BEFORE THE HEARING OFFICER
OF THE TAXATION AND REVENUE DEPARTMENT
OF THE STATE OF NEW MEXICO

IN THE MATTER OF THE CONSOLIDATED PROTESTS OF
GUADALUPE MEDICAL CENTER,
ID. NO. 01-835119-00-0, PROTEST TO
ASSESSMENT NOS. 1937855 AND 1296576, AND **No. 01-19**
LEA REGIONAL HOSPITAL,
ID. NO. 01-873138-00-4, PROTEST TO
ASSESSMENT NOS. 1937840 AND 1570900

DECISION AND ORDER

This matter came on for formal hearing on July 12, 2000 before Gerald B. Richardson, Hearing Officer. Guadalupe Medical Center and Lea Regional Hospital, hereinafter, "Hospitals", were represented by Paul M. Fish, Esquire of Modrall, Sperling, Roehl, Harris & Sisk, P.A. The Taxation and Revenue Department, hereinafter, "Department", was represented by Javier López, Special Assistant Attorney General. At the close of the evidentiary hearing it was determined that the parties would submit their arguments in the form of briefs, along with proposed findings of fact and conclusions of law. The Hospitals submitted their Reply Brief and Proposed Findings of Fact and Conclusions of Law on October 20, 2000, and the matter was considered submitted for decision at that time. On November 20, 2000, the Hearing Officer wrote to counsel for the parties, requesting an additional 45 days beyond the 30 days specified by § 7-1-24(H) NMSA 1978 to complete his decision in this matter, due to the number of complex matters pending before him. On November 21, 2000, Hospitals' counsel wrote to the Hearing Officer refusing the Hearing Officer's request for an extension of time to complete the decision. There followed additional correspondence between the Hearing Officer and counsel in which the issue of the Hearing Officer's jurisdiction to issue this decision was raised and the Hearing Officer determined that he retained jurisdiction to issue this decision.

Based on the evidence and arguments presented, IT IS DECIDED AND ORDERED AS FOLLOWS:

FINDINGS OF FACT

1. Guadalupe Medical Center operates a hospital located in Carlsbad, New Mexico.

2. Lea Regional Hospital operates a hospital located in Hobbs, New Mexico

3. Hospitals are both owned by HCA-The Healthcare Company, formerly known as Hospital Corporation of America.

4. During all relevant periods, Hospitals provided medical services to patients who were covered under the Federal Medicare program ("Medicare") and the Medicaid program managed by the State of New Mexico.

5. During all relevant periods, Hospitals provided tangible personal property in the form of medical supplies and equipment to patients who were covered under Medicare.

6. During all relevant periods, Hospitals reported and paid gross receipts tax to the Department on their receipts from providing medical services to patients who were covered under Medicare.

7. During all relevant periods, Hospitals included in their reported gross receipts the receipts they received from providing tangible personal property in the form of medical supplies and equipment to patients who were covered under Medicare. The Hospitals then claimed a deduction, pursuant to § 7-1-54 NMSA 1978, for the amounts they received for providing the medical supplies and equipment to Medicare patients.

8. On March 14, 1987, Guadalupe Medical Center filed a claim for refund in the amount of $199,158.73 with the Department for the January, 1985 through June, 1987 reporting periods. One of the grounds for the claim for refund was that Guadalupe Medical Center amended its monthly gross receipts tax returns to claim a deduction for its receipts from the sale of tangible

personal property to patients covered by the Medicare and Medicaid programs. Guadalupe Medical Center claimed eligibility for a deduction under § 7-9-54 NMSA 1978 for sales of tangible personal property to the government.

9. In December, 1986, Lea Regional Hospital filed a similar refund claim with the Department, claiming eligibility for the same deduction.

10. The Department granted both claims for refund filed by the Hospitals.

11. In 1990, the Department audited Guadalupe Medical Center. Among other things, the Department examined the deductions claimed by Guadalupe Medical Center for reimbursements received from Medicare and Medicaid for sales of tangible personal property. Although the Department's audit resulted in the issuance of an assessment, the assessment was based upon the Department's contention that Guadalupe Medical Center had made a computational error in the manner it calculated the amount of gross receipts tax payable to the Department. The Department did not deny the deduction claimed by Guadalupe Medical Center for its receipts from sales of tangible personal property to patients covered by Medicare and Medicaid.

12. As a result of the Department's 1990 audit of Guadalupe Medical Center, on July 20, 1990, the Department mailed Assessment No. 1296576 to Guadalupe Medical Center, assessing $278,796.43 in gross receipts tax, $2,586.97 in compensating tax, $48,138.34 in penalty and $80,582.73 in interest for the January 1987 through December 1989 reporting periods.

13. On August 17, 1990, Guadalupe Medical Center wrote to the Department, requesting an extension of time in which to file a protest to Assessment No. 1296576.

14. On August 24, 1990, the Department granted Guadalupe Medical Center an extension of time until September 20, 1990 to file a protest to Assessment No. 1296576.

