Bridging the Gap: Community Health Centers and Geographic Inequities in Medicaid Healthcare Access

October 2025

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JAMA Health Forum™

Original Investigation

Medicaid Primary Care Utilization and Area-Level Social Vulnerability

Jordan Herring, PhD[1]; Yoon Hong Park, MPP[2]; Qian Luo, PhD[2] ;
Anushree Vichare, PhD[2]; Clese Erikson, MPA[2]; Patricia Pittman, PhD[2]

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Fitzhugh Mullan Institute for Health Workforce Equity

THE GEORGE WASHINGTON UNIVERSITY

This project was supported by the Bureau of Health Workforce (BHW), National Center for Health Workforce Analysis (NCHWA), Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $450,000, with zero percent financed with non-governmental sources. The contents are those of the author[s] and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS, or the U.S. Government.

Substantial variation in access to care in Medicaid

Key Question: How should resources be targeted to close need gaps?

- HPSAs, other similar definitions rely mostly on county-level supply factors

By Justin H. Markowski, Jacob Wallace, and Chima D. Ndumele

After 50 Years, Health Professional Shortage Areas Had No Significant Impact On Mortality Or Physician Density

DOI: 10.1377/hlthaff.2023.00478
HEALTH AFFAIRS 42,
NO. 11 (2023): 1507–1516

ABSTRACT **Since 1965, the US federal government has incentivized physicians to practice in high-need areas of the country through the designation of Health Professional Shortage Areas (HPSAs). Despite its being in place for more than half a century and directing more than a billion dollars annually, there is limited evidence of the HPSA program's effectiveness at reducing geographic disparities in access to care and health outcomes. Using a generalized difference-in-differences design with matching, we found no statistically significant changes in mortality or physician density from 1970 to 2018 after a county-level HPSA designation. As a result, we found that 73 percent of counties designated as HPSAs remained physician shortage areas for at least ten years after their inclusion in the program. Fundamental improvements to the program's design and incentive structure may be necessary for it to achieve its intended results.**

Justin H. Markowski (justin.markowski@yale.edu), Yale University, New Haven, Connecticut.

Jacob Wallace, Yale University.

Chima D. Ndumele, Yale University.

Substantial variation in access to care in Medicaid

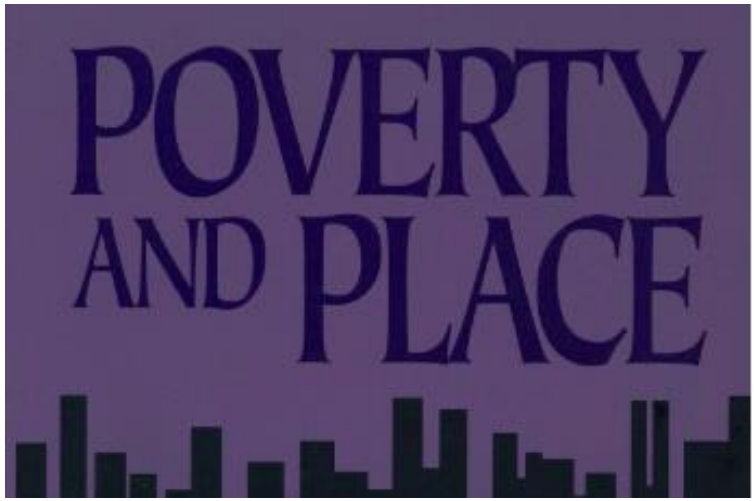
Key Question: How should resources be targeted to close need gaps?

- HPSAs, other similar definitions rely mostly on county-level supply factors

New approach: Can we target small-scale areas based on need and access gaps?

Conceptual Framework

Geographic factors related to variation in health care access

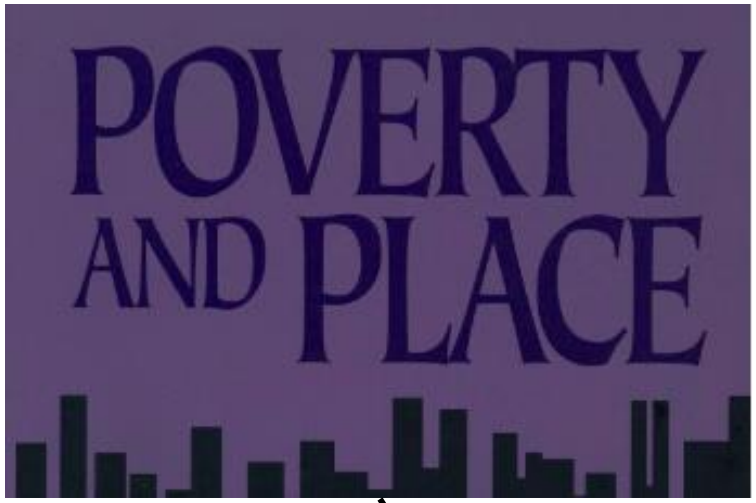


- Jargowsky (1997) Concentrated poverty
- American poverty becoming highly concentrated in certain areas – making *places* very important determinants of access to certain services.

