GROSS RECEIPTS TAXATION OF SELECTED PHYSICIANS SERVICES*

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*Author's Note: This pamphlet is for general informational purposes only. Practitioners should seek advice from their own tax professionals with respect to the subject matter of these materials and with respect to any specific tax issues that may arise in the course of their practice. This version of this general outline has been revised and updated through July 7, 2007.

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A. Pre-1998

Prior to 1998 health care services provided by physicians were subject to New Mexico gross receipts tax. Two general exceptions applied to health care services provided by physicians employed by §501(c)(3) non-profits or health maintenance organizations. In those situations, the services were not subject to gross receipts tax.[1]

Illustrative Examples:

Example #1: P is a general practitioner in Roswell, New Mexico. In August 1997, T, a resident of Roswell develops the flu. T visits P for treatment. P charges T $20 for the office visit. P must report and pay gross receipts tax on the receipts for the service.[2]

Example #2: P is a general practitioner in Farmington, New Mexico. In August 1997, Z, a resident of Farmington falls and breaks her arm. Z visits P to set her broken arm. Z is covered by Medicare. In accordance with applicable fee payment guidelines, P charges Z $30 for setting her broken arm. Z assigns her Medicare reimbursement rights to P. P must report and pay gross receipts tax on the fee for the service.

Example #3: The facts are the same as in Example #2, except that Z is covered by Medicaid. In accordance with applicable Medicaid payment guidelines, P charges Z $25 for setting her broken arm. P must report and pay gross receipts tax on the fee for the service. Medicaid's reimbursement rate includes the gross receipts tax due.

Example #4: The facts are the same as in Example #2, except that Z travels to her local hospital, H, for treatment. P, under contract within the hospital, sets Z's broken arm. Z assigns her Medicare reimbursement claim to H. H pays P $15 for his services. P must report and pay gross receipts tax on the fee for the service.

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[1] Receipts for health care services provided by physicians employed by §501(c)(3)s (under applicable federal rules), and health maintenance organizations (subject to the premium tax) are exempt from gross receipts tax. *See* NMSA §§7-9-29; 7-9-24.

[2] Where the tax is included in the fee, the amount of tax is determined by dividing the fee (i.e. the amount received) by 1 plus the applicable tax rate.

B. Section 7-9-77.1 Deduction–Health Care Services Provided to Medicare Patients.

In 1998 the New Mexico State Legislature passed legislation providing a deduction from gross receipts for receipts derived by certain healthcare professionals from performing health care services for Medicare patients.[3] The deduction took effect on July 1, 1998 and has been amended several times since then, most recently in 2007.[4] See NMSA §7-9-77.1.

In its current form, the §7-9-77.1 deduction consists of five separate deductions. Three of the §7-9-77.1 deductions apply to receipts from providing health care services to Medicare beneficiaries. One of the §7-9-77.1 deductions applies to receipts from providing health care services to Tricare beneficiaries. The last of the five §7-9-77.1 deductions applies to receipts from providing health care services to beneficiaries of the Indian Health Services, Indian health care plan.

(1) Section §7-9-77.1A Requirements. The §7-9-77.1A deduction is available if the following requirements are met:

a. The receipts are derived from providing health care services to Medicare beneficiaries (i.e. Part B services).

b. The health care services are performed by a listed practitioner, including, but not limited to, licensed medical doctors, osteopaths, hospices and podiatrists.[5]

c. Payment for the health care service is made by the United States Government (i.e., CMS).

(2) Section §7-9-77.1B Requirements. The §7-9-77.1B deduction is available if the following requirements are met:

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[3] The amount of the original deduction was phased in over a three-year period beginning July 1, 1998 at the rate of 33 1/3% (of qualifying receipts) per year.

[4] The deduction was expanded to cover health care and palliative services provided by hospices in 2000, health care services provided by podiatrists in 2003, health care services provided to TriCare beneficiaries in 2003, Medicare receipts of clinical laboratories in 2003, and Medicare receipts of home health care agencies in 2005. The 2007 amendments expand the type of practitioners that quality for the deduction and add a new deduction for certain health care practitioners providing health care services to beneficiaries of the United States Department of Health, Indian Health Services healthcare program.

