CareFirst
Family of health care plans

CERL Report

Cultural, Ethnic, Race, and Language Report

CareFirst

Family of health care plans

2025

Assessment of the adequacy of primary care, behavioral healthcare and specialty care practitioners in CareFirst's network to meet the needs and preferences of members

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Background

CareFirst Blue Cross Blue Shield (CareFirst) is dedicated to delivering culturally competent care to its diverse member population. Recognizing the distinctive cultural requirements of its consumers, CareFirst has crafted a robust Culturally and Linguistically Appropriate Services (CLAS) Program. This program is specifically designed to ensure that member needs are addressed effectively and respectfully, reflecting CareFirst's dedication to delivering high-quality healthcare services tailored to diverse cultural backgrounds.

To ensure the CLAS program is effectively meeting the member population's needs, CareFirst annually:

1. Assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the practitioner network, if necessary
2. Analyzes the capacity of the network to meet the language needs of individuals
3. Analyzes the capacity of the network to meet the needs of members for culturally appropriate care
4. Develops a plan to address gaps identified as part of the analysis

The cultural, ethnic, racial or linguistic information presented in this report was collected through a variety of sources that include:

- The U.S. Census Bureau 2023 American Community Survey (ACS): https://www.census.gov/programs-surveys/acs and 2019–2023 ACS 5-Year Data Profile Data Profiles | American Community Survey | U.S. Census Bureau
- Association of American Colleges (AAMC) Race and Ethnicity Study
- CAHPS member satisfaction questions regarding age, sex, education, ethnicity and cultural and language needs
- CareFirst membership data
- Network provider characteristics including age, sex and languages spoken
- Member complaint data
- Pew Research Center Religious Landscape Study
- Use of language assistance/translator services, via the language line

The analysis outlined will serve as a crucial tool for evaluating the network's ability to meet the CLAS needs of its members. By leveraging this analysis, CareFirst can identify areas of strength and opportunities for improvement within its CLAS Program and provider network. Findings will be reported to the Quality Improvement Advisory Committee (which is composed of practicing community practitioners) and the Quality Improvement Committee (QIC). This allows informed decision-making and targeted efforts to enhance the delivery of culturally competent care.

Through ongoing assessment and refinement, CareFirst remains steadfast in its commitment to providing exemplary healthcare services that honor and respect the diverse cultural backgrounds of its members.

Cultural, Ethnic, Race and Linguistic Assessment

To understand the needs of members, CareFirst analyzes its member populations each year to understand their unique demographic needs. Below is an overview of the CareFirst population for each jurisdiction and comparisons with the U.S. Census Bureau data.

U.S. Census Bureau 2023 American Community Survey (ACS)

U.S. Census Bureau conducts the American Community Survey (ACS) annually to provide information about the social, economic and language characteristics of communities around the country. Data collected includes demographics such as age, sex, race, educational attainment and language spoken at home. The Bureau conducts this survey on a yearly basis and releases 1-year and 5-year estimates based on monthly data samples collected from small areas, including census tracts and block groups. The ACS collects data on an ongoing basis, to provide every community with the information they need to make important decisions including funding for programs and to understand any changes within each state and the community. It shares the data with the public in the form of estimates presented in a variety of tables, tools and analytical reports.

This report includes the 2023 ACS 1-year estimates released September 12, 2024 and the 2019–2023 ACS 5-year estimates released December 12, 2024. ACS data is for the United States, as well as the states/regions in which CareFirst serves members—specifically, Maryland, Virginia and Washington, D.C. CareFirst uses the data to assess the cultural, racial, ethnic and linguistic needs of populations in which it has membership. Overall, census data did not vary significantly from what was reported in 2024.

Population Distribution by Age and Sex

According to the 2023 American Community Survey data (see Figures 1, 2 and Table 1), nationally men and women are nearly equally distributed at 49% and 50% respectively. Washington, D.C. has the largest gender gap when compared to the United States, with 5% more females than males, compared to that of the other areas we serve: Maryland (3%), Virginia (1%), and the U.S. (1%). In the areas serviced by CareFirst, members are concentrated in the 25–54 age range. Washington, D.C. stands out as having a much higher percentage in this age group at 49%, compared to the United States [39%], Maryland and Virginia [39%].

Washington, D.C. has a considerably larger population between the ages of 25–34 [21%] compared to Maryland and Virginia [13%]. This is true for 35–44 as well, with Washington, D.C. [17%], compared to Maryland, Virginia and the U.S. [14%]. Washington, D.C. has a

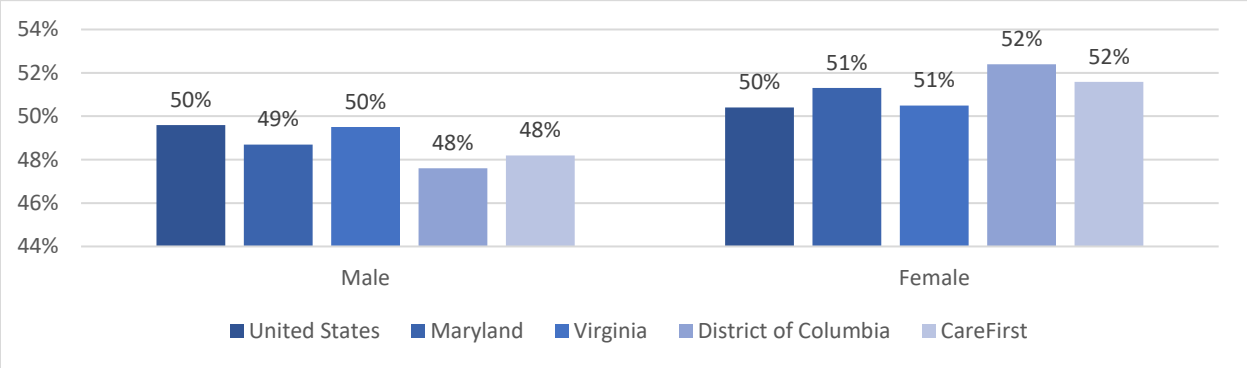
lower concentration in the 5–19 age range [16%] compared to Maryland, Virginia and the U.S.—all at 19%. Similarly, Washington, D.C. has less of its population concentrated in the 55–85 age range [22%], compared to Maryland, Virginia and the U.S.—all at 30%.

Washington, D.C. stands out as an Urban Center, with its population concentrated in a largely "working age" of 25–54. these comparisons are unchanged between 2022–2024 census data. It is notable that there has been a decrease in all jurisdictions and the United States in the percent of the population <5 years of age.

Table 1. Population distribution by age groups for Maryland, Washington, D.C. and Virginia, 2023 1-year ACS census data

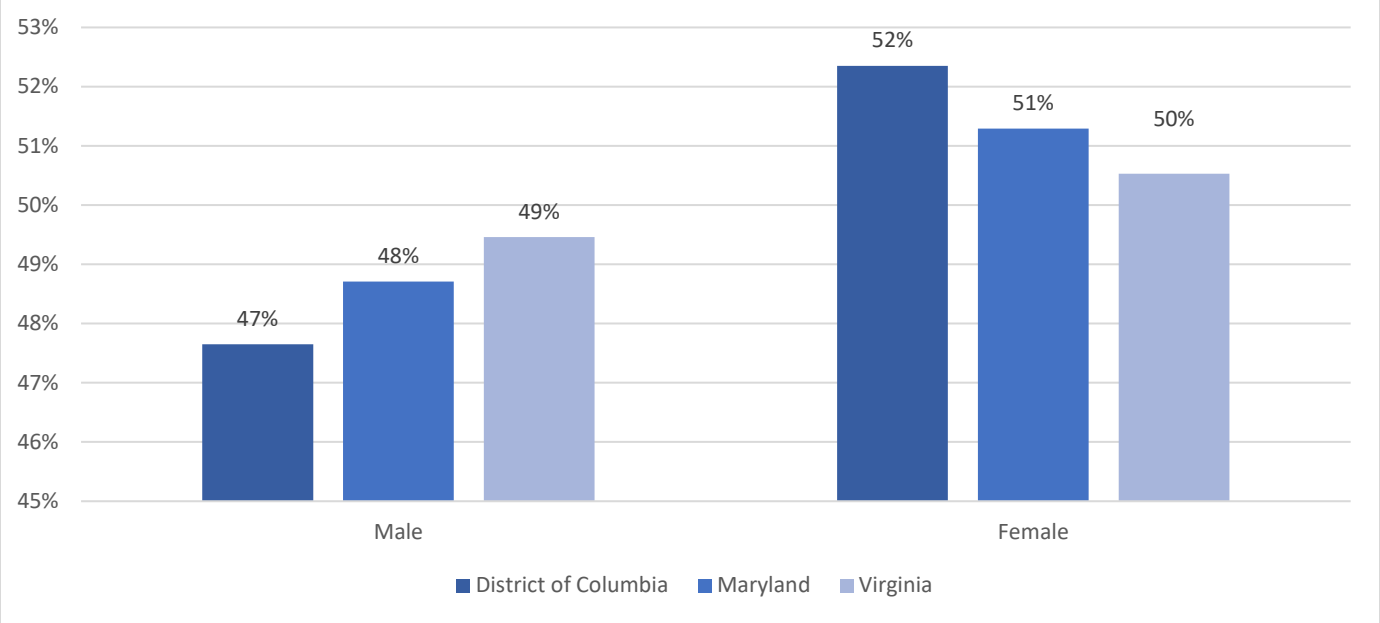
	Washington, D.C.		Maryland		Virginia		United States	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
SEX AND AGE								
Tot. pop.	**678,972**	–	**6,180,253**	–	**8,715,698**	–	**334,914,896**	
Male	321,590	*47.36%*	3,000,104	*48.54%*	4,302,096	*49.36%*	165,729,373	*49.48%*
Female	357,382	*52.64%*	3,180,149	*51.46%*	4,413,602	*50.64%*	169,185,523	*50.52%*
Under 5	38,512	*5.67%*	346,836	*5.61%*	476,744	*5.46%*	18,333,697	*5.47%*
5 to 9	36,388	*5.35%*	375,815	*6.08%*	512,565	*5.88%*	19,799,430	*5.91%*
10 to 14	34,113	*5.02%*	390,863	*6.32%*	546,266	*6.26%*	21,203,879	*6.33%*
15 to 19	36,112	*5.31%*	401,595	*6.49%*	580,019	*6.65%*	22,168,390	*6.61%*
20 to 24	50.928	*7.50%*	367,705	*5.94%*	562,765	*6.45%*	21,618,383	*6.45%*
25 to 34	144,710	*21.31%*	792,152	*12.81%*	1,162,172	*13.33%*	45,311,762	*13.52%*
35 to 44	114,104	*16.80%*	850,476	*13.76%*	1,208,026	*13.86%*	44,776,584	*13.36%*
45 to 54	71,869	*10.58%*	768,211	*12.43%*	1,065,740	*12.22%*	40,521,171	*12.09%*
55 to 59	32,059	*4.72%*	405,301	*6.55%*	540,862	*6.20%*	20,198,508	*6.03%*
60 to 64	31,181	*4.59%*	414,661	*6.70%*	561,608	*6.44%*	21,676,036	*6.47%*
65 to 74	51,071	*7.52%*	626,076	*10.13%*	880,968	*10.10%*	34,824,818	*10.39%*
75 to 84	28,985	*4.26%*	331,257	*5.35%*	471,406	*5.40%*	18,360,170	*5.48%*
≥ 85	8,940	*1.31%*	109,305	*1.76%*	146,557	*1.68%*	6,122,068	*1.82%*

Figure 1. Population distribution by age groups for CareFirst, United States, Maryland, Washington, D.C. and Virginia, 2023 census data



With respect to age, the CareFirst jurisdictions are comparable to what is seen within the United States as a whole, except for Washington, D.C. Washington, D.C.'s age distribution indicates it is an urban center with a population concentrated in a largely "working age" group of 25–54.

