INDEPENDENT PHYSICIAN PERSPECTIVE ON STATE TAXATION OF MEDICINE

PRESENTED BY: NEW MEXICO MEDICAL SOCIETY

- Todd Williams, MD - San Juan Plastic Surgery
- Lynn Paul, Chief Financial Officer – Eye Associates of NM

REVENUE STABILIZATION AND TAX POLICY COMMITTEE

REPRESENTATIVE CHRISTINE CHANDLER, CHAIR

SENATOR BENNY SHENDO, VICE-CHAIR

OCTOBER 7, 2022

WE ARE ON THE PRECIPICE…

WORKFORCE SHORTAGE ISSUES

2022 SUMMARY OF LICENSED HEALTH CARE PROFESSIONALS

New Mexico has **lost** physicians since 2013:

- 308 **fewer** Primary Care Physicians
  - 181 **below** the national benchmark
- 37 **fewer** OB-GYNs (NM lost more OB-GYNs in 2022)
  - 19 **below** the national benchmark
- 20 **fewer** General Surgeons
  - 11 **above** the national benchmark
- 12 **fewer** Psychiatrists
  - 15 **below** the national benchmark

Summary of Health Care Professionals with New Mexico Licenses Practicing in the State

A. Physicians

Profession Metric	2013	2016[b]	2017	2018	2019[c]	2020	2021	Net Change Since 2013
PCPs								
# in New Mexico	1,957	2,076	2,360	2,162	1,581	1,607	1,649	-308
Total Below Benchmark[a]	153	139	126	136	336	328	334	181
Counties Below Benchmark	23	22	16	18	26	27	25	2
OB-GYNs								
# in New Mexico	256	273	282	279	230	229	219	-37
Total Below Benchmark[a]	40	31	30	39	59	56	59	19
Counties Below Benchmark	14	9	11	15	17	17	19	5
General Surgeons								
# in New Mexico	179	188	194	188	155	154	159	-20
Total Below Benchmark[a]	21	14	12	11	11	10	10	-11
Counties Below Benchmark	12	7	7	6	5	5	4	-8
Psychiatrists								
# in New Mexico	321	332	332	317	296	305	309	-12
Total Below Benchmark[a]	104	106	111	108	106	117	119	15
Counties Below Benchmark	25	26	26	26	26	26	24	-1

[a] Total below benchmark reflects the number of providers needed to bring all counties below benchmarks to national provider-to-population values without reducing workforce in counties above benchmarks.

[b] This is the first year for which DO specialties were analyzed, correcting prior years' overestimation of DOs in primary care and underestimation in OB-GYN, general surgery and psychiatry.

[c] Non-practicing providers for all professions were excluded beginning with 2019.

Shortages

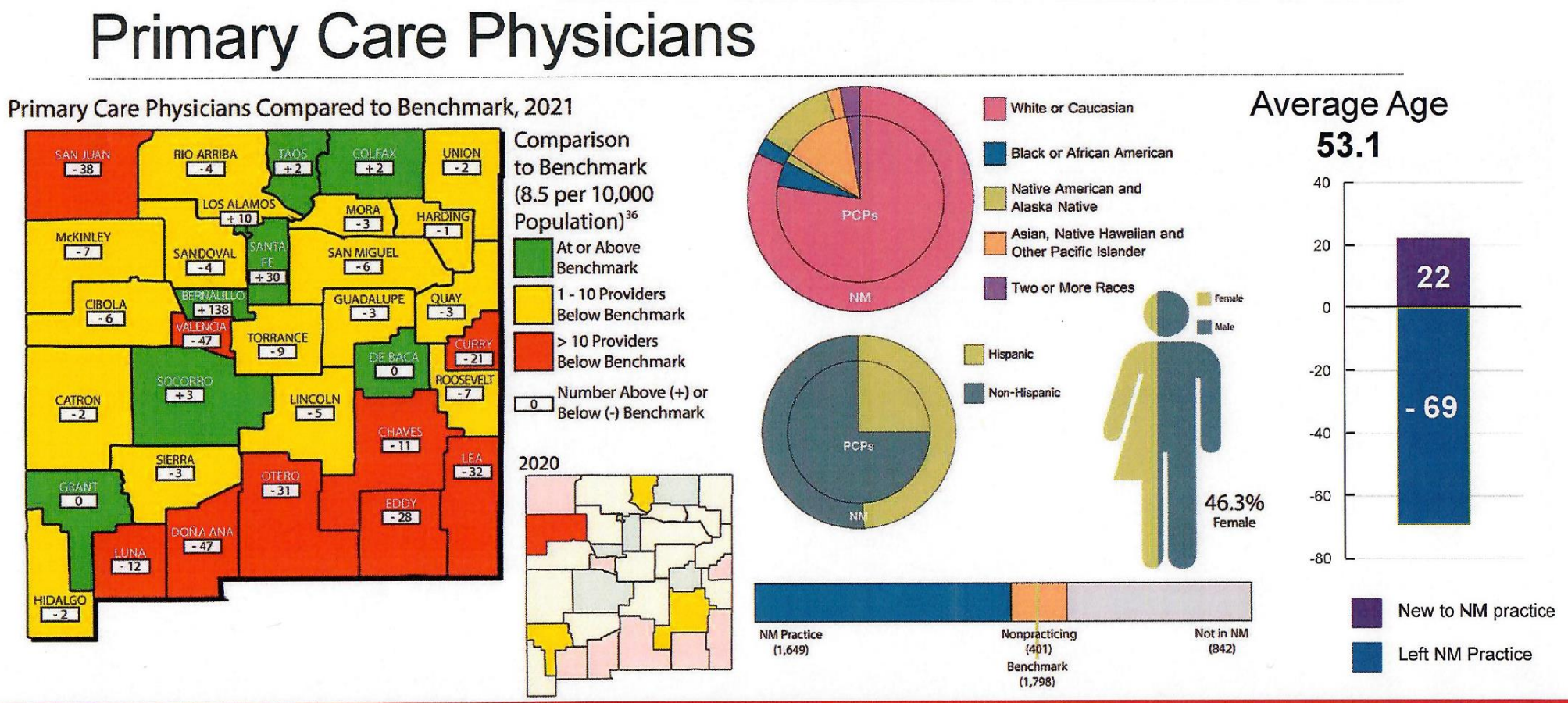
As of 31 December 2021[1]:

