaluate the options and effectively communicate with potential partners. In particular, erroneously describing a proposed practice acquisition as a “merger” may cause significant confusion on the part of regulatory agencies. This, in turn, could result in delays or fundamental errors in the review process. Generally, the terms are defined as follows:

Merger: Also referred to as a statutory merger, a merger is the combination of two corporations through which one corporation merges into, and becomes a part of, the surviving entity. The merging corporation is referred to as the disappearing corporation. Since the surviving corporation generally assumes all of the legal obligations of the disappearing corporation, known or unknown, this approach involves significant risk, longer due diligence review, and more expertise. For these reasons, it is seldom used by FQHCs as a means of acquiring external provider entities or their assets.

Nonprofit mergers nonetheless can be relatively simple to complete from a corporate law standpoint when compared to asset transfers. However, the substantial risks associated with the total assumption of the disappearing corporation’s

obligations significantly expand the need for thorough and resource-consuming due diligence. Since all rights of creditors, liabilities, liens, pending litigation or claims, charitable trust obligations, and trusts of the disappearing corporation are transferred to the surviving corporation, due diligence is significantly broader in scope and more time-intensive.

Acquisition: An acquisition is defined as an asset purchase that involves one party purchasing all or some of the assets of another on a negotiated basis. The assumption of the seller’s liabilities, if any, is generally limited to those the buyer specifically identifies and the transfer of which was approved by the buyer. Liabilities of the acquired entity are not transferred without an explicit agreement for their assumption, and thus assets can generally be acquired free and clear. Only those assets that are needed can be acquired.

Assets of for-profit, professional corporations, or partnerships (e.g., a private practice provider) can be acquired to avoid concerns regarding the corporate practice of medicine and the unavailability of a merger option in such situations. Asset purchases generally avoid hidden liabilities associated with prior operation of the acquired provider. Asset acquisitions also may provide an alternative in cases where debt refunding limitations or debt prepayment penalties excessively complicate or prevent utilization of the merger option.

In general, the disadvantages of the asset purchase approach include delays associated with a requirement to enroll newly added provider sites in key public payer programs, such as Medicare and Medicaid. New sites that were previously operated as physicians’ offices will be subject to the costly Office of Statewide Health Planning and Development (OSHPD-3) building code requirements if they are converted to be used as nonprofit clinics in largely the same manner as if they were new construction. Asset purchase agreements also require an inventory of all assets to be transferred, fair market valuation, more third-party agreements if payer, vendor, or staffing agreements are intended to be transferred, and,

generally speaking, a greater number of closing documents than would be required for a merger.

Defining Objectives

A range of scenarios can lead health centers to explore a strategic change in direction. They may want to expand their geographic reach, increase the range of services they offer, or seek to add more Medi-Cal lives to their patient mix to improve the organization's fiscal health. Conversely, a health center may be struggling financially and operationally. They may be located in a community that is suffering economically and losing residents. They may find it difficult to hire necessary staff. Or they may have been unable to obtain Federally Qualified Health Center (FQHC) 330 status and as a result, could be having trouble meeting financial targets.

Regardless of the underlying trigger, linking up with another entity interested in a merger or acquisition can be an effective way to ensure services are sustained in the community. This is true not only for health centers but also for private physician practices that provide care to high numbers of Medicaid patients. Some physician groups, for example, may be looking for an organization to take over their practice ahead of a key physician retirement. Assuming their missions align, a merger or acquisition in this scenario could represent a win-win for all concerned.

Common objectives can include:

Preserving and Expanding Patient Access

Most health systems seek additional points of entry to facilitate access for patients and to enhance continuity of care. In urban and rural areas alike, the number of providers has increased substantially in recent years. Patients typically have the opportunity to choose from a wide variety of health service organizations. As a result, the potential of patients seeking care from multiple health centers has increased. This kind of fragmentation can undermine continuity of care, exert pressure on provider finances, and weaken quality improvement efforts. By seeking a merger or acquisition partner, systems can consolidate services while protecting and increasing patient access.

Increasing Managed Care Lives

California health centers are paid cost-based reimbursement for Medicaid visits. Most Medicaid patients in the state are enrolled in capitated managed care Medicaid or Community Health Plans. Major plans include L.A. Care Health Plan (Los Angeles County), San Francisco Health Plan (San Francisco), Alameda Alliance for Health (Alameda County), CalOptima (Orange County), and Partnership HealthPlan of California (14 counties in Northern California).

Boosting enrollment in managed care plans helps health centers maintain a sound financial footing and allows them to invest in hiring and innovation. It also supports a stronger financial risk pool, which, in turn, increases their capacity to provide high-quality care to uninsured patients. Growing the number of covered lives additionally strengthens a health center's capacity to undertake more advanced population health management strategies. Finally, increasing enrollment can give a health center better contracting leverage, not just with health plans but with other kinds of business partners as well.

Achieving Economies of Scale

Building scale and capacity allows organizations to spread fixed costs over a larger base, eliminates administrative duplication, and delivers higher quality care through the adoption of best practices in quality assurance, quality improvement, and risk management. Given the combined complexity and broad scope of the regulatory oversight that FQHCs are subjected to, creating larger mass can pay substantial dividends. Insofar as most health centers can earn a gross margin of between 5% and 10%, building scale also can make a significant difference in ensuring financial stability and sustainability.

Alternative Strategies

Once your objectives are clearly defined, it is important to explore alternatives for supporting the organization's growth and mission before committing to a merger or acquisition. As both a practical matter and a matter of law, health centers have an obligation to "make every reasonable effort to establish and maintain collaborative relationships with other health care providers, including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not

available through the health center, and to reduce the non-urgent use of hospital emergency departments.”¹⁴ Satisfying these obligations is essential to fulfilling the needs of FQHC patients and ensuring timely and appropriate access to care in underserved areas.

Carefully structured colocated clinics and care delivery arrangements can ensure that the full range of services needed in underserved areas are available to FQHC patients. However, these types of arrangements must be understood in the context of applicable laws relating to licensing, provider certification, restrictions on referral, and compensation relationships between health care providers, charitable restrictions on nonprofit/for-profit joint ventures, and the like. Early legal guidance as part of the planning process is therefore critical.

Perhaps most importantly, it is vital that each health center consider what is right for their community and patient population. Because no one correct answer exists and each situation differs, it is important to evaluate all available options.

Potential alternatives strategies may include:

Organic Growth

Health Resources and Services Administration (HRSA) has prioritized health center growth by streamlining approval processes to add new service sites and adjunct new service lines, and by offering supplemental funding streams to assist in building capacity and expertise in the delivery of integrated services. These services can include integrated oral health, mental health, and substance abuse. In this context, there may be opportunities for a health center to pursue a growth strategy that does not include a merger or acquisition. For instance, they could implement more intensive patient outreach and marketing, develop new locations in areas of high need, or integrate new services that help a health center both retain and attract patients.

An example of this approach can be found in the implementation of the Integrated Behavioral Health (IBH) model. IBH relies on collaboration between primary care providers and behavioral health providers in order to deliver quality, patient-centered care. This integration between care teams allows for the patient to easily access both physical and behavioral health care services under the same roof and

provides a cost-effective care option that enhances patient compliance to treatment as well as overall health outcomes.

Pursuing an IBH model also enables movement toward a population health management model. Population health management focuses on strategies of health promotion and prevention for the whole community versus diagnoses and treatment of the individual. This creates a mechanism for effectively reaching and treating a larger population of those in need.

Colocation with Program Partners

Colocation can be an effective way to remove barriers to care, develop a new base of patients, and play to the strengths of your health center. Whether the potential partner is a provider of ancillary health services (e.g., substance abuse services or inpatient care), a hospital-affiliated integrated delivery network, or a social service provider, health centers increasingly are viewed as attractive allies with strong reimbursement potential and a mandate to deliver care across the medical, dental, behavioral health, and substance abuse continuum.

Consolidation

FQHCs, clinics, or physicians’ offices may find that circumstances necessitate the suspension of operations at one, several, or even all clinic sites. This may be the case if, for example, finances are strained, patient numbers are low, or competent and consistent staffing has become problematic. In these kinds of scenarios, it may be possible to reach out to community providers who are in a position to absorb or purchase practice assets, staff, or locations, and thereby help ensure continuity of care for the provider’s patients.

Acquisitions: Advantages and Pitfalls

If you decide that a merger or acquisition is the most effective way to achieve your objectives, you need to be cognizant not only of the advantages such a transaction could produce, but also of the potential pitfalls that can sabotage progress toward your goals.

Advantages

As previously noted, combining resources with another entity can create a number of strategic benefits. Some of the most important benefits include:

Improved compliance: FQHCs operate under an extremely complex regulatory framework that is generally more involved than those encountered by most other kinds of California businesses. For example, nonprofit community clinics must comply with licensing through the California Department of Public Health (CDPH), which coordinates with the California Department of Health Care Services (DHCS) Provider Enrollment Division to enroll licensed clinics in Medi-Cal. Building code requirements are developed by the Office of Statewide Health Planning and Development (OSHPD), implemented/negotiated on behalf of CDPH by OSHPD, and enforced by local building departments. FQHC status is obtained and regulated by HRSA. Certification of FQHCs as providers involves both HRSA and the Centers for Medicare & Medicaid Services (CMS). DHCS and CMS implement the rules applicable to California's Medicaid program, while CMS regulates compliance by Medicare providers. The California Board of Pharmacy (BOP) regulates clinic dispensaries and in-house pharmacies. The California and Federal Drug Enforcement Agencies are involved in overseeing the handling and dispensing of prescription drugs. HRSA's Office of Pharmacy Affairs regulates compliance with the rules relating to the 340B Discount Drug Program. Providers performing health care services in an FQHC also are subject to a range of professional boards, and compliance with these varied obligations must be ensured by the FQHC. The California Attorney General regulates compliance with charitable obligations and the transfer of nonprofit assets. Depending on the assets and services provided by the FQHC, a wide range of additional state, federal, and local regulatory bodies may be relevant to the FQHC's operations.

In addition to statutory law and formally adopted regulations, California FQHCs and other providers to low-income and underserved populations historically have been subjected to a wide range of informal policies, or "underground regulations," which can be difficult to predict, particularly for new, small, or thinly staffed safety net providers. In general, larger, more experienced, and better organized FQHCs are more effectively positioned to streamline compliance and to anticipate the impact of both formal and informal regulatory policies.

Improved analytics and business intelligence: Organizations with a deeper administrative and management bench typically have better tools and resources to analyze data in support of a wide range of financial, operational,

and clinical decisions. Areas of assessment can include determining where additional services may be warranted, measuring clinical quality, gauging financial performance by location or provider, and monitoring coding, compliance, and other key revenue cycle metrics.

Greater negotiating power: Larger entities can often negotiate better rates with suppliers and payers and can more effectively access or help establish group purchasing organizations. These benefits may have a substantial and lasting impact on cost reduction efforts.

Deeper financial resources: Larger health centers generally have bigger budgets, which can improve access to capital and strengthen an organization's ability to weather financial interruptions. Greater capacity to invest in operations can mean the creation of new service lines, such as podiatry and dermatology, or improved access opportunities, such as telemedicine and online patient portals. If well-managed, increasing size and scale can have a dramatic impact on the patient experience by enabling new points of access and more comprehensive patient services.

Pitfalls

The potential upside of expansion through a merger or acquisition is substantial and the environment in California remains supportive of these transactions. Yet numerous pitfalls exist. Not all deals go well, nor does every union make strategic sense. By assessing past situations in which difficulties have arisen, it is possible to identify some of the most common mistakes or problems that health center leaders must strive to avoid. Some of these include:

Under-resourced deals: Expansions, either through merger or asset acquisition, should not be undertaken unless sufficient resources exist to ensure the project can be brought to fruition even as existing operations are maintained. More detailed guidance in this area is discussed later in this guidebook.

Unclear chain of command: Some entities that increase their size do not benefit from improved performance because of a failure to clarify new decisionmaking pathways and responsibilities. This can lead to a collection of fiefdoms rather than a unified entity with consistent direction.

Failure to exploit economies of scale: Some combined entities continue to maintain duplicative and/or inconsistent

operations at different sites and consequently fail to increase efficiencies or reduce their overall administrative cost burden. Common examples of this problem include the maintenance of separate electronic health records and accounting systems or competing models of care.

Mergers and acquisitions can be productive and powerful solutions if the overarching missions and visions align. Nonetheless, it should be remembered that even under the best of circumstances, integrating different staffs, cultures, and systems can be expensive, time-consuming, and relentlessly challenging. Merger or acquisition activity is not a magic bullet and therefore should not be undertaken lightly.

2. Choosing a Partner and Developing a Plan



Once you've decided to move forward, it is time to set a course of action. The first step is to create a road map that includes the predetermined milestones that must be achieved to ensure continued progress toward your goals.

Identifying a Potential Partner

For most health centers, two primary partnership types are available: combining with another health center or with a private physician's practice. Other types of entities obviously may present strategic opportunities, including dental practices and behavioral health organizations. However, for the purposes of this guidebook, we are focusing on the most common forms of health center planned acquisitions currently occurring in California.

Private Physician Practices

Provider networks, particularly those in older urban neighborhoods or rural areas, were frequently built around solo practitioners or small-to-midsize physician-owned practices. Hence, one strategy for identifying potential physician partners is to ask those associated with your network (e.g., health plans, attorneys, and insurance brokers) about practices in which the owner-physician may be nearing retirement, looking for an exit strategy, or seeking the stability of a larger network. Practices with a high Medi-Cal payer mix and a significant number of capitated lives can represent an opportunity for health centers seeking ways to increase their patient volume while controlling the utilization and cost-related risks of capitation agreements.

Clinics/Community Health Centers/Freestanding Hospital Clinics

Clinics that typically serve low-income and minority populations and that are having financial or operational difficulties may be interested in transferring some or all of their practice assets or locations to another health center. The impact of the COVID-19 crisis on safety-net facilities continues to be one of historic proportions and will undoubtedly result in significant consolidation of resources in underserved areas in the months and years ahead. At the same time, organizations may not have enough patients to properly sustain necessary utilization, or they may find it difficult to hire employees with requisite skills or expertise. Alternatively, they may have been unable to obtain an FQHC 330 designation on their own. Analysis should be conducted to determine how the target

health center would complement your own. Are the service areas adjacent? Is your range of service offerings and service delivery model similar? If the preliminary answers are yes, due diligence will answer the rest of your questions.

Outreach to a Potential Partner

Once a potential partner has been identified, it's time to reach out to the leadership of that organization. Depending on how the parties were introduced, the chief executive of the acquiring entity should meet with the chief executive officer and/or board chair of the potential partner to discuss a possible relationship or acquisition. Before any proprietary data are shared, however, it is advisable for both parties to ensure that the relevant provider's board of directors has approved the initial inquiries. The bottom line is that the full engagement of both organizations' boards and/or executive committees is necessary before initial discussions advance too far.

Once this initial approval agreement has been secured, the following points represent some key topics of discussion you may want to introduce during your initial conversations. As with any high-stakes first meeting, it is important to walk into these conversations with a solid understanding of why you are there. It is likewise critical to be prepared to talk about what you have to offer the prospective partner, as opposed to focusing solely on what they can bring to your organization. Below is an interview guide for health center chief executive officers (CEOs), with questions meant to be asked in a bilateral direction:

- ▶ What is the reason for seeking an acquisition?
- ▶ Is the health center under any pressures, internal or external, that would suggest an acquisition is mandatory?
- ▶ Has the health center completed acquisitions in the past?
- ▶ If acquisitions were completed in the past, were they successful?

- ▶ Are the corporate goals or charitable missions of the parties compatible/consistent?
- ▶ How is the health center perceived by stakeholders?
 - ▶ Board of Directors
 - ▶ Employees
 - ▶ Patients
 - ▶ Funders
 - ▶ Collaborative partners
 - ▶ Communities it serves
- ▶ What might an acquisition look like and why would it be beneficial?
- ▶ Is the acquirer intending to accept/purchase less than all of the assets/locations/staff of the target?
- ▶ If so, how will the remaining staff, assets, or locations be addressed to avoid negative impacts on continuity of care, wasted assets, or other avoidable negative effects?
- ▶ Is the health center obligated under current union collective bargaining agreements?
- ▶ Would health center employees be protected under an acquisition or are cuts likely?
- ▶ Are there any particular liabilities of the health center that would be potential barriers?
 - ▶ Lawsuits
 - ▶ Judgments
 - ▶ Balance sheet deterioration
 - ▶ Other disclosures
- ▶ How important is culture to the current health center organization?
- ▶ Are providers and other employees engaged?
- ▶ Would the providers and other employees be champions of an acquisition or would they be potential barriers?
- ▶ In addition to the boards, CEO, and chief financial officer, which staff from each organization would be necessary to assess and/or implement any proposed transaction?

Many deals are done for the wrong reasons, including simply to gratify a CEO's ego or in response to unwarranted

pressure from the board or other stakeholders. Any transaction done without both parties' best interests in mind is likely to fail. The purpose of the preliminary discussion is to establish a common vision, lay out an initial framework for what a deal might look like, and, if possible, discuss the prospects for fully employing or finding slots for all current health center employees.

