CMS 1500 forms, or in whatever format is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims.

(c) For purposes of this chapter, the term "uninsured patient" means a patient that a physician and surgeon has determined after reasonable and prudent inquiry is without public or private third party health coverage. Payments by hospitals to physicians and surgeons to help assure the availability of physicians and surgeons to an emergency department or trauma center shall not be considered third party health coverage.

(d) The amount of reimbursement paid shall be based on the value of claims received by the administering agency during the calendar quarter for services rendered to uninsured patients, using the Relative Value Units ("RVUs") established by the Resource Based Relative Value Scale ("RBRVS") as the reimbursement methodology. For each calendar quarter, the administering agency will determine the total number of RVUs of services submitted, and shall pay each physician and surgeon submitting claims that physician's percentage of the total funds in the Account attributed to claims received for that calendar quarter, based on that physician's percentage of the total RVU pool. The administering agency, upon approval by the Emergency and Trauma Physician Services Commission, may adopt a different reimbursement methodology to promote equitable compensation to the physician community as a whole for uncompensated emergency services and care. For the purpose of submission and reimbursement of claims, the administering agency shall adopt and use the current version of the Physician's Current Procedural Terminology, published by the American Medical Association, or whatever coding set is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims. No physician shall be reimbursed in an amount greater than the total the physician has billed for the services claimed. The administering agency shall issue such reimbursements within ninety (90) days following the end of each calendar quarter. Undisbursed funds, if any, shall remain in the Account, and be rolled over to the following quarter.

(e) Within 30 days following the end of each calendar quarter, physicians and surgeons shall provide the administering agency with:

(1) a list of all claims for which reimbursement is received within one year of the date of service from any public or private third party health coverage and the amount which was received from the Uninsured Claims Account for each of these claims; and

(2) a list of all claims reimbursed by the Uninsured Claims Account for which the total reimbursement from all sources exceeds the physician's billed charges, and the amount of that excess reimbursement for each of these claims.

After such notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the Account by the amount the physician received for claims reported pursuant to subdivision (1), and by the amount of the excess payment for those claims reported pursuant to subdivision (2). In lieu of a reduction in future payments from the Account, the physician and surgeon shall refund excess payments to the Account with the lists referred to in subdivisions (1) and (2) described above. Physicians and surgeons who receive reimbursement

from the Uninsured Account shall agree to stop any current, and waive any future, collection efforts to obtain additional reimbursement from the patient should the total reimbursement from all sources reach or exceed the physician's or surgeon's billed charges.

SECTION 7. Administration of The Emergency and Trauma Hospital Services Account.

Chapter 2.6 of Division 2.5 of the Health and Safety Code (commencing with section 1797.99h) is added to read:

§ 1797.99h The following definitions shall apply to terms utilized in this Chapter:

(a) "Bad debt cost" means the aggregate amount of accounts and notes receivable during a calendar year by an eligible hospital as credit losses, using any method generally accepted for estimating such amounts that on the date this Act became effective, based on a patient's unwillingness to pay, and multiplied by the eligible hospital's cost to charges ratio.

(b) "County indigent program effort cost" means the amount of care during a calendar year by an eligible hospital, expressed in dollars and based upon the hospital's full established rates, provided to indigent patients for whom the county is responsible, whether the hospital is a county hospital or a non county hospital providing services to indigent patients under arrangements with a county, multiplied by the eligible hospital's cost to charges ratio.

(c) "Charity care cost" means amounts actually written off, using any method generally accepted for determining such amounts on the date this Act became effective, by an eligible hospital during a calendar year for that portion of care provided to a patient for whom a third party payer is not responsible and the patient is unable to pay, multiplied by the hospital's cost to charges ratio.

(d) "Cost to charges ratio" means a ratio determined by dividing an eligible hospital's operating expenses less other operating revenue by gross patient revenue for its most recent reporting period.

(e) "Operating expenses" means the total direct expenses incurred for providing patient care by the hospital. Direct expenses include (without limitation) salaries and wages, employee benefits, professional fees, supplies, purchased services, and other expenses.

(f) "Other operating revenue" means revenue generated by health care operations from non-patient care services to patients and others.

(g) "Gross patient revenue" means the total charges at the hospital's full established rates for the provision of patient care services and includes charges related to hospital-based physician professional services.

(h) "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are delivered.

(i) "Eligible hospital" means a hospital licensed under Section 1250 of the Health and Safety Code that operates an Emergency Department or a children's hospital as defined in Section 10727 of the Welfare & Institutions Code.

(j) "Emergency department encounter" or "emergency department visit" each means a face to face contact between a patient and the provider who has primary responsibility for assessing and treating the patient in an emergency department and exercises independent judgment in the care of the patient. An emergency department encounter or visit is counted for each patient of the emergency department, regardless of whether the patient is admitted as an inpatient or treated and released as an outpatient. An emergency department encounter or visit shall not be counted where a patient receives triage services only.

(k) "Emergency and disaster management plan" means a plan developed to provide appropriate response to emergencies and disasters, including preparedness activities, response activities, recovery activities, and mitigation activities.

(l) "Office" means the Office of Statewide Health Planning and Development.

(m) "Disaster" means a natural or man-made event that significantly: (A) disrupts the environment of care, such as damage to buildings and grounds due to severe wind storms, tornadoes, hurricanes, or earthquakes; (B) disrupts care and treatment due to: (i) loss of utilities including, but not limited to, power, water, and telephones, or (ii) floods, civil disturbances, accidents or emergencies in the surrounding community; or (C) changes or increases demand for the organization's services such as a terrorist attack, building collapse, or airplane crash in the organization's community.

(n) "Department" means the State Department of Health Services.

(o) "Funding percentage" means the sum of (1) an eligible hospital's percentage of hospital emergency care (as defined in subparagraph (s) below) multiplied by a factor of .80, added to (2) such hospital's percentage of effort (as defined in subparagraph (r) below) multiplied by a factor of .20, the sum to be expressed as a percentage.

(p) "Hospital Account" means the Emergency and Trauma Hospital Services Account of the 911 Fund established pursuant to subdivision (f) Section 41135 of the Revenue and Taxation Code.

(q) "911 Fund" means the 911 Emergency and Trauma Care Fund established pursuant to Section 41135 of the Revenue and Taxation Code.

(r) "Percentage of effort" means the sum of an eligible hospital's total amount of charity care cost plus that hospital's total amount of bad debt cost plus that hospital's county indigent program effort cost, as a percentage of the sum of the total amount of charity care cost plus the