- Shortages are most severe in less-populated counties
- *Without redistributing* the current workforce, New Mexico needs:
  - 334 Primary Care Physicians
  - 59 Obstetrics and Gynecology Physicians
  - 10 General Surgeons
  - 119 Psychiatrists
  - 5,863 RNs/CNSs
  - 227 CNPs
  - 14 CNMs
- Average national age is 53.2 years[2]
- Highest percentage of physicians 60 years or older (39.2% versus 33.7%nationwide)[3]

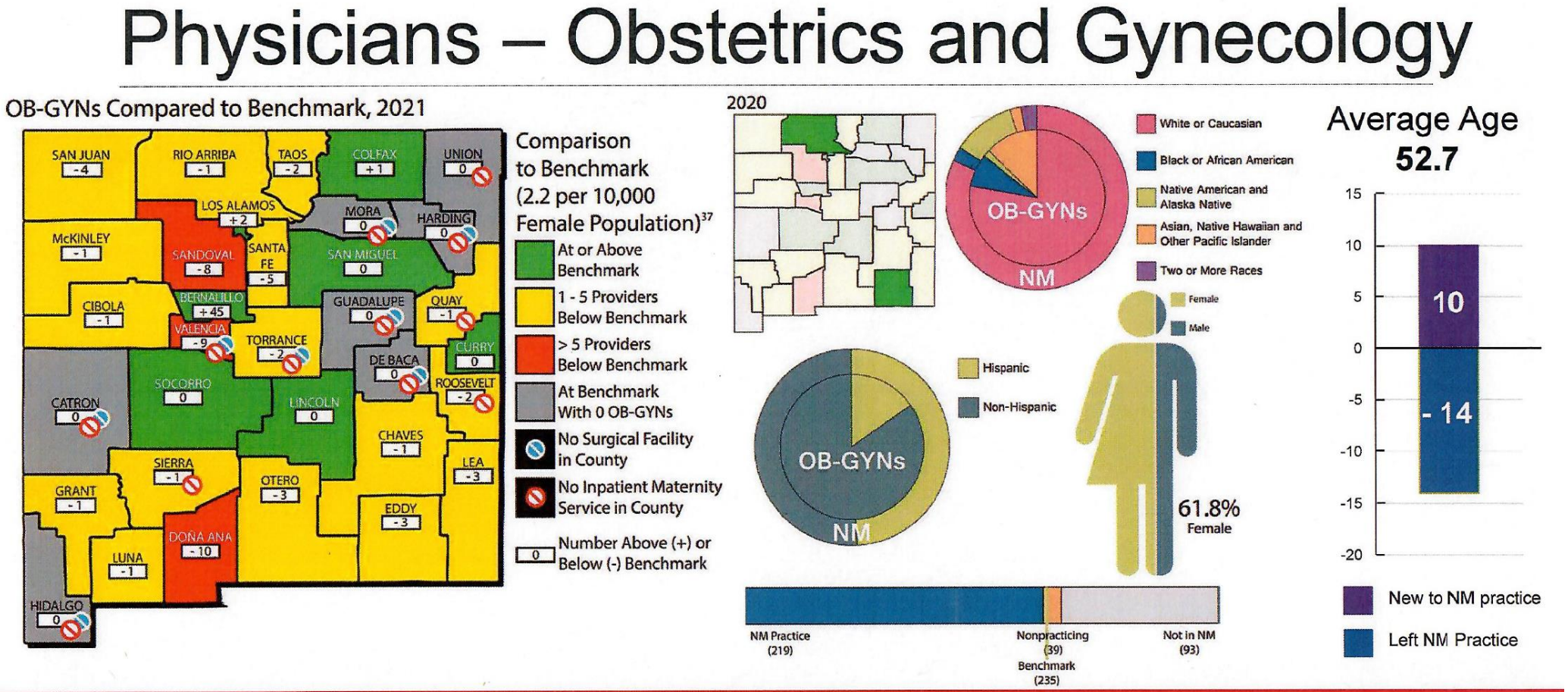
1. New Mexico Health Care Workforce Committee. *2022 Pending Annual Report*. Albuquerque NM: University of New Mexico Health Sciences Center; 2022
2. Definitive Healthcare
3. Association of American Medical Colleges. *2021 State Physician Workforce Data Report*. Association of American Medical Colleges; 2021.

