From the website
http://reportcard.opa.ca.gov/rc2012/medicalgroupwhatis.aspx
Specifically pertains to CALIFORNIA
What is a Medical Group?

Health plans contract with groups of doctors to provide your health care. These groups of doctors are called medical groups. Medical groups can range from small practices with several doctors to very large organizations with hundreds of doctors. While a small number of health plans – fewer than twenty – insure most people in California, there are hundreds of medical groups in the State.

The difference between a medical group and a health plan sometimes isn't clear. The medical group's job is to care for patients – this work is done by the doctors, nurses, therapists and other professionals in the medical group. The health plan is responsible for seeing that its members get care easily by contracting with enough medical groups and their doctors in a local area, so it is convenient for members to get care nearby. The health plan pays for the care and typically makes the rules to determine the types of care that are covered.

The job of a health plan and its contracted medical groups can vary depending upon the type of health plan. In a PPO plan, the doctors' and medical groups' main responsibility is to care for patients. In an HMO plan, the doctors and medical group often have a bigger job – in addition to providing patient care, the medical group is responsible for the patient's overall health – including steps to avoid future health problems. Because of these added responsibilities for HMO members, the Report Card's medical group ratings concern the care and services for HMO members. The medical group and its doctors' care and service for HMO members is explained below.

How Are Medical Groups Important to Me?

There are two main reasons why medical groups are important to you, as an HMO member. First, it is usually the medical group or one of its doctors, not the HMO, that decides what care you receive and how you receive it. For example, the medical group:

- Checks that its doctors give care that's been proven to work.
- Sets the rules for you to "get an ok" (a referral) to see specialists and get other care.
- Decides the steps doctors must follow to diagnose and treat health problems.
- Checks the training and experience of new doctors.
- Schedules when and how long you see your doctor or other staff.
- Decides where you go for hospital care and other medical services.

Second, one doctor cannot take care of every medical problem that you may have. The doctors in a medical group work together to make sure that you get all the care you need. These doctors include your main (primary care) doctor and other doctors who are specialists.

How Do I See the Doctors in the Medical Group?

Most HMOs require that their members choose a main doctor. This doctor is called a Primary Care Physician, or PCP. You can choose your PCP from a list of doctors who work with the HMO.

PCPs are doctors with special training in one of the four primary care specialties. These specialties are pediatrics (children's medicine), family medicine, obstetrics and gynecology (women's medicine), and internal medicine.

You may see your PCP for most of your health care. This can include preventive services and care for acute and chronic conditions, psychosocial issues, and more. Your PCP also coordinates the other health care services that you may need. For example, if you need to see a specialist to treat a problem, your PCP refers you to a specialist in the medical group.

A specialist has training in a special area of health care. Surgeons, urologists, radiologists, cardiologists, and dermatologists are among the more familiar specialists. Specialists treat particular conditions or health problems. Depending upon the patient's illness, a specialist may care for the patient over a long period of time.

About Health Insurance Plans

There are many types of health insurance coverage. These are the most common ones:

Group Plan - Many people get their health insurance through their employer. This is called “group” coverage. When you pay your share of the insurance premium it is usually deducted from your paycheck.

Individual Plan - If you are not employed, not a full-time employee, self-employed, or your employer does not offer health insurance, you may be able to buy health insurance directly from the insurance company. This is called “individual” coverage. You pay your premiums either directly to the insurance company or through an insurance broker. Group plans and individual coverage are forms of “commercial” coverage – these are “private insurance,” not government, plans.

Government Plans - Some people may be eligible for government insurance programs. People who are 65 years and older or who have disabilities often are eligible for Medicare, an insurance program run by the federal government. Some people who have low incomes may be eligible for the Medi-Cal programs which are run by the State of California. In some cases, you may be eligible for both Medicare and Medi-Cal.

The Federal and State Governments also provide insurance for its own employees including CalPERS (for public employees in California), the **Federal Employees Health Benefits Program** for federal government workers, and the **Veteran's Administration** for people who have been discharged from the military and need medical care due to their military service.

In addition, commercial insurance companies and the government offer different kinds of “insurance products”:

HMO - You may be offered an HMO (health maintenance organization). In an HMO, you must use the doctors and facilities that are on the HMO’s list of doctors, hospitals and other providers. If you use providers who are not part of the HMO, you will have to pay the entire cost yourself (except for a medical emergency). An HMO also may require you to choose a primary care doctor who will be your main doctor and can refer you to specialists if you need them.