- Sen (1999) Multidimensional disadvantage
- "Poverty"/disadvantage is much more than low incomes

Conceptual Framework

Geographic factors related to variation in health care access



- Extend framework of concentrated poverty to understand access issues, but with expanded definition of multidimensional disadvantage → ***concentrated multidimensional disadvantage***
- *Supported by the vast literature on SDOH

Research Questions:

1. How does the CDC’s Social Vulnerability Index (SVI) explain geographic variation in Medicaid primary care use?

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1. How does the **CDC's Social Vulnerability Index (SVI)** explain geographic variation in Medicaid primary care use?

*The SVI is a **multidimensional index** based on area-level variables.*

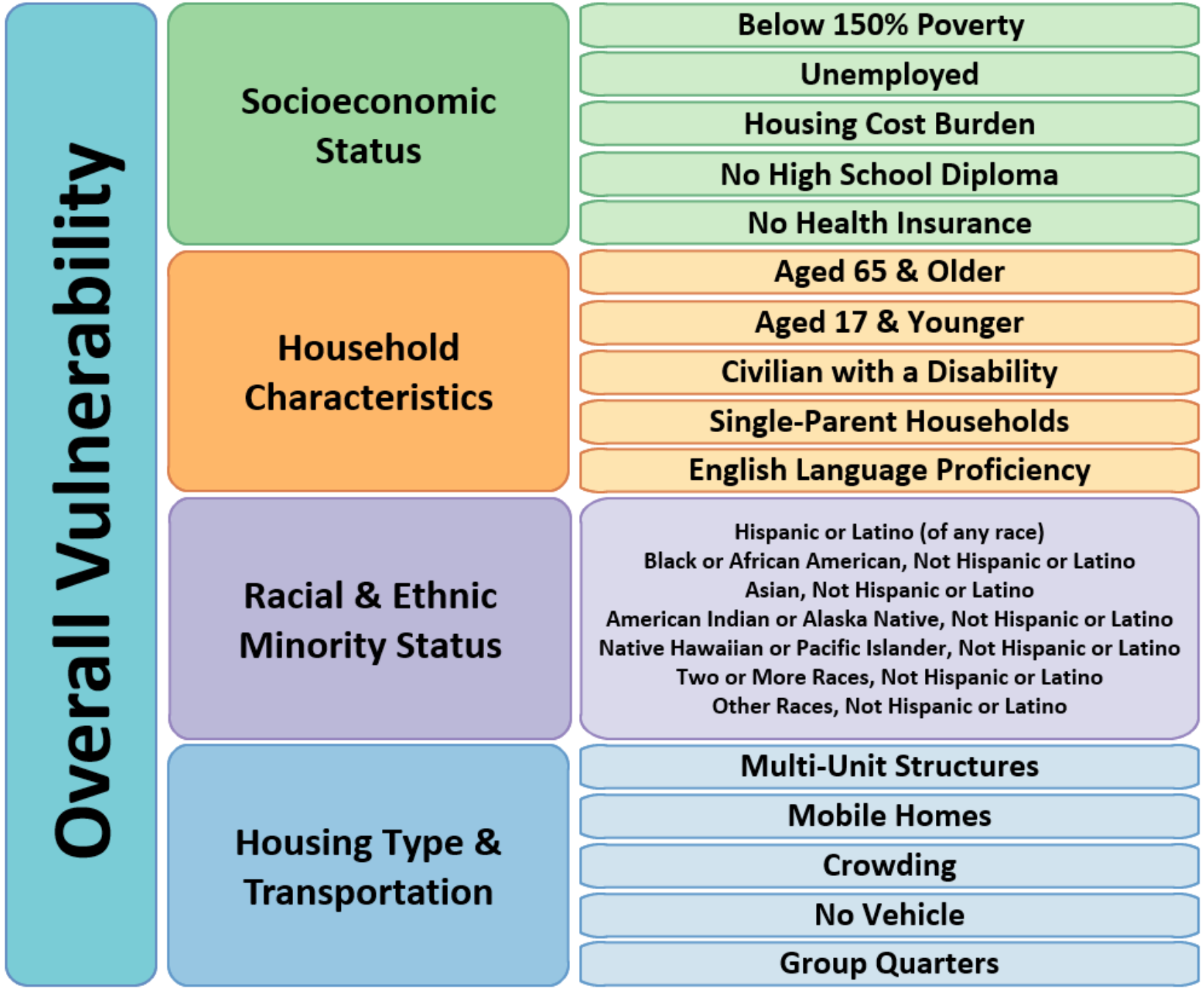
The CDC's Multidimensional SVI

SVI in action

The CDC/ATSDR SVI databases and maps can help communities prepare for and recover from public health emergencies, and prevent adverse effects among socially vulnerable populations, such as emotional distress, loss of property, illness, and death.