NECESSARY HIRES TO MEET BENCHMARK

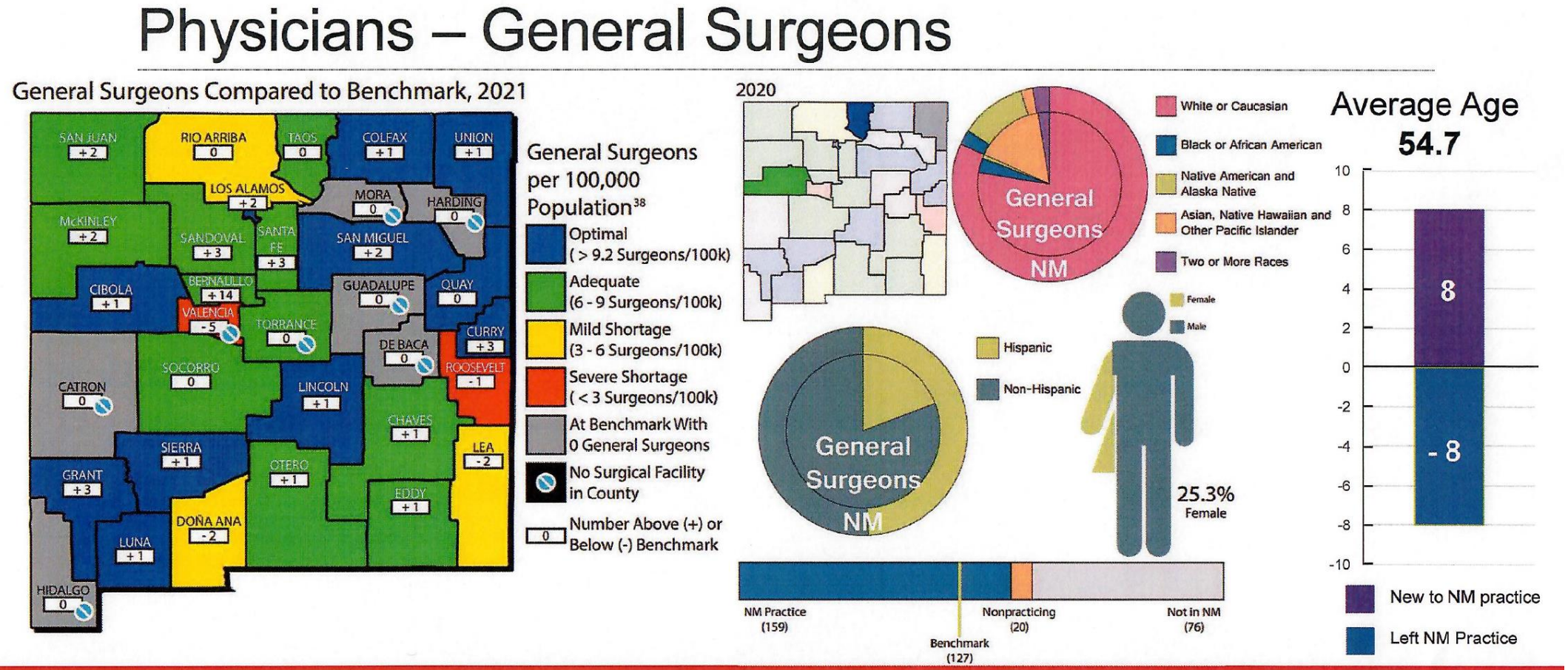
2022 PRIMARY CARE PHYSICIAN REPORT



2022 OBGYN REPORT

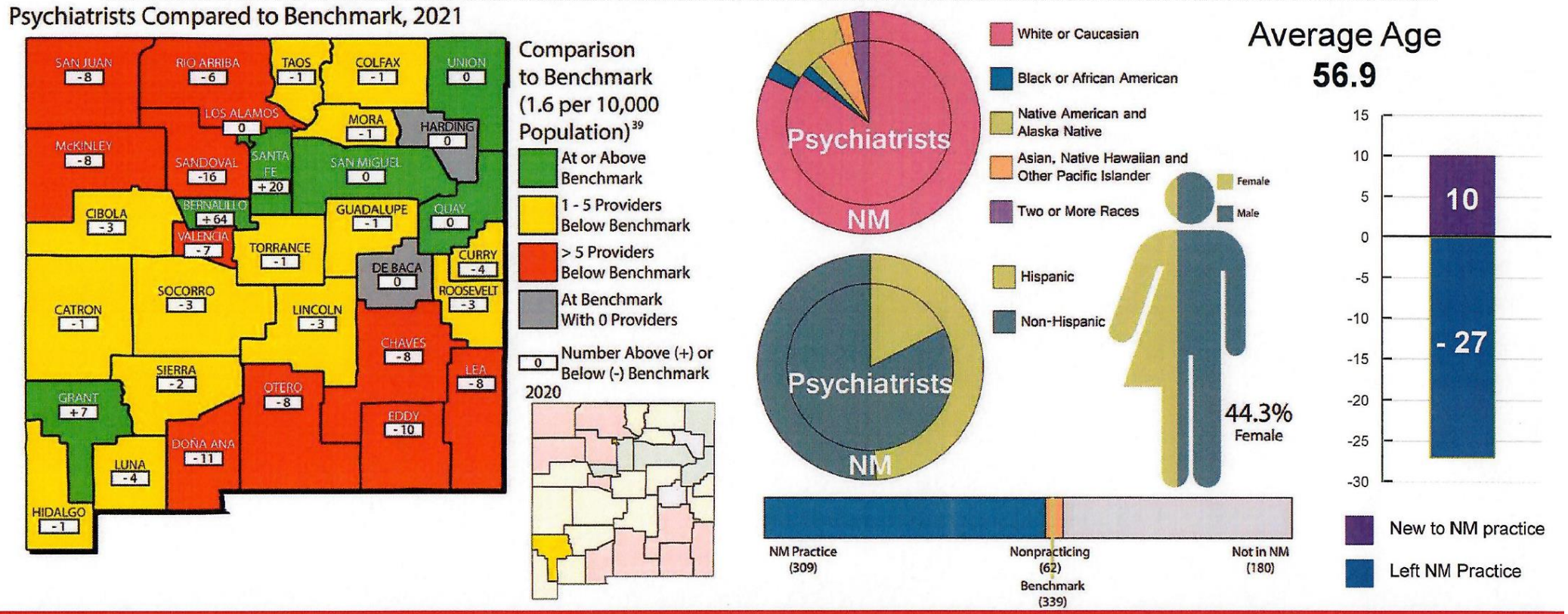


2022 GENERAL SURGEON REPORT



2022 PSYCHIATRIST REPORT

Physicians - Psychiatrists



THERE IS NO "ONE" REASON FOR THE SHORTAGE, BUT TAXES CONTRIBUTE

- New Mexico has made the list of worst states to practice medicine for **three of the past five years.** – Becker's Health Review
- New Mexico's main competitor for independent physician practices is Texas.
- Texas does **not** tax medical services – in fact, New Mexico is only **one of four states in the union** that taxes medical services at all (Ohio, Michigan, New Mexico, Hawaii).
- Texas also has **no** personal income taxes, meaning physicians not only make higher salaries in Texas, but they keep more of that salary as "take home pay."
- There is a national health care clinician shortage, meaning New Mexico must do **more** to outcompete fellow states and attract clinicians to move here, stay here provide high quality care here.
- We know that if we can have more practices in here, we will save lives, improve the health of our communities, and lift New Mexico communities.