Once the parties are aware of each other's intentions and willing to move forward for further consideration, the parties should retain independent legal counsel. Counsel will provide preliminary guidance regarding the legal obligations of the board and negotiators acting on behalf of the nonprofit. They also will draft a confidentiality and data sharing agreement that will bind both the acquirer and the target, as well as the relevant staff, experts, consultants, and in general any person or entity handling shared proprietary data or participating in the negotiations.

In working with legal counsel to develop a confidentiality and data sharing agreement in advance of any substantive preliminary negotiations, the parties should consider the following to ensure the agreement accurately reflects their needs:

- ▶ Fully and correct legal name of the parties and their corporate/individual status (i.e., XYZ, a California nonprofit public benefit corporation, or Jane Doe, an individual)
- ▶ Effective date and termination date of the agreement
- ▶ General description of the information to be protected (e.g., all proprietary information shared in relation to the consideration and evaluation of the practice acquisition)
- ▶ Limits on sharing, handling, and copying the data
- ▶ Affirmation of who owns what data
- ▶ Whether either party is making representations or warranties regarding the accuracy or adequacy of the exchanged data
- ▶ Limitations on nonproprietary or third-party data
- ▶ How the parties would address subpoenas, audits, or court-ordered or litigation-related document production requests

- ▶ The specific rights of the parties in the event of a breach
- ▶ Where notices are to be sent and to whom
- ▶ Whether the parties intend negotiations to be exclusive, and if so, for how long
- ▶ Specific obligations of the parties if the negotiations fall through

Once the confidentiality and data sharing agreement has been signed, the parties should ensure that both the board and leadership are aware of their obligations to engage in and exercise due diligence, the extent to which they can rely on outside or internal experts, their fiduciary duties and duty of loyalty to the corporation, and their prohibitions on self-dealing and private benefit. A failure to address these issues in advance can lead to costly, deal-breaking conflicts down the road.

Merger or Asset Acquisition: What’s the Right Approach?

Most health center expansions involving a combination of health center provider entities or assets are structured as asset acquisitions rather than mergers. Asset purchase agreements permit acquiring entities to selectively limit potential liabilities and assumed obligations. Mergers, on the other hand, result in the assumption of both known and unknown liabilities of the acquired entity, which become the obligations of the acquiring health center once the deal is complete.

FQHC leadership preliminarily considering whether to structure a transaction as either a merger or asset acquisition should consider the following pros and cons:

Asset Acquisition	
Definition: An asset purchase involves one party purchasing all or some of the assets of another on a negotiated basis.	
PRO	CON
<ul style="list-style-type: none"> • The assumption of the seller’s liabilities, if any, is generally limited to those the buyer specifically identifies and the transfer of which was approved by the buyer • Liabilities of the acquired entity are not transferred without an explicit agreement for their assumption, and thus assets can generally be acquired free and clear • Only those assets that are needed are acquired • Assets of for-profit, professional corporations, or partnerships can be acquired, avoiding concerns regarding the corporate practice of medicine and the unavailability of a merger option • Asset purchase generally avoids hidden liabilities associated with prior operation of the acquired provider • May provide an alternative if a merger would trigger debt prepayment or other contractual obligations that would make a merger infeasible 	<ul style="list-style-type: none"> • Required to enroll in Medicare and Medicaid as a new provider with the attendant delays • Required to comply with costly OSHPD-3 requirements as though the clinic were “new construction” and license the site (if no new site is operated as an exempt intermittent clinic under California Health & Safety Code § 1206[h]) • Requires more third-party agreements and consents if payer, vendor, or staffing agreements are to be transferred • Requires an inventory of all assets to be transferred and an independent appraisal of fair market value • Involves greater cost and complexity for transfer of titled and leased property rights, as compared to a merger • Involves a greater number of closing documents than would otherwise be required for a merger • Cultural differences between organizations may impact success and the efficacy of integration, increase cost, or decrease the efficiency of the surviving corporation

Merger

Definition: A merger of FQHCs generally involves two nonprofit, public benefit corporations wherein one corporation merges into and becomes a part of the surviving corporation. The merging corporation is referred to as the disappearing corporation.

PRO

- Nonprofit mergers are relatively simple to complete with respect to the corporate law aspects of the transaction, compared to asset transfers
- Limited interruption in licensing and Medi-Cal and Medicare compensation to the extent that the change of ownership process in 42 CFR § 489.18 is utilized
- Possible limitation of cost associated with OSHPD-3 compliance to renovations, if any, if the change of ownership (CHOW) process is followed

CON

- Since all rights of creditors and all liens and trusts of the disappearing corporation are transferred to the surviving corporation, due diligence is significantly more important and time-consuming to control and understand the extent of risk/liability to be assumed
- While there is generally no need for renegotiation of most agreements, given that the assets and liabilities transfer to the surviving corporation as a matter of law, third-party consent is frequently required for professional services agreements with third-party payers
- Bond and other debt agreements may include acceleration provisions, prepayment penalties triggered by a merger, or other terms limiting the right to merge or that otherwise impact the timing of a merger
- Cultural differences between merging organizations may impact success and the efficacy of integration, increase cost, or decrease the efficiency of the surviving corporation
- Misrepresentations or omissions in the representations and warranties of the disappearing corporation may be difficult to address post-merger

It generally isn't possible to determine if a merger is feasible or the extent to which an asset acquisition may work until the completion of the due diligence phase of the transaction. In other words, until an FQHC has assessed the extent of potential liabilities, it cannot conclude whether the addition of assets will contribute to the achievement of the health center's goals and would be consistent with its charitable mission.

Laying the Groundwork — Teams and Timelines

Assuming your preliminary discussions are fruitful and the parties understand the nature and scope of the transaction as initially proposed, the next step is to identify key leadership and operational staff, as well as outside consultants

and experts. These individuals will be needed to evaluate the feasibility of the proposal and to make decisions or provide the input necessary to revise or approve the ultimate structure of the transaction.

Establishing Decisionmaking Teams

The parties should have skills appropriate to the scope and nature of the transaction. Typically, decisionmaking teams will include key senior leadership members, as well as a subgroup of the board and external experts, depending on the nature of the acquisition contemplated. The target of the acquisition should similarly identify key decisionmakers and operations staff appropriate to the nature of the proposed transaction.

The initial function of the workgroups will be to identify the vision and goals associated with the contemplated acquisition. They also will work with legal counsel and relevant independent financial and other consultants and experts to evaluate the costs and benefits of the proposed transaction. This process should culminate with a presentation (or potentially several presentations) to the respective boards and potentially joint meetings of the boards and the decisionmaking groups.

Identifying and Retaining Appropriate Outside Experts

In addition to legal counsel, the nature of the transaction may necessitate the inclusion of experts in a number of areas to enable the board to discharge its due diligence obligations and fully evaluate the propriety and scope of the proposed acquisition. Some of the issue areas that typically trigger a need for outside guidance include the following:

- ▶ Unique tax and accounting issues
- ▶ Fair market value assessments
- ▶ Environmental issues (generally only if ownership of real property is being transferred)
- ▶ Human resources/Employment Income Retirement Security Act (ERISA)/employee benefit issues
- ▶ Debt financing, bond, and other third-party financing issues and obligations
- ▶ Insurance and litigation issues
- ▶ Regulatory consents and approvals that are outside the experience or comfort zone of the acquirer

In the event that multiple consultants or experts are being retained, the health center needs to establish a clear chain of command. This will help ensure proper management of the team and reduce the likelihood of duplication of efforts, as well as conflicts and distractions, that could delay or confuse achievement of the health center's goals.

Developing a Preliminary Timeline

As you begin to develop a preliminary timeline for the proposed acquisition, consider the unique needs of each entity. For example, if the initiating organization is pursuing a consolidation due to cash flow issues and/or the possibility of imminent financial collapse, the timeline may need to

be accelerated and the scope of the acquisition limited or otherwise restructured. Conversely, if neither party is facing financial or operational duress, the pace can be slower. The time from inception to completion therefore may vary — from as little as eight months to up to 24 months.

As with any timeline, it is probable this one will be revised as the project moves forward. The timeline is not a static guide, but rather an evolving and dynamic road map that the workgroup and key staff can use to refine and strengthen the project plan as circumstances warrant. At this early stage, the timeline should identify agreed-upon milestones and potential roadblocks, with an understanding that some steps will happen sequentially and others concurrently. The timeline goal is to set a clear path forward to:

- ▶ Identify and exchange relevant documents
- ▶ Analyze the relevant data and documents
- ▶ Determine whether the transaction's structure as initially contemplated is feasible or must be altered
- ▶ Understand the timing and scope of regulatory approvals that must be obtained in order to operate new sites or provide newly added services

Along with identifying key steps on the journey, a timeline helps foster an appropriate sense of urgency and bolsters trust between the parties. Setting a deadline to complete the initial phase of exclusive discussions, for example, should give both parties confidence that their potential partner is not secretly courting other organizations.

Establishing deadlines also can help sustain momentum, since both organizations understand the window available to solve problems and move ahead is not infinite. Indeed, tentative deadlines embedded in the timeline reduce the likelihood that organizations linger too long in the initial, decisionmaking phase. A lengthy, drawn-out process for arriving at broad strategic and operational decisions can lead to "analysis paralysis" and also increase the risk of information leaking prematurely. An open-ended decisionmaking phase also can become a drain on organizational resources. It therefore is recommended that leadership review progress on a monthly basis, and by month three of the initial timeline, make a decision about whether to move forward with the deal or not.

How long the analysis and implementation of the transaction ultimately takes depends on a variety of factors, including, but not limited to, the following:

- ▶ Does the target have sufficient assets to satisfy existing creditors and claims, or is there a risk that the assets proposed to be transferred will render it insolvent?
- ▶ Is the proposed target a nonprofit intending to transfer “all or substantially all” of their assets and therefore prior approval by the California Attorney General is required?
- ▶ Does the transaction require HRSA approval of the transfer of a grant, assets subject to an existing federal interest, approval of a new FQHC Scope of Project, or any other significant change that requires prior approval?
- ▶ If a new site is being added, will the facility be fully licensed as a community clinic?
- ▶ If a new service site is to be added, what changes to the facility will be required to comply with the OSHPD-3 building code requirements?
- ▶ If the new service site costs significantly exceed the cost of leasing the facility, is it possible to either purchase the site, or can it be operated in a manner that exempts the location from application of the OSHPD-3 requirements (i.e., an intermittent clinic)?
- ▶ Will the site or providers be enrolled in Medicare, Medi-Cal, the Child Health and Disability Prevention (CHDP) program, the Family Planning Access Care and Treatment (Family PACT) program, and the like, and if so, what site surveys or approvals will be required and how long will they realistically take to complete?

- ▶ You may want to use this *Sample Project Work Plan and Timeline*,⁵ which can be downloaded as part of the *Mergers and Acquisitions Tools* (ZIP) available from the CHCF website, as a starting point for assembling your own document. As the timeline is built out, consideration should be given to deadlines for applying for, and receiving, essential regulatory approvals from key agencies. This includes Change of Ownership (CHOW) processing for Community Clinic Licensure from the California Department of Public Health (CDPH), as well as approvals from HRSA and the California Attorney General’s office. Note that interim management and billing agreements can be used to handle transition periods while regulatory approval is pending.

Also, make sure to delineate essential integration steps along the timeline. Again, these issues are revisited in greater detail further into this guide. Relevant tasks will likely include:

- ▶ Employee-constituent communication plan development
- ▶ Human resources integration
- ▶ Information technologies integration
- ▶ Financial integration
- ▶ Payroll integration

Understanding the steps that will be required to arrive at a cohesive and unified operational environment will be essential to the success of the merger. Hence, organizations should be sure that adequate expertise, leadership, and resources are available in each of these areas. Be aware that although these logistical steps are not strategic, their operational importance should not be understated. Careful planning and testing can reduce significant costs and inefficiencies down the line.

3. Conducting Due Diligence



The central question organizations must try to answer as they initiate the due diligence process is whether the prospective merger or acquisition will likely achieve all that is expected. The due diligence process itself must be predicated on confidentiality agreements that will ensure critical information shared between the parties will be appropriately safeguarded.

The scope of the due diligence to be conducted and the extent of data and documents that must be shared depends on the initial structure of the proposed acquisition. Donation of a typewriter, for example, requires few documents. Conversely, the merger of two heavily regulated FQHCs requires a lot of paperwork. Most transactions will fall in between these two extremes. Not all documents can be obtained directly from the other party. Searches of pending litigation, the existence of liens on assets, corporate standing, environmental issues, and professional or facility licensure deficiencies or oversights often can be initially identified through various public databases.

Both organizations should agree on what information will be exchanged, consistent with the parties' obligations under the confidentiality and data sharing agreements. Although legal counsel should assist in the development of the list of documents to be exchanged, input should be obtained from the operational staff of both parties, as well as appropriate external experts, given the scope and scale of the transaction.

Identification of a Liaison to Manage Data and Document Exchange

Depending on the size of the contemplated transaction and the sophistication of the parties, both the acquirer and the target should identify a point person to act as a liaison. This may or may not be the CEO. Regardless, it should be someone capable of coordinating with outside counsel, ensuring that appropriately requested documents are provided or obtained, and one that is in a position to make or coordinate timely decisions on matters relating to deal analysis and negotiations. Importantly, it should also be an individual who understands their own strengths and weaknesses.

Financial Information

▶ When conducting financial due diligence, it is necessary to develop insight in two areas: the organization's current state and its future state. With these objectives in mind, your chief financial officer (CFO) should analyze the current budget and forecast and assess whether the health center has a strong balance sheet, a healthy payer mix, appropriate utilization, and a balanced budget. As you process this information and begin to understand what the financials of the combined entity might look like, a prospective pro forma budget should be developed for your Board of Directors. (See *Sample Health Center Pro Forma*, which can be downloaded as part of the [Mergers and Acquisitions Tools](#) [ZIP] available from the CHCF website.)⁶

▶ It's also valuable to remember that California has created a streamlined regulatory pathway whereby health centers can bill at the existing prospective payment system (PPS) rates for newly added health center sites. This is particularly important when considering a merged entity structure. Does one health center have higher rates than the other? Will one of the entities be disappearing? In either instance, it would be preferable to surrender the licenses of the lower-rate or disappearing entity and add them as an intermittent site or sites of the other. Under current California law, health centers can add a satellite clinic and operate it for up to 40 hours a week by providing notice to the California Department of Health Care Services (DHCS) Provider Enrollment Division prior to opening.⁷ This is an alternative pathway to site-specific enrollment, licensure, and rate setting that may be appropriate, depending on the specific circumstances and needs of the parties.⁸ Many factors come into play when determining if, and when, an existing or newly acquired intermittent site would be best transitioning to a fully licensed primary care clinic under DHCS. Key issues for consideration include current OSHPD-3 designation or ability to meet current OSHPD-3 building and safety standards, desired operating hours per week,

current PPS rate of linked parent clinic, and future rate setting strategies.

If due diligence indicates that both the current and future financial states are positive and it therefore makes sense to continue moving forward, additional work can begin to identify economies of scale and cost reduction opportunities. Generally, these efforts will involve eliminating redundancies from the proposed combined organizational chart (See Chapter 8: Developing a Human Resource Integration Plan).

If, on the other hand, you determine that your potential partner's financial picture is cause for concern, then the decisionmaking teams need to assess whether it makes sense to keep moving ahead with the deal. In these circumstances, it's important to carefully and independently weigh both the current and future states before making a decision. For instance, if the current state is weak but the future state looks promising, opportunities may exist to mitigate near-term risk by consolidating debt or increasing fundraising. Because organizations typically provide a vital community service by keeping key access points open and maintaining maximum availability for patients, campaigns to ensure these capabilities remain viable can often elicit local, political, or philanthropic support.

For detailed financial checklists that apply to both non-FQHC and FQHC entities, see Appendix Item 1.

In addition to straightforward financial disclosures, completing several other types of due diligence exercises is critical ahead of an acquisition. Below are several items that fall outside the domain of a traditional financial inquiry but nonetheless are essential, given their legal, compliance, and strategic import.

Restriction of Any Assets Acquired in the Process

As part of due diligence, decisionmaking teams must determine if any current and/or potential asset restrictions exist at either organization. Restrictions are a common way for funders, including federal agencies, to ensure that assets, property, and/or dollars are used for specific (often charitable) purposes. Because restrictions frequently carry forward, you will want to make sure you're aware of any that are in force and understand their potential implications for the partnership.

Valuation, if Non-FQHC

If the potential transaction involves the purchase of a non-FQHC private practice, an asset valuation will be required. Once completed, the valuation profile should be presented to your board for review and approval. Consulting firms specializing in provider practice valuations can assist with this process. For recommendations on such firms, health centers can contact peer clinics, their regional clinic associations, and/or the California Primary Care Association.

Needs Assessment

Another important component of due diligence is a review of the organization's community needs assessment, which HRSA requires to be compiled every three years. This is something any FQHC must have, although it likely will not be relevant for a transaction involving a private practice. The assessment should be reviewed for timeliness and completeness. Key considerations include determining how the identified components — including target population, service area, and identified health disparities and barriers — compare with those of the acquiring agency. The respective service areas should be considered to determine if they're complementary, if they overlap, or if they are unduly attenuated. Other key questions: Does the entity being acquired demonstrate competency in serving the same populations as the acquirer, and do they bring any new expertise to the combined entity?