15. On September 20, 1990, Guadalupe Medical Center filed a protest to Assessment No. 1296576.

16. In 1991, the Department audited Lea Regional Hospital. Among other things, the Department's audit examined deductions claimed by Lea Regional Hospital for reimbursements received from Medicare and Medicaid for sales of tangible personal property. Although an assessment was issued as a result of the audit, the assessment was based upon the Department's contention that Lea Regional Hospital had twice claimed the same deduction for reimbursements received from Medicare and Medicaid for sales of tangible personal property on the same transaction. The Department's audit allowed the deduction to be claimed only once.

17. As a result of the Department's 1991 audit of Lea Regional Hospital, on August 26, 1992, the Department mailed Assessment No. 1570900 to Lea Regional Hospital, assessing $227,640.57 in gross receipts tax, $1,710.41 in compensating tax, $23,015.55 in penalty and $43,451.44 in interest for the January, 1989 through December, 1991 reporting periods.

18. On September 4, 1992, Lea Regional Hospital wrote to the Department requesting an extension of time to file a protest to the assessment.

19. The Department granted Lea Regional Hospital an extension of time, until October 25, 1992, to file a protest to Assessment No. 1570900.

20. On October 22, 1992, Lea Regional Hospital filed a written protest to Assessment No. 1570900.

21. At the formal hearing of this matter, Lea Regional Hospital chose not to present any evidence or arguments to dispute the accuracy or correctness of Assessment No. 1570900.

22. In 1995, the Department again audited the Hospitals. In those audits, the Department changed its prior position and it denied the deductions which had been claimed by the Hospitals for reimbursements for tangible personal property sold to patients covered by the Medicare program. The assessments which resulted from the 1995 audits were based entirely upon the

denial of the deduction related to the Medicare payments for tangible personal property, plus penalty and interest.

23. The Department's change of position with respect to whether amounts the Hospitals received from Medicare for tangible personal property provided to Medicare patients was based upon Ruling 405-92-1 which was issued by the Department to a taxpayer other than the Hospitals.

24. The Department's earlier position that amounts hospitals received from Medicare for tangible personal property provided to Medicare patients was deductible for gross receipts tax purposes as a sale of tangible personal property sold to the government was a position taken as early as 1977, as reflected in a letter from Fred O'Cheskey, Commissioner of Revenue of the Department's predecessor, the New Mexico Bureau of Revenue.

25. On June 15, 1995, the Department mailed Assessment No. 1937855 to Guadalupe Medical Center, assessing $1,004,923.13 in gross receipts tax, $98,005.15 in penalty and $397,424.06 in interest for the reporting periods of March, 1989 through March, 1995.

26. On June 23, 1995, Guadalupe Medical Center wrote to the Department requesting an extension of time to protest the assessment.

27. On July 13, 1995, the Department granted an extension of time until September 13, 1995 to file a protest.

28. On September 8, 1995, Guadalupe Medical Center filed a written protest to Assessment No. 1937855.

29. On August 8, 1995, the Department mailed Assessment No. 1937840 to Lea Regional Hospital, assessing $762,101.18 in gross receipts tax, $53,791.49 in penalty and $146,771.16 in interest for the reporting periods October, 1990 through March, 1995.

30. On August 30, 1995, Lea Regional Hospital wrote to the Department requesting an extension of time to protest the assessment.

31. The Department granted Lea Regional Hospital an extension of time until November 6, 1995.

32. On September 11, 1995, Lea Regional Hospital filed a protest to Assessment No. 1937840.

33. On June 8, 1999, Guadalupe Medical Center tendered payment in the amount of $276,955 to the Department pursuant to Regulation 3 NMAC 1.7.9. The amount tendered was to be applied exclusively to the gross receipts tax portion of Assessment No. 1937855 and was paid to stop the accrual of interest on that portion of the gross receipts tax assessed.

34. On June 8, 1999, Lea Regional Hospital tendered payment in the amount of $124,566 to the Department pursuant to Regulation 3 NMAC 1.7.9. The amount tendered was to be applied exclusively to the gross receipts tax portion of Assessment No. 1937840 and was paid to stop the accrual of interest on that portion of the gross receipts tax assessed.

35. The payments represented that portion of Assessment Nos. 1937855 and 1937840 which were attributable to the gross receipts tax which had been assessed by the Department on reimbursements for tangible personal property received by the Hospitals under Medicare Part B.

36. The Medicare program is administered by the Health Care Financing Administration ("HCFA"), an agency of the Federal government.

37. The Medicare program has two parts, Part A and Part B.

38. Medicare Part A is a program which provides hospitalization benefits, including medical services and supplies related to hospitalization, to individuals who qualify for Part A coverage.

39. Participation in Medicare Part A by individuals is not voluntary and is funded in part by FICA taxes withheld from an individual's wages.

40. Medicare Part B is a program which supplements the benefits available under Medicare Part A. Medicare Part B provides medical coverage benefits for medical services and supplies which would not be covered under Medicare Part A because they are unrelated to hospitalization.