PRACTICE EXPERIENCES

THE BUSINESS STORIES OF OUR PRACTICES

SAN JUAN PLASTIC SURGERY – TODD WILLIAMS, MD

- San Juan Plastic Surgery – where we practice, who we are, who we serve, and what care we provide.
- The Farmington GRT rate is 8.3125%.
- Despite the GRT deductions taken for Medicare, other government pay, and payments from MCOs, the effective GRT rate for Todd Williams, MD, PC in 2021 was 5%
- Unlike other businesses in New Mexico, medical practices cannot pass those taxes onto consumers.
- Overhead costs in my practice in 2021 were 60% (national average is 60% to 70%).
- That GRT number of 5% effectively becomes a 12.5% tax on my "net receipts." This is for all practical purposes a 12.5% income tax.
- Added to the New Mexico personal income tax rate of 5.9%, as a sole proprietor, I effectively pay a 18.4% full state tax to the state.
- If my overhead increased to 70%, that would be "net receipts tax" (or full state tax) of 16.67% + 5.9% = 22.7%

SAN JUAN PLASTIC SURGERY – TODD WILLIAMS, MD

- Because Texas has no GRT and no personal income tax, if my practice moved to Texas, I would experience a 18% to 22% decrease in tax liability.
- Medical practices that are a 501(c)3 have protection from GRT – Medical practices that are **not** a 501(c)3 are taxed at extremely high rates when compared nationally. This is especially true because, as previously stated, NM is only one of four states that tax medical services at all. And, it is only one of two states that tax through a GRT system.
- To make matters worse – if you add the federal tax liability of 35% federal tax rate, the over income tax burden on my medical practice is 53% to 57%.

LYNN PAUL, CFO – EYE ASSOCIATES OF NM

- Eye Associates of NM has been in business for over 40 years – we help people keep their sight.
- We employ over 60 ophthalmologists and optometrists and over 550 clinical and administrative support staff across the state.
- We serve patients in 12 locations across New Mexico including Farmington, Taos, and Roswell and we have two surgery centers.
- We recruit physicians to our practice from all over the United States, so we know first-hand the difficulties of recruiting physicians to NM.
- Like all medical practices, we operate in an environment where reimbursements decrease or remain flat while our costs of doing business increase.
- Our largest expense is salaries – we compete with other businesses for our clinical and administrative support staff. Those non-medical businesses can pass their wage cost to their customers, but we cannot pass that cost to our patients or to their health plans.
  - In order to attract the best providers to our state, we've recently had to start paying more money than we've previously had to pay to recruit new providers.

LYNN PAUL, CFO – EYE ASSOCIATES OF NM

- Our supply costs have been steadily increasing as well as our costs for services such as janitorial and security. Those service businesses are passing along their increased costs of doing business to us. We were just informed, for example, that the cost of our medical disposal service will increase 20%.
- We are currently in the process of expanding at our Retina Center location. Not only has the cost of medical equipment increased, but there's a 9 month wait time for the equipment we utilize in our exam rooms.
- A business model with declining or flat reimbursement rates and increasing costs is not a sustainable business model.
- The gross receipts tax in effect lowers our reimbursement even further as we are not allowed to collect that tax from our patients.
- With 12 locations across the state, we have a large, involved GRT reporting responsibility that takes considerable administrative time to accomplish each month.

IS IT WORKING?