Consents and Disclosures

Most, if not all, potential merger or acquisition partners come with a large amount of preexisting, contracted relationships. These contracts serve many different purposes and may include special rights or responsibilities for the contracting parties in the event of a merger or acquisition. Some contracts will include a requirement of formal notification and some will include the right for contracted parties to issue consent to a merger or acquisition. The latter is quite common with contracted financial entities, such as banks, lenders, and leaseholders. It is therefore critical to identify early on what the entities' responsibilities will be in terms of notifying and receiving approval from these contracted parties. This can impact the critical path of the merger or acquisition both by informing the timeline — some entities may take 60 or more days to process a consent request — and by requiring positive outreach to all who would issue consent.

Contracted parties with the right to issue consent often require a long conversation to learn about the pros and cons of a merger or acquisition. Additionally, many may enter into such a conversation with recent negative experiences top-of-mind. This is particularly likely if a merger/acquisition partner has been under distress and is not meeting their obligations with financial institutions. For these reasons, it's essential to know who the merging groups need to engage and to begin this process early on.

Strategic and Operational Plans

Your health center also should review your potential partner's most current board strategic plan, which is required every three years by HRSA. The operational plan mapped to the goals and objectives presented in the strategic plan also should be reviewed. When you assess both the strategic and operational plans, important questions to consider include:

- ▶ Does their strategic plan have realistic goals and objectives?
- ▶ Do they monitor the progress quarterly or annually?
- ▶ How often does management review the operational plan?
- ▶ How often does management report back to the board?
- ▶ What has been their track record in meeting the objectives of the operational plan over the past three years?
- ▶ What changes to the plan will be necessary as a result of the partnership?

Decisionmaking Report

When two organizations elect to join forces, each will likely have different reasons for pursuing the union. It is therefore important to determine early on — and as specifically as possible — how those visions align. Similarly, it is critical to define what success looks like for the respective parties. To achieve this alignment, be fully transparent with your potential partner about your objectives. Both parties need to be sure they're on the same page with respect to where the combined entity is heading.

That said, some topics may need to be presented or discussed internally only. Doing so provides both boards and decisionmaking teams with an opportunity to air any concerns in a protected setting. Topics for these kinds of internal discussions could, for example, focus on perceived risks associated with the partnership.

Along with the above information, a decisionmaking report should include elements that will promote a vision for the partnership and delineate any items or questions critical to the decisionmaking process. To that end, it may be helpful to identify which components are considered essential for both “go” and “no go” decisions. Some of these issues may need to be addressed later, due to the prioritization of more pressing questions or concerns.

The decisionmaking report should be created by the organizational teams working on the merger or acquisition and delivered to the boards at each organization. If the primary decisionmakers agree that a merger or acquisition makes sense, they should present the report as an aspirational vision for why the organizations will be stronger together.

It is not unusual at this point to become overwhelmed by the challenges associated with unifying two separate entities. The report therefore should not focus solely on challenges but also address the positive potential in the areas noted. (See the *Create Your Core Message* component of Chapter 7: Developing a Communications Plan for additional information.)

While it is optimal to identify and address potential dealbreakers at this early stage in the process, organizations should attempt to come to the table in the spirit of give-and-take, coupled with an awareness of their financial position and consequent negotiating strength. Merger and acquisition negotiations require both transparency and humility. That means each party (even the one in the more-advantageous negotiating position) should adopt a mindset of mutual respect and be willing to clearly articulate the benefits and assets their potential partner will bring to the deal.

The following list identifies the types of specific issues and questions a decisionmaking document should address, along with the conversations that should be occurring at this point:

- ▶ Define your respective goals for the partnership and how this partnership will advance those goals.
 - ▶ Do you hope to expand service offerings?
 - ▶ Do you hope to acquire new staff talent?
 - ▶ Do you hope to increase the number of Medicaid managed care lives served?
- ▶ Does either organization have any deal-breakers that need to be addressed (e.g., commitments to maintaining their existing electronic health records [EHRs], certain services, or specific staff members)?
- ▶ Review the respective organizational missions and visions and evaluate how they align with one another.
 - ▶ Will one of the prospective partners need to reevaluate any components of their mission and vision?
 - ▶ Whose mission and vision will remain standing?
- ▶ Develop staffing plans and a preliminary organizational chart.
 - ▶ What will the leadership structure look like?
 - ▶ Are all employees of both organizations being offered full employment?
 - ▶ If not, which positions may need to be eliminated?
 - ▶ Will those employees be offered other employment?
- ▶ Evaluate the entities' financial health and develop pro formas (including planned productivity improvements).
 - ▶ What is the financial health of the respective organizations?
 - ▶ What do the combined financial statements look like?
 - ▶ Will there be any significant changes to productivity?
- ▶ Evaluate service areas and review needs assessments.
 - ▶ What is the existing service area (if the entity being evaluated is already an FQHC)?
 - ▶ What will the combined service areas look like post-transaction?

- ▶ Consider any changes to services or programs.
 - ▶ Will programs be improved as a result of the transaction?
 - ▶ Will clients obtain access to new services?
 - ▶ Will programs need to be cut?
- ▶ Develop the potential legal requirements and structure for the consolidation.
- ▶ Consider any significant operational changes (e.g., transitioning the EHRs).
- ▶ Discuss organizational cultures and values (See Chapter 8: Developing a Human Resource Integration Plan for more detail.).

Assuming this process leads both organizations to agree that they have enough information to move ahead, the parties may choose to sign a nonbinding letter of intent. This confirms that the organizations intend to continue with the process, based on their initial assessment. This document should be prepared by legal counsel and explicitly state that it is nonbinding. Until the due diligence has been completed, it will not be possible to realistically determine whether the initially proposed structure of the transaction is financially viable or appropriate to the goals and needs of the parties.

At this point, it is important to revisit the decisionmaking document to be sure all outstanding items are addressed. For example, many people do not incorporate organizational culture and values as a critical element in their decisionmaking. However, if organizational culture differences are not addressed, it could result in culture clash. This often manifests as sites that never fully integrate into the surviving entity and do not accomplish the anticipated efficiencies or expansion that served as the foundation of the union in the first place.

Culture clash, in fact, is commonly recognized as a top reason for merger failures. This issue of cultural integration is discussed in Chapter 8: Developing a Human Resource Integration Plan. Health centers also are encouraged to consult the CHCF's October 2019 publication *[Building to a Sum Greater Than Its Parts: A Hands-On Guide to Cultural Integration in Community Health Partnerships and Alliances](#)*.⁹

The due diligence and decisionmaking phases can happen quickly or take months, depending on the scope of the proposed transaction. The parties consequently should tailor the timeline to reflect the complexity of the transaction and available time and financial resources. If the scope of the proposed transaction is broad (e.g., a merger or full integration of all staff and assets), the nature of the transaction should be revised. Regardless, identification of specific dates will keep the parties focused on moving forward.

Development of an Initial Due Diligence List

The documents to be exchanged by the parties are intended to aid the respective teams and relevant consultants and experts in determining the viability of the transaction as initially proposed and the likelihood that it will achieve the anticipated benefits. The nature of the final document request will vary widely depending on the scope of the acquisition, but may include information relevant to the following:

- ▶ Corporate Compliance — Articles of incorporation and bylaws, as originally adopted and all amendments, current organizational charts, board and committee minutes, Internal Revenue Service (IRS) and Franchise Tax Board exemption approvals
- ▶ Licenses and Permits — All licenses, permits, and relevant communications with regulators
- ▶ Contracts and Written Commitments — This should include all third-party payer agreements (e.g., IPAs, health plans, etc.), employment or independent contractor agreements, information technology (IT) agreements/licenses, real estate commitments (e.g., lease, purchase, deed, and the like), grant agreements with philanthropic partners, and vendor agreements
- ▶ Human resources agreements/policies
- ▶ Claims, liens, Uniform Commercial Code (UCC) Commitments, litigation, regulatory Issues
- ▶ Insurance and Federal Tort Claims Act (FTCA) Deemed Coverage documentation and claims
- ▶ Public payer enrollment, rate-setting, and reimbursement documentation
- ▶ Credentialing and quality assurance-related documentation and policies

- ▶ Inventory of physical assets and depreciation schedules
- ▶ Audit reports and auditors' letters to management
- ▶ Tax filings and disclosures

It is advisable to initiate the due diligence process using a central digital location through which files can be shared and exchanged. Ideally, each organization should have a central digital document library that utilizes standard labeling conventions and includes both core and associated documents. If this is not the case, adequate resources and time should be dedicated to creating one.

The documents to be requested will depend on the nature of the transaction as initially proposed. The goal is to understand, particularly with respect to financially distressed targets, the extent to which the target provider has complied with existing regulatory and contractual obligations, actually owns the assets to be transferred, and whether they have entered into questionable transactions with insiders or others. The overriding objective is to determine whether changes need to be made in the structure based on available information.

The listing of documents to be exchanged should be developed collaboratively with legal counsel. The list should include the specific documents that are sought, the person or team responsible for reviewing the documents, and an anticipated timeline for the review.

The review should be sufficient to ensure that the FQHC's board of directors is able to discharge their statutory obligations as the governing board of a charity. The governing board's consideration of acquisition of its assets must be preceded by a legally sufficient review of the circumstances and potential consequences of the proposed transaction (due diligence).

California law governing nonprofit public benefit corporations provides that the board of directors are required to perform their duties "in good faith, in a manner that director believes to be in the best interests of the corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances."

Clearly, a board member's obligation to make a reasonable inquiry cannot be accomplished in a vacuum, and in

exercising this duty, directors are entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, that are prepared or presented by:

1. One or more officers or employees of the corporation whom the director believes to be reliable and competent in the matters presented;
2. Counsel, independent accountants, or other persons as to matters which the director believes to be within that person's professional or expert competence; or
3. A committee upon which the director does not serve that is composed exclusively of any combination of directors, persons described in above-item (1) or persons described in item (2), as to matters within the committee's designated authority, which committee the director believes to merit confidence, so long as, in any case, the director acts in good faith,

after reasonable inquiry when the need therefore is indicated by the circumstances and without knowledge that would cause that reliance to be unwarranted.

While directors of a nonprofit charity are generally exempt from personal liability for the debts, liabilities, or obligations of the corporation, they are not immune from personal liability for their own fraud, bad faith, negligent acts, or other breaches of duty, including a duty to make a reasonable inquiry consistent with Corporations Code § 5231.¹⁰

The nature and extent of the inquiry depends in large part on the type of transaction under consideration. The documents to be exchanged as a part of a review of a proposed transaction are intended to ensure that board members are able to discharge these duties and can understand whether the proposed transaction will in fact benefit the corporation, or, alternatively, whether the structure, as initially contemplated, needs to be modified.

4. Establishing Teams and Reviewing Documents



Congratulations! You've signed a letter of intent. Now the real work begins. But first, make time to celebrate — it has undoubtedly taken a lot of hard work to get to this point and you have found a potential partner. A get-to-know-you event involving both boards can set a positive tone for the journey you're about to embark on together.

With the festivities concluded, the first step is to revisit the timeline and continue to build out key steps and milestones. Because the timeline represents the map you'll follow, you should include significant details about the various tasks to be completed, such as who has direct responsibility for a given step and what the tentative deadlines are. You'll want to be sure nothing falls through the cracks.

To foster transparency and accountability, the project stakeholders and subgroups/teams can use a project management tool or application that clearly indicates the activities and deliverables, deliverable dates, sponsors, owners, and relevant notes. As a living document, the work plan should be revisited at regular intervals to be determined by the project teams. For example, subgroups may want to update the action items and owners more regularly than the overall project team if they're meeting on a more frequent basis.

Creating an Integration Team

While you may want to maintain your initial decisionmaking team, it makes sense at this point to create a larger integration group that includes individuals from both organizations and potentially, outside experts or consultants, with the latter preferably working pro bono. You may be able to identify external resources, such as legal counsel, through existing relationships. But be sure these experts have the background and time necessary to successfully execute the tasks you'll be asking them to undertake.

The integration team should include, but not be limited to, the following roles and/or areas of expertise:

- ▶ **Project Manager:** This may be an internal individual or external consultant, depending on the organizations' collective capabilities and expertise
- ▶ **Legal Counsel**
- ▶ **Accounting and Tax Expert**
- ▶ **Information Technology Consultant:** Critical responsibilities include selecting a unified electronic health

record (EHR) for the combined entity, facilitating integration and adoption of the system, evaluating existing software and technology platforms across both organizations and integrating, as necessary

- ▶ **Operational and Organizational Assessment Team:** This workgroup is responsible for evaluating the proposed service delivery models, standardizing QA/QI programs, and combining operational business units and shared service departments
- ▶ **Compliance Expert(s):** Responsibilities include addressing multiple and overlapping regulatory compliance issues, including [HRSA Compliance Manual](#) program requirements, [CMS Medicare](#), [California Medi-Cal](#), and the [California Department of Public Health](#) (community clinic licensure), along with other program regulations
- ▶ **Human Resources Consultant/Employment Specialist:** Duties include integration of employee benefits/ERISA, handling terminations and buyouts, and recruiting staff, as necessary
- ▶ **Facilities Lead:** Responsibilities include, but are not limited to, overseeing fair market value assessments and assessing any environmental issues
- ▶ **Financial Lead:** Expertise needed in health plan contracting, federal grant issues, bonds, and other financial instruments and insurance

Conducting a Document and Protocol Review

Arguably one of the most tedious tasks that must be completed ahead of a proposed acquisition is a review of all governance documents and contractual agreements. The focus should be on identifying governance items that may impact the procedural order of operations and reviewing contractual agreements to support the identification of liabilities, future obligations, and appropriate post-merger/acquisition planning discussions. Administrative and operational

policies, procedures, and protocols also should be collected and cataloged.

High-level analysis focused on any sizable differences should generate healthy discussions that will inform gap analysis and reconciliation planning. This process is separate from the previously conducted due diligence reviews and is focused on understanding current work streams and policies at the respective organizations. A thorough document cataloging review and gap analysis of both entities' documentation establishes a solid foundation for discussing workflow alignment. This can help prevent surprises once the combined organization begins to offer services. By clearly defining approved workflows, leaders can ensure accountability and adherence after the transaction is complete.

An effective document labeling and sharing protocol should include the following information:

- ▶ Functional business unit/department name
- ▶ Type of document (policy, procedure, guide, workflow, template)
- ▶ Document title (enter title using standard nomenclature)
- ▶ Document catalog number (assign numbers to all documents)
- ▶ Last reviewed/edited (enter date)
- ▶ Approved by (name and title)
- ▶ Document reviewed by (acquiring entity personnel name and date)
- ▶ Document most closely aligned (name of document most closely aligned with acquiring entity document)
- ▶ Modifications needed to acquiring entity documents (Yes/No)
- ▶ Person(s) responsible for making edits or drafting a new document (name of individual)
- ▶ Review and revisions due date (insert date for when action item is due)
- ▶ Action Items completed (enter date of action item completion)

- ▶ See *Sample Document Catalog Template*, which can be downloaded as part of the *Mergers and Acquisitions Tools* (ZIP) available from the CHCF website.¹¹

- For a detailed list of Key Documents to be Reviewed, see *Appendix Item 2*.

Leadership, Employee, and Board Considerations

Leadership Assessment

The process of determining leadership roles for the combined entity shouldn't wait until the deal is approved. Preliminary discussions should have taken place during the due diligence and decisionmaking processes. At this point, more detailed conversations should be initiated, including a thoughtful analysis of the suitability of tentative or proposed leaders. This is a critical and delicate step. While this is ultimately a business transaction, these conversations involve people's careers, livelihoods, and professional identities. Employee considerations are discussed in further detail in Chapter 8: Developing a Human Resources Integration Plan.

A good place to start is to assess whether current or potential openings exist in the merged organizational chart. Additionally, it should be determined if there are current HR issues involving a potential leader and whether a clear pathway is available to install the strongest candidate in the appropriate position. As for CEOs, the larger or more dominant organization's CEO typically prevails. The question of whether an appropriate position exists for the smaller organization's CEO should be addressed.

In a merger/acquisition of equals, an additional option may be to create a co-CEO structure. One person, for instance, would have responsibilities that focus on all things external, while the other would concentrate on internal matters. Intensively concentrating on leadership issues and personnel early on will provide important and appropriate assurances to the respective board members, managers, and employees. Once tentative decisions have been reached, a mockup of the proposed organizational chart can be useful to illuminate lines of authority and new job classifications in the combined entity.

Employee Considerations

A salary and benefit comparative analysis should be conducted across the merging entities to ensure parity and to preserve employee goodwill (See *Benefits Comparison Sample*, which can be downloaded as part of the *Mergers and Acquisitions Tools* [ZIP] available from the CHCF website.).¹² Consideration will need to be given to the question of whether all employees will be offered employment in the new entity at their current level or will be required to apply for a new position. Key issues that should be addressed include identifying any new efficiencies and whether open positions that result from attrition will be subject to rehire. Communication to the employees should follow the recommended Communications Plan (See Chapter 7: Developing a Communications Plan.). Leadership should remember that employees are essential and valued stakeholders in the process.

Board Dynamics

Board membership of the acquiring or surviving entity will need to reflect the new organization's combined service area and target population. FQHC governing boards are required to have between nine and 25 members. It generally is a good idea to keep the number on the lower end of the

range to make the structure manageable, but also to have a sufficient number of board members to enable the entity to remain compliant even if several members leave. Thought should be given to whether any board members from the acquired entity will be invited to join the new board. If the acquired or merged entity represents a new region or a particular medically underserved population, representation will be a key consideration. If not, an advisory, development, or consumer-focused, nonvoting board can provide a viable way for displaced members to continue playing a role in the merged organization.