Figure 2. Population distribution by sex for Maryland, Washington, D.C. and Virginia, 2023 ACS data



Source: US Census Bureau

Population Distribution by Race and Ethnicity

In the United States, approximately 12% of the population identified as Black or African American, 61% as White, 1.12% as American Indian and Alaska Native, and 6% as Asian, while 19% identified as Hispanic. The Black population in Washington, D.C. is more than triple the national average, and the White population is nearly 40% lower than the national average.

In Washington, D.C., most people identify as either White (39%), Black (41%) or Hispanic (11%), with only a minority identifying as Asian (5%) and American Indian and Alaska Native (.46%). Native Hawaiian/Pacific Islander is only 0.20% in the U.S., thus too small to be sampled and compared across all jurisdictions we serve. Maryland and Virginia have a significantly higher percentage of whites (48% and 60% respectively) and Asians (approximately 7% in both jurisdictions) than Washington, D.C. The number identifying as Black is far greater in Washington, D.C. (41%) compared to Maryland (29%) and Virginia (18%). The percentage of Hispanic or Latino against the total population is consistent in all jurisdictions at approximately 11%, compared to the U.S. population of nearly 19%.

Females outnumber males in all jurisdictions we serve, but the gap is largest in Washington, D.C. at 5%. The 2023 U.S. Census Data shows little change from 2022 data.

Table 2. Population distribution by race & ethnicity* for Maryland, Washington, D.C. and Virginia, 2023 census data

	Washington, D.C.		Maryland		Virginia		U.S.	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Tot. pop.	***689,545***	–	***6,177,224***	–	***8,631,393***	–	***331,449,281***	–
White	***273,194***	39.62%	***3,007,874***	48.69%	***5,208,856***	60.34%	***204,277,273***	61.63%
Black or African American	***285,810***	41.44%	***1,820,472***	29.47%	***1,607,581***	18.62%	***41,104,200***	12.40%
American Indian and Alaska Native	***3,193***	*0.46%*	***31,845***	*0.51%*	***40,007***	*0.46%*	***3,727,135***	*1.12%*
Asian	***33,545***	*4.86%*	***420,944***	*6.10%*	***615,436***	*7.13%*	***19,886,049***	*5.99%*
Native Hawaiian/ Pacific Islander	**432**	*0.00%*	**3,247**	*0.00%*	**7,156**	*0.00%*	**689,966**	*0.20%*
Hispanic or Latino*	***77,652***	*11.26%*	***729,745***	*11.81%*	***908,749***	*10.52%*	***62,080,044***	*18.73%*

**Hispanic or Latino is an ethnic category*

Figure 3. Population distribution by race for Maryland, Virginia and Washington, D.C., 2023 census data

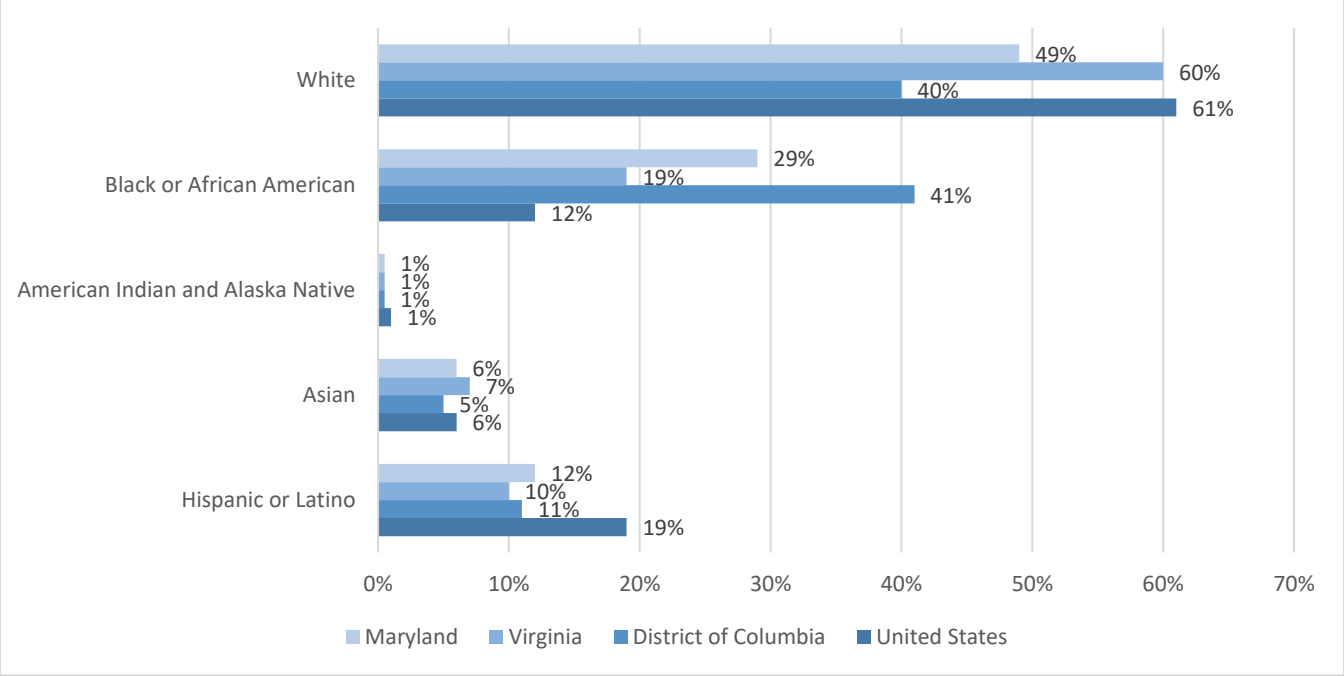
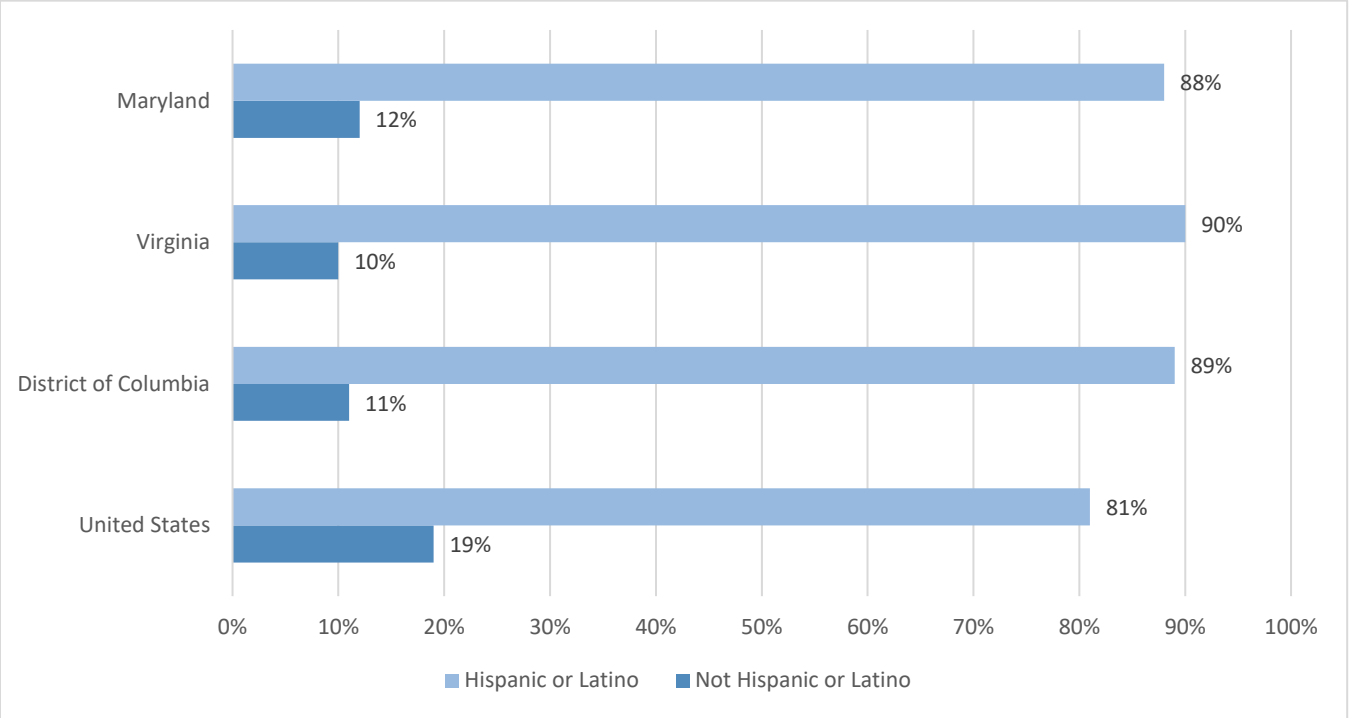


Figure 4. Population distribution by ethnicity for the United States, Maryland, Virginia and Washington, D.C., 2023 census data



The Census Bureau considers Hispanic to be an ethnicity rather than a race and analyzes the populations as Hispanic and Not Hispanic. The CareFirst jurisdictions consistently contain a significantly smaller percentage of Hispanics than the national rate.