CURRENT TAX STRUCTURE

MEDICAL PRACTICES ARE UNIQUE BUSINESSES

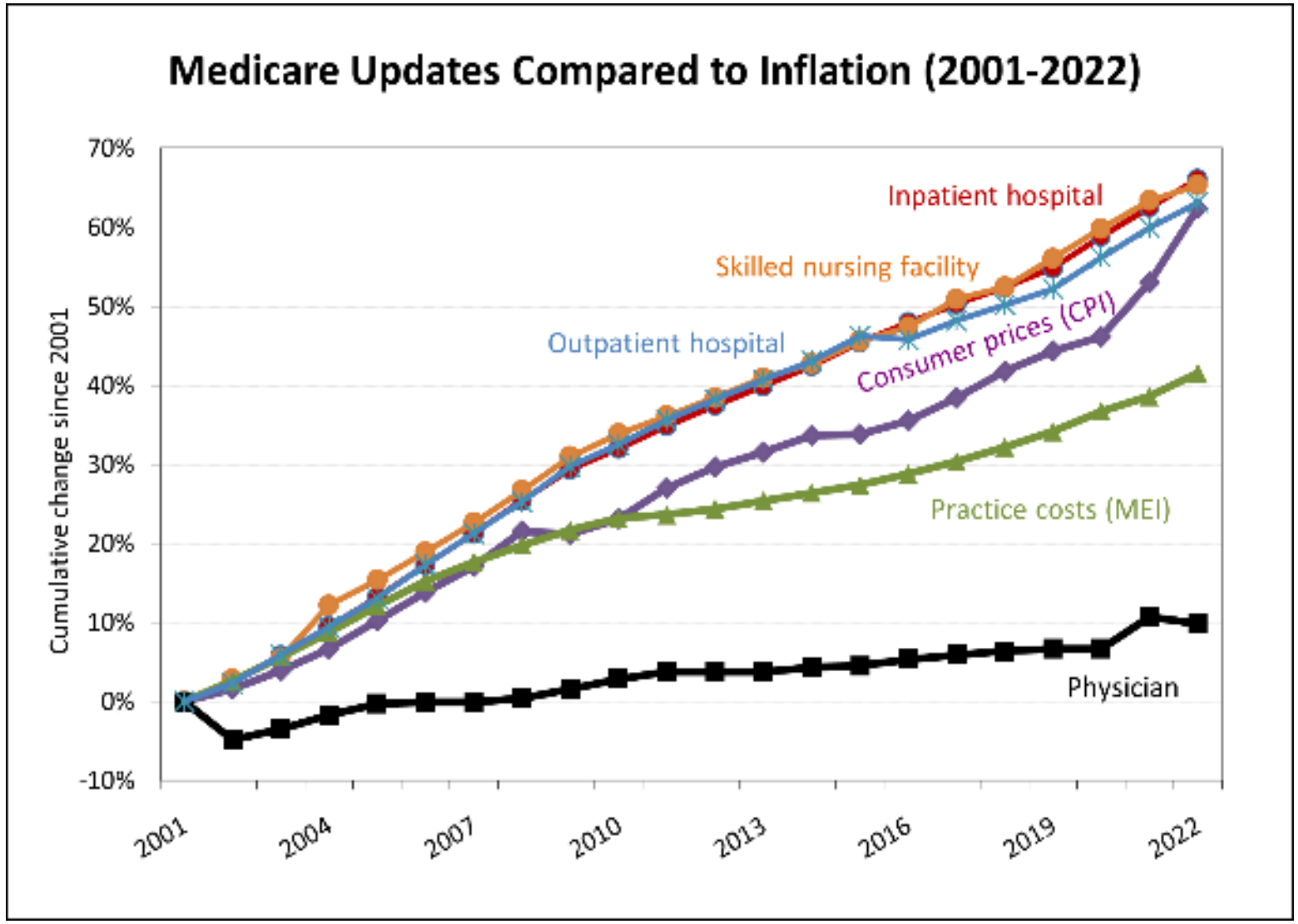
- Why is it so hard to run a medical practice?
  - Because medicine is the **only** industry in which the business cannot control the price of the services or goods we provide.
- The rates practices receive for procedures are set through a lopsided negotiation process with an MCO where the practitioners almost always receive less payment for the service than the cost to provide it.
  - The rates for commercial plans often fall back on Medicaid and Medicare rates, which we show on the next slide are lower than practice costs.