Once a signed letter of intent agreement is in place, organizations should maintain parallel, concurrent boards until the transaction is finalized. Because the health centers may be operating under an interim agreement (wherein the acquiring or surviving entity is assuming contractual obligations on behalf of the acquired agency), both boards must continue to operate in a compliant manner and retain full administrative oversight for their HRSA-approved scope of operations. If the use of an interim agreement is being considered, both parties are strongly encouraged to seek legal counsel as to the regulatory issues that may arise.

5. Managing Payer Transitions



New sites and providers will need to be enrolled in most public payer programs for services covered by these programs to be reimbursed. FQHCs are required to have, or be working toward, enrollment in Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP) (42 U.S.C. § 254b[k][3][E]).¹³

Depending on the nature of the acquisition transaction, enrollment under most programs will fall into one of four categories:

1. New enrollment
2. Change of information
3. Change of ownership
4. Special Medi-Cal rules for intermittent clinics

When adding a new site as part of an acquisition, the site will need to be enrolled in Medicare as a new FQHC provider. FQHCs can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- ▶ Internet-based Provider Enrollment, Chain, and Ownership System (PECOS), or
- ▶ The paper enrollment application process (i.e., CMS 855-A form).

A change of any of the information reported on the CMS 855-A form must be reported within 90 days of the effective date of the change, per 42 CFR 424.516(e)¹⁴; changes of ownership or control must be reported within 30 days of the effective date of the change.

FQHCs must obtain a National Provider Identification (NPI) number prior to enrolling in Medicare or before submitting a change to existing Medicare enrollment information. Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at <https://nppes.cms.hhs.gov>. FQHCs are responsible for determining if you have subparts for purposes of obtaining NPI numbers. A subpart is defined as a component of an organization that furnishes health care and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly. FQHCs are designated as Type 2 entities under the NPI system.

While California exempts intermittent clinics from site-specific enrollment in Medi-Cal, this exception does not apply

to Medicare. California intermittent clinics are required to enroll in Medicare on a site-specific basis prior to delivery of Medicare services to patients for which reimbursement will be sought.

The term *intermittent clinic* is defined by California law as a site that is exempt from the clinic licensing requirement under California Health and Safety Code section 1206(h).¹⁵ It is also exempt from Medi-Cal’s site-specific enrollment requirement under California’s Welfare and Institutions Code section 14043.15(e),¹⁶ which only requires that the Department of Health Care Services (DHCS) be notified of the existence of the intermittent clinic. HRSA uses the term intermittent clinic differently, and the two types of intermittent clinics should not be viewed as synonymous. They are not.

California’s Medi-Cal program enrolls FQHC sites that are licensed community clinics, as defined by California Health and Safety Code section 1204(a),¹⁷ initially through the California Department of Public Health (CDPH). The CDPH coordinates the Medi-Cal enrollment of the FQHC through DHCS’s Provider Enrollment Division.

Changes of Medi-Cal enrollment information previously submitted by existing licensees/enrollees is submitted by institutional providers, such as FQHCs, to the CDPH, rather than to DHCS, according to Medi-Cal’s Provider Manual.

HRSA requires that FQHCs provide notice of changes in the Scope of Project, stating that “After a change in scope of project that may generate a FQHC Medicaid reimbursement (e.g., PPS or Alternative Payment Method [APM]) adjustment is approved, it is the responsibility of the grantee to notify its State Medicaid Agency of the change(s) within 90 days following HRSA approval.”¹⁸

Intermittent clinics present an opportunity to control non-health care-related expenditures and waste resulting from costly delays in obtaining approval of new site licenses, enrollment, and FQHC rate-setting. California’s Legislature has addressed concerns from FQHCs about these issues by expanding the hours of operation of exempt intermittent sites

to no more than 40 hours per week. Intermittent sites offer the following advantages:

- ▶ They are exempt from the OSHPD-3 building code requirements, since they are not licensed clinics
- ▶ They are exempt from Medi-Cal's site-specific enrollment requirements under Welfare and Institutions Code section 14043.15(e),¹⁹ so long as they provide prior notice to DHCS (copies should also be sent to DHCS's Audits and Investigations and CDPH)
- ▶ Services provided by an FQHC at an intermittent clinic are billed by, and at the rate of, the parent FQHC under Welfare and Institutions Code section 14132.100(j)²⁰

California intermittent clinics must still enroll in Medicare. Certain Medi-Cal programs, such as Family PACT and CHDP,

require separate enrollment and/or surveys of intermittent clinics. It also should be noted that CDPH has recently sought to push back on this flexibility by purporting to require an application or CDPH prior approval of intermittent clinics before Medi-Cal services can be billed. Legal guidance should be sought to the extent that difficulties are encountered. However, the information that currently is required is generally basic, and timely submission can avoid conflicts.

It is nonetheless essential to verify current guidance regarding Medicare and Medi-Cal enrollment early in the acquisition planning process. Estimated time frames should be incorporated into the timeline, and applications should be reviewed carefully prior to submission. Errors in the forms or misunderstandings regarding applicable requirements can cause significant delays and financial losses.

6. Contract Review and Assessment



Once you've put the Medicare and Medi-Cal work streams into motion, transition leaders should turn their attention to assessing the full scope of active contractual relationships that exist with each entity.

Essentially, leadership must decide which contractual relationships will continue after the transaction and which will not. During this phase, it is important to prioritize the agreements that are of a most critical nature to the surviving entity — typically in terms of net revenue generated — as well as those that may require more time to transfer from one entity or another, such as those involving third-party payers.

After leadership has determined which relationships they wish to continue after the transaction closes, they can begin the process of altering the contractual agreements and commitments as necessary to meet the needs of the post-transaction combined entity. It may become evident that specific contracts or contract elements will need to be renegotiated. Some agreements also may require notices of an impending transaction and a notification period prior to any changes taking effect. If the transition leaders determine that a contractual relationship is to end altogether, the appropriate notice of termination will need to be provided consistent with the terms of the agreement.

Now is the time to get a handle on these issues. Waiting until the deal is finalized before suggesting or requiring contractual changes could delay or undermine the transaction and leave the surviving entity in a disadvantageous position. While much of the legwork in this area can be handled by health center staff, the process should be conducted in close coordination and consultation with legal counsel, as needed.

Because existing agreements have previously been identified during due diligence, it should be relatively straightforward to create or modify a contracts log for both agencies. Organize the log by general subject matter of the agreements, including those involving local, state, and federal government payers, commercial payers, ancillary service providers, referral partners, product and service vendors, foundations, and other philanthropic entities.

These agreements should be carefully reviewed through the prism of the surviving entity's anticipated requirements and capabilities, with particular attention paid to either services that will no longer be required or terms that may need to be substantially modified. Remember that some contracts

may include leases or other longer-term stipulations that are attached to some type of liability and consequently could require in-depth renegotiations to resolve.

Through this process, determinations should be made about whether the contract should be continued in its current form (no action), terminated (consistent with its terms), renewed, or modified by amendment. Based on the outcome of these assessments, new contracts, notices of termination, and/or amendments to existing agreements should be prepared. In situations where a notice or amendment is not specifically required under the agreement for it to continue following an acquisition, it is nonetheless strongly recommended that a courtesy notice be provided to ensure smooth operational transition of the relationship post-acquisition.

Due to the volume of active contracts at a typical health center, the effective transfer or expansion of contractual relationships, especially those with third-party payers, can take a significant amount of time to complete, usually a six- to eight-week period at a minimum. Internal staff can easily be overwhelmed by the process and ensuing time commitment. It is therefore strongly recommended that a Project Management Professional (PMP) — either internal or external — lead the process. Assistance should be provided by temporary staff, employees of other departments, or outside consultants. Legal counsel also will need to be available to the transition team throughout this process as issues arise to ensure existing contractual rights are properly exercised, if needed, and that the rights of the surviving entity are appropriately protected going forward.

Third-Party Payer Agreements

Because health plans and other third-party payer agreements directly impact a health center's financial stability, they should be given priority and close attention. Of primary importance is making sure the relationships that will continue post-transaction are handled correctly. This will help ensure continuity of patient care and no disruptions in revenue.

Analyze health plan agreements by creating a contracts log or matrix for each health center. Compare critical data points for each health plan. This information should include renewal dates, capitation and fee-for-service rates, patient visits in the prior year, and other relevant metrics. In cases where a larger number of third-party payer agreements exist, health center leadership should prioritize the relationships that impact the greatest number of patients and contribute the most to health center revenue. If time is short, agreements with health plans that are only billed occasionally can be handled later in the process or even after the transaction is completed.

Review each health center's log of health plan contracts and identify health plans that are unique to each pre-transaction entity. Determine whether that relationship will continue post-transaction. These health plans will be dealt with differently than health plans that already have existing agreements with both entities.

Develop an outreach plan for all health plans with contracts, including assigning a capable and responsible individual to

handle contract transitions. The process of transitioning health plan contracts can be time-consuming. Even identifying the right department or authority at each health plan to assist with the process can take time, especially with large health plans that serve thousands of providers and hundreds of thousands of enrollees.

It's important to note that health center care providers that are new to a specific health plan may need to be credentialed and existing providers may need to be re-credentialed, depending on the nature of the transaction and internal policies of individual health plans. Time for these processes to occur should be accounted for in transition planning.

As you explore the transition process for each health plan, consult with the health plan and legal counsel if it appears billing for patient care cannot begin immediately after the transaction date. Determine if direct patient care can be delivered through an interim management agreement and billed for under the old agreement for a short period after the transaction to ensure continuity of care and uninterrupted reimbursement.

7. Developing a Communications Plan



You now should focus on another mission-critical component in the acquisition process: developing a plan, message, and platform for communicating with stakeholders, including employees, the broader community, funders, regulatory bodies, the press, and elected officials.

As is the case with many complex organizational activities, defining a narrative and staying on-message before, during, and after the event is crucial. Without a coherent story, nuanced or multilayered changes are often oversimplified or mischaracterized. That’s why it’s crucial at the outset to develop a strong communications strategy that will address the unique realities of the entities involved and the communities they serve. (See *Communications Plan Outline with Sample Positioning Statements and Exercises*, which can be downloaded as part of the *Mergers and Acquisitions Tools* [ZIP] available from the CHCF website.).²¹

Begin using this guide early in the acquisition process to clarify your messaging, limit the flow of misinformation, and to create a vigorous communications platform that will support the acquisition objectives throughout the process. The figure below graphically incorporates the essentials of a robust integration-communications approach. It is important to adopt a strategic methodology to communications early on, rather than simply providing informational updates. By doing so, you’ll create a mechanism to clearly convey and amplify your organizational goals.

Six Essentials Help Build and Execute a Robust Integration-Communications Approach

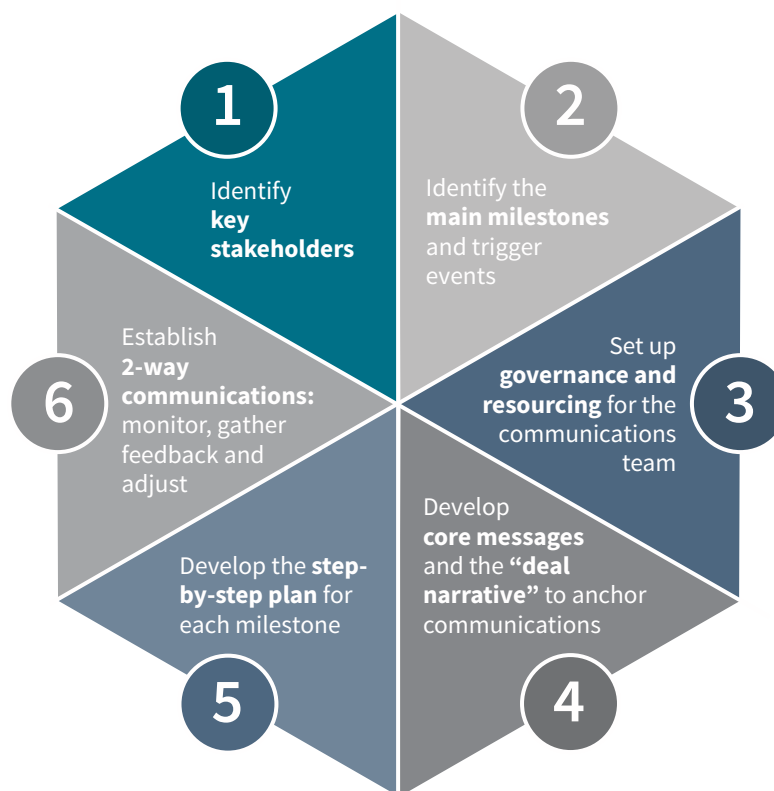


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Create Your Core Message

The initial step in creating an effective communications plan is for key decisionmakers to articulate the rationale for the acquisition. Why does this combination of two previously freestanding entities make sense? The core message should be concise, straightforward, and brief: Come up with a few sentences that someone who doesn't know much about health centers could easily understand. Because the message must be agreed upon by all decisionmakers, the process of creating it can serve as a valuable exercise in focusing and clarifying the logic behind a planned transaction.

The core message will serve as the foundation for all subsequent messaging. As such, it's not necessarily an external-facing document, but more of a shared internal resource that guides and informs external communications to various constituencies. As the project advances, you'll need to adapt and modify your messaging for different audiences, venues, and formats. But by first establishing the shared core message, you can ensure all subsequent variations will be consistent and compatible with the project's objectives.

Map the Audiences

When it comes to communication, what matters is not just what you said, but equally important, what your listener heard. This is a fundamental rule of effective communication. To design messages that your listeners interpret as planned, it's critical to understand your audiences within a psychographic context.

Understanding your audiences requires that you identify and segment them. Deliberately map out the various audiences who you expect will be aware of, and interested in, your project. Try to identify no more than 10 core audiences whose buy-in will be critical to the success of the transaction. Combine audiences who have relatively similar interests and motivations and segment those who will behave and react differently. Although audience lists will vary for each community and organization, a good starting point for most health centers would include:

Internal

- ▶ Executives and Managers
- ▶ Providers
- ▶ Other Staff

External

- ▶ Existing Patients
- ▶ Local Media
- ▶ Program Partners
- ▶ Elected Officials
- ▶ Community Leaders

Once the different audiences are identified, construct psychographic profiles of each group. Describe who they are: Their values, opinions, attitudes, aspirations, and concerns. Consider identifying individuals from each group who embody the characteristics of that audience.

Your efforts do not need to be exhaustive or detailed. But when this exercise is complete, you should have a firm understanding of what motivates the audiences as it relates to your acquisition project. As you undertake this work, try not to make assumptions about what these people will think about the project. Simply focus on defining them as clearly as you can. As you work, try to identify any well-known or well-regarded individuals within these groups whose approval likely will be important to the success of the project.

Develop Core Messages for Each Audience

Now things start to get interesting: Consider each of your audience psychographics within the context of your core message about the planned project. What kind of reactions, responses, concerns, and questions can you anticipate? Make a list for each psychographic category or factor. Below are some common examples of questions that come up in nearly every health center planned acquisition. Be sure to adapt and expand these for your community.

Common Internal Questions

- ▶ **Executives and Management:** Do I have a new boss? Will we combine systems with the merging entity or will one system displace the other?
- ▶ **Providers:** What does this mean for our model of care?
- ▶ **Other Staff:** Can I keep my job? Where will I sit?

Common External Questions

- ▶ **Existing Patients:** I love my health center and the people who work there! Please don't damage this community asset.
- ▶ **Local Media:** What does this mean for our community? How does it reflect other trends affecting our region?
- ▶ **Program Partners:** What does this mean for our collaboration? Do we need to renegotiate the contract?
- ▶ **Elected Officials:** Are you responding to the needs of my constituents? How does this affect the local continuum of care?
- ▶ **Community Leaders:** What does this mean for access to health care in our community?

Once you have an idea of the kinds of reactions you can expect from each audience, start adapting the core message to reach the various groups. How do you stay true to the core message while speaking to the specific concerns of different audiences or individuals? It's valuable for the key decisionmakers to document and practice these adaptations, so as to develop a shared understanding of how to communicate the core message in different contexts.

Below are simplified examples of this adaptation process in action:

- ▶ **Core Message:** Our organization is in financial trouble and we must merge in order to ensure financial sustainability.
- ▶ **Core Message Adapted to Key Audiences:**
 - ▶ **Providers:** Making this change will allow us to pay better wages and improve benefits.
 - ▶ **Other Staff:** Without a planned acquisition, we will need to implement a hiring freeze and delay cost-of-living adjustments.
 - ▶ **Existing Patients:** If we don't make this change, it is going to be harder to recruit new doctors to this community and we may need to close some sites.
 - ▶ **Local Media:** This move reflects changes in our local community: Medi-Cal patients have become harder to find and serve, and this is negatively impacting reimbursement.