Disabled Population Distribution

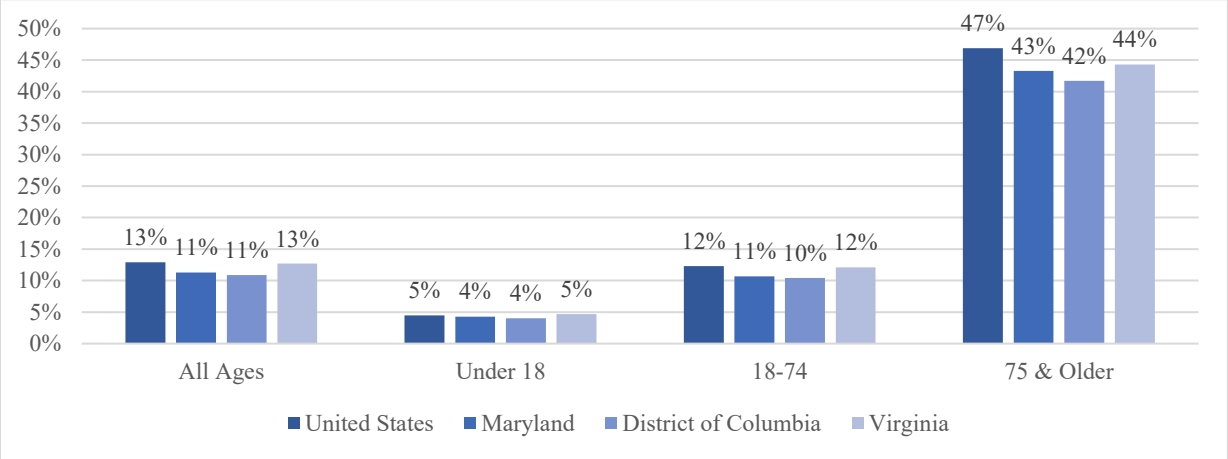
Unchanged in 2024, the percent of civilian, non-institutionalized population with disabilities by race, ethnicity and sex is similar in all jurisdictions served by CareFirst and the United States, with the smallest percentage in Washington, D.C. (11%). Females with disabilities outnumber males in all jurisdictions. This is likely true because women in general have greater longevity than men, with several health, disease, behavioral health and sociodemographic factors contributing to higher disability rates.

The true variance occurs in Washington, D.C., where Black or African Americans experience disabilities at nearly five times the national average (62% for Washington, D.C. vs. 13% for the U.S.), and twice as much as Maryland (31%). Interestingly, the number of whites reporting disabilities in Washington, D.C. is significantly less than other jurisdictions and the United States. For the overall population, disabilities in Washington, D.C. and Maryland are close at ~12%, and somewhat lower than Virginia and the United States at ~13%.

The 2025 report continues to examine disability information by gender and race/ethnicity, and by age group. The total percent of the civilian, non-institutionalized population with disabilities by sex is quite consistent across the jurisdictions we serve, but men in

Washington, D.C. are slightly lower (about 2%) than the national average. The greatest concentration of Americans living with disabilities is in the 35–64 age range at ~35%. For the 75+ population, Washington, D.C. experiences the lowest rate at 41.7% compared to a national average of nearly 47%. Women remain disproportionately affected with disabilities across all jurisdictions and the United States, but the variance is highest in Washington, D.C., with 60% of women with disabilities compared to 40% of men.

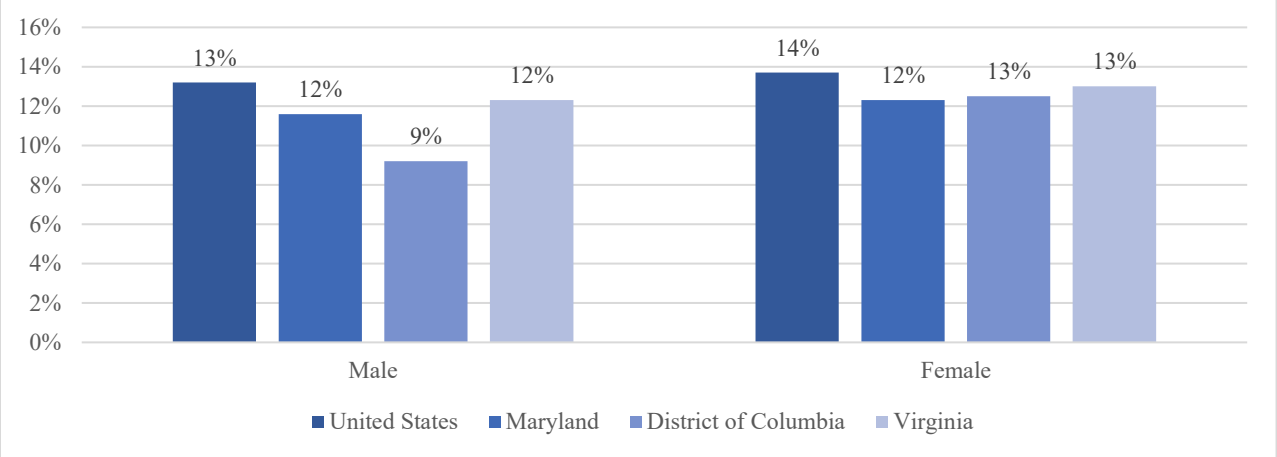
Figure 5. Distribution of Civilian, Non-institutionalized Population with Disabilities by Age



Source: United States Census Bureau

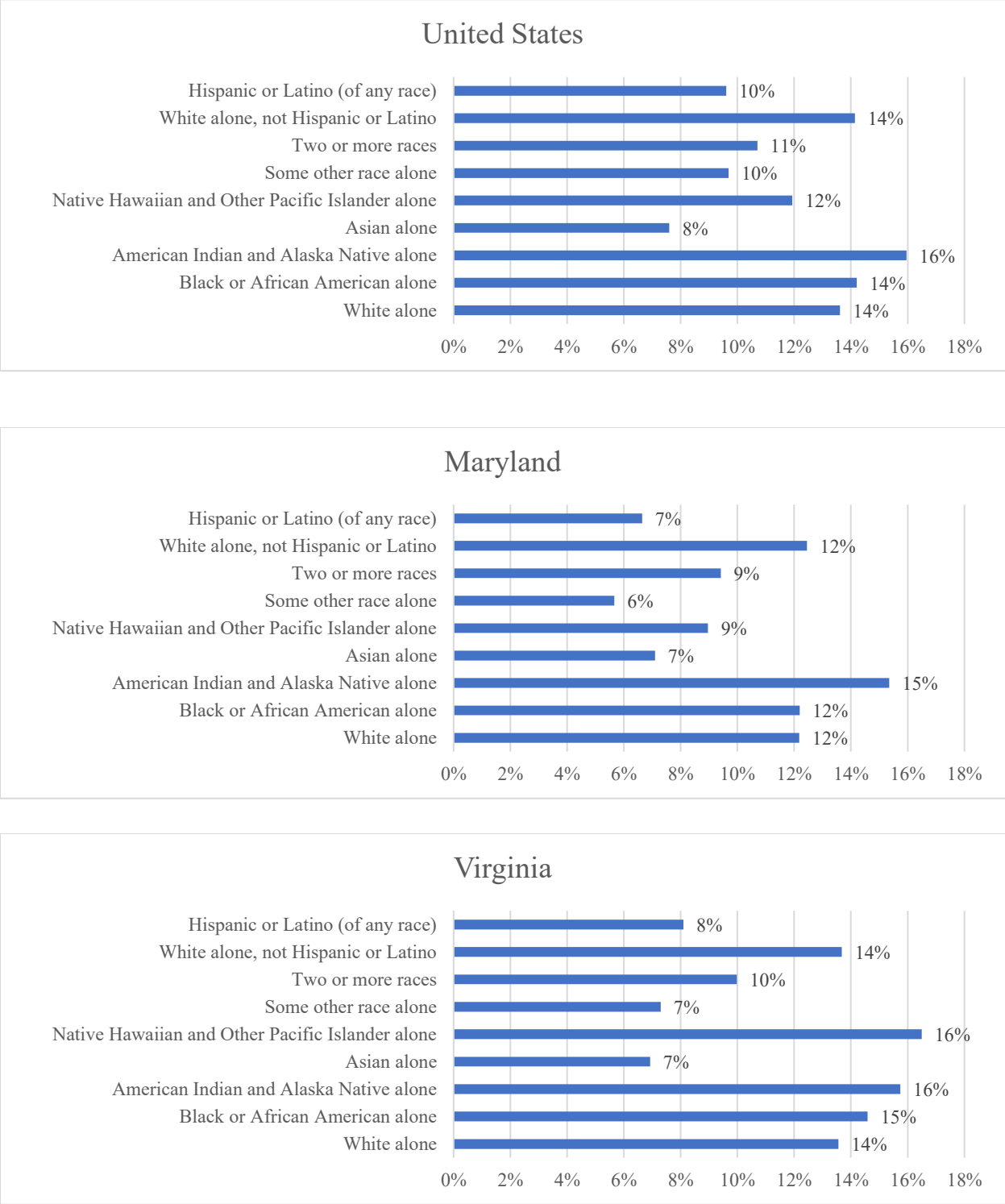
The percentage of females with disabilities is comparable to that of males across the United States and in all jurisdictions we serve, except in Washington, D.C., where the disabled male population is 3–4% percent lower than other regions.