- These rates are set, often, more than a year in advance of the service provided through the fee schedule. Some of the contracts have evergreen clauses that make it difficult for providers to renegotiate rates for years at a time.
  - This means "new price setting" cannot occur mid-year to react to growing costs.
- The only way to increase revenue is to see more patients, which is not the best quality of care, or to accept only private pay patients in which the provider can set their own prices. But most New Mexicans could never afford to receive care in that setting.

MEDICARE HELPS TELL THE STORY OF LOW REIMBURSEMENT RATES

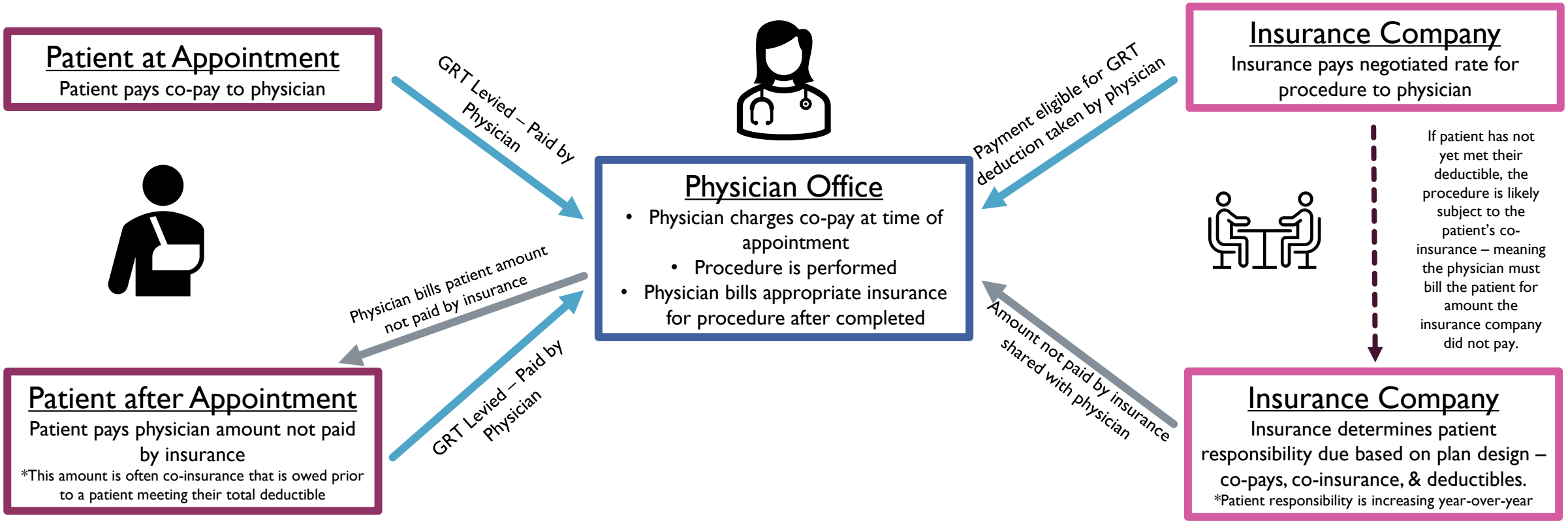
The State of New Mexico does not control Medicare, but stagnant Medicare reimbursements compound the revenue issues for physician practices.