41. Participation in Medicare Part B is optional for an individual and, in most cases, requires the payment of a premium. Approximately 15% of Medicare patients are eligible under the Medicaid program, however, for coverage under both the Medicare program and the Medicaid program. In such cases, the Medicaid program pays the Medicare Part B premium, any applicable Medicare Part A premium and any co-payments or deductibles that the patient would normally be responsible to pay.

42. The United States Department of the Treasury maintains two trust funds for the Medicare program, the Part A or Hospital Insurance trust fund and the Part B or Supplemental Medical Insurance trust fund. The Treasury Department receives FICA taxes and Self-Employment taxes and purchases bonds in an equivalent amount of the taxes collected and places those bonds in the Health Insurance trust fund. The Treasury Department receives Part B premiums from individuals and Medicaid payments and purchases bonds in an equivalent amount of the premiums collected and places those bonds in the Supplemental Medical Insurance trust fund.

43. The premiums the Treasury Department collects under Medicare Part B represent approximately 25% of the bonds in the Supplemental Medical Insurance trust fund. The remaining 75% are purchased with general revenues of the Federal government.

44. A hospital patient covered under Medicare Part A who receives hospitalization benefits covered under Part A may not elect to pay the hospital bill and receive the reimbursement directly from Medicare. Medicare payments under Part A are only paid directly to the hospital.

45. Under the Medicare program, there must be a contractual relationship between a hospital and the Medicare program in order for the hospital to be eligible to receive payment for medical services and related supplies provided to Medicare patients. The hospital is also limited in the amounts it may charge for various medical services and supplies under the Medicare program. Even if the hospital might charge a non-Medicare covered patient more for a medical service or supply, the hospital is limited in the amount it may charge under the Medicare program and the hospital is prohibited from asking the Medicare covered patient to make up the difference, except for the amount of any deductible or co-payment amount established under the Medicare program.

46. The HFCA contracts with private carriers and intermediaries to review claims, review coverage and process claims for claims by medical providers made under Medicare Part A and Part B. In processing and paying such claims, the carriers and intermediaries act on behalf of the HFCA and they must follow the policies and procedures established by the HFCA .

47. Although carriers and intermediaries write checks in payment of claims to providers under Medicare Part A and Part B, the funds upon which those checks are drawn are funds provided by the Federal government which are deposited on a daily basis into special accounts set up to hold only those funds.

48. The Medicaid program is an entitlement program which provides health benefits for qualifying individuals. Once an individual is determined to be eligible for the program, the individual is entitled to receive the benefits of the program.

49. In New Mexico, the Medicaid program is a medical assistance program for low income individuals and individuals who are elderly or disabled.

50. The Medicaid program is administered by the individual states pursuant to agreements with the Federal government. Each state has a separate agreement with the Federal government which spells out how they will administer the Medicaid program in their state, including the criteria for qualification, the services that are available for eligible individuals, the percentage of costs to be borne by the state and Federal governments, etc.

51. The Federal government provides part of the money to fund the Medicaid program. The amount provided varies from state to state. On average, the Federal government provides 55% of the funding for the Medicaid program and states provide the remaining 45% of the funding. In New Mexico, the Federal government contributes 73.32% of the program cost and the state government contributes 26.68% of the program cost.

52. New Mexico contracts with a private company to process and pay Medicaid claims. Payments for Medicaid claims are paid directly to the providers and not to the individual receiving Medicaid services.

53. The Department allows medical providers to claim the deduction for receipts from the sale of tangible personal property sold to the government with respect to the gross receipts of medical providers for tangible personal property sold to patients covered by the Medicaid program.

54. The Department has a regulation which allows pharmacists to claim a deduction under § 7-9-54 for sales of tangible personal property to a government when the pharmacist sells prescription drugs to welfare patients if the New Mexico Health and Environment Department or Human Services Department makes payment for the prescription drugs.

55. Under the Medicaid program, there are no co-payments or deductibles for which the patient is responsible. The Medicaid recipient pays nothing for covered medical services or supplies. The provider bills the state and receives full payment from the state Medicaid program.

56. In 1986, the Hospitals received an opinion from Ernst & Whinney, a national accounting firm, which advised them that if it is the practice in their industry to separately state the charges for tangible personal property provided to patients covered by Medicare and Medicaid, and the Hospitals receive payment for those items from Medicare and Medicaid, that those receipts are deductible from gross receipts tax as sales of tangible personal property to the government pursuant to § 7-9-54 NMSA 1978.

57. The Hospitals relied upon the advice given them by Ernst & Whinney when they made their 1986 and 1987 claims for refund of gross receipts tax they had reported and paid on tangible personal property provided to patients covered by Medicare and in claiming a deduction from gross receipts tax for tangible personal property provided to patients covered by Medicare.

58. The Department has conceded that the assessment of penalties in Assessment Nos. 1937855 and 1937840 against the Hospitals was improper.