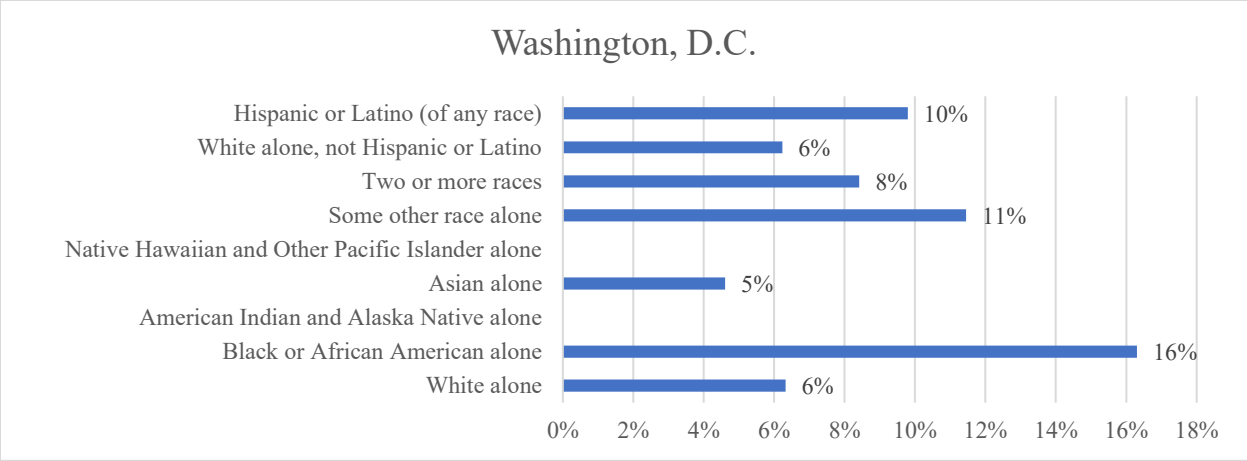
Figure 6. Distribution of Civilian, Non-institutionalized Population with Disabilities by Sex



Source: United States Census Bureau

Figure 7. Distribution of Civilian, Non-institutionalized Population with Disabilities by Race or Ethnicity





Source: United States Census Bureau

Language Spoken at Home Distribution

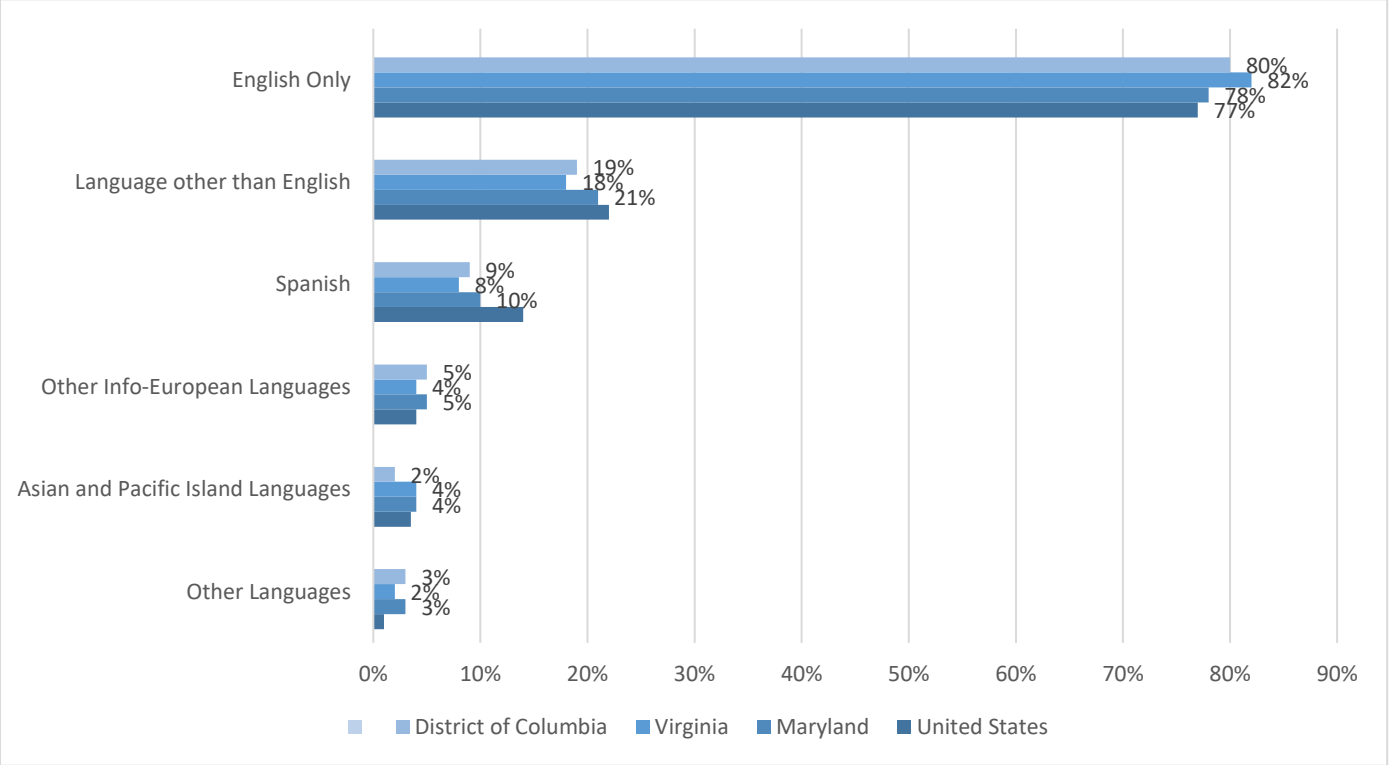
For languages spoken at home other than English, 2024 data was fairly consistent with the prior year. Of note, English as the sole language increased in Washington, D.C. but decreased across all other jurisdictions and the U.S. The same was true for languages other than English. Spanish decreased slightly in Washington, D.C. but increased across all other jurisdictions and the U.S.

In summary, much of the U.S. population speaks only English at home (77%) with Spanish consistently the most common language other than English spoken at home across all jurisdictions at approximately 9% compared to a national average of nearly 14%. Other Indo-European languages surpass 5% in Washington, D.C. (5.4%) and is lower in all other jurisdictions and the U.S. CareFirst has long considered the large number of Spanish speaking members by making member materials available in multiple languages (including Spanish).

Table 3. Languages spoken at home in Maryland, D.C., and Virginia, 2023 ACS data

	DC		Maryland		Virginia		U.S.	
	№	*%*	*№*	*%*	*№*	*%*	*№*	*%*
Population 5 years and over	**640,460**	–	**5,833,417**	–	**8,238,954**	–	**316,581,199**	–
English only	516,502	*80.6 %*	4,582,112	*78.54%*	6,769,936	*82.16%*	245,472,067	*77.53%*
Language other than English	**123,958**	***19.3 %***	**1,251,305**	***21.45 %***	**1,469,018**	***17.83 %***	**71,109,132**	***22.46%***
Spanish	56,833	*8.88 %*	577,157	*9.89%*	663,376	*8.05%*	43,369,734	*13.69%*
Other Indo-European languages	34,605	*5.4%*	291,483	*4.99%*	341,984	*4.15%*	12,411,769	*3.92%*
Asian and Pacific Islander languages	14,980	*2.3%*	218,697	*3.74%*	307,538	*3.73%*	11,346,338	*3.58%*
Other languages	17,540	*2.7%*	163,968	*2.8%*	153,120	*1.85%*	3,981,291	*1.25%*

Figure 8. Languages spoken at home in the United States, Maryland, Virginia and Washington, D.C., 2022 census data



Cultural Needs and Preferences Based on CareFirst's Member Population

As part of this analysis, CareFirst reviewed literature and data from the U.S. Census Bureau and Pew Research Center to better understand the cultural needs and preferences of the member population. CareFirst specifically evaluated geographic areas specific to the member population (Maryland, Washington, D.C. and Virginia).

Population Characteristics

In the United States, approximately one quarter of the population (26%) graduated from high school, approximately 9% have an associate degree, 22% have a bachelor's degree and 14% have a graduate or professional degree. Washington, D.C. far exceeds the national average in upper-level education at nearly three times the rate for graduate or professional degree (39%) and bachelor's degree or higher (66%). However, in all lower categories, Washington, D.C. trails the national average in education: <9th, 9th–12th, high school (13% vs. the national average of 26%), some college and associate degree. This is consistent with the previous year's report.

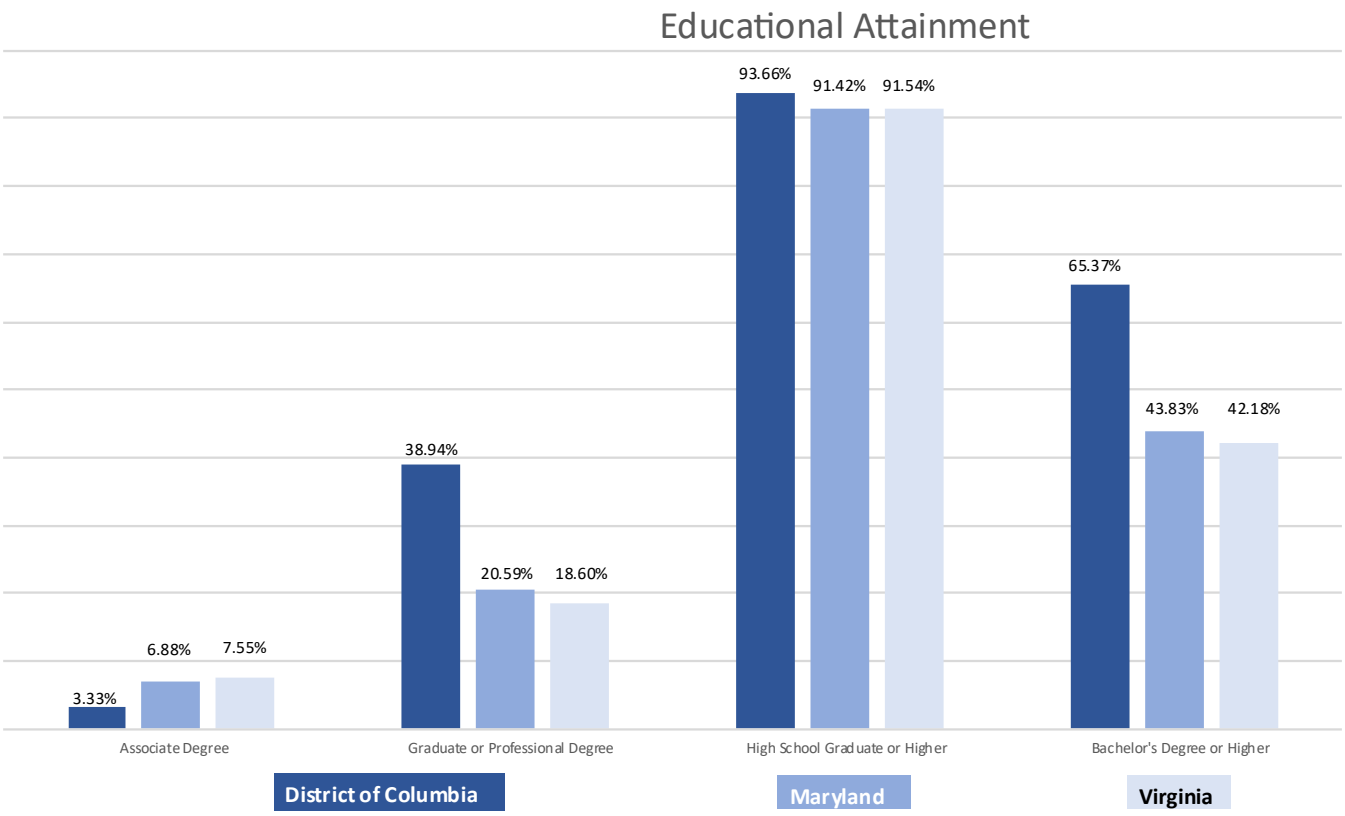
It is not until we reach completion of college and above that Washington, D.C., outperforms the national average by a significant percentage in all categories. For graduate or professional degree, the percent completion in Washington, D.C. (39%) compares to

Maryland (21%), Viginia (18%) and the U.S. (14%). Those who have an associate degree in Maryland and Virginia (7%) are fairly similar to the U.S. population (9%) and significantly higher than Washington, D.C. (2.5%). Maryland and Virginia show similar educational attainment rates, with nearly double the number of high school graduates than Washington, D.C., however a significantly lower percentage of graduate or professional degrees (21% and 18% respectively) compared to Washington, D.C. (39%). This gap of those with graduate degrees in Washington, D.C. compared to Maryland, Viginia and the U.S. continues to grow year-over-year.