Physician reimbursement rates have not kept up with inflation because there is no inflation adjuster in the rates.

Physicians have experienced no notable increase in Medicare in 20 years.



CURRENT DEDUCTIONS: MEDICARE, GOVERNMENT, MCO GRT



- GRT deduction may be taken on payments from Medicare, other government pay (like Tricare), and MCOs that the physician has a contract with.
  - Simply, practices deduct the GRT owed for payment they receive from the insurance company (MCO) that it has a contract with, not payment they receive from the patient.
  - Practices are prohibited from "passing GRT on" to their customers/patients. Therefore, the practices are required to absorb the GRT unlike other businesses in New Mexico.
  - GRT burden is increasing for practices because less money is paid by insurance companies as the insurance market shifts costs to patients **through higher co-pays, deductibles and co-insurance.**

GROSS RECEIPTS TAXES ARE CHALLENGING FOR BUSINESSES

- Independent healthcare providers appreciate the current GRT deduction for reimbursement/payments for services received from Medicare, government insurance (like Tricare), and MCOs.
- However, there is no GRT deduction on patient co-pays, co-insurance and deductibles.
- Physicians are required to pay GRT on Medicaid payments and reimbursement is inconsistent for the liability.
- Healthcare practices are unique from other business transactions because they are prohibited from "passing the GRT on" to the patient. The practice must, therefore, assume the GRT liability.
  - New Mexico is only one of two states that force practices into taking an automatic 7-8% hit to their revenue to simply operate. In fact, New Mexico is one of only 4 states that tax medical services at all.
  - Fewer and fewer healthcare payments are made by insurance companies as deductibles, co-insurance, and co-pays continue to grow, so the tax burden is shifting to the providers on payments which currently have no GRT deduction.
  - Plus, with growing cost of deductibles, many patients pay with credit cards and the practice must absorb the 2-3% bank fee.
- Remember, medical practices are also unique from other businesses because they cannot pass growing costs (like inflation) onto the consumer.

CURRENT RESPONSIBILITY: MEDICAID PAYMENTS AND GRT

Medical Assistance Department (MAD - HSD Medicaid Office) contracts with different insurance companies to provide Centennial Care Plans and enroll Medicaid eligible clients in these plans.

The Centennial Care Plans negotiate rates with individual providers. These rates are, on average, less than 70% of Medicare reimbursement rates.

MAD pays Centennial Care insurance companies a per member per month (PMPM) rate which is a capitated rate. This rate includes 7% - 8.5% so Centennial Care insurance companies can include GRT in negotiated rates with individual providers.

Although they receive GRT in the PMPM rate, Centennial Care insurance companies have issued contracts with providers that specifically state rates **do not include GRT.** Even contracts that claim to include GRT, there is no itemization of the tax included in the rates and, therefore, there is no transparency if GRT is included in the contract. And there may be "double taxation" where physicians pay the GRT on the GRT they receive.

GRT collected through Medicaid payments is supposed to be dedicated to the Medicaid Budget so it can be leveraged for federal matching funds. However, it is unclear if the GRT collected serves this purpose since provider rates have not been increased since 2019 and Centennial Care insurance companies have not passed on increases the legislature has made to the Medicaid budget over the last three years.