DISCUSSION

The primary issue to be determined herein is whether the Hospitals are eligible to claim the deduction provided at § 7-9-54(A) NMSA 1978 for their receipts from selling tangible personal property, such as medical supplies and equipment, to patients who are covered by the Medicare program. Section 7-9-54 provides a deduction for sales of tangible personal property[1] to the United States, the State of New Mexico and their subdivisions, agencies, departments or

[1] In 1998, the legislature enacted a deduction for receipts from providing medical services to Medicare beneficiaries which was phased in over three years to now provide a complete deduction for receipts for such medical services. ***See,*** § 7-9-77.1. During the audit periods covered by the assessments at issue herein, Hospitals reported and paid gross receipts tax on their receipts from providing medical services to Medicare beneficiaries and such taxes are not at issue herein.

instrumentalities. The Department had previously granted refunds to the Hospitals of the gross receipts tax that they had reported and paid on such sales, and the Department's 1990 and 1991 audits of the Hospitals had also allowed such deductions, but the Department's audits had concluded that the Hospitals had claimed the deductions twice for the same receipts and assessments were issued to disallow the second claim of deduction. In the process of reviewing the protests to those assessments, the Department's protest officer noted that an earlier ruling by the Department, Ruling No. 405-92-1, had concluded that such sales of tangible personal property to Medicare beneficiaries were not deductible. The Hospitals were then re-audited and new assessments were issued in 1995 denying the deductions.

The Department argues that the Hospitals are not entitled to claim the deduction at issue because Medicare operates like and should be treated like an insurance program and there is no deduction or exemption from gross receipts tax for tangible personal property sold to patients covered by private health insurance. The Department thus relies upon the fact that in general, those individuals covered by Medicare have been required to make some payment or contribution towards their Medicare coverage, just as beneficiaries of private health insurance must pay premiums, and Medicare beneficiaries are subject to co-pays and deductibles when they receive coverage benefits just as beneficiaries of private insurance are subject to co-pays and deductibles under the terms of their private insurance.

Medicare is a Federal program which is authorized under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* Medicare coverage depends, in general, upon eligibility for Social Security coverage. Social Security coverage generally requires a minimum number of "covered" quarters of employment which would be subject to the payment of FICA tax[2], or self-

[2] The Federal Insurance Contributions Act imposes a tax on employees and employers who must withhold and remit the tax, made up of the Old Age, Survivors and Disability Tax (OASDI tax) more commonly known as "Social

employment subject to the payment of Self-Employment tax[3], both of which taxes are imposed under the Internal Revenue Code. These taxes are appropriated into the Federal Health Insurance Trust Fund carried on the books of the United States Treasury and which is administered by a Board of Trustees pursuant to 42 U.S.C. § 1395i of the Social Security Act.

Medicare has two separate coverage programs. Medicare Part A covers eligible individuals for specified inpatient hospitalization benefits, including bed and board, treatment, drugs, nursing services, supplies, appliances and equipment as are ordinarily furnished for care and treatment of inpatients. 42 U.S.C § 1395x. Generally, participation in Medicare Part A is not voluntary and eligibility for coverage is extended to individuals age 65 and over who qualify for monthly Social Security benefits or Railroad Retirement benefits. Certain other individuals are also eligible, such as those who have been eligible for Social Security disability benefits for at least 24 months[4] , persons with end-stage renal disease who require dialysis or a kidney transplant[5], and individuals age 65 and over who are not otherwise eligible for Medicare Part A but who pay a designated premium.[6]

Medicare Part B is a voluntary program that pays medical expenses not covered under the Part A hospital insurance program because they are unrelated to hospitalization. To be eligible to enroll in Medicare Part B, an individual must be entitled to Medicare Part A coverage or be 65 years or older and be a citizen or lawfully admitted alien who has continuously resided in the United States for the preceding five years. 42 U.S.C. § 1395o. To be eligible to receive Part B benefits, a premium must be paid for each month of coverage. Approximately 15% of Medicare

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Security Tax" and the Hospital Insurance Tax (HI tax), more commonly known as "Medicare Tax". 26 U.S.C. § 3101.

[3] Self-Employment Tax is also made up of OASDI tax and HI tax, which is imposed on the income of individuals from self-employment. 26 U.S.C. § 1401.

[4] 42 U.S.C. § 426(b)

[5] 42 U.S.C. § 426-1

[6] 42 U.S.C. § 1395i-2(a)

patients are dually eligible for both Medicare and Medicaid. For those individuals, Medicaid pays the premium for Part B Medicare coverage.

The Department distinguishes its tax treatment of the receipts of medical providers from providing tangible personal property to patients covered by the Medicaid program and allows such providers to claim the deduction at issue herein. For example, Department Regulation 3 NMAC 3.2.212.18 provides that the receipts of a pharmacist from selling drugs to welfare patients where the Human Services Department pays the pharmacist for the drugs are deductible from gross receipts tax pursuant to § 7-9-54 NMSA 1978 as the sale of tangible personal property to the State of New Mexico. Although this regulation only specifically covers drugs, the Department agrees that it treats all receipts for sales of tangible personal property to persons covered by Medicaid, where the payment for that property is made directly to the seller by the State under the Medicaid program, as receipts from the sale of tangible personal property to the State of New Mexico and are thus eligible for the deduction found at § 7-9-54. As explained by the Department's witness, Debbie Martinez, the Department considers the Medicaid program to be a government entitlement program, rather than being analogous to a private insurance program, because Medicaid beneficiaries are not required to pay anything in order to qualify for coverage and medical benefits under the program.