Table 4. Distribution of educational attainment for Maryland, Washington, D.C. and Virginia, 2023 census data

	Washington, D.C.		***Maryland***		***Virginia***		***U.S.***	
	№	***%***	***№***	***%***	***№***	***%***	***№***	***%***
Population ≥25	**482,919**	–	**4,297,439**	–	**6,037,339**	–	**231,791,117**	–
<9th grade	15,862	*3.28%*	175,738	*4.08%*	213,181	*3.53%*	10,711,801	*4.62%*
9th-12th grade	19,161	*3.96%*	204,242	*4.75%*	303,286	*5.02%*	12,986,652	*5.60%*
High school	63,274	*13.10%*	1,025,379	*23.86%*	1,452,078	*24.05%*	60,105,924	*25.93%*
Some college	53,895	*11.16%*	710,628	*16.53%*	1,044,919	*17.30%*	43,700,984	*18.85%*
Associate degree	12,270	*2.54%*	301,452	*7.01%*	462,513	*7.66%*	20,469,668	*8.83%*
Bachelor's degree	129,951	*26.90%*	964,064	*22.43%*	1,446,760	*23.96%*	50,567,878	*21.81%*
Graduate or professional degree	188,506	*39.03%*	915,936	*21.31%*	1,114,602	*18.46%*	33,248,210	*14.34%*
High school graduate or higher	447,896	*92.74%*	3,917,459	*91.15%*	5,520,872	*91.44%*	208,092,664	*89.77%*
Bachelor's degree or higher	318,457	*65.94%*	1,880,000	*43.74%*	2,561,362	*42.42%*	83,816,088	*36.16%*

Figure 9. Distribution of educational attainment for Maryland, Washington, D.C. and Virginia, 2023 census data by percent of respondents



Beliefs/Religion

The data in Table 5 (below) remains current and is from the last religious affiliation study conducted by the Pew Research Center in 2014. The study, based on telephone interviews with more than 35,000 Americans in all 50 states, is the second Religious Landscape Study conducted by the Pew Research Center. The first one in 2007 used the same methodology. The religious affiliations of residents of Maryland, Virginia and Washington, D.C. cited below may influence cultural beliefs and practices.

According to the Pew Research Center, since the 1990s, large numbers of Americans have left organized religion. Coined “Nones” by the Pew Research Center, they describe their religious identity as atheist (17%), agnostic (20%) or “nothing in particular” (63%). Results of this 2023 study, published in January 2024, indicate about 28% of U.S. adults are religiously unaffiliated. Without a new study and relying on projections, in 2022 the Pew Research Center estimated that in 2020, about 64% of Americans, including children, were Christian,

religiously unaffiliated accounted for 30% of the U.S. population, and adherents of all other religions—including Jews, Muslims, Hindus and Buddhists—totaled about 6%.

Depending upon whether religious switching continues at recent rates, speeds up or stops entirely, projections show Christians shrinking from 64% to a little more than half (54%) and a little more than one-third (35%) of all Americans by 2070. Over the same period, "Nones" would rise from the current 30% to somewhere between 34–52% of the U.S. population. The religious beliefs of CareFirst members are likely reflective of the beliefs of the residents of the state in which they reside. There is no reason to believe that the religions in Maryland, Virginia and Washington, D.C. would vary substantially between practitioners and members.

Table 5. Data from the Pew Research Center Religious Affiliations

Religious Affiliation	Maryland	Virginia	Washington, D.C.
Christian	69%	73%	65%
• Evangelical Protestant	18%	30%	14%
• Mainline Protestant	18%	16%	15%
• Historically Black Protestant	16%	12%	12%
• Catholic	15%	12%	19%
• Mormon	1%	2%	1%
• Orthodox Christian	1%	1%	2%
• Jehovah's Witness	<1%	<1%	<1%
• Other Christian	1%	<1%	1%
Non-Christian Faiths	8%	6%	10%
• Jewish	3%	1%	4%
• Muslim	1%	1%	2%
• Buddhist	1%	1%	2%
• Hindu	1%	<1%	1%
• Other World Religions	<1%	<1%	<1%
• Other Faiths	2%	1%	2%
Unaffiliated	23%	20%	24%
• Atheist	3%	2%	4%
• Agnostic	3%	4%	4%
Nothing in particular	17%	15%	16%
Don't know	<1%	<1%	1%

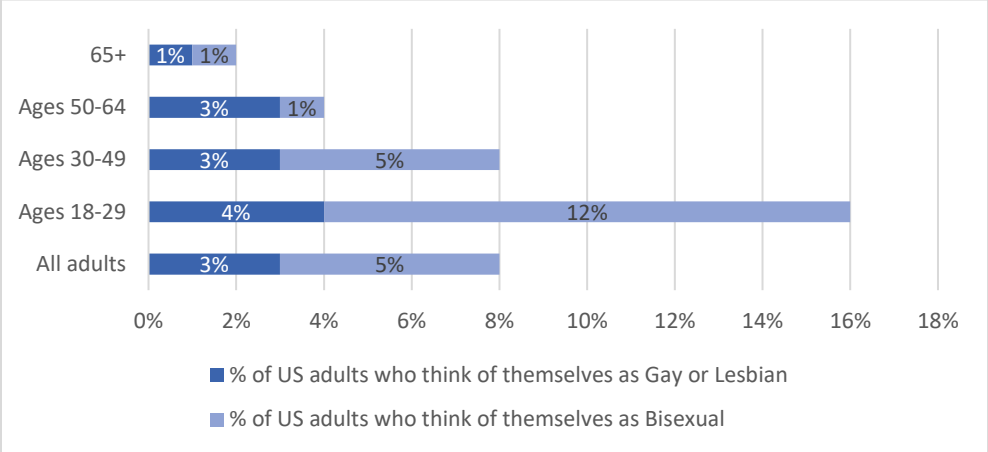
Pew Research Center. 2025. "2023-24 U.S. Religious Landscape Study Interactive Database." doi: 10.58094/3zs9-jc14
Pew Research Center, September, 2022, "Modeling the Future of Religion in America"

Sexual Orientation and Gender Identity (SOGI)

As part of this analysis, CareFirst reviewed literature and data from the U.S. Census Bureau and Pew Research Center to better understand the cultural needs and preferences of the member population. The Pew Research Center conducted a survey of 12,147 U.S. adults in summer 2022, showing that approximately 7% of Americans identify as lesbian, gay or bisexual. A later poll of >12K Americans aged 18 and older conducted by Gallup and reported by National Public Radio in March 2024 Number of U.S. adults who identify as LGBTQ+ has doubled since 2012 : NPR showed a slight increase in these numbers. The Gallup polling indicates the LGBTQ+ identification has more than doubled in the last 12 years with 7.6% identifying as lesbian, gay, bisexual, transgender, queer or some other sexual orientation besides heterosexual. The current figure is up from 5.6% four years ago and 3.5% in 2012.

The Pew Research Center report measuring sexual orientation and transgender identity (Figure 10 below) still reflects the most reliable and current LGBTQ+ data by age group.

Figure 10. Percentage of Americans Identifying as Lesbian, Gay, or Bisexual by Age Group



Source: Pew Research LGBQT+ Americans

Similar percentages of men and women identify with any of these terms, as do similar shares of adults across racial and ethnic groups. CareFirst is committed to offering its member population equitable standards of care, access and health coverage. We are deeply committed to the LGBTQ+ community and believe that all people should have equal opportunity to live consistently with their gender identity. We are committed to supporting LGBTQ+ individuals, their families and their employers. Over the past year, CareFirst has recognized a gap in member data to adequately assess the member population's needs based on sexual orientation and gender identity.

CareFirst has implemented several workgroups to ensure our systems and processes are designed to collect, store, and report SOGI data. Corporate goals and organization action

plans/timelines have been developed to address this data gap. While this gap will take several years to completely mitigate, work is already underway to ensure CareFirst can better understand the needs of this specific member population.

CareFirst Member Demographics Compared to U.S. Census Data

On average, the 2023 American Community Survey (ACS) results found similar distribution of males to females to CareFirst membership. Nationally, the split is 50% female/49% male. For CareFirst overall, the split is 52% female/48% male. Within our jurisdictions, Virginia had the highest percentage of males (49%) to females (40%) and is identical to the U.S. overall. Washington, D.C. and Maryland were nearly identical for males at 47% and 48%, respectively. Females (53%) outnumber males (47%) by the greatest amount in Washington, D.C.

CareFirst's member population mirrors the U.S. Census data with 48% male and 52% female. The age distribution of CareFirst members is somewhat younger than the 2023 US Census ACS Survey. Of CareFirst's overall population, 89% are under 65 years of age. This compares to 82% for the U.S. Census. Of the jurisdictions we serve the under 65 population is quite consistent, although Washington, D.C. has a slightly higher percentage at 87%, compared to 83% for Maryland and Virginia (Table 1). White was the largest racial group represented in the 2023 Census ACS Survey at 62%.

CareFirst continues to make strides in gathering self-reported member data for race and ethnicity. That said, the numbers remain quite small, representing about 36% of the total member population.

Of the total number of members responding, the data is as follows:

Race	White	411,233	18.94%
	Black or African American	151,036	6.96%
	Asian	48,131	2.22%
	Native Hawaiian or Pacific Islander	1,366	0.06%
	American Indian or Alaska Native	2,106	0.10%
Ethnicity	Hispanic or Latino	13,209	0.61%

We can infer from this data that the total population of whites is approximately 50% which is higher than Maryland (48.69%), substantially higher than Washington, D.C. (39.62%) and only lower than Virginia (60.34%).