Develop Ambassadors

Once you've established a core message and understand who your audiences are and why they're likely to care about the deal, it's time to think about how best to roll out your story. Begin by identifying your messengers or ambassadors. Who will be the point people to distribute messages about the project and respond to inquiries? Choose individuals from both organizations, as well as those who have the appropriate authority and credibility to respond to specific concerns. Select people who are well spoken, can think on their feet, can be trusted to stay on-message, and who have credibility in the community. Frequently, organizations will look to the following groups when identifying potential ambassadors:

- ▶ Executive leadership, especially CEOs
- ▶ Board members, especially officers/chairs
- ▶ Providers with a community following
- ▶ Community or government relations staff
- ▶ Nonexecutive employees who are well known, liked, and trusted by staff

Train your ambassadors around your core message, audiences, and how to adapt the message to address various specific concerns. Make sure at least one ambassador at each organization is designated as a media and governmental point of contact. That way you'll know who will be responsible for dealing with formal, high-exposure inquiries about the project.

Update Marketing Collateral

Depending on how the new entity will be positioned in the community, updates to marketing collateral may be required. The simplest approach is to maintain the branding of the surviving entity. Another common strategy is to present the branding of the dissolved entity as a program within the surviving organization. One example involves Lyon Martin Health Center (dissolved entity), a program of HealthRIGHT 360 (surviving entity). HealthRIGHT 360 is a fast-growing health center system based in San Francisco. They've expanded primarily through acquisitions but have allowed each joining entity to retain its own naming convention and identity as part of the larger HealthRIGHT 360 brand.

Level of Communication During Integration Timeline

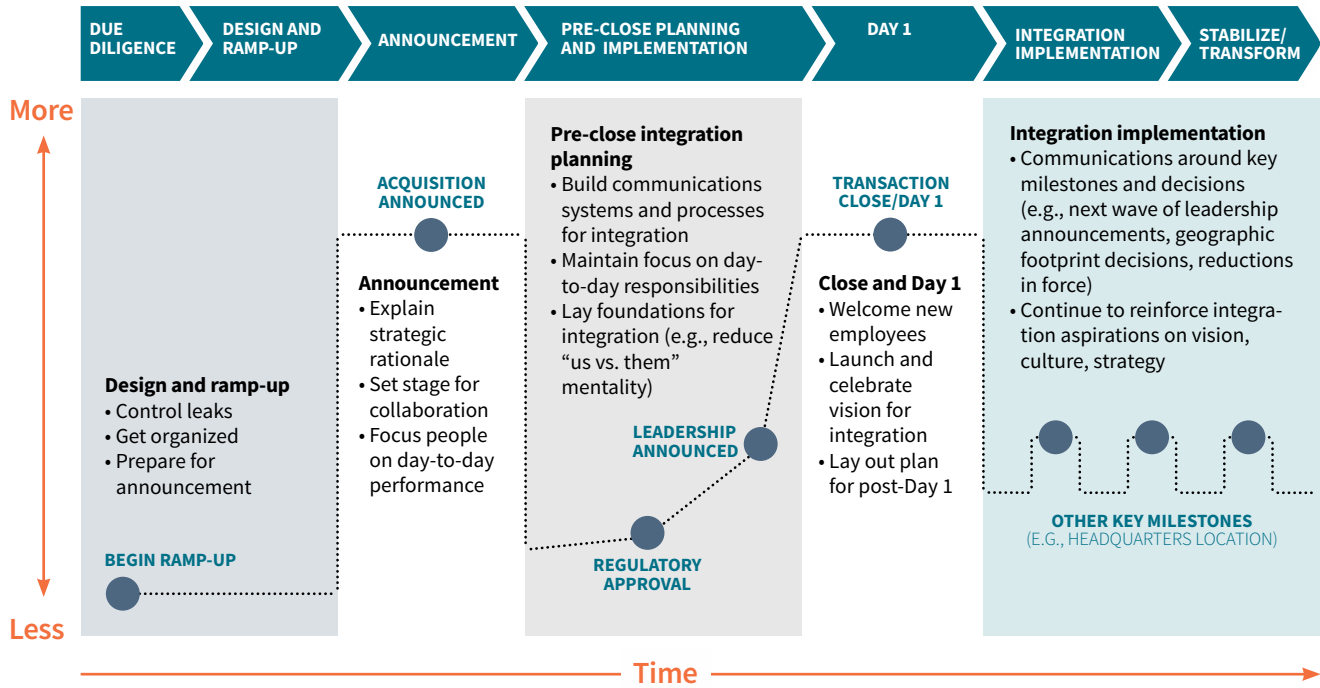


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Organizations with more resources may elect to use the planned acquisition as an opportunity to completely re-brand and relaunch the new, combined entity. However, this approach entails considerably more work at a time when the combined administrative staff may already be highly taxed. Either way, you will want to map out any critical modifications required for logos, signage, and printed marketing materials. Many organizations will opt to produce special temporary signage or websites prior to the planned acquisition so patients and stakeholders can become aware of the pending organizational integration.

Create a Timeline

Now it's time to share your plans and message with the community. Start by developing a timeline that specifies the types of communications you will have, their frequency, and order. Remember not to begin communicating too late: The goal here is to get your message to the community before rumors spread and misinformation takes root.

A wide range of ways to roll out your message exists. The following list of communication formats and venues

represents a valuable starting point when crafting your communications timeline:

- ▶ Press release
- ▶ Email blast to distribution list
- ▶ Social media posts
- ▶ Website page update
- ▶ Community forum
- ▶ Interview or article with local media
- ▶ Company meeting
- ▶ Open house/reception
- ▶ Sit-downs with community leaders and elected officials
- ▶ Ribbon-cutting celebrations

As you develop your communications timeline, be sure to keep the requirements of your audiences in mind. Some will need to be engaged at different points than others. There also may be influential leaders you'll want to communicate with before your messaging goes out to the

broader community. If necessary, plan a quiet period to engage these selected individuals. This way, they'll be in a position to advocate on behalf of the transaction once the information is widely disseminated.

Monitor Varying Communications Intensity

Nearly all planned acquisitions require a substantial amount of time and energy to plan, implement, and finalize. The intensity of actions relating to the transaction typically will ebb and flow during the life cycle of the process, with periods of high activity followed by intervals of relative inactivity. Developing a sense of these variations throughout the project life cycle will enable health center leaders to plan and target their messaging accordingly. Generally, communications surrounding the process should be timely

and prompt once the communications strategy is launched. However, they do not necessarily need to be constant or regular throughout the process. (See the McKinsey & Company figure on the previous page.)

For example, while you do not want to make dramatic changes before the community has become aware and supportive, you also do not want to create an open-ended narrative that seemingly never comes to fruition. This can engender a vague and unsettling perception of change without resolution. Address this by starting your communications early, staging them in logical order, and giving time for them to sink in. Then deliberately focus on messages of closure, success, and celebration once the project has wrapped. Also, be cognizant of common patterns or rhythms in your community when staging your messaging. Think about people coming and going with the seasons, vacations, school schedules, and more.

8. Developing a Human Resources Integration Plan



This chapter offers guidance about the development of an effective human resources (HR) integration plan. Because successful HR integration requires well-conceived communications, it will be useful to consult the preceding chapter for further clarity about how to effectively connect with employees, your most essential stakeholder group.

Note that successful HR integration means not just successfully communicating with, and managing, staff but also bringing HR leadership into the acquisition discussions early in the process. Too often, acquisition conversations happen without involving HR until after key decisions have been made, many of which HR is then asked to implement. This is understandable, but misses some major opportunities for HR to provide critical input. When key HR leaders are involved from the outset, pitfalls can be identified and avoided. Additionally, HR can provide valuable insight into broader, strategic issues — again from the perspective of staff.

Taking Care of Staff During Planned Acquisitions

In all likelihood, staff represents the largest single area of expense for your health center. They also embody all dimensions of the health center's mission. They're the ones treating your patients, ensuring efficient operations, and representing the business 24 hours a day, seven days a week. As such, it's no exaggeration to say that employees are a health center's most valuable, prominent, and strategic asset.

Yet unlike other assets on your balance sheet, employees have distinct needs and are not afraid to voice their concerns or even leave the organization if those needs are not met. Managing employee concerns and effectively engaging this crucial constituency should therefore be a fundamental component of every planned acquisition. Developing a comprehensive and actionable HR integration plan is the key to ensuring overall project success. This task is particularly important at a time when many health centers struggle to find and retain qualified staff, including — and most especially — licensed providers.

Understanding HR Integration Risks and Opportunities

Most experienced community health leaders have a general understanding of the business, regulatory, and compliance risks associated with planned acquisitions. These areas are relatively prominent and, to an extent, objectively quantifiable.

What is far less understood are both the risks and opportunities that come with integrating two employee groups. Despite being difficult to measure and define, managing HR risk and opportunity are as vital to a successful transaction as payer mix, patient volume, service area, or cash on hand.

What are the most significant change management risks associated with HR integration? The chart on the following page offers a general overview of types of HR risks that pose the biggest challenges for health centers.

Risks

In a health center context, HR risks tend to manifest in a variety of ways. Some of the most prominent include:

Key Personnel Departures Resulting from a Slow Integration Process

When projects take 12 months or longer to complete, key executives may be asked to continue performing at a high level without fully understanding what their role in the surviving entity will be. Ideally, CEO contracts will already contain some kind of incentive provisions relating to persevering through major organizational changes. If not, it is important for the board, in partnership with the CEO, to address if, how, and when a potential leadership transition may take place. Without this kind of clarity, valuable executives may decide to leave if they feel they've been left in professional limbo for too long.

Change Management Pain Points

Most common change management pain points that must be overcome to achieve a successful merger integration.

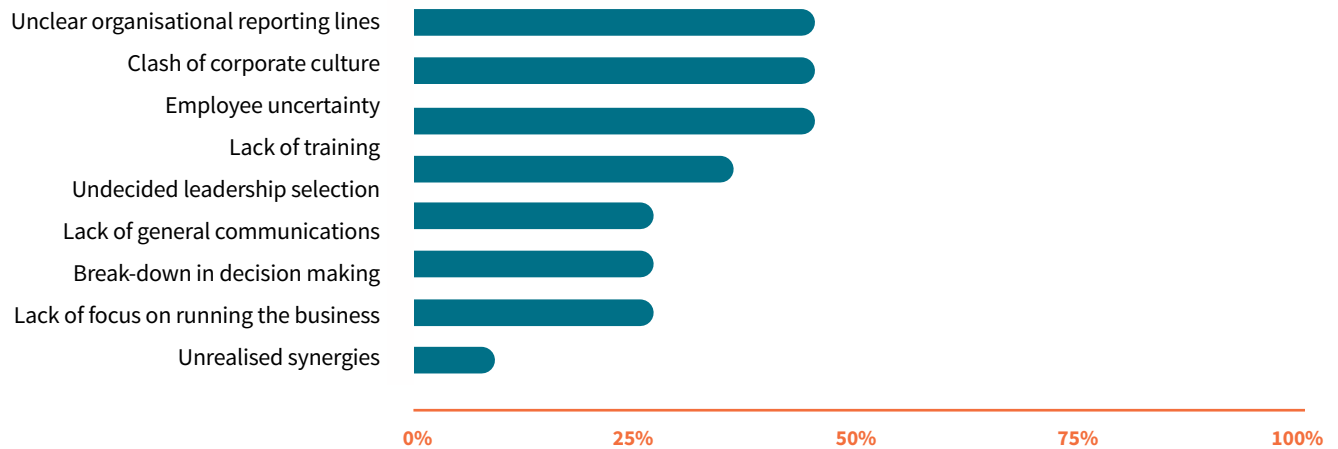


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That said, it is not unreasonable to ask your senior staff to work with uncertainty for a limited period of time. However, even the most dedicated leader, when put in a situation where their future is unclear, may begin searching for other employment options. Avoid this risk by developing a timeline and work plan, communicating frequently and appropriately about integration plans, and completing the other tasks identified here. This will help prevent a sense of chronic uncertainty from taking hold within senior management. As more staff become aware of the planned acquisition, you also may need to offer retention bonuses to keep those critical to the process or to retain those you hope will stay with the consolidated entity.

Failure to Identify HR Operating Risks During Due Diligence

The due diligence process typically prioritizes an understanding of the acquisition target's financial projections, patient mix, and assets. Less attention is paid to employee and human resources issues. This can lead to unfortunate surprises. Common issues that belatedly may emerge include histories of employment lawsuits, persistent compliance problems, and regulatory gaps. If these problems are missed or ignored, the surviving entity may inherit

significant HR issues that could delay or undermine transaction objectives.

To avoid this kind of outcome, make sure senior HR leaders have a seat at the table when performing pre-acquisition due diligence. It is also important to be honest and open about these issues early in the process, especially if they're potentially significant. Trust is degraded when HR-related problems emerge late in the game: The belatedly informed party may rightly feel they've wasted valuable time investing in a transaction that ultimately may be undone by legal issues.

Failure to Address or Accommodate Cultural Differences Between Organizations

Many health center leaders assume merging entities possess similar cultures and standards of practice and that any differences will not be significant. While this is sometimes the case, the sheer number of FQHCs and their diversity have resulted in a broad range of practices, attitudes, and beliefs. These variations can manifest in very different work styles and cultures. The potential for resulting friction, if unaddressed, can metastasize into a core strategic risk that may threaten the entire planned acquisition.

Problems can include serious culture clashes between leaders upon whom implementation depends. Longer term, unresolved cultural issues can result in sites that never fully integrate into the surviving entity. That can mean a failure to achieve the planned efficiencies or expansions that served as the rationale for the transaction in the first place.

Organizations should therefore manage this issue proactively by nominating a team to lead a culture assessment at both entities, and then map the culture of the entity being acquired against the surviving or acquiring entity's culture. If a serious gap exists, outside change management consultants and HR experts may be useful in helping resolve differences. Other resources also are available that will help you to address many of these issues without external assistance. We specifically encourage you to consult CHCF's October 2019 publication *Building to a Sum Greater Than Its Parts: A Hands-On Guide to Cultural Integration in Community Health Partnerships and Alliances*.

Seizing HR Opportunities

Although the HR components of a planned acquisition are often understood in terms of potential risk, it can be equally beneficial to consider staffing-related opportunities that could result from organizational integration. For example, a health center that may be struggling to find providers to staff their health center could discover that they'll gain several well-qualified and mission-aligned employees through an organizational consolidation.

Alternatively, a health center that does not have a robust fundraising infrastructure may pick up several qualified fund development professionals who can help build organizational capacity for identifying new funding sources. The important point here is that employees are a rich and sometimes untapped asset that affects mission, operations, and financial health.

Health centers therefore should identify their human resource aspirations so that they can take steps to achieve these objectives over the course of the process. For instance, if a health center wants to retain certain staff, they should consider what it will take to make that outcome more likely. This could include retention bonuses, promotions, raises, opportunities for future advancement, or changes to job descriptions.

The timing and manner in which these incentives are communicated to employees should be managed carefully. Valuable existing employees may need to be courted in the same way one might pursue a new hire. If done well, this process can not only help you retain important staff, but also build goodwill with employees during an often-challenging period of change. If, on the other hand, the process is not handled appropriately, trust will be undermined. One example: If you are seen to be offering preferential treatment to some employees but not others, the results will likely be problematic.

Retaining Employees

One of the first employee questions that follows the announcement of a proposed acquisition project is "Will I lose my job?" Having an answer to this is crucial before you begin communicating about the project to staff. In the absence of solid information, employee anxiety can grow rapidly, leading to productivity and quality declines just as both organizations begin the heavy lifting of an integration. Many organizations considering planned acquisitions elect to offer all existing staff jobs at the new, combined organization. While this is generally an optimal scenario for all concerned, it is crucial that you take steps to mitigate staffing risks for the surviving entity if this is the path you take.

Releasing Employees Not Being Kept

Give early consideration to how you will transition out employees who won't have a continued role in the combined entity. It can be useful to do this well before the actual transaction takes place. As with any HR situation, these changes should be handled thoughtfully and respectfully. Because planned acquisitions can often take 12 months or longer, there usually is plenty of time to appropriately complete the separations. Consult with your HR leaders on the best way to proceed, but adequate documentation is a necessity for initiating separations without liability. Depending on the financial conditions of the combining entities, opportunities may exist to offer severance or to support these individuals in their job transitions. The approach will vary from person to person.

Completing Preplanned Departures and Transitions

Take the time to consult with any employees who may be considering retirement or job changes, irrespective of the planned acquisition, to learn more about their needs and timelines. Attrition or current job openings also should be factored into the equation. For those who are considering leaving, it is crucial to plan for their departures so their functions and responsibilities will be covered. HR leaders also should push to accelerate the timing of the exit, if necessary, so it will precede the completed transaction date.

Making HR Decisions with the Staffing Model of the Combined Entity in Mind

Have deliberate conversations with your acquisition partners about what the intended staffing and care models will look like in the combined entity. These discussions should take into account factors like medical assistant (MA) to provider ratios and duplicative administrative staff specialization. Once clarity is achieved, begin evolving the existing staffing models of both entities toward the anticipated standard. In other words, don't keep hiring in support of a staffing model that will soon be obsolete. This will reduce friction at the time of the actual acquisition by minimizing the extent of staffing changes that each organization is required to make.

Taking these straightforward steps will help ensure that immediately prior to consummation of the planned acquisition, staffing at both organizations will have already moved toward rightsizing. Those individuals that are committed to remaining for the foreseeable future are onboard and working within a staffing model that aligns with the intended approach. These actions will greatly reduce the chances that the laudable message of "everyone keeps their jobs" does not produce unintended, negative consequences.

