

November 5, 2025

REVISED: Help Us Improve Member and Provider Relationships by Sharing Your Demographic and Language Data

At AmeriHealth Caritas Next and First Choice Next, we believe quality care starts with informed choice and culturally responsive connections between members and providers. AmeriHealth Caritas Next and First Choice Next collects, stores, and reports race, ethnicity, and language (REL) data from providers and their offices that is made available to members upon request.

By sharing your demographic information, including but not limited to race, ethnicity, and/or language, you help empower our members to make informed decisions about their care, improve health equity, and support stronger health outcomes for the communities we serve.

This data allows us to:

- Provide members with meaningful, choice-based information when selecting a provider.
- Tailor resources and services to meet the cultural and linguistic needs of our diverse member population.
- Monitor and address health disparities across our network.

What is race and ethnicity data?

Race is a classification of humans based on genetic characteristics, such as lineage, which is when a group is connected by common descent. The federal government uses six racial categories when collecting data on race:

- | | |
|-------------------------------------|------------------------------------|
| • American Indian* or Alaska Native | • Pacific Islander/Native Hawaiian |
| • Asian | • White |
| • Black/African American | • Middle Eastern/North African |

***Please be aware that some people consider “American Indian” outdated; please use community or individual preferred terminology whenever possible.**

Ethnicity is a classification of humans based on historical connection by a common national origin or language. Ethnicity could also be defined as a person’s roots, ancestry, heritage, country of origin, or cultural background. The two ethnicity categories as defined by the federal government are:

- Hispanic
- Non-Hispanic

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Why is language data necessary?

The first step to strong patient-centered care is direct communication. Language is more than a communication tool; we express emotions, retain critical information, and make decisions in the language that we most prefer. Providing data on the language(s) spoken by the provider and their staff is the first step in strong communication between patients and providers.

Spoken language refers to the language in which a member prefers to speak about their health care.

Written language refers to the language in which a member prefers to read or write about their health care. Federal laws and other guidance speak to nondiscrimination practices such as meaningful access through language access programs.

How do we collect this information?

AmeriHealth Caritas Next and First Choice Next collects provider REL data through our standard processes such as credentialing, re-credentialing and provider roster updates using the federal categories established by the Office of Management and Budget (OMB).

How do we store and share this information?

REL data is housed in a database that is made available to members.

- Gender data is available through the AmeriHealth Caritas Next and First Choice Next provider directories.
- Provider's language, staff's language, and additional language services are also available through the provider directory.

Please note: Race and ethnicity data is not displayed in our provider directories and will only be provided upon direct request by the member. Only language and gender information are shown publicly.

Demystifying common provider concerns

"My race and ethnicity have no impact on the care I give." Being grounded in cultural responsiveness is critical to building rapport, comfort, and trust with patients from various cultures.¹ REL data is one essential tool that health plans use to establish, enhance, and promote cultural competence.²

"My practice is equipped to support language services, so how does what language I or my staff speak matter?"

When the health plan shares other languages spoken by the provider network, members have the autonomy to select a provider that matches their cultural and linguistic preferences.

¹ Carrington Moore et al., "It's Important to Work with People that Look Like Me': Black Patients' Preferences for Patient-Provider Race Concordance," *J Racial Ethn Health Disparities*, Vol. 10, No. 5, December 19, 2022, <https://web.archive.org/web/20250114092031/https://pmc.ncbi.nlm.nih.gov/articles/PMC9640880/>, accessed July 31, 2025.

² Megan Johnson Shen et al., "The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature," *J Racial Ethn Health Disparities*, Vol. 5, No. 1, 2018, pp. 117 – 140

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Sharing your race, ethnicity, and language with AmeriHealth Caritas Next and First Choice Next may feel uncomfortable at first. However, this is an important piece of provider-patient shared decision-making. Racial or ethnic concordance has been shown to have a positive impact on health outcomes³ and reduce health expenditures.⁴

Additional resources

Marcella Alsan et al., “Does Diversity Matter for Health? Experimental Evidence from Oakland,” Working Paper 24787, National Bureau of Economic Research, June 2018.

Erin Dehon et al., “A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making,” *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine*, Vol. 24, No. 8, August 2017, pp. 895 – 904.

Sherman James, “The Strangest of All Encounters: Racial and Ethnic Discrimination in US Health Care.” *Cadernos De Saude Publica*, Vol. 33, No. Supl 1, May 8, 2017,

Rachel Johnson et al., “Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits,” *American Journal of Public Health*, Vol. 94, No.12, December 2004, pp. 2084 – 2090.

Ivy Maina et al., “A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers Using the Implicit Association Test,” *Social Science & Medicine*, Vol. 199, February 2018, pp. 219 – 229.

Salimah Meghani et al., “Patient–Provider Race-Concordance: Does It Matter in Improving Minority Patients’ Health Outcomes?” *Ethnicity & Health* Vol. 14, No. 1, February 2009, pp.107 – 130.

Richard Street et al., “Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity,” *The Annals of Family Medicine*, Vol. 6, No. 3, May 1, 2008, pp. 198 – 205.

Questions:

Thank you for your participation in our network and your continued commitment to the care of our members. If you have questions about this communication, please contact your Provider Account Executive or the Provider Services Department for your state.

<https://web.archive.org/web/20241228034235/https://pmc.ncbi.nlm.nih.gov/articles/PMC5591056/pdf/nihms858748.pdf>, accessed May 16, 2025.

³ “Do Black Patients Fare Better With Black Doctors?” American Association of Medical Colleges, June 6, 2023, <https://web.archive.org/web/20250119013744/https://www.aamc.org/news/do-black-patients-fare-better-black-doctors>, accessed January 19, 2025.

⁴ Timothy T. Brown et al., “Shared Decision-Making & Racial or Ethnic Concordance Reduces Health Expenditures,” National Institute for Health Care Management Foundation, August 2023, https://nihcm.org/assets/articles/FINAL_RI-PDF-Tim-Brown_2023-07-12-032727.pdf, accessed July 22, 2025.

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