2024 CareFirst CAHPS Member Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a series of patient surveys rating health care experiences in the United States. The survey is conducted annually and focuses on member satisfaction based upon healthcare quality aspects that patients find important and are well equipped to assess. The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with healthcare. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals to determine which areas of service have the greatest effect on members' overall satisfaction and to identify areas of opportunity for improvement.

CareFirst CAHPS results include age, sex, education, ethnicity and race, as well as information about cultural and/or language needs. All data points are used to enhance the assessment of CareFirst member needs, and how well CareFirst meets them.
CareFirst analyzed results of the CAHPS survey for each product line. Findings were as follows:

HMO CAHPS

For the HMO commercial product line, the Quality Team within CareFirst analyzed CAHPS measure results stratified by race, ethnicity and language (REL) using the two-tailed z-test with 95% confidence to determine statistical significance between cohorts. Measures analyzed included Time to Get Preventive Care with 30 days, Rating of a Personal Doctor, and Dr. Met Cultural/Ethnical/Linguistic Needs/Preferences.

Many of the populations analyzed for comparison had <30 members within the denominator, hence they were not included in analysis due to the sample size. There were not sufficient denominator sizes for all races among all categories except for White. Thus, a disparity comparison could not be made. Additionally, a disparity comparison could not be made for ethnicity and language, as only the Not Hispanic/Latino ethnicities and English-speaking members had a large enough denominator.

PPO CAHPS

For the PPO commercial products, the Quality Team within CareFirst analyzed CAHPS measure results stratified by race, ethnicity and language (REL) using the two tailed z-test with 95% confidence to determine statistical significance between cohorts. Measures analyzed included: Time to Get Preventive Care with 30 Days, Rating of a Personal Doctor, and Dr. Met Cultural/Ethnical/Linguistic Needs/Preferences.

Because there were insufficient denominators to assess for disparities among ethnicities and language in the CAHPS survey results, CareFirst summarized CAHPS REL data for all PPO populations. There were sufficient denominators to compare between Time to Get

Preventive Care with 30 days, Rating of a Personal Doctor, and Dr. Met Cultural/Ethnical/Linguistic Needs/Preferences. No disparities were noted upon comparison of these two subgroups.

FEP HMO CAHPS

For each product, the Quality Team within CareFirst analyzed three CAHPS measure results stratified by REL using the two-tailed z-test with 95% confidence to determine statistical significance between cohorts. Measures analyzed included:

- Time to get Preventative Care within 30 Days
- Dr. Met Cultural/Ethnical/Linguistic Needs/Preferences or Cultural Competence
- Rating of a Personal Doctor

Many of the populations analyzed for comparison, had <30 members within the denominator, hence they were not included in the analysis due to the sample size. There were sufficient denominators to compare between White and Black or African American populations. No disparities were noted upon comparison of these two subgroups.
Based on the analysis of each product, CareFirst recommends the following interventions based on the findings:

1. Continue to encourage network providers to complete newly developed provider education classes specific to health equity.
2. Monitor provider completion of health equity training classes.
3. Continue to review annual CAHPS specific data to monitor progress.
4. Increase the collection of REL data directly from members.

CareFirst offered several structured programs to Associates and Providers in 2024 as a part of the Week of Equity and Action, with curriculum designed to increase to increase awareness and sensitivity to members, regardless of sexual identity. CareFirst also developed an action plan and timeline to increase the collection of REL data from members. CareFirst also developed an action plan and timeline to increase the collection of REL data from members.

Member Preferences Based on CareFirst Member Complaint Data

Member complaints are collected in real time and on an ongoing basis to evaluate practitioners' ability to meet member ethnic, racial, cultural and linguistic needs. CareFirst carefully evaluates all member complaints and maintains a complaints and appeals collection and resolution process. Upon analysis, this data is compiled into an Annual Customer Complaint and Appeals Report and presented to the Quality Improvement Committee.

The 2024 Customer Complaint and Appeals report did not reflect any member complaints related to culture, ethnicity, race or language. The CareFirst Special Investigations Unit (SIU) also tracks SOGI/REL related complaints. There was one member complaint of race and age

discrimination against a provider; This concern was addressed by the CareFirst Quality of Care Department.

The results of future studies, as well as any issues related to ethnic, racial, cultural, or linguistic complaints, will be reported and addressed here on an annual basis.

Network Responsiveness

Each year, CareFirst analyzes the capacity of its network to ensure it can meet the language needs and needs and preferences of its member population. As part of this analysis, CareFirst reviewed the multiple characteristics of its provider network. These characteristics are described in detail below.

Network Composition

As of January 16, 2025, there were a total of 76,881 practitioners (if a practitioner is affiliated with more than one practice, the practitioner is counted in the data for each practice affiliation) participating in the CareFirst network. The top ten degrees are listed below, and include medical doctors (36%), registered physical therapists (7%), nurse practitioners (12%), licensed clinical social workers (10%), licensed professional counselors (8%), certified registered nurse anesthetists (2%), optometrists (2%), occupational therapists (2%), osteopaths (2%) and PhDs (2%) (Table 6).

Table 6. Top 10 professional degrees, 2025 CareFirst network data (N=76,881).

Degree		№	%
MD	Medical Doctor	27,891	36.28%
CRNP	Certified Registered Nurse Practitioner	9,352	12.16%
LCSW	Licensed Clinical Social Worker	8,067	10.49%
LPC	Licensed Professional Counselor	6,047	7.87%
RPT	Registered Physical Therapist	5,396	7.02%
DO	Doctor of Osteopathy	1,786	2.32%
CRNA	Certified Registered Nurse Anesthetist	1,591	2.07%
PHD	Doctor of Philosophy	1,580	2.06%
OT	Occupational Therapist	1,314	1.71%
OD	Doctor of Optometry	1,275	1.66%

Practitioners in the network are distributed among six states, including Maryland, Washington, D.C., Virginia, Delaware, Pennsylvania and West Virginia. Most practitioners are in Maryland (66%), followed by Virginia (25%), Washington, D.C. (13%), Delaware (1.49%), Pennsylvania (1.07%) and West Virginia (0.23%).

Overall, practitioners between the ages of 25–64 represent approximately 86% of the network, with only 14% older than 64 years of age. Virginia has the highest percentage of practitioners ages 25–64 (90%) and West Virginia has the lowest, with 81%. Approximately 67% of practitioners are females and 33% males, with West Virginia having the highest percentage of male practitioners (46%) followed by Delaware (43%) and Pennsylvania (40%). Virginia has the highest percentage of female practitioners (68%) followed by Maryland (67%).

On average, 49% of practitioners have an MD degree, with the lowest percent in Pennsylvania (23%) and the highest percent in Washington, D.C. (48%). Delaware (19%) and West Virginia (17%) have a noticeably larger percentage of practitioners with a Certified Registered Nurse Practitioner degree compared to the rest of the states. Pennsylvania (21%) and West Virginia (9%) also have a higher percentage of optometrists compared to the rest of the states. Delaware (4.29%) and Pennsylvania (3.66%) also have a higher percentage of doctors of osteopathy compared to the rest of the states.

Table 7. Practitioner demographics, 2025 network data

	Distinct Total		DC		DE		MD		PA		VA		WV	
Age	№	%	№	%	№	%	№	%	№	%	№	%	№	%
< 20	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
20-24	17	0.02%	0	0.00%	0	0.00%	14	0.03%	1	0.12%	2	0.01%	0	0.00%
25-34	10,599	13.79%	1,035	10.34%	121	10.60%	6,938	13.76%	143	17.46%	2,807	14.63%	13	7.34%
35-44	23,515	30.59%	3,378	33.76%	308	26.97%	15,043	29.83%	233	28.45%	6,099	31.78%	44	24.86%
45-54	18,770	24.41%	2,530	25.29%	298	26.09%	12,205	24.20%	207	25.27%	4,969	25.89%	56	31.64%
55-64	13,594	17.68%	1,634	16.33%	270	23.64%	9,098	18.04%	146	17.83%	3,319	17.29%	30	16.95%
65-74	7,769	10.11%	957	9.57%	125	10.95%	5,363	10.63%	79	9.65%	1,570	8.18%	33	18.64%
75-84	2,334	3.04%	402	4.02%	20	1.75%	1,595	3.16%	8	0.98%	386	2.01%	1	0.56%
85+	283	0.37%	69	0.69%	0	0.00%	178	0.35%	2	0.24%	40	0.21%	0	0.00%
	76,881		**10,005**	13.01%	**1,142**	1.49%	**50,434**	65.60%	**819**	1.07%	**19,192**	24.96%	**177**	0.23%
Sex	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*
Male	25,442	33.09%	3,419	34.17%	493	43.17%	16,752	33.22%	325	39.68%	6,147	32.03%	81	45.76%
Female	51,382	66.83%	6,579	65.76%	648	56.74%	33,640	66.70%	494	60.32%	13,037	67.93%	96	54.24%
Unknown	57	0.07%	7	0.07%	1	0.09%	42	0.08%	0	0.00%	8	0.04%	0	0.00%
	76,881		**10,005**		**1,142**		**50,434**		**819**		**19,192**		**177**	
Degree	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*	*№*	*%*
CRNA	1,591	2.90%	145	1.45%	12	1.05%	922	1.83%	35	4.27%	684	3.56%	3	1.69%
CRNP	9,352	14.13%	1,079	10.78%	215	18.83%	6,679	13.24%	74	9.04%	1,923	10.02%	30	16.95%
DO	1,786	2.95%	212	2.12%	49	4.29%	1,092	2.17%	30	3.66%	509	2.65%	3	1.69%
LCSW	8,067	0.01%	938	9.38%	42	3.68%	5,548	11.00%	41	5.01%	1,777	9.26%	15	8.47%
LPC	6,047	0.05%	461	4.61%	50	4.38%	3,858	7.65%	51	6.23%	1,796	9.36%	9	5.08%
MD	27,891	48.55%	4,801	47.99%	380	33.27%	17,817	35.33%	188	22.95%	6,583	34.30%	53	29.94%
OD	1,275	1.93%	70	0.70%	66	5.78%	708	1.40%	169	20.63%	446	2.32%	15	8.47%
OT	1,314	2.57%	209	2.09%	18	1.58%	915	1.81%	25	3.05%	293	1.53%	4	2.26%
PHD	1,580	0.02%	288	2.88%	4	0.35%	973	1.93%	5	0.61%	354	1.84%	3	1.69%
RPT	5,396	11.29%	729	7.29%	133	11.65%	3,537	7.01%	80	9.77%	1,559	8.12%	16	9.04%
Other	12,582	15.60%	1,073	10.72%	173	15.15%	8,385	16.63%	121	14.77%	3,268	17.03%	26	14.69%
	76,881		**10,005**		**1,142**		**50,434**		**819**		**19,192**		**177**	

**An NPI could be represented in more than one state, but will only be represented in the total once*

Race and Ethnicity Characteristics of Practitioner Network

CareFirst reviewed the data available regarding its practitioner network based on race and ethnicity. Complete data was not available for analysis for some lines of business, as

CareFirst is prohibited from collecting additional information from practitioners due to COMAR 31.10.26.03B, which states:

> *B. A carrier may not, for purposes of credentialing or recredentialing, require a health care provider to:*
> *(1) Modify the uniform credentialing form;*
> *(2) Submit additional credentialing forms;*
> *(3) Use any other credentialing form not designated by the Commissioner; or*
> *(4) Submit any additional information not specified by the uniform credentialing form, except as stated in §F of this regulation.*

CareFirst uses the CAQH ProView application to credential providers. As part of completing a provider profile, and to complete the ProView application, provider race/ethnicity data is requested (race/ethnicity data requested is voluntary; not mandatory when creating a profile).