PPO - You may be offered a PPO (preferred provider organization). In a PPO, you are encouraged to use doctors and facilities that are on the PPO’s list of doctors, hospitals and other providers. If you use providers who are not part of the PPO, you have to pay a higher share of the cost when you get care.

Fee-for-Service – You may be offered a “fee-for-service” insurance plan. With fee-for-service, you can go to any doctor or facility that “accepts your insurance card”. The government programs, Medicare and Medi-Cal, offer this option as do some employers who offer private insurance to their workforce.

It is important to know the type of insurance coverage you have because that determines which doctors, hospitals and other providers are covered by your insurance and the rules for choosing and using these providers. Sometimes you can tell what kind of insurance you have by looking at your insurance card. If you are unsure, call the member services telephone number on the card and ask your insurance company for assistance. The personnel office in the workplace also should have this information.

GLOSSARY OF TERMS

Accreditation:
Usually a professionally sponsored, voluntary process that provides a measure of an organization's quality and performance.

Administrative Data:
Cost and utilization data collected by a health plan, hospital or medical group.

Appeal:
A process by which an individual asks his or her health plan to reconsider a decision not to pay for or provide medical services.

Benefits:
The money or health services to which an individual is entitled under his/her insurance plan.

Board-Certified:
Refers to a physician who has passed an examination given by a medical specialty board, and who has been certified as a specialist in that area (e.g. pediatrics, internal medicine).

Breast Cancer:
Growth of malignant cells in the breast.

Breast Cancer Screening:
Preventive exams to detect breast cancer. Includes breast self-exams, clinical breast exams, and mammograms.

CalPERS
CalPERS stands for California Public Employees' Retirement System. It provides retirement and health benefits to approximately 1.5 million public employees, retirees, and their families and more than 2,500 employers.

California Cooperative Healthcare Reporting Initiative (CCHRI):
CCHRI is a statewide collaborative of employers, health plans, and providers dedicated to providing accurate, standardized, comparable reports on health care performance. The CCHRI commitment to precise standardization supports "apples to apples" comparison of plan performance so consumers can easily make informed choices about their health care.

Capitation:
A method of payment used in managed care in which doctors or hospitals are paid a fixed amount for each person cared for, regardless of the actual number or type of services they deliver.

Cervical Cancer:
The growth of cancerous cells in the cervix. Cervical cancer is described as noninvasive when it exists only on the surface of the cervix, while cancer that has spread into deeper layers of the cervix or to other organs is classified as invasive.

Cervical Cancer Screening:
A preventive service to detect the presence of abnormal cells indicating cervical cancer or precursors to cervical cancer. The screening procedure is called a Pap smear and is conducted during a pelvic exam.

Cervix:
The opening to the uterus (or womb).

Cholesterol:
A type of fat cell found in the blood, also known as a lipid. High levels of cholesterol in the blood can lead to clogging of the arteries, heart disease, and stroke.

Cholesterol Tests/Screening:
A blood test to identify people with high blood cholesterol levels. Used to identify individuals at risk for heart disease and stroke, who can then be given guidance on how to lower their risks.

Claim:
A document submitted to an insurance company by either a health care provider or a patient for payment of medical services under an insurance contract.

Consumer Assessment of Health Plans Survey (CAHPS):
A patient survey developed with support from the Agency for Health Care Research and Quality to assess patient satisfaction with health care services. (CAHPS) is now used by National Committee for Quality Assurance, among others, as part of it's voluntary accreditation process for health plans or HMOs. To get information on how members feel about their health plan or HMO, randomly selected people who are HMO members are asked to complete the CAHPS survey.

Consumer Driven Health Plans (CDHPs):

CDHPS are health insurance products that attempt to control rising health insurance costs by keeping premiums low while shifting more responsibility for health care costs to consumers. CDHPs may reduce costs by encouraging members to "shop around" for their health care. They generally encourage members to obtain preventive services by covering the costs of preventive services.

Contract Provider:

Any hospital, skilled nursing facility, extended care facility, individual, organization or agency that has a contractual arrangement with an insurance company to provide services to enrollees.

Co-payment:

A cost-sharing arrangement of a health plan in which the patient pays a fixed fee for a specific service (such as $10.00 for an office visit). This fee does not vary with the cost of the service. Also referred to as co-insurance.

Cost Sharing:

A general set of financing arrangements whereby patients pay a certain amount of their own money to receive care, typically at the time that care is provided. Includes co-payments, deductibles, and the employee-paid portion of the monthly premium for health care insurance.

Coverage:

The scope of the health benefits provided by a health insurance plan.