Reducing Staffing

Unfortunately, not every organization has time to go through the process outlined above. Some have timing or financial pressures that require moving more quickly. This may make layoffs a regrettable necessity. In those instances, clarity, transparency, and fairness become absolutely critical. If your planned acquisition project does not intend to retain all staff or simply doesn't have the time, budget,

or resources to do so, use a combination of the following tactics to mitigate staff disruption.

Being Transparent

Because the respective financial situations of participant organizations generally will dictate staffing for the combined entity, be open and communicative about the financial realities guiding your actions. Reference specific economic drivers when possible, such as known community or target population issues. Be proactive and transparent and enlist support from providers, board members, and community leaders.

That said, you should not provide actual numbers that employees can analyze, since they typically will not have access to the full details guiding the planned acquisition. As a result, they may come to alternative, incomplete conclusions that could impact staff morale. Moreover, do not expect employees who are fearful about their employment status to be comforted by explanations regarding the organization's financial limitations. Anyone about to lose their job will likely be experiencing a considerable amount of anxiety and negative emotion, and it is important not to downplay or deflect their concerns.

Communicating Early

Be sure to restrict knowledge of a possible planned acquisition to a limited group unless you are virtually certain it will occur, given that partial or inaccurate information can have negative repercussions. However, if a transition that will involve staffing reductions is imminent, let staff know as early as possible so they can plan, prepare, and adjust.

Avoiding Reapplications

Some organizations involved in a financially pressured transaction will allow employees to reapply for their jobs. This approach typically does not end well for those involved. Competing against coworkers or staff at the other acquisition partner can generate negative and lasting emotions. Instead, leadership should carefully and deliberately pick which staff will have continued employment.

It's safe to assume that any transition, whether planned deliberately or executed quickly under financial duress, will be difficult for some employees. Regardless of the scenario, taking the above actions can help your health center

minimize staffing disruptions and the associated impacts on both individuals and organizational performance.

Producing New Organizational Chart

Early in the process, it's important to begin studying the participants' organizational designs. Instruct HR leads at both entities to review current organizational charts and update them as necessary. Then sit down with key representatives from both entities to engage in a joint review process. The goal should be to produce a hypothetical, combined organizational chart that reflects updated staffing for both entities.

A range of key dynamics should be considered when developing a proposed or tentative organizational chart for the merged entity. While each transaction will have its own unique concerns, most combined organizational charts should reflect the following factors:

- ▶ **Updated Staffing Models:** As previously discussed, the post-transaction entity may have staffing and care models that differ from those of the predecessor organizations. For example, billing may be distributed across each site or it may be centralized, while MA to provider ratios may vary between service lines or sites. In these cases, the new organizational chart will need to reflect the prevailing staffing and care model. This, in turn, may require the movement or reclassification of some employees.
- ▶ **New Locations:** Once the transaction is complete, it may be that some employees will live much closer to sites that are now, but were not previously, part of their organization. That's why it is important to consider employee proximity to clinical and administrative sites when developing new organizational charts, as well as how possible relocations could affect lines of reporting. The implications of this analysis might be quite different for various types of staff. For instance, a provider or MA may be able to work at whichever clinic is closest to them, but an accountant or IT staffer may only be eligible to work at certain administrative sites.
- ▶ **New Lines of Reporting:** "Who will I report to?" is often the second-most-asked question among employees upon learning of a proposed acquisition. Clearly articulating new lines of authority or confirming existing structures is therefore critical to providing employees

and managers with a sense of continuity, as well as insight around the new relationships they may be required to build.

Regardless of where you land with your new organizational chart, remember that it is only a hypothesis and that it will evolve over the duration of the process, given changes in staffing, operational models, and care sites. Nevertheless, a working, combined organizational chart is an important tool to have on hand, both for employees and leaders, as once-separate entities accelerate toward integration.

Comparing Compensation and Reconciling Employee Handbooks

Once it's clear who is participating in the combined entity and how the workforce will be structured, it is useful to consider existing differences in the terms of employment between the merging organizations. Many staff categories and compensation levels are roughly equivalent across health centers, given standardized roles and duties, as well as geographical salaries and cost-of-living adjustments. But this isn't always the case. Ensuring equivalency across the combined organization or establishing a gradual plan to achieve it should be a priority. Doing so will help you retain employees and maintain morale.

The best way to begin this process is by performing a salary survey of existing staff. The [California Primary Care Association \(CPCA\)](#) and the [National Association of Community Health Centers \(NACHC\)](#) provide compensation surveys to benchmark salaries for community health center positions across all regions, sizes, and settings. Additional resources include the [Nonprofit Compensation Associates' Wage and Benefit Survey](#) and the [Center for Nonprofit Management's Compensation and Benefits Report](#). Instruct your HR department to perform a salary survey and determine where your organization lands with respect to the mean for each position type.

In addition, have HR leads from each organization compare the pay rates of similar positions. Analyze which employees should get raises — to achieve equivalency within the new organization or to reach salary survey standards — and project out the overall financial impact of these increases on the combined entity. Reducing salaries in response to survey data is usually not a viable option. In cases where adverse finances are putting an organization in distress,

cash shortfalls are usually addressed by cutting positions rather than pay.

Along with compensation, other types of benefits should be considered as well. Look at each organization's health insurance offerings, retirement contributions, incentive pay programs, and anything else that contributes to an employee's total compensation. (See *Benefits Comparison Sample*, which can be downloaded as part of the *Mergers and Acquisitions Tools* [ZIP] available from the CHCF website.)²² Engage financial analysts to model the impact of increased numbers of employees utilizing these benefits and to determine if this increased expense is something your budget can bear. While there is generally no way to reduce compensation via direct employee pay, benefit designs offer leaders greater flexibility to select packages that meet staff needs without being financially unsustainable.

Another important task involves auditing the employee handbooks of each organization. Assign staff to catalog policies and identify material differences. HR leaders again will need to decide what to keep, what to discard, and what to harmonize. This is an area where health center leaders generally have flexibility to make changes. But be cognizant that some policies or practices may reflect the unique culture of an organization and changing them could affect morale. It can therefore be useful to solicit staff feedback to identify important, as well as both popular and unpopular, policies. This feedback could be generated from listening sessions surrounding acquisition plan updates or perhaps through surveys.

Identifying and Engaging Integration Champions

Merging with another organization can upend an employee's daily life. Without being asked, staff is suddenly required to adapt to potentially new practices, expectations, supervisors, benefits, and more. That's why it's not unusual for morale to drop during a planned acquisition. Having trusted and known peers that can provide accurate information on the status of the acquisition consequently may be helpful. If deliberately engaged and coached, these individuals can be effective internal advocates for the project. Like external messaging ambassadors, internal champions should be well known and liked and respected by their peers.

Ideally, internal champions form a temporary, interdisciplinary team that includes selected staff from all levels

and functions. This team should be kept informed about changes surrounding the integration to ensure employees have access to accurate information. At the same time, team members can serve as listening posts to assess how employees generally are reacting to acquisition-associated changes. Working with a team of integration champions should extend and complement other communications, such as all-staff meetings and memos. This will reduce the spread of misinformation and provide a distributed way to respond to the many questions that will inevitably emerge.

Documenting Everything in a Timeline and in Work Plans

As with any major new initiative, it is useful to create a project timeline and work plan when organizing HR integration activities. (See *Sample Project Work Plan and Timeline*, which can be downloaded as part of the *Mergers and Acquisitions Tools* [ZIP] available from the CHCF website.)²³ The plan should include all key decision points reached in the previous sections of this HR discussion, as well as a timeline for performing the necessary research, analysis, communication, and implementation. Include the resources that will be responsible for the specific activities. This is yet another instance in which strong overlap and coordination with the Communication Plan are required.

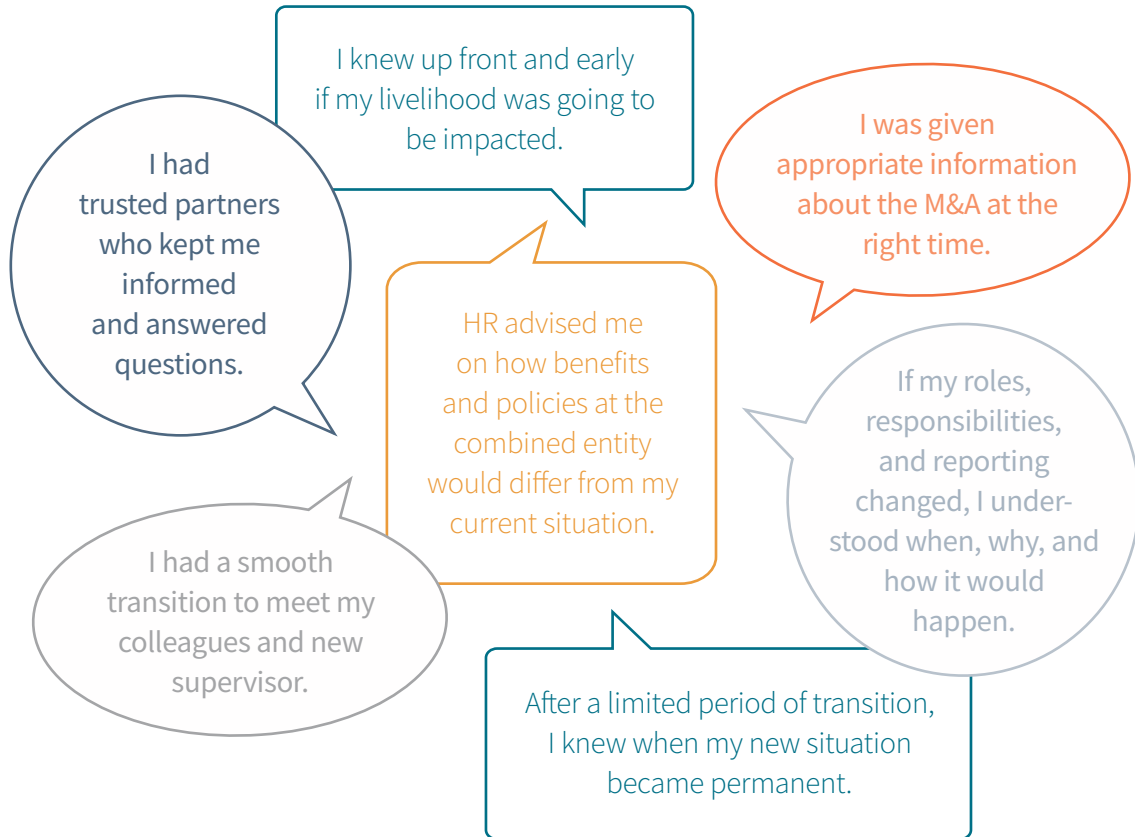
Timelines and work plans often look different. Some of this variation in appearance is due to the task at hand and complexity involved in executing it. Most frequently, however, the work plan is a reflection of the project manager's or project stakeholders' preferences. Use a plan format that is comfortable for those maintaining and viewing the document most frequently. There are pros and cons to using cloud-based project management software versus a more traditional tool, such as Microsoft Excel, Microsoft Project, or an industry or activity-specific project management software. The authors recommend a solution that fosters easy editing, publishing, and the ability to collaborate with others. Because work plans can be all-encompassing, incorporating significant detail for any and all tasks related to the planned acquisition project is useful, with the larger subactivities and work plans rolling up into the master.

As the date of integration approaches, begin planning events to enable staff to become more familiar with their new situation and future coworkers. Organize mixers between new team members and plan times for supervisors

to meet one-on-one with new reports. Operationalize all the plans made to date by assigning specific owners, deadlines, and required deliverables. There also may be opportunities to extend and update job descriptions that will require sharing, discussion, and signing.

Once the acquisition formally takes effect, look for ways to maintain some regular contact between staff and their previous supervisors. This helps solidify continuity as employees transition into a new situation and supports a warm handoff as the previously independent organizations become one.

How do you know your HR Integration plan succeeded?



9. Integrating Service Lines, Departments, and Facilities



A successful merger or acquisition requires detailed assessments of the merging entities' core operational and support systems and capabilities, including service lines, departments, and facilities. These evaluations help inform the integration plan and highlight areas where adjustments may be necessary.

Direct Care Service Lines

Begin by focusing on direct care service lines — typically medical, dental, behavioral health, specialty, vision, and substance abuse. Identify the model of care used by the organization being acquired across all program offerings, and then compare and contrast with the approach or approaches taken by the acquiring entity. The goal is to understand what, if any, changes will be necessary in care models, training, and staffing. Use the following sets of questions to help determine where adjustments may be needed.

Medical Questions:

- Are medical teams colocated?
- What workflows are dependent upon space?
- Are the medical assistant and provider teams functioning as “teamlets”?
- What are the current triage protocols and who performs triage?
- What are the established medical assistant/provider staffing ratios and are these aligned between organizations?
- What ancillary staff exists and how do they support the care delivery model? (e.g., registered nurses, licensed vocational nurses, care coordinators, case managers)
- Are all providers privileged in a way that supports the new model?
- Are standing orders used? If so, which ones? And are they aligned with the new organization's policies and procedures?

Dental Questions:

- Specifically, what services are provided and do these align? (e.g., extractions, fillings, crowns, root canals, endodontics)
- Does the previous staffing approach align with the acquiring entity's model?
- Are referral networks different or the same?
- Treatment philosophy: Are patients treated for as many issues as possible in one visit, or are they asked to schedule additional visits for multiple issues?

Behavioral Health Questions:

- Does the organization provide specialty mental health, integrated behavioral health, and/or substance use services?
- If providing integrated mental health services, are the services truly integrated or simply colocated? Does the model reflect mostly psychotherapy offerings, or rely more on a brief intervention population health model?
- What screening forms are currently being used and do they align with the acquiring entity's forms?

Specialty Medical Questions:

- What is the scope of current specialty medical offerings and does it align with the acquiring entity's? If not, are shifts in the model of care required?
- What are the current referral sources? Are they coming from internal referral or referrals from a health plan?
- How much staffing is required to ensure that staffing levels support the model?

The above questions will help you focus on a range of specific components related to service line integration, including:

- Model alignment
- Staffing requirements
- Staff training needs
- Workflow modifications
- Physical space modifications
- Support systems
- Health plan contracts for specialty care
- Medically assisted treatment (MAT) waiver needs
- State reporting requirements (if a state-licensed specialty mental health provider)
- HRSA Form 5A modifications through Change in Scope (CIS) modifications

Information Technology Department

Information technologies (IT) are essential to ensure staff and caregivers have the tools and information needed to perform their job responsibilities. That's why proper IT transition assessment and planning is paramount. A successful IT transition begins with the identification of best practices to support an integration work plan for both clinical and support IT functions.

The work plan should include an assessment of technology access and security, hardware and software use and licenses, as well as an inventory assessment. Create a list of software and hardware used at both organizations and include information such as what the platforms are used for, who uses them, what they cost, and other pertinent data.

Use this list to objectively determine which platforms should be used by the new entity — including consequent training requirements and budgetary implications — and which platforms and technologies should go away. Acquiring entities may possess software, tools, and platforms that they'd like to see adopted by the organization being acquired, while the inverse also may be true. Alternatively, the combined entity may wish to deploy entirely new software and platforms. Regardless of the technology solutions ultimately decided upon, developing an understanding of specific hardware and software needs through development of the

work plan will pay dividends during the implementation phase. Once the work plan is complete, establish a timeline for system purchases, migration, training, and adoption.

IT Questions:

- Who is using the hardware/software currently?
- Is the hardware leased or owned?
- Where is it on the depreciation schedule (if applicable)?
- Is this technology being replaced or phased out, or is augmentation needed?
- If the technology is to be adopted organization-wide, what are the implications of this decision? (i.e., Is a server upgrade required? What about additional fiber lines into the facility?)
- Who needs training on the hardware or software, who will provide that training, and what is the training and roll-out calendar?
- Can our current IT team handle the influx of work created by the merger/acquisition or do we need to consider a contractor to assist during this period?

Finance and Accounting Department

The transition of financial management and the development of a clear pathway for the assumption of financial oversight are usually among the most discussed components of an acquisition. As is the case with the transition of clinical and support IT capabilities, identifying the platforms in use and developing transition timelines are of the utmost importance. Key steps in this transition process include:

1. Integration of financial management software
2. Revenue cycle management considerations (billing)
3. Final reporting and audit of disappearing entity

The following questions can help organizations define a range of specific issues relating to finance and accounting integration:

Finance Questions:

- What will be the prevailing financial management software and associated platforms for the combined entity?

- ☑ At what point will the acquiring entity command fiscal oversight?
- ☑ Will the current claims clearinghouse be used?
- ☑ Are bad debt accounting and collection practices aligned?
- ☑ Will the surviving entity use internal or external billing functions or a hybrid model? Do contracts need to be altered or personnel adjusted to support the new billing model?
- ☑ Who will be conducting the final audit for the acquired entity and when will it occur?

Insofar as health centers' accounting and finance departments typically are a reflection of the entity's size, history, and leadership, they are no different from many other for-profit and nonprofit organizations. Financial experts with the acquiring organization should develop an understanding of this historical knowledge to better assess specific systems, functions, and practices within the acquired organization.

Asking questions about the finance department's role in key projects, budgeting, billing, procurement, forecasting, staffing, and other typical business functions will illuminate how the new entity may want to engage internal stakeholders and other department heads.