[5] A complete list of qualifying practitioners is as follows: medical doctors, osteopathic physicians, doctors of oriental medicine, athletic trainers, chiropractic physicians, counselor and therapist practitioners, dentists, massage therapists, naprapaths, nurses, nutritionists, dietitians, occupational therapists, optometrists, pharmacists, physical therapists, psychologists, radiologic technologists, respiratory care practitioners, audiologists, speech-language pathologists, social workers, podiatrists, hospices, and nursing homes. Section 7-9-77.1F provides definitions for each type of practitioner.

a. The receipts are derived from providing health care services to TriCare beneficiaries.

b. The health care services are performed by either a licensed medical doctor or osteopath.

c. Payment for the health care service is made by a third party administrator of the TriCare program.

(3) Section 7-9-77.1C Requirements. The §7-9-77.1C deduction is available if the following requirements are met:

a. The receipts are derived from providing medical or other health care services to beneficiaries covered by the Indian Health Services, Indian health plan.

b. The medical or health care services are performed by either a licensed medical doctor or osteopath.

c. Payment for the medical or other health care service is made by or on behalf of the Indian Health Service of the United States Department of Health and Human Services.

(4) Section 7-9-77.1D Requirements. The §7-9-77.1D deduction is available if the following requirements are met:

a. The receipts are derived from providing medical services to Medicare beneficiaries.

b. The medical services are provided by a clinical laboratory.

c. Payment for the medical services is made by the United States government (or an agency thereof).

(5) Section 7-9-77.1E Requirements. The §7-9-77.1E deduction is available if the following requirements are met:

a. The receipts are derived from providing medical, other health and palliative services to Medicare beneficiaries.

b. The services are provided by a home health agency.

c. Payment for the medical services is made by the United States government (or an agency thereof).

The §7-9-77.1 deductions are not available for receipts derived from the performance of contract health care services for other health care organizations, such as an HMO, PSO, IPA,[6] or non-profit hospital (but see §7-9-93, discussed below).[7]

Illustrative Examples. The §7-9-77.1 deductions may be illustrated by the following examples (all events occurring in 2007):

> Example #5: The facts are the same as in Example #2. By virtue of §7-9-77.1A, P must report, but may claim an offsetting deduction for, the receipts derived from the sale of health care services to Z.
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> Example #6: The facts are the same as in Example #2 except that P has a contract with A to process P=s Medicare reimbursement claims. A, as agent for P, processes the claim for Z=s treatment and remits payment (net of a $3 fee) to P. P must report the $30 fee (including the amount paid to the billing agent), but is entitled to an offsetting deduction of $30 from P=s taxable gross receipts.
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> Example #7: The facts are the same as in Example #1, except that T is a covered beneficiary of the TriCare health care program. A, as a third party administrator of the TriCare program, processes the claim for T=s treatment and remits payment to P. P must report the fee but is entitled to an offsetting deduction from P=s taxable gross receipts.
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> Example #8: The facts are the same as in Example #1, except that T is covered by a managed care plan through her employer, L. P, under contract with the managed care plan, treats T's flu. The plan pays P for his services. P may not deduct any part of the plan=s payment to P under §7-9-77.1.

C. Section §7-9-93 Deduction -- Sales of Certain Contract Health Care Services to Managed Care Plans and Health Care Insurers

In 2004 the New Mexico State Legislature enacted §7-9-93, which provides a deduction from gross receipts for contract health care services. The deduction took effect on January 1, 2005. The deduction was expanded in 2006 to cover certain mental health professionals and social workers, and again in 2007 to cover certain clinical laboratories.

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[6] The §7-9-77.1 deductions generally are **not** available for receipts derived from the sale of contract health care services to managed care organizations. In New Mexico Department of Taxation and Revenue Ruling 450-07-01, however, the Department concluded that emergency heath care services provided by a contract emergency room physician to Medicare patients qualified for the Medicare deduction under §7-9-77.1A.

[7] In New Mexico Department of Taxation and Revenue Ruling 450-07-01, the Department concluded that emergency heath care services provided by a contract emergency room physician to Native Americans covered by the Indian Health Services plan qualified as a sale of commercial contract services to a managed health care organization under §7-9-93.