Deductible:

The amount an individual must pay for health services each year before the individual's insurance company starts to pay. For example, a $500 deductible means that an individual must pay for the first $500 worth of health care expenses before the insurance company begins to pay for services.

Denial of Service:

When a health plan either refuses to pay for a medical procedure received by a patient or refuses to authorize a patient to receive a certain service.

Department of Health and Human Services (DHHS):

An agency of the federal government that is responsible for health-related programs and issues. DHHS oversees Medicare, Medicaid, and public health programs.

Diabetes:

A condition/disease caused by the body's inability to process sugar, usually due to a lack of insulin.

Diabetic Retinal Exam:

An eye exam which checks for diseases of the retina in diabetic patients. The patient's eyes are dilated so that the professional can examine the interior of the eyes for signs of the disease.

Disease:

Any interruption of the normal function of any body organ, part, or system that appears abnormal.

Disenroll:

When any member of a health plan decides to terminate his or her enrollment.

Enrollee:

A member of a health plan.

Evidence of Coverage (Member Handbook):

This document, often called an "Evidence of Coverage" (EOC), is your binding agreement or contract with your HMO. It explains your health care benefits, any limits to your coverage, the HMO's policies and procedures and what costs you will have to pay.

Exclusions:

Clauses in an insurance contract that deny coverage for certain individuals, groups, locations, properties, or types of risks.

Family Physician:

A physician who provides a broad range of services and specializes in primary care. Family physicians must complete a three-year Family Medicine residency and pass a standardized exam to become certified by the American Board of Family Physicians.

Fee-for-Service Plans (FFS):

The traditional form of health care delivery. FFS providers are paid for each service they provide to a patient, as opposed to receiving a salary or fixed amount for all of the patient's expected health care needs.

Gatekeeper:

The term applied to the personal or primary care physician (see below) such as a pediatrician, family physician, internist, or obstetrician/gynecologist in a managed care plan. The personal or primary care physician is responsible for overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, typically the personal or primary care physician must authorize the visit, unless there is an emergency. Because the personal or primary care physician is the gateway to specialty services, they are sometimes called the gatekeeper.

Grievance:

Formal complaints patients file with their health plan.

Health Maintenance Organization (HMO):

Also known a health plan or managed care organization, an HMO is a type of health insurance plan that provides health care services for members who prepay a premium that generally covers a comprehensive range of both inpatient and ambulatory care with limited co-payments. There are four types of HMOs:

- Staff model (Closed-panel): Hires its physicians individually and pays them a salary to practice in the HMO facility or clinic.
- Group model: The HMO contracts with a group of physicians and pays them a set amount per patient to provide a specified range of services. The group of physicians determines the compensation of each individual physician in the practice and often shares profits.
- IPA (Independent Practice Association): The HMO contracts with individual physicians who see HMO members as well as patients covered by other types of health insurance in their own private offices. Physicians in an IPA are paid on either a capitation or a modified fee-for- service basis.
- Network: The HMO contracts with a network of medical groups rather than individual physicians. Medical groups may see HMO patients as well as fee-for-service patients.

Healthcare Effectiveness Data and Information Set (HEDIS):

A set of health plan performance measures developed by National Committee for Quality Assurance. HEDIS measures show how well health plans do at providing specific preventive care services to their enrollees.

Healthy Kids:

Healthy Kids is health insurance for children and teens who not qualify for free Medi-Cal or Healthy Families coverage and do not have other health insurance. Healthy Kids programs are funded by a mix of public and private dollars in each county or region, of which the largest philanthropic contributors are First 5 California (funded by a ballot initiative) and The California Endowment.

Healthy Families:

Healthy Families is low cost insurance for children and teens. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal.

Heart Attack:

A sudden decrease in the flow of blood to the heart muscle resulting in impaired heart functioning. Can result in death.

High deductible health plans (HDHPs):

HDHPs are CDHPs that are coupled with either health savings accounts (HSAs) or health reimbursement accounts (HRAs)

Home Health Care:

Services provided by nurses and other health professionals in patients' homes to patients who are unable to care for themselves.

Hospice:

A manner of providing care for terminally ill patients, either in their home or in special care facilities. Hospice care allows terminally ill individuals to live their final days in as natural and comfortable a setting as possible.

Hospital:

A health care organization that has an organized medical and professional staff and inpatient care facilities. There are four basic types: general medical and surgical, specialty, psychiatric, and rehabilitation.