For example, does finance typically require that senior leadership produce their departmental budgets, or does finance define the budgets for leaders to work within? Does finance solely own procurement and group purchasing organization (GPO) contracting, or is this a shared responsibility with members of the operations team? Understanding these kinds of dynamics will help the CFO of the new entity establish consistent protocols and ensure that the finance team is adequately staffed to either lead or support core business functions.

Call Center and Scheduling Department

Because call centers and scheduling departments typically are a patient's first point of contact with a health center, evaluating how phone calls are received and routed can pay dividends once the new organization is operational.

Answering the following questions will help create an overview of existing systems and provide insight into how call center and scheduling operations can be harmonized:

Call Center Questions:

- ☑ What is the current call center staffing schedule?
- ☑ Who provides after-hour phone services?
- ☑ What is the current provider-on-call schedule?
- ☑ What call center key performance indicators (KPIs) currently exist and how does current performance compare to industry standards?
- ☑ What phone system hardware and software currently are in use?
- ☑ Is oversight of those who answer phones performed centrally?
- ☑ Are call routing and scheduling guidelines clearly published?

Assessing the overall effectiveness of the current scheduling model will help you determine whether a centralized or decentralized approach should be followed. You also should be able to identify any necessary software or hardware modifications and likewise determine if updates are needed to the scheduling or call routing guidelines.

Referrals Department

Referrals represent a significant, ongoing challenge for many outpatient clinics. Understanding the current referral state and developing a plan to support referrals will help sustain both provider and patient satisfaction. The following questions can assist you in gauging the current state as well as formulating an effective support and integration plan.

Referral Questions:

- ☑ Are referrals processed using a module inside of the EHR or through an alternate platform?
- ☑ Is there a current backlog of referrals? Provide the number of open or pending referrals of the following time frames:
 - ▶ > 30 days
 - ▶ 30-60 days
 - ▶ 61-90 days
 - ▶ < 90 days

- ☑ How many full-time equivalents are processing referrals?
- ☑ Are there other personnel responsible for resulting referrals, prior authorizations, or durable medical equipment orders?
- ☑ What is the current referral volume? What are the current referral volumes by specialty referred to?
- ☑ Who oversees site- and/or system-level referrals? How are the work queues designed?

Using these questions, you can determine if critical compliance issues may be associated with closing the referral loop. You should identify the current platforms and communication mediums used to order, track, and communicate about referrals. It is important to understand the number of FTEs associated with referrals and linked tasks, as well as the patient population, specialty referral needs, and the referring providers' referral habits or preferences.

Once this information is assembled, the focus should shift from understanding the current state to developing a work plan for merging the existing systems. Tasks that should be incorporated into the referrals work plan include:

1. Defining the processes used to place, process, and result in an order
2. Identifying personnel needed to support these processes
3. Establishing workflows or workflow modifications as necessary to accommodate new systems, processes, or personnel
4. Deciding on centralized or decentralized oversight and allocation of work
5. Outlining training needs for current or new referral staff, providers, and health information staff

Health Information Management Department

A health information management (HIM) technology assessment should include an evaluation of the department structure and existing protocols and workflows for scanning, indexing, charting, and developing chart audit reports. Although separate from the referrals department, HIM often supports referrals and both departmental functions frequently are intertwined. For purposes of this guidebook,

HIM activities will be defined as the processes and personnel associated with scanning, indexing, records release, and fax management.

Thanks to the increased ubiquity and functionality of the EHR, the HIM department and associated staff functions have evolved considerably over the last decade. Staff who previously focused solely on reviewing and filing paper documents have shifted to using the EHR to document, uploading information, communicating with care team members, and managing virtual fax folders.

To support a thorough assessment of the HIM department, the following questions should be addressed:

HIM Questions:

- ☑ How many FTEs are allocated to this function and how is the work distributed?
- ☑ Do HIM personnel perform all of the following and what percent of time is spent on each function?
 - ▶ Communicating with staff and patients
 - ▶ Resulting referrals and consult notes
 - ▶ Processing requests for records
 - ▶ Processing subpoenas
 - ▶ Scanning and indexing information (laboratory results, consult notes, outside records)

As with referrals, this assessment will help leadership understand whether additional training, technology, or process investments and/or modifications will be needed for the surviving entity.

Quality Improvement and Quality Assurance Plan

HRSA requires that FQHCs maintain a Quality Improvement (QI) Plan and conduct risk management activities. These activities also are best practices for non-FQHC organizations. Health plans and payers are investing heavily in payment incentive programs that align clinical quality outcomes. Given the regulatory and monetary implications associated with value-based care, it behooves an acquiring entity to fully understand the culture of quality and associated activities at the acquired organization.

You may want to begin by identifying the type and frequency of Quality Improvement/Quality Assurance (QI/QA) metrics, dashboards, and reports required by both organizations. Do these align with the surviving agency's QI/QA requirements? It also is important to include a risk and liability assessment of the entity being acquired using their identified risk management protocols. This allows leadership to obtain and review credentialing files for all providers (both internal and external) and determine if any clinicians need to be recredentialed.

Below are questions that can help you gather the necessary data to assess an organization's quality efforts:

QI/QA Questions:

- What are the published quality key performance indicators (KPIs)?
- What risk management committees and functions currently exist and who performs these functions?
- Who leads process improvement functions and what is the interface between the organizational QI lead and site-level leaders?
- Is credentialing performed in-house or outsourced? Are all functions currently compliant and up-to-date? (e.g., HRSA, health plans, organizational policies and procedures [P&Ps], FTCA).

Answering these questions will provide insight into the staffing required to perform all necessary QI/QA, risk management, credentialing, and privileging duties, as well as current processes, committee structure, and functions being performed.

When formulating a plan to support operational readiness and integrate staff and functions associated with QI and QA, be sure to incorporate credentialing and privileging work streams into the existing workflow and document-tracking capabilities. You will need to decide if you intend to use an external credentialing service provider and if so, to what extent. Ultimately, your goal is to develop an aligned and/or modified QI/QA plan for the combined entity that has consistent key performance indicators, reporting intervals, and publishing mediums, and that is clearly understood by staff.

The following QI resources are recommended:

[*Quality Improvement*](#) (PDF)²⁴.

[*FTCA Program and Risk Management slide deck*](#) (PDF)²⁵.

[*FTCA Health Center Program Site Visit Protocol*](#) (PDF)²⁶ — This document includes a checklist for pre-visits and site visits that can be used to assess program compliance and guide the acquiring health center in addressing any compliance deficiencies.

Fund Development/Transition of Donors

Increasing the likelihood that existing donors will continue to invest in the new organization requires detailed analysis and the development of a plan for properly managing donors and funders.

Key elements of the plan should include:

1. Identifying active awards, reporting requirements, and timelines
2. Understanding current grant tracking systems and procedures
3. Creating an engagement plan that focuses on the specific interests of each funder

Donors and funders are key stakeholders and therefore require ongoing engagement, just like staff, leaders, and community members. Timely and effective communication will be most important during and after the acquisition. Please see the communication plan section of this guidebook (Chapter 7: Developing a Communications Plan) to identify best practices for engaging this important group.

You will want to organize your inventory of donors and funders by donation dollar amount and active-versus-inactive. You also should indicate if any active awards require reporting. Other issues to address include understanding special charitable events, planned giving and annual giving programs, and whether these events align with other development programs. Completing these tasks will help you prioritize work efforts associated with previously awarded funds and their associated compliance and post-award requirements. Since most grant and award information is not tracked in the EHR, it will be important to analyze the grant management systems of the acquired entity and current protocols for funder engagement, and then create a map to the acquiring entity's systems and protocols.

As previously noted, active grants include contracts that typically stipulate written approval that must be obtained before transferring the grant to a new entity.

Facilities Assessment

A comprehensive facilities assessment is designed to provide an inventory of physical assets and their worth, help prioritize facility maintenance plans, and support improvements in risk mitigation and the provider and patient experiences. Begin by gathering all relevant data, including physical asset and depreciation schedules for facility furniture, fixtures, and equipment (FF&E); facility and maintenance work plans; any safety claims that were facility-related and not fully resolved; and other pertinent documents.

Consider interviewing organizational leaders about facilities to better inform the assessment. Ask questions, such as:

Facilities Questions:

- Do current facilities support program offerings? If not, explain.
- Are there any known facility issues that are not indicated on the Facilities Plan?
- Have staff made comments as to a particular facility improvement or improvements that would make a positive impact on their experience at work?
- Have patients made comments about a facility improvement that would enhance their patient experience?
- If OSHPD-3 Certification was obtained, what year and under what code revision?
- If OSHPD-3 Certification is a goal, has a gap analysis and/or Rough Order of Magnitude been performed to assess upgrade costs, efforts, and timeline? If so, when?

You may want to gather input from stakeholders who use specific facilities on a regular basis to ensure important maintenance tasks have been, or are being, performed. As the acquiring organization, you'll also be in a position to determine whether existing workspaces support current program offerings. Making these assessments can help you identify possible opportunities for quick wins to improve facility utilization, as well as the potential for larger

improvements that may dramatically and positively impact patient care and clinician and patient satisfaction.

Prioritized Facility Deficiencies Work Plan and Timeline

Using the comprehensive assessment results, create a plan and timeline to address all facility items, from critical compliance issues or requirements through beautification projects. Consider prioritizing using the following categories, with safety at the top of the list and aesthetic enhancements at the bottom.

Categories

- ▶ **Safety:** Any maintenance that needs to be addressed to ensure the safety of staff and patients.
- ▶ **Critical deferred maintenance:** Items that support the facility infrastructure, which, if left unaddressed, could cause a negative ripple effect impacting patient care. Examples include roof leaks, known failing pipes, and mold or dry rot.
- ▶ **Failing or end-of-life FF&E:** If FF&E are included in physical facility assessment, be sure to identify the condition of the equipment. If potential failures could pose a risk to safety or the staff's ability to conduct their work, these items should go near the top of the list. Examples could include replacing aging, back-up generators, poor light fixtures, aging dental chairs, or obsolete medical room cabinetry and cubicles.
- ▶ **Planned and budgeted maintenance:** Ideally, all planned and deferred maintenance should be represented on an organization's facility plan. However, information may vary depending on the size of the organization and personnel responsible for creating and updating the plan. All non-deferred and critical maintenance should be incorporated into this assessment. Examples include planned replacement of a water heater, HVAC unit, or sinks.
- ▶ **Programmatic space upgrades:** Here's an example of a program-driven space upgrade: When an FQHC that utilizes team-based care acquires a small private medical practice, the acquiring entity may quickly realize that the medical group's back office is not physically configured to support team-based care core principles. As a result, reconfiguring and upgrading the back-office

space is tagged as high priority on the facility assessment and subsequent plan. Other common programmatic space enhancements that occur during acquisition include creating an environment of care in the lobby and adding spaces for programs that currently are not offered by the entity being acquired.

- ▶ **Aesthetic enhancements:** Staff and patients certainly appreciate functional fixes and/or improvements. Generally speaking, items that have the potential to foster excitement or improved environmental satisfaction fall in this category. Examples include providing a fresh coat of paint, aligning facility colors and graphics with the acquiring entity color palate, replacing light bulbs, and laying new carpet or flooring.

Organizing the assessment findings using these or similar categories enables the acquiring entity to accurately quantify the purchase price or transfer of assets and liabilities. It also creates a strategic plan for ensuring staff and patient safety and for optimizing the workspace in ways that enable staff to continue performing their jobs properly and with a high level of satisfaction.

Comprehensive Document Library

Develop a comprehensive set of facility-specific spreadsheets that document fixed assets and capitalized equipment, including all major items that must be accounted and budgeted for. Consider applying the acquiring entities' documentation format to the organization being acquired and then creating a merged list from which a facility manager or appointed individual can work.

Environment-of-Care Review

Components of an environment-of-care review should be incorporated into the safety assessment portion of the facility deficiencies work plan. Use a standardized checklist to ensure that the facility is set up to address and support the various regulatory requirements and best practices associated with providing outpatient primary care. This will create a safeguard mechanism to ensure all relevant items are addressed. Examples could include making sure flooring

does not have major cracks, walkways are clear and surfaces, such as countertops and chairs, are nonporous to support infection control.

When conducting a facility assessment and developing a work plan, consider harnessing facility compliance audit tools available through health plans or state and federal agencies. Applicable and pertinent facility checklists can be useful in supporting a thorough assessment. The following checklists are recommended:

[Joint Commission — Environment of Care Documentation Checklist](#)²⁷

[Occupational Health & Safety Association — Safety and Health Program Audit Tool](#) (PDF)²⁸

[California Department of Health Care Services — Facility Site Review Survey](#) (PDF)²⁹

When performing a facilities assessment for valuation or budgeting purposes, you may want to enlist a licensed contractor to provide a Rough Order of Magnitude (ROM) estimate. A ROM can place a dollar value next to an associated and specific scope of work and also provide total project costs.

In addition, determine if any upgrades will affect facility licensure, parking requirements, or conditional use permits (CUPs). Sometimes facilities operate under CUPs to satisfy local municipality land and use codes. Before budgeting for any major renovation, exterior modifications, or changes in the use of a property, first understand local use and zoning requirements.

If a CUP is in place, be sure that the desired modifications do not alter the use permit's parking exceptions or other zoning- or use-related requirements. It also will be necessary to understand the licensure status of each facility to ensure that the current license and associated physical facility will not need to be modified for future use.

10. Reviewing Acquisition Agreements



Health Centers should involve their attorneys early in the acquisition process to ensure that the terms of the agreement reflect their intentions and that issues which must be addressed prior to the closing can be resolved without causing unanticipated delays. While health centers have a history of self-sufficiency, the expansion in the size of California’s nonprofit safety net, together with the rapid evolution and scope of regulatory oversight, necessitates that health centers obtain competent legal guidance in the acquisition process to properly mitigate risks.

Most California health centers are nonprofit public benefit corporations and thus subject to the standards of conduct described in Corporation Code §§ 5230-5239.³⁰ In general, these provisions require members of the board of directors to perform their duties in good faith, in a manner that the director believes to be in the best interests of the corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.

In performing these duties, board members are entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, in each case prepared or presented by officers or employees whom the director believes to be reliable and competent in the matters presented; outside experts, including counsel, independent accountants, or other persons as to matters which the director believes to be within that person’s professional or expert competence; or board committees under more circumscribed circumstances.

In order to discharge these duties, board members will need to carefully review and understand the meaning of draft acquisition agreements, and have adequate time to obtain expert guidance needed to discharge their duty to act in good faith and with reasonable inquiry with respect to consideration of the proposed transaction. Of central importance in consideration of the terms of an acquisition agreement is the review and understanding of three common and inter-related categories of obligations in the agreement:

1. Representations and warranties
2. Covenants
3. Indemnification/remedies

While these terms will vary depending on the needs of the parties, differences in leverage of the buyer versus the seller, and the structuring of the agreement, the following are issues that should be considered with respect to each category:

Representations and Warranties

The terms generally address the status of the corporation as a legally valid entity legally authorized to enter into the transaction and disclosures of material facts, including pending claims, licensing or enrollment issues, unsatisfied overpayment obligations or billing errors, threatened legal actions, environmental issues, and the like.

- ▶ While these representations and warranties cannot serve as a substitute for a due diligence review of the seller’s documents, depending on the size and complexity of the transaction and the feasibility of enforcing the remedies in the event of a breach, they can help to manage the risks associated with an incomplete document review or material nondisclosures by the seller.
- ▶ Board members and officers being bound by the representations and warranties should carefully review the accuracy of the representations and the scope of inquiry required: actual knowledge, reasonable inquiry, or due inquiry. It is essential to tailor the extent of inquiry to the circumstances. More leverage or risk generally favors imposing a broader obligation on the other party to make an inquiry prior to making the representation.
- ▶ Disclosures regarding limitations in the accuracy of the representations are generally identified in attachments. For example, the existence of pending or threatened claims or liabilities can be disclosed as limitations on the scope of the representation.
- ▶ Representations can be structured so that material issues and assumptions that would be deal breakers in the most fundamental sense are clearly stated and can provide a basis for termination of the transaction in the event of a breach.

- ▶ The “Bring Down” clause addresses the date on which the representations and warranties are true and material limitations are fully disclosed. In general, the parties need the representations and warranties to be true both on the date the agreement is executed and at the closing, and the terms of the agreement must be consistent in this respect.

Covenants

Covenants are promises that generally are more operational in nature than representations and warranties. They can relate to obligations to be performed (or refrained from), either prior to or following the closing. In the event of an affirmative covenant, the agreement should clearly identify the person or entity that is responsible. Covenants can include:

- ▶ Execution or delivery of additional or collateral agreements
- ▶ Obtaining of or cooperating in the receipt of necessary regulatory approvals from HRSA, the California Department of Public Health, California Board of Pharmacy, California Department of Health Care Services, California Attorney General (for transfer of nonprofit assets), and the like
- ▶ Filing of necessary Medi-Cal and Medicare disclosures, reports of changes, or new enrollments
- ▶ Satisfaction of pre-conditions to transfer arising from loan agreements, liens, litigation, bond agreements, grant agreements, and the like
- ▶ Express assumption of liabilities
- ▶ Responsibility for attorneys’ fees, accounting, brokers’ fees, and closing costs and fees
- ▶ Maintenance of the assets prior to the transfer
- ▶ Specifics regarding transfer of assets and assumptions of liabilities
- ▶ Mitigation of impact on patients
- ▶ Handling of medical and business records
- ▶ Cooperation regarding audits or litigations relating to the pre-closing time period
- ▶ Obtaining of acceptable appraisals and ensuring of payments that are at fair market value

- ▶ Assurance that there are no self-dealing transactions
- ▶ Extent of rehiring/continued employment of seller’s staff
- ▶ Transition of insurance coverage impacted by acquisition
- ▶ Interim service agreements (e.g., accounting/CFO/billing, professional staff, etc.)