(1) Current §7-9-93 Requirements. The §7-9-93 deduction is available if the following three principal requirements are met:

a. The receipts are derived from payments by a managed health care provider or health care insurer (other than fee for service payments by a health care insurer).[8]

b. The payment is made for either commercial contract services or Medicare Part C services;

c. The services are provided by a health care practitioner.

(2) Definitions: Section 7-9-93 includes definitions for important statutory terms including the services covered by the deduction--"commercial contract services" and "Medicare Part C services", and the providers and payment sources that qualify for the deduction---"health care practitioners" "managed health care provider" and "health care insurer".

The definitions of commercial contract services, Medicare part C services, and health care practitioner are fairly straightforward. Commercial contract services are defined broadly to include health care services performed by a health care practitioner pursuant to a contract with a managed care organization or insurer, except for services provided to Medicare and Medicaid patients. Medicare Part C services are services performed pursuant to a contract with a managed health care provider for Medicare patients under title 18 of the federal Social Security Act. Health care practitioners are defined by list (rather than general description) and include most of the traditional types of medical service providers, including physicians and osteopaths.

The definition of a managed health care provider and health care insurer are a bit more complicated. The defined term managed health care provider includes both a general descriptive definition, and a laundry list of covered organizations and plans. If the organization or plan is listed, it qualifies. If not, it still may qualify if it meets the descriptive definition in the statute. Under the general descriptive definition, a "managed health care provider" is a person that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in a plan through its own employed health care providers or by contracting with selected or participating health care providers. The laundry list of covered organizations includes health maintenance organizations, preferred provider organizations, individual practice associations, competitive medical plans, exclusive provider organizations, integrated delivery systems, independent physician-provider organizations, physician hospital-provider organizations, and managed care services organizations. However, the listed organizations and plans are not themselves defined by statute and, therefore, administrators and practitioners will very likely have to look elsewhere for help in understanding which organizations and plans are covered by the new law.

[8] **Note**: Fee for service payments are not defined by statute.

Health care insurer is defined in two parts as (i) a person with a valid certificate of authority in good standing to act as an insurer, health maintenance organization, non profit health care plan, or prepaid dental plan that (ii) contracts to reimburse licensed health care practitioners for providing basic health care service to enrollees at negotiated fee rates. The purpose of the second part of this definition is not clear. It may be intended to make clear (again) that the deduction does not cover fee for service payments.

Illustrative Examples:

Example #9: The facts are the same as in Example #1, except that T is covered by a managed care plan through her employer, L. P, under contract with the managed care plan, treats T's flu. The plan pays P for his services. P may deduct the plan=s payment to P under §7-9-93.

Example #10: The facts are the same as in Example #1, except that T is covered by a health care plan with an insurance company that has been issued a certificate of authority to act as an insurer (under the insurance code). P has a contract with the insurance company to treat insureds at negotiated contract rates. The plan pays P for his services. P may deduct the plan=s payment to P under §7-9-93.

Example #11: The facts are the same as in Example #1, except that T is covered by a health care plan with an insurance company that has been issued a certificate of authority to act as an insurer (under the insurance code). T visits M for treatment. M does not have a contract with the insurance company to treat insureds at negotiated contract rates. The plan pays M a reduced rate for his services and Z pays the balance. M may not deduct any part of the payment under §7-9-93.

(3) Co-Pays and Deductibles:

The deduction applies only to payments by a managed health care provider or health care insurer. Accordingly, any co-payment required by a health plan would not be deductible under §7-9-93.[9]

(4) Medicaid Services:

The deduction does not apply to services provided to Medicaid beneficiaries. The Medicaid reimbursement rate includes an amount for gross receipts tax.

(5) Reporting and Penalties:

The §7-9-93 deduction must be separately stated by the taxpayer (i.e. the practitioner), on its CRS-1 tax forms. The Department has modified its forms to

[9] A bill introduced in the 2007 legislature session would have expanded the §7-9-93 deduction to cover co-payments and deductibles. The bill did not pass.

accommodate the statutory mandate. At the time of enactment of §7-9-93, the legislature also enacted a new provision in the Tax Administration Act (which governs administration of the gross receipts tax) to provide for a special penalty if a taxpayer (i.e. health care practitioner) failed to "correctly report the deduction to which the taxpayer is entitled" under §7-9-93. The penalty was—to say the least--unusual in that it applied whether the error was in favor of or against the taxpayer and irrespective of the reason for the mistake. In act of legislative wisdom, the legislature repealed the special penalty, effective July 1, 2007, and enacted a temporary credit to enable practitioners penalized under the old rule to recover the penalty paid.

