~~3. ARE DEVELOPED IN CONSULTATION WITH EXPERTS IN THE FIELD OF HEALTH CARE QUALITY FOR THOSE POPULATIONS SERVED BY MANAGED CARE ORGANIZATIONS;~~

~~4. ARE BASED ON ABSOLUTE RATHER THAN RELATIVE PERFORMANCE BY MANAGED CARE ORGANIZATIONS; AND~~

~~5. ARE GROUPED INTO THE FOLLOWING CATEGORIES OF PERFORMANCE:~~

~~A. "ACCEPTABLE";~~

~~B. "INCENTIVE"; AND~~

~~C. "DISINCENTIVE";~~

~~(II) PROVIDE FOR A SYSTEM OF FINANCIAL INCENTIVES AND DISINCENTIVES LINKED TO THE SCORES OF THE MANAGED CARE ORGANIZATIONS ON EACH OF THE QUALITY MEASURES AND PERFORMANCE STANDARDS;~~

~~(III) SERVE AS THE SINGLE, COMPREHENSIVE QUALITY MEASUREMENT AND IMPROVEMENT INITIATIVE OF THE SECRETARY; AND~~

~~(IV) BE ADOPTED BY REGULATION.~~

SECTION 2. AND BE IT FURTHER ENACTED, That ~~the requirements of this Act may not be implemented until the Secretary of Health and Mental Hygiene adopts regulations as required by this Act. The Secretary shall adopt regulations as required by this Act on or before December 31, 2005~~:

(a) Prior to making any adjustments to capitation payments for a managed care organization, the Secretary of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner, shall adopt regulations to implement the provisions of § 15–605(c)(5) of the Insurance Article.

(b) The regulations adopted under subsection (a) of this section shall:

(1) establish the definition of "loss ratio" for uniform application by all managed care organizations;

(2) establish procedures requiring the Secretary of Health and Mental Hygiene to consider the financial performance of a managed care organization in prior periods;

(3) establish standard data collection and reporting requirements for all managed care organizations;

(4) consistent with the provisions of § 15–605(c)(5) of the Insurance Article, establish a process for allowing a managed care organization to appeal a decision of the Secretary of Health and Mental Hygiene to adjust a managed care organization's capitation payments; and

(5) establish a mechanism for, and the conditions under which, an adjustment to the capitation rates of a managed care organization are made.