Hypertension:

Also known as high blood pressure. A disease characterized by blood pressure equal to or above 140/90. Individuals with high blood pressure are at risk for kidney disease, heart disease and stroke. Hypertension can be treated with medication, exercise, and diet.

Immunization:

The process of obtaining resistance to a specific disease, typically delivered through vaccinations administered by shots into the skin, orally, or with a nasal spray. A vaccination introduces harmless forms of the disease into the body using killed or weakened viruses, bacterial molecules or inactivated toxins. The body then develops antibodies to fight the foreign substance introduced in the vaccine to create immunity to the disease.

Indemnity Plan:
A plan which reimburses physicians for individual services performed or reimburses patients for medical expenses incurred.

Internal Medicine:
Internal medicine physicians care for medical conditions of adults. They are also known as internists. Internists must complete a three-year internal medicine residency and pass a standardized exam to become certified by the American Board of Internal Medicine. Internists can also elect to receive additional training to become certified in internal medicine subspecialties such as critical care or dermatology.

Interpreter:
Individuals who are bilingual and who provide verbal translation services by telephone, or face-to-face for members who do not speak English. Individuals who can communicate with American Sign Language and provide translation services for those who are hard of hearing are also called interpreters.

IPA (Independent Practice Association) or Medical Group:
IPA stands for Independent Practice Association, which is a group of independent doctors who negotiate contracts together to provide care to HMO members, as well as patients covered by other types of health insurance. Doctors in an IPA are paid on either a capitation or a modified fee-for-service basis depending on their with your HMO. An IPA is generally less highly structured than a Medical Group.

Language Line:
A contracted company of telephone interpreters that your HMO uses when you call the HMO's customer service number and there is not a staff member available that speaks your language.

Language Services:
Services available from your HMO if you or a family member use American Sign Language or speak a language other than English. HMOs must provide interpreter services and some translated written materials to their members who do not speak or understand English well or who use American Sign Language. These services may assist you with obtaining medical care in your preferred language.

Mammograms:
X-ray examination of breast tissue used to detect breast cancer.

Managed Care:
Any system of delivering health services in which care is delivered by a specified network of doctors and hospitals who agree to comply with established care approaches. Providers may receive a capitated payment for providing all medically necessary care to enrollees or may be paid on a fee-for-service basis.

Managed Risk Medical Insurance Board (MRMIB)
MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians through programs such as Healthy Families.

Measles:
An infectious viral disease, usually occurring in childhood, characterized by reddish skin eruptions appearing on the face and body, elevation of temperature, headache and loss of appetite. Can be prevented through immunizations.

Medicaid:
A federal and state health insurance program designed to provide access to health services for persons below a certain income level. Provides health care to women and children who qualify for Aid to Families with Dependent Children (AFDC) and to the elderly who are poor and in poor health.

Medi-Cal:
California's Medicaid program.

Medical Group:
Medical Groups are highly structured groups of doctors, who have come together to provide care to patients and negotiate payment rates with HMOs.

Medically Necessary:
Determination by a health care provider that the physical or mental condition of a patient warrants a certain type of medical care.

Medicare:
A federal health insurance program designed to provide health care for the elderly who have paid into Social Security or who are permanently disabled. People who qualify for Social Security benefits are automatically eligible for Medicare.

Mumps:
A contagious disease occurring mainly in childhood marked by swelling in front of the ears. Can be prevented through childhood immunization.

National Committee for Quality Assurance (NCQA):
A private, non-profit organization that accredits managed care health plans, and assesses and reports on their quality. The National Committee for Quality Assurance publishes the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Nursing Home:
A facility that provides care to a person who is not able to remain home alone due to physical health problems, mental health problems or functional disabilities. It is a broad term which encompasses a range of facilities from privately-owned adult residential care homes to community hospitals and government-operated institutions.

Obstetrician/Gynecologist (OB/GYN):
A physician who treats women during pregnancy, labor, and immediately following childbirth as well as for diseases of the female reproductive system. OB/GYNs must complete a four-year OB/GYN residency and pass a standardized exam to become certified by the American College of Obstetricians and Gynecologists.

Open Enrollment:
The time period during which health plan enrollees have the opportunity to change their health plan (usually a 30-day period held once a year).

Outcome:
The consequence of a medical intervention (e.g. improved health status, death).

Out-of-Area Care:
Medical care received outside an approved network of facilities in a particular area. Can occur when a patient is traveling, has temporarily relocated, or has an emergency situation.

Over-utilization:
Excess use of health services.

Pacific Business Group on Health (PBGH):
A nonprofit coalition of public and private sector purchasers of health care who are located in California. The organization aims to improve the quality of health care and moderate rising health care costs.