The breadth of the covenants and extent to which they extend beyond the closing will depend on the scope and circumstances of the transaction. Additionally, the scope of the covenants should reflect in part the extent to which the buyer is assuming liabilities of the seller, as well as the financial condition of the seller. A distressed seller is likely to generate a need for a more cautious approach. It is essential that health centers work with their legal counsel to make sure the needs of the parties are accurately and fairly reflected in the acquisition agreement.

Indemnification/Remedies

The ability to enforce the parties’ rights under the agreement depend on the circumstances. In a merger agreement, a failure to make a material disclosure could have significant consequences. However, mergers pose a challenge with respect to crafting an enforceable remedy, since after the merger, the parties form a single entity. In that case, unwinding the transaction may be the most operationally feasible remedy. Additionally, health centers are by design not lucrative operations, and imposition of individual liability for breaches short of fraud may be impossible or difficult as a practical or ethical matter. Considerations in the review of an acquisition agreements may include the following:

- ▶ Remedies can be tailored to the needs and abilities of the parties, including triggering a right to unwind the transaction, maintenance of a hold-back account to address specific or reasonably anticipated liabilities, indemnification by the corporate entity, or indemnification by officers or board members.
- ▶ The agreement may distinguish between remedies arising from breaches of the representations and warranties or from the covenants. In general, it is essential to review the proposed terms to ensure that breaches triggering the remedy are material to the transaction and that the remedy is not in excess of the reasonable

needs, expectations, and abilities of the parties, and that it can in fact be enforced.

- ▶ Remedies that survive the effective date of the transaction may include a need to address a refusal or failure to maintain records necessary to defend professional or employment liability claims or Medicare/Medi-Cal or other third-party payer audits. These risks should be considered and the agreement's language appropriately tailored to ensure reasonable protection for the parties, taking into consideration the extent of the liability that may arise from the breach.

In addition to the above, the health center should ensure that the terms of the acquisition agreement accurately reflect their needs and that they understand the mechanics of the transfer. This review is critical if the transaction is to operationalize the intentions of the parties with respect to the transfer, as well as to avoid routine causes of loss or delay. Among the issues to be considered and discussed with legal counsel are the following:

- ▶ When does the closing take place and what exactly happens at the closing?
- ▶ Is the inventory of assets complete and accurate to the extent required by applicable law, and does it reflect a valid assessment of fair market value?
- ▶ Are any of the assets subject to a federal interest, UCC financing statement, lien, or the like?
- ▶ Is the specific effective time and date of the transfer identified to the extent necessary?

- ▶ When is the site defined as an FQHC site (e.g., licensed, enrolled, and within the scope of project of the buyer)?
- ▶ Do the terms ensure that there is no improper overlap in operations?
- ▶ Is there any risk of a post-closing gap period due to regulatory delays, wherein neither party is legally permitted to operate the site? If so, how can this be addressed?
- ▶ How will the OSHPD-3 building code requirements impact the transfer?
 - ▶ How long will the construction take?
 - ▶ Should the buyer seek a waiver from CDPH?
 - ▶ Can the site be operated as an intermittent clinic exempt from licensure under Health & Safety Code § 1206(h) to address delays in licensure and the costs of the OSHPD-3 requirements?
- ▶ Are there any third-party approvals that must be obtained as part of the transaction?
- ▶ Has the health center discussed with counsel any potential issues relating to the Corporate Practice of Medicaid, Anti-Kickback Act, Stark Act, Physician Ownership and Referral Act, and the like?

Working and regularly communicating with legal counsel from the initial consideration of an acquisition through the closing makes it more likely that the acquisition agreement and collateral documents address the health center's concerns and that costly errors or delays can be avoided.

11. Final Thoughts



This guidebook has been designed to provide those interested in pursuing a merger or acquisition with a clear path of action. It includes necessary steps and tasks required to bring a transaction to a successful conclusion and is grounded in practical experience. As such, the authors and sponsors of this project hope it will be used as a road map for a broad range of future consolidations.

It's important to keep in mind that even if you carefully follow each step described here, every acquisition, merger, or expansion — no matter how well conceived — is accompanied by a certain level of uncertainty, risk, and even upheaval. As a result, the process can be stressful and sometimes messy. But that's typically the nature of progress. It is therefore important to maintain perspective when encountering difficulties and keep your eye on the final objective.

Another point to be aware of: The lengthy duration of a merger or acquisition can have both positive and negative consequences. On the one hand, a slow timeline can be quite useful, given the complexity of most processes and the extensive planning and effort they require. Yet from the vantage point of employees, board members, and the larger community, an interminable process may suggest mission drift, lack of attention to the core business, and at worst, a growing and intractable quagmire.

The best way to overcome these negative perceptions is to maintain consistent progress and communicate about major milestones, including announcing when one phase ends and another begins. In other words, like any good story, mergers or acquisitions should have a beginning, middle, and end.

Once you have finished critical activities during each phase, try to make sure everyone is aware of the progress. And after the transaction is formerly completed and the period of transition is over, be sure to communicate and celebrate the fact that the organizations have reached their long-desired goal.

While this guidebook ends with the execution of the final agreement, health center leaders should understand that the merger/acquisition process, at its most fundamental level, is only beginning with the consummation of the deal. Newly integrated organizations can be fragile and often need ongoing care and maintenance.

For these reasons, we encourage you to maintain transition teams for at least a year or longer after the deal closes. Necessary course corrections may be required across the spectrum, from service integrations and change management issues to human resources and cultural integration. Veteran leaders of the merger/acquisition process will be best-equipped to handle these issues.

And remember this: One of the key lessons that the authors have learned over the course of many years working in this area is that when good planning, hard work, and dedication come together, the details generally work themselves out.

Good luck!

Appendix

Item 1:

Financial Checklists: Data Needed to Populate Financial Pro Forma

Visits and Payer Mix

- Visits by Payer and by Service for the last fiscal year and current fiscal year-to-date (FYTD). Note that this report should identify unique encounters and should not be a count of all CPT codes. Payer definitions:
 - ✓ Medicare (including Medi-Medi dual-eligible)
 - ✓ Medi-Cal fee-for-service
 - ✓ Medi-Cal managed care
 - ✓ Commercial/other
 - ✓ Self-pay
 - ✓ Family PACT
 - ✓ CHDP
 - ✓ CDP
 - ✓ CPSP

- Visits by type of provider, including:
 - ✓ Primary care physicians
 - ✓ Mid-level providers (nurse practitioners, physician assistants, midwives)
 - ✓ Behavioral health provided by an MD, PhD, or LCSW
 - ✓ Dental by a DDS or hygienist
 - ✓ Optometrist
 - ✓ Specialty provider

Patient Service Revenue

- Net revenue (defined as charges minus contractual adjustment minus bad debt. [Figure should not be cash collected.]) by payer and service for the last fiscal year and YTD for:
 - ✓ Medicare (include and identify Medi-Medi state revenue)
 - ✓ Medi-Cal fee-for-service
 - ✓ Medi-Cal managed care
 - ✓ Commercial/other
 - ✓ Self-pay
 - ✓ Family PACT

- ✓ CHDP
- ✓ CDP
- ✓ CPSP

Other Revenue

- Description and amount of prior fiscal year and current FYTD revenue related to:
 - ✓ County programs
 - ✓ Federal 330 grant
 - ✓ Other federal grants
 - ✓ Other grants, including foundation
 - ✓ Fundraising
 - ✓ Other

Staffing and Salary Expense

- Complete staff roster by clinic including: titles, FTEs, and total salary costs, for provider and nonprovider staff
- Listing of vacant/budgeted positions
- Indication of grant-supported staff with: titles, FTEs, and salaries/benefits
- Estimated fringe benefits percentage:
 - ✓ Detail of health insurance program
 - ✓ Detail of any retirement benefits (pension, 401k/403b)

Operating Expenses

- Last fiscal year and current FYTD operating expenses detail by line item
- Description of facility arrangements (e.g., lease/ownership) and listings of occupancy costs

Infrastructure

- Description of current practice management system and EHR system, if applicable

Other

- Last 3 years' IRS tax returns for the practice
- Identification of practice ownership structure, including documentation of any financial relationships

between the owners and the practice, such as building or equipment ownership

- ☑ Terms of any current loans
- ☑ Copies of managed care/IPA contracts

Visits and Payer Mix

- ☑ Visits by Payer and by Service for the last fiscal year and current FYTD. Payer definitions:

- ✓ Medicare (including Medi-Medi dual-eligible)
- ✓ Medi-Cal fee-for-service
- ✓ Medi-Cal managed care
- ✓ Commercial/other
- ✓ Self-pay
- ✓ Family PACT
- ✓ CHDP
- ✓ CDP
- ✓ CPSP

- ☑ Visits by type of provider, including:

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- ✓ Medi-Cal fee-for-service
- ✓ Medi-Cal managed care
- ✓ Commercial/other
- ✓ Self-pay
- ✓ Family PACT
- ✓ CHDP
- ✓ CDP
- ✓ LCSW

Other Revenue

- ☑ Description and amount of prior fiscal year and current FYTD revenue related to:

- ✓ County programs
- ✓ Federal 330 grant
- ✓ Other federal grants
- ✓ Other grants, including foundation
- ✓ Fundraising
- ✓ Other

Staffing and Salary Expense

- ☑ Complete staff roster by clinic including: titles, FTEs, and total salary costs, for provider and nonprovider staff
- ☑ Listing of vacant/budgeted positions
- ☑ Indication of grant-supported staff with: titles, FTEs, and salaries/benefits
- ☑ Estimated fringe benefits percentage

Operating Expenses

- ☑ Last fiscal year and current FYTD operating expenses detail by line item
- ☑ Description of facility arrangements (e.g., lease/ownership) and listings of occupancy costs

Infrastructure

- ☑ Description of current practice management system and EHR system, if applicable

Other

- ☑ 2018 Uniform Data System report
- ☑ Most recent federal Notice of Award (NOA) for 330 grant
- ☑ Most recent audited financial statements and most recent monthly financials
- ☑ Terms of any current loans
- ☑ Current Medi-Cal PPS rate by site (including notation of any sites with interim rate/undergoing PPS Change in Scope)
- ☑ Current Medi-Cal Code 18 rate by site

Item 2:

Key Documents to Be Reviewed List

Corporate documents (articles, bylaws, board minutes [five years], amendments to articles, and bylaws)

Inventory physical assets (owned or leased)

Professional services agreement (five years)

Third-party agreements

- Payers
- Indemnification
- Non-competition
- Health Information Exchange agreements
- Restrictions on transfer of assets, including gift, bequest, or grant agreements
- Identification of financial interests, investments, joint ventures, network agreements, etc.
- Vendor agreements (services, equipment, food, maintenance, software and other maintenance, cleaning services, billing services, etc.)
- All contracts that cannot be cancelled (without cause) with more than 30 days' prior notice
- Description of all related party transactions (five years)
- Billing, coding, and collection agreements
- All "interested party" agreements

Legal liabilities

- Pending or threatened claims, disputes, audits, investigations, inquiries, involving target of merger or acquisition (or its property), its officers, directors, key staff, or other insiders potentially affecting the value of the company
- Listing of all judgments, awards, consent decrees, settlement agreements, administrative orders, etc.
- All documents (emails, notes, letters, etc.) relating to the licensing or use of technology
- CDPH HS 215A forms
- Summary of criminal convictions of any officer, director, or professional

Summary of events or occurrences that may lead to a claim by/against the company, its officers, directors, professionals, or other staff

Tax exemption

Debts and other liabilities

Real property, leases, and building code issues

Identify any property subject to a "federal interest"

Trade and service marks

Employee compensation and benefit issues

Licensure, certification, and permits

Public payer compliance

An effective document sharing labeling and sharing protocol should include the following information:

- ▶ Functional Business Unit/Department Name
- ▶ Type of document (policy, procedure, guide, workflow, template)
- ▶ Document title (enter title using standard nomenclature)
- ▶ Document catalog number (assign number to all documents)
- ▶ Last reviewed/edited (enter date)
- ▶ Approved by (name and title)
- ▶ Document Reviewed by (acquiring entity personnel name and date)
- ▶ Document most closely aligned (name of document most closely aligned with acquiring entity document)
- ▶ Modifications needed to current (acquiring entity) documents? (Yes/No?)
- ▶ Person(s) responsible for making edits or drafting a new document (name of individual)
- ▶ Review and revisions due date (Insert date of when action item is due)
- ▶ Action Items complete? (enter date of action item completion)

Endnotes

- ¹ Note that the terms community health center, health center, and FQHC are used interchangeably throughout this report.
- ² [*California Federally Qualified Health Centers: Financial and Operational Performance Analysis, 2013-2017*](#), Capital Link, April 2019.
- ³ Ben Grossman-Kahn and Tim Schmuckal, [*Building to a Sum Greater Than Its Parts: A Hands-On Guide to Cultural Integration in Community Health Partnerships and Alliances*](#), California Health Care Foundation (CHCF), October 2019.
- ⁴ “[Chapter 14: Collaborative Relationships](#),” in Health Center Program Compliance Manual, Health Resources and Services Administration (HRSA), last reviewed January 2018.
- ⁵ Sample Project Work Plan and Timeline, CHCF, October 2020. This supplement to [*Mergers and Acquisitions: A Practical Guide for Community Health Centers*](#) is offered as a template for health centers to adapt as needed. A complete set of tools is available for download.
- ⁶ Sample Health Center Pro Forma, CHCF, October 2020. This supplement to [*Mergers and Acquisitions: A Practical Guide for Community Health Centers*](#) is offered as a template for health centers to adapt as needed. A complete set of tools is available for download.
- ⁷ [Cal. Welf. & Inst. Code §§ 14043.15\(e\) and 14132.100\(j\)\(1\)](#); and [Cal. Health & Safety Code § 1206\(h\)](#). Prior notice should also be provided to the California Department of Health Care Services’ Audits and Investigations, which oversees FQHC reimbursement, as well as the California Department of Public Health, which oversees licensed clinics.
- ⁸ Some programs, including Medicare, CHDP, and Family PACT, require site-specific enrollment or surveys. The current formal and informal policies should be verified as part of developing the timeline.
- ⁹ Grossman-Kahn and Schmuckal, *Building*.
- ¹⁰ [1 Cal. Corp. Code § 5231](#).
- ¹¹ Sample Document Catalog Template, CHCF, October 2020. This supplement to [*Mergers and Acquisitions: A Practical Guide for Community Health Centers*](#) is offered as a template for health centers to adapt as needed. A complete set of tools is available for download.
- ¹² Benefits Comparison Sample, CHCF, October 2020. This supplement to [*Mergers and Acquisitions: A Practical Guide for Community Health Centers*](#) is offered as a template for health centers to adapt as needed. A complete set of tools is available for download.
- ¹³ [42 U.S.C. § 254b](#).
- ¹⁴ [42 C.F.R. § 424.516\(e\) \(2016\)](#).
- ¹⁵ [Cal. Health & Safety Code § 1206\(h\)](#).
- ¹⁶ [Cal. Welf. & Inst. Code § 14043.15\(e\)](#).
- ¹⁷ [Cal. Health & Safety Code § 1204\(a\)](#).
- ¹⁸ [PIN 2008-01: Defining Scope of Project & Policy for Requesting Changes](#) (PDF), HRSA, last modified January 13, 2009, 27.
- ¹⁹ [Cal. Welf. & Inst. Code § 14043.15\(e\)](#).
- ²⁰ [Cal. Welf. & Inst. Code § 14132.100\(j\)](#).
- ²¹ Communications Plan Outline with Sample Positioning Statements and Exercises, CHCF, October 2020. This supplement to [*Mergers and Acquisitions: A Practical Guide for Community Health Centers*](#) is offered as a template for health centers to adapt as needed. A complete set of tools is available for download.
- ²² Benefits Comparison Sample, CHCF.
- ²³ Sample Project Work Plan, CHCF.
- ²⁴ [Quality Improvement](#) (PDF), HRSA, April 2011.
- ²⁵ Jay R. Anderson, “[HRSA FTCA Program and Risk Management](#)” (PDF), (paper presented at National Primary Oral Health Conference, Orlando, Florida, October 27, 2010).

²⁶ [“Federal Tort Claims Act \(FTCA\) Health Center Program Site Visit Protocol,”](#) HRSA, last reviewed April 2019.

²⁷ [Environment of Care Documentation Checklist \(PDF\)](#), The Joint Commission, 2016.

²⁸ [Safety and Health Program Audit Tool \(PDF\)](#), Occupational Safety and Health Administration, December 2017.

²⁹ [Facility Site Review Survey \(PDF\)](#), California Dept. of Health Care Services, n.d.

³⁰ [1 Cal. Corps. Code §§ 5230–39.](#)