Based on data obtained as part of the credentialing process, CareFirst reviewed available data on the racial composition of its practitioners. The table below reflects all practitioners with active NPIs, practicing in the Commercial and Medicare Advantage Networks and *with CAQH ID's.* Of all practitioners in the CareFirst Network, (78,916), 61% have CAHQ ID's (48,469). The racial composition of the 61% is reflected below.

Table 8. CareFirst physician network by racial composition.

	№	%
Tot. pop.	***48,469***	–
White	***19,107***	39.6%
Black or African American	***8,036***	16.9%
Prefer not to say	***8,198***	*16.6%*
Unknown	***6,810***	*14.1%*
Asian	***4,279***	*8.9%*
Hispanic or Latino*	***1,583***	*3.3%*
American Indian or Alaska Native	***172***	*0.4%*
Native Hawaiian or Other Pacific Islander	***100***	*0.2%*
Total	***48,285***	*100%*

Hispanic or Latino is an ethnic category

Recognizing that there is not data for every physician, what is reported indicates the percentage of white physicians most closely mirrors the population of Washington, D.C. (39.62%) and is significantly less than Maryland (48.69%), Virginia (59.98%) and the U.S. (61.63%). Similarly, Black physicians are fewer than all percentages except the U.S., which is 12.40%. Hispanics are significantly lower than all populations we serve (approximately 11%) and the U.S. (19%).

On a positive note, the predominant language (aside from English) spoken by the largest number of members is Spanish, mirroring the most calls to the Language Line for Language Interpretation, as well as language spoken by providers. There was very little change in percentages from 2023 to 2024, but in raw numbers there was an increase in all ethnicities, likely due to the increased number of physicians in the Network.

Table 9. Practitioner demographics (Age, Sex and Degree) by language, January 2025 CareFirst network data

			Age Bracket															
Language	*Total Practitioners*	*% of Total*	*< 20*		*20-24*		*25-34*		*35-44*		*45-54*		*55-64*		*65-74*		*75-84*		*85 +*	
ARABIC	814	6.6%	0		0		36	4%	178	22%	215	26%	198	24%	136	17%	46	6%	5	1%
CHINESE	666	5.4%	0		0		25	4%	108	16%	171	26%	216	32%	111	17%	34	5%	1	0%
FARSI	334	2.7%	0		0		4	1%	56	17%	77	23%	111	33%	49	15%	29	9%	8	2%
GERMAN	438	3.6%	0		0		6	1%	46	11%	96	22%	132	30%	114	26%	35	8%	9	2%
GUJARATI	351	2.9%	0		0		29	8%	118	34%	103	29%	48	14%	34	10%	19	5%	0	0%
HAITIAN CREOLE	22	0.2%	0		0		3	14%	13	59%	3	14%	1	5%	2	9%	0	0%	0	0%
HINDI	1,854	15.1%	0		0		79	4%	473	26%	562	30%	388	21%	245	13%	98	5%	9	0%
KOREAN	688	5.6%	0		0		35	5%	173	25%	223	32%	149	22%	80	12%	25	4%	3	0%
MANDARIN	281	2.3%	0		0		29	10%	101	36%	78	28%	48	17%	18	6%	6	2%	1	0%
RUSSIAN	449	3.7%	0		0		8	2%	98	22%	143	32%	105	23%	74	16%	19	4%	2	0%
SPANISH	6,047	49.4%	0		0		376	6%	1,541	25%	1,633	27%	1,415	23%	809	13%	244	4%	29	0%
VIETNAMESE	302	2.5%	0		0		20	7%	75	25%	92	30%	76	25%	31	10%	8	3%	0	0%
Total	*12,246*	*100%*	*0*		*0*		*650*		*2,980*		*3,396*		*2,887*		*1,703*		*563*		*67*	

				Gender				
Language	*Total Practitioners*	*% of Total*		*Male*		*Female*		*Unknown*
ARABIC	814	6.6%		490	60%	323	40%	1
CHINESE	666	5.4%		288	43%	378	57%	0
FARSI	334	2.7%		203	61%	131	39%	0
GERMAN	438	3.6%		215	49%	223	51%	0
GUJARATI	351	2.9%		163	46%	188	54%	0
HAITIAN CREOLE	22	0.2%		7	32%	15	68%	0
HINDI	1,854	15.1%		862	46%	992	54%	0
KOREAN	688	5.6%		354	51%	334	49%	0
MANDARIN	281	2.3%		110	39%	171	61%	0
RUSSIAN	449	3.7%		189	42%	259	58%	1
SPANISH	6,047	49.4%		2,458	41%	3,584	59%	5
VIETNAMESE	302	2.5%		129	43%	173	57%	0
Total	***12,246***	***100%***		***5,468***		***6,771***		***7***

Table 9. Practitioner demographics by language (cont.), 2025 CareFirst network data

				Degrees										
Language	*Total Practitioners*	*% of Total*		*CRNA*	*CRNP*	*DO*	*LCSW*	*LPC*	*MD*	*OD*	*OT*	*PHD*	*RPT*	*Other*
ARABIC	814	6.6%		4	29	11	20	25	633	10	4	7	29	42
CHINESE	666	5.4%		5	39	7	7	17	353	24	2	6	23	183
FARSI	334	2.7%		1	9	9	9	8	239	10	1	1	5	42
GERMAN	438	3.6%		5	30	5	31	38	270	5	4	11	9	30
GUJARATI	351	2.9%		1	25	16	4	3	217	23	3	0	41	18
HAITIAN CREOLE	22	0.2%		1	4	0	4	0	7	0	0	0	0	6
HINDI	1,854	15.1%		8	88	28	29	35	1,415	39	10	11	109	82
KOREAN	688	5.6%		9	55	12	13	16	288	28	3	5	46	213
MANDARIN	281	2.3%		3	16	6	6	10	162	8	5	5	9	51
RUSSIAN	449	3.7%		4	30	5	17	19	283	4	2	8	22	55
SPANISH	6,047	49.4%		79	521	123	480	373	3,037	164	59	89	294	828
VIETNAMESE	302	2.5%		0	22	17	4	2	158	44	0	2	7	46
Total	*12,246*	*100%*		*120*	*868*	*239*	*624*	*546*	*7,062*	*359*	*93*	*145*	*594*	*1,596*

Table 9 includes key variables across the U.S. Census for Washington, D.C., Maryland and Virginia; CareFirst members; and the CareFirst network provider populations. The key variables include age, sex, education, race, ethnicity (limited to Hispanic or Latino) and academic degree. Age, sex, education, race and ethnicity are included in both the U.S. Census data and CareFirst member data. Education and race are not reported for CareFirst provider data, although included is the academic/professional degree as a proxy for education.

Table 9 reveals that in addition to English, a significant portion of CareFirst providers speak Spanish (49.9%) and Hindi (15.1%). This linguistic distribution is notable, considering that only about 8% of the population in Washington, D.C., Virginia and Maryland speaks Spanish, 5% speaks Indo-European languages, and around 3% speaks Asian and Pacific Islander languages. While the network contains adequate amounts of Spanish-speaking practitioners to meet the needs of our Spanish-speaking membership, there is a shortage of practitioners for those who speak Indo-European and Asian and Pacific Islander languages. This disparity could lead to language barriers and hinder effective communication between members and providers.

Most CareFirst providers (86%) are between the ages of 25–64 with CareFirst members a good deal younger at 61%. For the populations we serve in the 25–64 age group, this compares to 77.98% for Maryland, 78.36% for Virginia and 82.7% for Washington, D.C., which of our jurisdictions most closely reflects the ages of our providers. CareFirst practitioner representation is somewhat older than plan membership and the populations represented in the regions where networks are based.

Looking at age groups for 65+, the number of providers, members and the overall U.S. population decreases. But interestingly, they are quite similar across these groups, with providers (14%), CareFirst members (11%) and the U.S. census (12%). This can be expected as practitioners move toward retirement, but it is useful to know the provider age distribution mirrors that of our members and the populations we serve.
Females represent a slight majority of the U.S. population (52%) and the CareFirst member population (53%), but represent a significantly larger majority in the practitioner population, with 67% female and 33% male.

Approximately 84% of practitioners in CareFirst networks have a graduate degree, both at the master's and doctoral levels. The educational level of CareFirst members was not captured so this information is unavailable. It can be ascertained through reviewing the data, network practitioners have the appropriate and adequate education, licensure and are credentialed to provide services to CareFirst members.

As seen in Table 10, there was too little data available to make inferences about the CareFirst member population for race. However, for the data that is listed, there are more whites (6%) and even fewer percentages of all other races.