Pap Smear:
A preventive screening test for cervical cancer. Conducted during a pelvic exam.

Pediatric:
Pertains to the care of children. Pediatricians as well as Family Physicians provide pediatric care. Pediatricians must complete a three-year Pediatric residency and pass a standardized exam to become board certified. Pediatricians can also elect to receive additional training to become certified in pediatric specialties such as orthopedics or neurology.

Performance Measures:
Any measure designed to quantify how well or how poorly an organization performs. In the health care industry, performance measures are used to assess the quality of care provided by health plans, hospitals and doctors.

Personal doctor:
Also known as primary care physicians, personal doctors are physicians with special training in one of the four primary care specialties; pediatrics, family medicine, obstetrics and gynecology, and internal medicine. Most health plans or HMOs require members to sign up with a personal doctor. The personal doctor in a health plan or HMO has the responsibility for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referrals for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. Personal doctors in a health plan or HMO should be aware of and coordinate the range of health care services you are receiving even if the personal doctor does not provide these services themselves.

Physician:
An individual qualified by education and training, and legally authorized to practice medicine.

Physician Assessment Survey (PAS):
A survey of California HMO enrollees regarding the care they receive from their doctors in organized medical groups. PAS is sponsored by the California Cooperative Healthcare Reporting Initiative (CCHRI). The survey is conducted mostly by mail, but also by phone and the web. The majority of participants are English speaking, but PAS is available in other languages including Spanish, Chinese, Vietnamese, and Korean. Close to 40% of the over 150,000 people contacted responded to the survey.

Point-of-Service Plan (POS):
A health plan that combines features of prepaid and indemnity insurance. Enrollees decide whether to use network or non-network providers at the time care is needed but are usually charged additional fees for using non-network providers.

Preferred Provider Organization (PPO):
Some combination of hospitals and physicians that agree to provide health care services to a group of people, under a contract with a private insurer. The services may be furnished at discounted rates. Patients may incur expenses for covered services they receive outside the PPO, if the charge from the non-PPO provider exceeds the PPO reimbursement rate.

Premium:
The amount paid to a health plan or insurance company by an employer or beneficiary for health insurance coverage.

Prenatal Care:
Medical care provided to a pregnant woman to ensure the health of the mother and unborn child.

Prepaid Health Care:
Providers are paid a fixed fee per person to provide services for a stipulated length of time (see capitation). Payment occurs whether a patient actually uses services or not.

Prevention:
The concept of preventing or slowing the development of disease and promoting health through screening programs and healthy lifestyle education.

Preventive Care Guidelines:
Recommendations for how often individuals should receive certain preventive card services such as mammography or cholesterol screening. Guidelines are typically based on clinical research findings.

Preventive Care Services:
Services designed to promote health and prevent disease such as prenatal care, childhood immunization, cholesterol screening, breast cancer screening, cervical cancer screening, and diabetic retinal exams.

Primary Care:
Health care designed to prevent diseases from becoming more serious. Primary care emphasizes cost-effectiveness, comprehensive care, continuity of care, and coordination of care. Primary care is usually provided by physicians who specialize in family medicine, pediatrics, internal medicine, or in some cases obstetricians/gynecologists.

Purchaser:
The buyer of health care coverage and/or services; typically, employers, the government, or individuals.

Referral:
In healthcare, a process in which a doctor recommends that a patient see a medical professional with advanced knowledge of a certain medical specialty or technique (such as heart disease or dermatology). Also known as a consultation.

Report Cards:
A performance report which evaluates the quality of health services.

Retinopathy:
Damage to the blood vessels in the retina, a part of the eye critical for vision. Often found in individuals with diabetes.

Rubella:
German measles; an acute viral infection that resembles measles but runs a shorter course. Can be prevented with immunization.

Skilled Nursing Facility (SNF):
A facility that accepts patients in need of medical care provided by skilled medical personnel and nurses. Typically provides rehabilitation and skilled medical care.

Specialist:
A medical doctor who specializes in a specific area of medicine, for example cardiology or gynecology.

Statistical Significance:
The probability that an event did not happen by chance alone. A result is deemed statistically significant if statistical methods have been used to show that a certain event is highly unlikely to have happened by chance alone.

U.S. Preventive Services Task Force:
An expert panel assembled by the U.S. Department of Health and Human Services to make recommendations regarding the delivery of preventive care services.

Utilization Management:
Planning, organizing, directing, and controlling the use of medical services by a health care organization.