D. Enactment of Credit for On Call Services in Hospital.

In the 2007 legislative session, the New Mexico State Legislature passed House Bill 638 (NMSA §7-9-96.2) providing a gross receipts tax credit for medical doctors and osteopath's who are not paid for health care services provided while on call in a hospital. The governor signed the bill in April and it took effect on July 1, 2007.

The amount of the credit is a percentage of the "value of unpaid qualified health care services." The value of unpaid qualified health care services is the lesser of the amount charged for the qualified health care service or one hundred thirty percent of the Medicaid reimbursement rate for the service. Qualified health care services are medical care services provided by a licensed medical doctor or osteopath while on call to a hospital and are considered unpaid if the following requirements are met:

a. The medical doctor or osteopath's bill for the service remains unpaid one year after billing; and

b. The medical doctor or osteopath has reason to believe the bill will not be paid because (i) at the time the services were provided, the patient was not eligible for Medicaid, had no health insurance, or had health insurance that did not cover the service; and (ii) the charges are not reimbursable under programs established under the Indigent Hospital and County Health Care Act.

The amount of the credit percentage is phased in over three years. The initial credit percentage is set at thirty three percent (33%) of the value of the unpaid qualified health care service, increasing to sixty seven percent (67%) on July 1, 2008, and one hundred percent on July 1, 2009.

The legislation did not specifically address whether the credit is available for services performed prior to the effective date of the bill. However, because the credit is available only with respect to charges that remain unpaid for at least a year, the legislature necessarily must have intended that the credit would apply to unpaid services performed before the effective date of the legislation or the first one third phase of the credit could never apply.

Last summer the Department of Taxation and Revenue published RPD-41323 to facilitate the filing claims for the new credit. The instructions provide guidance on three important issues: First, the instructions make clear that physicians who otherwise meet the requirements of the statute may claim the credit for services performed prior to July 1, 2007 (the effective date of the legislation) as long as they claim the credit on their CRS report for the period ending July 31, 2007. Physicians who missed filing for the credit on their July 2007 report may, subject to the statutory limitations on filing refund claims, file an amended report claiming the credit. Second, the instructions require physicians claiming credits for years after July 1, 2008, to claim the credit on the CRS report for the month exactly one year after the service was billed. As with the pre effective date claims for credits, physicians who missed the filing for the credit on their monthly report covering the one year anniversary of the billing may, subject to statutory limitations on refunds, file an amended report claiming the credit. Third, the instructions provide that the amount of the tax credit constitutes gross receipts for gross receipts tax reporting services. According to the Department, the credit was written to compensate physicians for performing healthcare services and should be treated as gross receipts as if payment was made by the patient.

Illustrative Examples:

Example # 12: In June 2006 L, an individual, falls and breaks her arm. L is taken to her local hospital, H, for treatment. P, a surgeon on call at the hospital, operates and resets L's broken arm. P bills L $500 for P's surgical services. P's bill is less than 130% of the Medicaid reimbursement rate for the procedure. At the time of her surgery, L had no health care insurance and did not qualify for Medicaid. P's charge for the surgical service is not reimbursable under any program established under the Indigent Hospital and County Heath Care Act. P's bill remains unpaid for over twelve months. In August of 2007, P determines that his bill to L for surgical services will not be paid because, at the time P performed the surgery, L had no health insurance or Medicaid coverage, and because P's charge is not reimbursable under programs established under the Indigent Hospital and County Heath Care Act. P may claim a credit against gross receipts tax in an amount equal to 1/3 of the amount of his bill to L for surgical services.

Example # 13: The facts are the same as in Example #12, except that P's charge for the surgical service is 150% of the Medicaid reimbursement rate for the procedure. P may claim a credit against gross receipts tax in an amount equal to 1/3 of 130% of the Medicaid reimbursement rate for P's surgical services.