OTHER BURDENS FROM GRT

- GRT impacts other parts of the practice that go beyond payment for services. Examples include:
  - Independent Contractors – contracted amount is subject to GRT
  - Professional Services that do not have a current GRT deduction (pyramiding)
  - Medical Equipment purchased by the practice for patient care
    - Large equipment (X-Ray, MRI, Ultrasound, etc.)
    - Disposable equipment (personal protection equipment, bandages, IV tubing, etc.)
    - This increased in July because practices used to pay only the State GRT rate but now practices pay the local GRT rate due to destination sourcing

PERSONAL INCOME TAXES

- Physicians in New Mexico make less, on average, than their counterparts in surrounding states. This is especially true in specialty areas.
- New Mexico has made significant investments in our teachers to pay them **more than surrounding states** so we may compete in the teacher market.
- This mentality must spill over to recruitment strategies for physicians, and we must make decisions to facilitate more "take home pay" for physicians.
- New Mexico allows a personal income tax credit of $5,000 for some healthcare providers working 52 weeks in a rural community.
- While this tax credit is appreciated, it does not cover all healthcare clinicians, nor does it do enough to make up for the smaller salary clinicians receive in the state.

OTHER TAX RELIEF PROVIDED TO HEALTH CARE CLINICIANS

- Unpaid Charges for Hospital Services Credit against GRT
  - A licensed medical doctor or licensed osteopathic physician may claim a credit against gross receipts taxes due for the value of unpaid qualified health care services. Qualified health care services must be provided by the doctor or physician while on call to a hospital.
- This credit does not extend to all clinicians that may serve on call shifts in a hospital – notably advanced practice nurses like certified nurse midwives and certified registered nurse anesthetist.

ACTIONABLE SOLUTIONS FOR THE NM LEGISLATURE

MAKING NEW MEXICO'S TAX ENVIRONMENT ATTRACTIVE TO MEDICINE

IMPROVING MEDICAID FOR CLINICIANS

- In addition to increasing the overall Medicaid budget, the Legislature and HSD should do more to ensure increases in Medicaid investments make it to frontline providers and their patients.
- Adequate funding for the Medicaid budget includes:
  - Funding so Medicaid reimbursement rates are at least 120% of Medicare rates – or comparable to fair commercial market rates. This will require both legislative and NM Medicaid plan changes.
  - Ensure adequate funding so reimbursements rates keep up with inflation and use language in HB2 to ensure reimbursement rates include those inflation indicators when passed through the MCOs.
  - Provide specific funding in HB2 to increase provider reimbursement rates and include language that requires MCOs to pass increases onto providers.
- Increase MCO/Centennial Care accountability
  - Require 7-8% in funding be included in all negotiated rates, including those negotiated with providers through Centennial Care, as part of the RFP and HSD approved contracts with all Centennial Care insurers to cover appropriate tax liabilities.

GROSS RECEIPT TAX SOLUTIONS

- Consider GRT deductions on deductibles, co-insurance, and co-pays on commercial insurance plans charged to patients but collected by health care clinicians.
  - Last introduced in 2019 – Rep. Jim Trujillo, Rep. Bill Pratt, Rep. Susan Herrera, Rep. Debbie Armstrong, Rep. Joanne Ferrary
  - Full deduction phased in over three years – 33% deduction in year 1, 66% deduction in year 2, 100% deduction in year 3

Fund	Year 1	Year 2	Year 3
General Fund	($5.1 million)	($10.4 million)	($16.5 million)
Local Government	($3.2 million)	($6.6 million)	($10.2 million)

- Consider additional GRT & compensating tax deductions for large & disposable medical equipment purchases.
  - Analogous to equipment GRT deductions in the construction and energy industries.

INCREASING TAKE HOME PAY THROUGH PIT CREDITS

- Consider increasing the personal income tax credit for healthcare providers as a recruitment and retention tool while recognizing personal income tax credits allow physicians, and other clinicians, to experience more "take home pay."
- Expand the type clinicians eligible for the PIT credit – Rep. Miguel Garcia has sponsored legislation for several years.
- Increase the total amount for the rural PIT credit – up to $10,000 per year for those employed full-time at a rural practice.
  - Change requirement of 52 weeks working at a rural practice to "employed full time by a rural practice."
- Consider creating a new urban healthcare provider PIT credit – up to $5,000 per year for those employed full time at an urban practice.

QUESTIONS?

ANNIE JUNG, EXECUTIVE DIRECTOR, NMMS – AJUNG@NMMS.ORG

NICK AUTIO, GENERAL COUNSEL, NMMS – NAUTIO@NMMS.ORG

CARRIE ROBIN BRUNDER, LOBBYIST, NMMS – CARRIEROBIN@ZIASTRATEGIES.COM