Because of the differential tax treatment the Department accords to the receipts of health care providers from selling tangible personal property to patients covered under Medicare and Medicaid, a brief explanation of the Medicaid program follows. Medicaid is a medical assistance program provided for under Federal law whereby the Federal government provides grants to states to provide necessary medical services to families with dependent children and the aged, blind or disabled individuals whose income and resources are insufficient to meet the cost of such medical services. 42 U.S.C. § 1396. Under the Medicaid program, each state designs its

own Medicaid program, but it must meet certain requirements to receive Federal approval. For example, the program must be available throughout the state, provide for financial participation by the state, provide an opportunity for hearing to individuals whose claims are denied, provide for the designation of a single state agency to administer the state plan, and provide for reasonably prompt rendition of services to eligible individuals. 42 U.S.C. § 1396a(a).

Under the New Mexico Medicaid program, the Federal government picks up 73.32% of the costs and the state picks up 26.68% of the costs of the program. The New Mexico Human Services Department administers the New Mexico Medicaid program. Although it is difficult to qualify for Medicaid benefits under the New Mexico plan, once an individual is found to be eligible, that individual can receive all medically necessary services at no cost to the individual. The Human Services Department contracts with a private contractor, Consultek, to process Medicaid claims. Consultek reviews and processes all claims and issues a state warrant directly to the medical provider.

The Taxpayers argue that Medicare is a government entitlement program run by a government agency, the Health Care Financing Administration, which cannot be equated with a private insurance program nor can it be distinguished from Medicaid for purposes of the deduction at issue. Taxpayers point out that in both the case of Medicare payments and Medicaid payments, that the funds are drawn on government accounts and paid directly to the medical provider. Also, both Medicare and Medicaid use third party contractors to process claims. Although in the case of Medicare, most beneficiaries have been required to pay taxes and/or premiums in order to qualify for coverage, the terms of coverage, and, indeed, all aspects of the operation of the program are determined by Congress. Approximately 15% of the persons covered by Medicare Part B do not pay the premiums entitling them to coverage. Instead, the premiums are paid for by Medicaid, which in turn, is partially funded by the Federal government

and part by the state. Even with respect to those eligible for Medicare Part B coverage, their premiums only pay for approximately 25% of the cost of such coverage, with the Federal government picking up the tab for the rest of the costs of the program.

Admittedly, there are many aspects of the Medicare program which resemble private insurance, but there is one crucial difference. The relationship between an insuror and a beneficiary under an insurance policy is a contractual relationship where the rights and obligations of the parties are defined by the terms of the insurance contract. Medicare is a government benefit program whose terms and benefits can be altered by Congress to adjust to the changing needs of the public, the changes in medical technology, changes in the cost of administering the program, etc. The Medicare program was created by Congress in 1965 as an amendment to the Social Security Act. Pub. L. 89-97, Title 1, the "Health Insurance for the Aged Act", also popularly known as the "Medicare Act". Congress explicitly reserved to itself the right to alter, amend or repeal any provision of the Social Security Act. 42 U.S.C. § 1304. The seminal case confirming Congress' right to amend the Social Security Act to deny benefits previously earned under the Act is ***Flemming v. Nestor,*** 363 U.S. 603, 80 S.Ct. 1367 (1960). In that case, the Court upheld the denial of benefits to a man who emigrated to the United States in 1913, worked here throughout his life, and became eligible for Social Security benefits in 1955. In 1954, Congress amended the Social Security Act to deny benefits to persons deported under certain provisions of the Immigration and Nationality Act. In 1956, Mr. Nestor was deported for having been a member of the Communist Party from 1933 to 1939 and his Social Security benefits were then terminated. The Court found that the 1954 amendment to the Social Security Act did not deny Mr. Nestor of his property in violation of the Due Process Clause of the Fifth Amendment. The Court's characterization of the Social Security program and Congress' right to

alter its terms and provisions is instructive. The Court clearly distinguished the rights of a beneficiary of the Social Security program from those of the holder of an insurance policy.

> The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to "spend money in aid of the 'general welfare,'" (citation omitted), whereby persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive work force will in turn become beneficiaries rather than supporters of the program. *But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation. It is apparent that the non-contractual interest of an employee covered by the Act cannot be soundly analogized to that of the holder of an annuity, whose right to benefits is bottomed on his contractual premium payments.*

Id., 363 U.S. at 609-610, 80 S.Ct. at 1372 (emphasis added). The Court went on to discuss the complexity of the demands upon Social Security and Congress' need for flexibility to change the program to meet changing needs, stating:

> Integrated treatment of the manifold specific problems presented by the Social Security program demands more than a generalization. That program was designed to function into the indefinite future, and its specific provisions rest on predictions as to expected economic conditions which must inevitably prove less than wholly accurate, and on judgments and preferences as to the proper allocation of the Nation's resources which evolving economic and social conditions will of necessity in some degree modify.
>
> To engraft upon the Social Security system a concept of "accrued property rights" would deprive it of the flexibility and boldness in adjustment to ever-changing conditions which it demands.