CareFirst cannot assess the racial and/or ethnic composition of the member and provider populations. CareFirst is prohibited from collecting racial or ethnic data from providers. We are prohibited from collecting additional information from practitioners due to COMAR 31.10.26.03(B), which states:

> *B. A carrier may not, for purposes of credentialing or recredentialing, require a health care provider to:*
> *(1) Modify the uniform credentialing form;*
> *(2) Submit additional credentialing forms;*
> *(3) Use any other credentialing form not designated by the Commissioner; or*
> *(4) Submit any additional information not specified by the uniform credentialing form, except as stated in §F of this regulation.*

Table 10. Demographic characteristics comparison of Census versus CareFirst Members and Providers

		Census[1]		Members[2]		Providers	
		No.	%	No.	%	No.	%
Age †	20-24	981528	*6.63%*	561518	*27.55%*	17	0.02%
	25-34	2159605	*16.90%*	316324	*15.51%*	10599	*13.79%*
	35-44	2023981	*13.87%*	321364	*15.76%*	23515	*30.59%*
	45-54	1966341	*12.20%*	302556	*14.84%*	18770	*24.41%*
	55-64	2006073	*12.17%*	311397	*15.27%*	13594	*17.68%*
	65-74	1424761	*8.83%*	139222	*6.82%*	7769	*10.11%*
	75 or older	980999	*3.03%*	86085	*4.22%*	2617	*3.41%*
Sex	Male	7464167	*48.33%*	967834	*47.47%*	25442	*33.09%*
	Female	7822781	*51.67%*	10700625	*52.53%*	51382	*66.83%*
Education	≤ 9th grade	407004	*3.70%*	-	-	-	-
	9th to 12th grade, no diploma	621028	*5.57%*	-	-	-	-
	High school or GED	2498127	*21.33%*	-	-	-	-
	Some college or 2-year degree	2698872	*11.35%*	-	-	-	-
	4-year college graduate	2354406	*23.30%*	-	-	-	-
	> 4-year college degree	1982323	*23.43%*	-	-	-	-
Race*[2]	White	8245339	*53.20%*	92315	*5.62%*	-	-
	Black or African American	3658927	*23.61%*	55281	*3.37%*	-	-
	Asian	1061766	*6.85%*	11658	*0.71%*	-	-
	Native Hawaiian or Pacific Islander	9119	*0.00%*	50	*0.00%*	-	-
	American Indian or Alaska Native	34328	*0.30%*	247	*0.02%*	-	-
Ethnicity	Hispanic or Latino	1716146	*11.07%*	9433	*0.57%*		
Degree±	MD	-	-	-	-	27891	*36.28%*
	RPT	-	-	-	-	5396	*7.02%*
	CRNP	-	-	-	-	9352	*12.16%*

LCSW	-	-	-	-	8067	*10.49%*
LPC	-	-	-	-	6047	*7.87%*
OD	-	-	-	-	1275	*1.66%*
CRNA	-	-	-	-	1591	*2.07%*
OT	-	-	-	-	1314	*1.71%*
DO	-	-	-	-	1786	*2.32%*
PhD	-	-	-	-	1580	*2.06%*

† Excludes people younger than 20 years; aggregates 75 years-and-older groups. Percentages based on total population.
‡ 9-12th grade from Census data are included in this category, whether they graduated or not. Provider education is shown under "Degree".

± Information only available for providers

** CareFirst does not collect provider race or ethnicity*

[1] Population percentages do not add to 100%; younger age groups are not included on the table

[2] 2020 HEDIS Data

Considering the limitations of practitioner race/ethnicity data available from the credentialing process, CareFirst also analyzed the Association of American Medical Colleges (AAMC) U.S. Physician Workforce Data Dashboard.

Tables 11 and 12 provide a comparison of physician race and ethnic data for Maryland, Washington, D.C. and Virginia compared to the general population. The AAMC collected information reflecting the racial and ethnic composition of active physicians nationally, as follows: Asian (17.1%), Black (5%), Hispanic (5.8%), White (56.2%), American Indian or Alaska Native (0%). Tables below compare data within the jurisdictions CareFirst serves and compared to population data for the same regions.

Table 11: data from the AAMC 2021 State Physician Workforce Data Report published in January 2022

State	Asian – Alone or in Combination (Race)	Black or African American (Race)	Hispanic, Latino, or of Spanish origin (Ethnicity)	Native Hawaiian or Other Pacific Islander (Race)	White (Race)	Other (Race or Ethnicity)	American Indian or Alaska Native (Ethnicity)	Total
Maryland	20.5%	12.3%	3.3%	.2%	50.6%	1.6%	.3%	88.8%
DC	20.9%	16.6%	4.6%	.2%	49.9%	1.7%	.2%	94.1%
VA	18.8%	7.7%	3.3%	.4%	61.4%	1.5%	.3%	93.4%

https://www.aamc.org/data-reports/report/demographic-characteristics-and-work-experiences-physician-scientists-us
https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019. https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

Table 12: Population data from 2023 Census Data

State	Asian (Race)	Black (Race)	Hispanic or Latino (Ethnicity)	White (Race)	American Indian or Alaska Native (Ethnicity)	Other	Total
Maryland	6%	29%	11%	48%	0%	6%	100%
DC	5%	41%	11%	39%	0%	4%	100%
VA	7%	18%	10%	60%	0%	5%	100%

The analysis of population by race and ethnicity compares the overall racial and ethnic makeup of physicians to the general population in Maryland, Washington, D.C. and VA. Across these states, there are significantly fewer Black physicians compared to the general population, and there are fewer white physicians than the general population. This disparity of physicians to the population is significantly worse in the Black community than white. The comparison of Asian physicians to the general population reveals a somewhat greater number of Asian physicians than the general population across these states. The Hispanic population is significantly underrepresented for physicians, with the general population 11% Hispanic and the physician population 3%. The American Indian or Alaska Native population for both is negligible.

CareFirst recognizes these disparities but is also constrained in resolving this issue by the availability of practitioners to meet the racial, ethnicity and language needs. The credentialing application is completely unbiased and there is no conscious effort to recruit and retain more heavily any race or ethnicity. That said, the organization partners with many hospitals, physician practices and community organizations and can use its considerable influence to encourage recruitment that more closely aligns with the demographics of our population.

CareFirst continually seeks to improve relationships with providers and promote health equity within our communities. We are focused on developing resources and specialized content to support providers as they interact with CareFirst and their patients. CareFirst maintains a Learning and Engagement Center for all in-network providers.

As part of our effort to advance an equity strategy, the Learning and Engagement Center offers courses focusing on structural competency, allowing providers to gain an understanding of the terms, concepts and history associated with health equity, information about inclusive behaviors and best practices for the LGBTQ+ population, and the current demographics and prevalence of health disparities in the regions we serve. As we focus more on value-based care and community health, understanding the language and topics related to health equity is at the core of the work.

CareFirst Language Line Interpreter Services Data 2024 vs. 2023

In calendar year 2024, CareFirst received a total of 20,417 calls on its telephone line for interpreter assistance services through the language line. This was a very slight decrease of 345 calls compared to CY2023. However, it does represent a continuing trend in reduced calls to the Language Line for as long as we have been tracking and comparing, from 2021–2024. The distribution of callers by language did change somewhat. Calls for our top three languages decreased, and there was a broader distribution of requests for interpreter services in many other languages. Spanish translation had the largest number of requests for interpretation at nearly 90% of total calls. Spanish is also the language other than English spoken most frequently by our practitioners at 25%.

Table 13. Top five (5) languages requested in 2024, language line data

Language	Number of Calls	% of Total Calls
Spanish	18,241	89.34 %
Mandarin	520	2.54%
Korean	463	2.26%
Haitian Creole	252	1.23%
Russian	178	.871%

CareFirst received a total of 20,417 calls on its telephone line for interpreter assistance services (language line) in calendar year 2024, representing a 10.6% decrease in total calls from 2023. Approximately 90% of the requests for interpretation were for Spanish translations, representing a 20% increase from 2023. Next was Mandarin (2.54%), Korean (2.26%) and Haitian Creole (1.23%), all of which decreased substantially from the previous year. Russian [.871%] replaced Vietnamese as the fifth most requested language for interpreter services. (Table 13).

Table 14. Top 10 Languages Spoken (after English) by CareFirst physician network

Languages Spoken	Count	% of Total
Spanish	3,155	25.07%
Hindi	1,301	10.34%
French	874	6.94%
Urdu	682	5.42%
Korean	494	3.92%
Arabic	493	3.92%
Persian (Farsi)	472	3.75%
Punjabi	403	3.20%
Chinese	390	3.10%
Russian	268	2.13%

Presence of Bilingual Staff in Practitioner Offices

CareFirst reviewed reports abstracted from the CAQH ProView credentialing application to understand which network practitioners offered bilingual services in practices. Data gleaned from the reports indicate that over 5,071 practitioner offices provide translation and/or interpretation services in their offices (including over 167 different languages represented). Spanish was the most common second language available within network practices (supporting the most common language need of the CareFirst member population). Additionally, all hospital system partners provide interpretation and translation services to members as needed during a healthcare encounter.

CERL Analysis and Action Plan

Review of nationally available data sources (member demographic data and U.S. census data etc.) compared to CareFirst's member and provider demographic data, member experience data, complaint data, and practitioner access and availability data, suggests that CareFirst appropriately and adequately meets the assessed cultural, ethnic, racial and linguistic needs of its members.

Opportunities for improvement include:

1. Increase collection, storage and reporting of the member race/ethnicity, language and sexual orientation and gender identity data for the member population. This will help to ensure CareFirst can leverage member specific data as opposed to jurisdiction specific data during the evaluation process of the network. A multi-departmental team has been assembled to work on this project. CareFirst is developing IT infrastructure and systems to capture, store and report REL and SOGI data. Preliminary reporting of data will begin in 2026/2027.
2. To further awareness, sensitivity and inclusivity of our practitioners, CareFirst continues to build on training modules in our Learning and Engagement Center online resources. The Center offers an entire section dedicated to Health Equity and includes these current offerings: LGBTQ+ Cultural Competency; Structural Competence: Moving Beyond Stereotypes; Understanding Implicit Bias; and What's Happening in My Backyard? (which explores the history of inequality in healthcare within our service area).
3. CareFirst has made a commitment to foster economic mobility through our "West Baltimore Workforce Development initiative" in zip codes (21215, 21216, 21217) within our service areas that displayed poor health outcomes as well as disparity in the representation of black healthcare providers. In 2024, CareFirst embarked on its third workforce development cohort. This cohort, launched in October 2024, included a Community Health Worker (CHW) training and practicum. Five individuals from the community graduated from the four-month training in February 2025. These CHWs will re-enter the community in which they live to serve in a new capacity as a frontline public health worker, connecting trusted resources back to our members. In March 2025, 10 new community members will begin another CHW training and 15 customer service agents are starting two weeks later. Following this next training cohort, a group of engaged elected officials, non-profit/community/faith leaders will prioritize what CareFirst does next in terms of community engagement/economic inclusion programming.

CareFirst will continue to complete a Cultural, Ethnic, Racial and Linguistic (CERL) Assessment each year to evaluate the ability of the practitioner network to meet the need of the member population. Additionally, CareFirst will continue to encourage network practitioners to complete the cultural competency training educational offerings provided. CareFirst will also continue to make translation/interpretation services available to practitioners when providing care to CareFirst members.