Id., 363 U.S. at 610, 80 S.Ct. at 1372. ***See, also, Richardson v. Belcher***, 404 U.S. 78, 92 S.Ct. 254 (1971) (the fact that social security benefits are financed in part by taxes on an employee's wages does not limit the power of Congress to fix the levels of benefits under the Act of the conditions upon which they may be paid).

An examination of the Medicare program confirms that it is a governmental entitlement program, more like Medicaid than private insurance. Premiums paid under Medicare Part B only pay 25% of the costs of that program, with the remainder of the cost being borne by taxpayers in general. The Medicare program has been altered and amended over time with additional benefits added as Congress has seen fit to do. For instance, the coverage for those with end-state renal disease was added in 1978. ***See,*** Pub. L. 95-272, § 1(a), 42 U.S.C. § 426-1. At the present time, Congress is considering whether to add a prescription drug benefit to Medicare in response to the sky-rocketing cost of prescription drugs and the burden that imposes on the elderly. What that benefit will look like and how the cost of such coverage will be met, and indeed, the long term solvency of the Medicare program, are all the subject of current national debate. The fact that the extent and cost of Medicare coverage are the subject of national political debate simply confirms that Medicare is a government benefit program which cannot be equated with private insurance coverage.

Under the Department's view, if Medicare is to be equated with a private insurance program and Medicare payments cannot to be treated as receipts from the Federal government pursuant to § 7-9-54, then it follows that the only beneficiaries of the program are the patients receiving medical services. The Medicare patient has simply received medical benefits that he has bought and paid for through his insurance agreement under the Medicare program. In ***Fischer v. United States,*** 120 S. Ct. 1780 (2000), the U.S. Supreme Court recently rejected this view. That case involved the prosecution of an individual involved in an illegal kickback and bribery scheme with a hospital that was an authorized Medicare provider under 18 U.S.C. § 666. That statute punishes anyone defrauding organizations which receive benefits in excess of $10,000 in any given year under a Federal program. The defendant had challenged his conviction on the grounds that Medicare payments only benefit the patients covered by the

program and therefore they cannot be considered "benefits" to the hospitals which are received "under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance or other form of Federal assistance" under 18 U.S.C. § 666(a)(2)(b). While the Court agreed that Medicare patients were the primary beneficiaries of the Medicare program, it disagreed that the hospitals did not also receive "benefits" under the Medicare program. It pointed out that the payments a provider can receive "are not limited to the immediate costs of an individual treatment procedure", but can also include costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities, such as amounts incurred for educational programs for interns and residents, and amounts available to small, rural hospitals to ensure that they can continue to maintain their necessary core staff and services so that Medicare patients can continue to have needed medical services available. ***Id.,*** 120 S.Ct. at 1784-1785. It is thus manifest that Medicare is a Federal assistance program whose goals and purposes are far more comprehensive than merely providing medical insurance for beneficiaries who have paid for such coverage. As such, although its funding mechanisms differ from those of the Medicaid program, it is more comparable to Medicaid than it is to private insurance. Given the fact that the Department allows the deduction found at § 7-9-54 to be applied to the receipts of hospitals from providing tangible personal property to Medicaid-covered patients, the Hospitals in this case are also entitled to claim that deduction for their receipts from providing tangible personal property to Medicare-covered patients.

ASSESSMENT NO. 1296576

Assessment No. 1296576 was mailed to Guadalupe Medical Center by the Department on July 20, 1990. Section 7-1-19 NMSA 1978 prevents the Department from taking any action or proceeding to collect taxes administered under the provisions of the Tax Administration Act after ten years have passed from the date of the assessment. An assessment of tax becomes effective

when a notice of assessment of taxes is mailed or delivered in person to the taxpayer against whom the liability for tax is asserted. Section 7-1-17(B) (2). Thus, Assessment No. 1296576 became effective on its mailing date, which will be considered the date of the assessment. Because the ten year statute of limitations for enforcing the collection of the assessment has run, the Department is barred from collecting the Assessment and the Hospital's protest is rendered moot by operation of § 7-1-19 NMSA 1978.

ASSESSMENT NO. 1570900

At the formal hearing of this matter, Lea Regional Hospital chose not to present any evidence or arguments to dispute the accuracy or correctness of Assessment No. 1570900. Section 7-1-17(C) NMSA 1978 provides for a presumption of correctness which attaches to any assessment of tax by the Department. This means that the Hospitals had the duty to present evidence or arguments to dispute the correctness of the assessment to overcome this presumption. Having failed to overcome the presumption of correctness, Lea Regional Hospital's protest to Assessment No. 1570900 is denied for lack of evidence.

PENALTY

The Department has conceded that the assessment of penalty in Assessment Nos. 1937855 and 1937840 was improper. Therefore, the Hospital's protest of the penalty portions of Assessment Nos. 19378940 and 1937855 is granted.

DID THE HEARING OFFICER LOSE JURISDICTION TO RENDER THIS DECISION?

Section 7-1-24(H) NMSA 1978 contains various provisions governing the hearing of protests brought pursuant to § 7-1-24. Among other things, it provides that, "[T]he hearing officer, within thirty days of the hearing, shall inform the protestant in writing of the decision, …." The hearing of this matter took place on July 12, 2000. The parties requested the opportunity to present their closing arguments in the form of briefs, and a briefing schedule was

agreed upon. The final submission, the Hospitals' Reply Brief, was filed on October 20, 2000. On November 20, 2000, the Hearing Officer wrote the parties requesting an additional 45 days to render his decision due to his work on other complex pending matters. In fact, the Hearing Officer was working to complete a decision, ***In the Matter of the Protest of Apple Computer, Inc.,*** Decision and Order No. 00-37, issued December 8, 2000.[7] On November 21, 2000, counsel for the Hospitals denied the Hearing Officer's request on the basis that the Department's counsel had informed the Hospitals' counsel that the Department cannot waive the running of interest on the assessments at issue. On December 7, 2000, counsel for the Hospitals wrote the Hearing Officer a letter purporting to confirm that the Hearing Officer had lost jurisdiction in the instant protest, thus resolving the protest in the Hospitals' favor. On December 14, 2000, the Hearing Officer wrote to counsel stating that he had not taken any further action to complete his decision because he had no opinion on the effect of his failure to complete his decision within the time specified in § 7-1-24(H) and requested that counsel advise of their respective positions and suggestions as to how the matter should be completed and to submit memoranda of law in support of their positions no later than December 29, 2000. Counsel for the Hospitals filed a response on December 29, 2000. The Department submitted no response. On January 5, 2001, the Hearing Officer wrote counsel, informing them that it had come to his attention that the Hospitals, who had engaged a court reporter to transcribe the hearing, had failed to comply with their obligation, pursuant to 3 NMAC 3.1.8.11, to provide the Hearing Officer with an original of the transcript, and that the Hearing Officer no longer considered that the matter had been properly submitted for decision so as to commence the time for rendering his decision pursuant

[7] The Decisions and Orders issued by the Department's hearing officers are a matter of public record and are published on the Department's web page under "Publications". The Department's web page may be accessed at www.state.nm.us/tax.

to § 7-1-24(H). Some correspondence between the parties ensued whereby it was determined that the court reporter had delivered both the original and a reduced version of the transcript to the Department's counsel and counsel had never filed the original with the Hearing Officer. On January 18, 2001, the Hearing Officer wrote counsel agreeing that providing Department's counsel with the original transcript fulfilled the Hospitals' obligations with respect to providing the transcript to the Hearing Officer. The Hearing Officer further informed the parties of his belief that he retained jurisdiction to issue his decision and that the issue would be preserved for appeal should the Hospitals wish to appeal the decision to be rendered.

Hospitals argue that the Hearing Officer lost jurisdiction to determine the protests, thus resolving and eliminating the effectiveness of the protested assessments. In support of this argument Hospitals cite to two decisions construing § 61-1-13 of the Uniform Licensing Act, §§ 61-1-1 through 61-1-33 NMSA 1978. In both ***Foster v. Board of Dentistry***, 103 N.M. 776, 714 P.2d 580 (1986) and ***Lopez v. N.M. Board of Medical Examiners***, 107 N.M. 145, 754 P.2d 522 (1988), the New Mexico Supreme Court ruled that the failure of the Boards to render their decisions in cases in which the Board proposed to either suspend or revoke a person's license to practice medicine or dentistry within the 90 days required by § 61-1-13 NMSA 1978 rendered the decisions void and beyond the jurisdiction of the Board to enter. If those decisions were the only New Mexico authority on the issue of the failure of a public authority to act in a timely manner with respect to matters in dispute before the agency or board, I would agree that they would determine the resolution of the instant matter.

I believe that those decisions are distinguishable because they involved professional licensing boards and there is contrary authority which specifically deals with the failure of the Department to comply with a statutory time requirement intended to ensure the prompt resolution of protests to assessments of tax, which is what is at issue herein. In ***Rancher's Tufco***

Limestone Project Joint Venture v. Revenue Division, New Mexico Taxation and Revenue Department, 100 N.M. 632, 674 P.2d 522, *cert. denied* 100 N.M. 505, 672 P.2d 1136 (1983), the court rejected the taxpayer's argument that the Department's failure to set a formal hearing "promptly" as required by § 7-1-24(D) NMSA 1978 should result in the abatement of the taxes assessed. Instead, the court reasoned that:

> [T]he general rule is that tardiness of public officers in the performance of statutory duties is not a defense to an action by the state to enforce a public right or to protect public interests. *State, ex rel. Dept. of Human Services v. Davis,* 99 N.M. 138, 654 P.2d 1038 (1982). The general rule is applicable in these cases unless Section 7-1-24 makes it inapplicable. Section 7-1-24 does not make the general rule inapplicable.

100 N.M. at 635, 674 P.2d at 525. Because both Subsections D and H of § 7-1-24 impose time requirements on the Department to ensure the prompt and timely resolution of protests to assessments of tax filed under § 7-1-24(A), it makes sense to apply the rule announced in ***Rancher's-Tufco*** to the instant issue.

It should be further noted that even if it is later determined that the Hearing Officer lost jurisdiction to render a decision in this matter, that would not result in the Hospitals' prevailing on their protests. If the Hearing Officer lacks jurisdiction to issue a decision, then there is no jurisdiction to take *any* action with respect to the protested assessments, either denying or granting the protests. The assessments as well as the pending protests would remain in place and unresolved. The result would merely be an additional burden upon the Hospitals because a new evidentiary hearing would be required, costing them additional attorney fees, expert witness fees, court reporter fees, etc. Surely such a result would benefit neither party and cause additional delay in resolving the matter.

Rancher's-Tufco is also instructive on what should be considered if, for some reason, it is determined that the general rule is inapplicable. In that case, a taxpayer would be required to

demonstrate prejudice. ***Id.***, 100 N.M. at 635, 674 P.2d at 525. In this case, the Hospitals asserted prejudice on the basis that interest continues to run on the assessments at issue until they are paid, and thus, the delay has cost the Hospitals additional money. While the Hospitals could demonstrate such prejudice if they had not prevailed with respect to assessments 1937855 and 1937840[8], the effect of this decision will be that the assessments must be abated in their entirety, including any interest which would have accrued on the taxes assessed. The only other outstanding assessment is Assessment No. 1570900, against Lea Regional Hospital. This assessment was based upon the hospital's claim of a double deduction for the same Medicare receipts. Apparently, the hospital determined that there was no basis to defend against the assessment, for it chose to present no evidence to dispute the correctness of the assessment when given the opportunity to do so at the formal hearing. Given that the assessment was issued in 1992, the hospital had many years to investigate the basis of the assessment and determine if it had a meritorious defense and to raise any appropriate defenses with the Department. Certainly, by the time of the formal hearing, when it chose not to present any evidence or argument in defense of the assessment, the hospital knew that it would not prevail against the assessment and that it would be prudent to pay the assessment to prevent the further accrual of interest. Thus, any accrual of interest on the assessment after that time was the result of the hospital's failure to pay the assessment for which it knew it was liable and not to any delay in issuing this decision.

[8] Although the Hospitals had tendered partial payments to stop the accrual of interest on those assessments, the payments were calculated to pay only that portion of the assessments related to the assessment of gross receipts tax on reimbursements under Medicare Part B. Thus, interest would still accrue on the portion of the assessments attributable to reimbursements under Medicare Part A.

CONCLUSIONS OF LAW

1. The Hospitals filed timely, written protests, pursuant to § 7-1-24 NMSA 1978, to Assessment Nos. 1937855, 1937840, 1296576 and 1570900 and jurisdiction lies over both the parties and the subject matter of those protests.

2. The Hospitals were not prejudiced by the delay in issuing the decision on their protests.

3. The Hearing Officer did not lose jurisdiction to issue this decision for failure to issue this decision within 30 days of the formal hearing as required by § 7-1-24 (H) NMSA 1978.

4. The Department is barred by § 7-1-19 NMSA 1978 from taking any action to enforce Assessment No. 1296576 and thus, the protest to that assessment is rendered moot.

5. Lea Regional Hospital failed to present any evidence or arguments to dispute Assessment No. 1570900 and that assessment is presumptively correct pursuant to § 7-1-17(C) NMSA 1978.

6. The Federal Medicare program is not a private insurance program.

7. Medicare beneficiaries do not have a contractual right to the benefits of a particular version of the Medicare program and those benefits may be altered by Congress.

8. Medicare is a government entitlement program, with the particulars of those entitlements subject to the enactments of Congress.

9. The receipts of the Hospitals from providing tangible personal property to patients covered by Medicare are deductible from gross receipts pursuant to § 7-9-54 NMSA 1978.

10. The Hospitals were not negligent for purposes of the imposition of penalty pursuant to § 7-1-69 NMSA 1978 for failing to report and pay gross receipts tax on their receipts from the sale of tangible personal property to patients covered by Medicare.

For the foregoing reasons, the Hospitals' protests to Assessment Nos. 1937855 and 1937840 ARE HEREBY GRANTED and the Department IS HEREBY ORDERED TO ABATE ASSESSMENT NOS. 1937855 AND 1937840.

IT IS FURTHER ORDERED that the protest of Lea Regional Hospital to Assessment No. 1570900 IS HEREBY DENIED.

DONE, this 30th day of August, 2001.