- Emergency planners use the SVI to decide the number of emergency personnel needed, plan the best way to evacuate people, and account for socially vulnerable populations.
- Public health officials use the SVI to identify areas in need of emergency shelters and estimate the amount of supplies needed.
- State and local health departments and non-profits use the SVI to guide community-based health promotion initiatives.

https://www.atsdr.cdc.gov/place-health/php/svi/index.html#cdc_generic_section_2-history


Overall Vulnerability
Socioeconomic Status
Below 150% Poverty
Unemployed
Housing Cost Burden
No High School Diploma
No Health Insurance
Household Characteristics
Aged 65 & Older
Aged 17 & Younger
Civilian with a Disability
Single-Parent Households
English Language Proficiency
Racial & Ethnic Minority Status
Hispanic or Latino (of any race)
Black or African American, Not Hispanic or Latino
Asian, Not Hispanic or Latino
American Indian or Alaska Native, Not Hispanic or Latino
Native Hawaiian or Pacific Islander, Not Hispanic or Latino
Two or More Races, Not Hispanic or Latino
Other Races, Not Hispanic or Latino
Housing Type & Transportation
Multi-Unit Structures
Mobile Homes
Crowding
No Vehicle
Group Quarters

Social indexes have grown in popularity in health services research

JAMA Network Open

Original Investigation | Health Policy

Area-Level Socioeconomic Disadvantage and Health Care Spending

A Systematic Review

Anna M. Morenz, MD[1,2]; Joshua M. Liao, MD, MSc[1,2,3,4]; David H. Au, MD[1,5]; Sophia A. Hayes, MD[1,5]

Govier et al. BMC Health Services Research (2022) 22:511
https://doi.org/10.1186/s12913-022-07858-x

BMC Health Services Research

RESEARCH ARTICLE Open Access

Differences in access to virtual and in-person primary care by race/ethnicity and community social vulnerability among adults diagnosed with COVID-19 in a large, multi-state health system

Diana J. Govier, Hannah Cohen-Cline, Katherine Marsi* and Sarah E. Roth

JAMA Network Open

Original Investigation | Psychiatry

Social Vulnerability and Risk of Suicide in US Adults, 2016-2020

Shuhan Liu, BA[1]; Samuel B. Morin, BA[1]; Natalie M. Bourand, BA[2]; Isabella L. DeClue[1]; Gustavo E. Delgado, BA[2]; Jiahe Fan, BSc[1]; Sabrina K. Foster, BA[2]; Maaz S. Imam, BS[2]; Coulter B. Johnston, BS[2]; Franklin B. Joseph, BA[3]; Yihao Lu, BA[4]; Ujjwal Sehrawat, BA[1]; Li Chun Su, BA[1]; Ketaki Tavan[1]; Kelly L. Zhang[1]; Xingruo Zhang, BS[4]; Loren Saulsberry, PhD[4]; Robert D. Gibbons, PhD[4,5]

American Journal of Preventive Medicine

RESEARCH ARTICLE

State-Level Social Vulnerability Index and Healthcare Access: The Behavioral Risk Factor Surveillance System Survey

Mahmoud Al Rifai, MD, MPH,[1] Vardhmaan Jain, MD,[2] Safi U. Khan, MD, MS,[3] Anupama BK, MD,[1] Jamal H. Mahar, MD,[1] Chayakrit Krittanawong, MD,[1] Shiva Raj Mishra, MPH,[4] Sourbha S. Dani, MD, MSc,[5] Laura A. Petersen, MD, MPH,[6,7] Salim S. Virani, MD, PhD[1,6,7,8]

JAMA Network Open

Original Investigation | Public Health

County-Level Social Vulnerability and Breast, Cervical, and Colorectal Cancer Screening Rates in the US, 2018

Cici Bauer, PhD, MS[1]; Kehe Zhang, MS[1]; Qian Xiao, PhD, MS[2]; Jiachen Lu, MS[1]; Young-Rock Hong, PhD, MPH[3,4]; Ryan Suk, PhD, MS[5]

JAMIA Open, 4(4), 2021, 1–11
https://doi.org/10.1093/jamiaopen/ooab111
Research and Applications

AMIA

Research and Applications

Estimating the effects of race and social vulnerability on hospital admission and mortality from COVID-19

Joshua M. Landman[1,2], Karen Steger-May[3], Karen E. Joynt Maddox[4], Gmerice Hammond[4], Aditi Gupta[1,3], Adriana M. Rauseo[5], Min Zhao[1], and Randi E. Foraker[1,6]

JAMA Network Open

Research Letter | Public Health

Pharmacy Accessibility and Social Vulnerability

Giovanni Catalano, MD[1]; Muhammad Muntazir Mehdi Khan, MBBS[1]; Odysseas P. Chatzipanagiotou, MD[1]; Timothy M. Pawlik, MD, PhD, MPH, MTS, MBA[1]

HealthAffairs Topics Journals Forefront Podcasts

REVIEW ARTICLE

HEALTH AFFAIRS > VOL. 41, NO. 12: EQUITABLE SOCIAL SUPPORTS & MORE

REVIEW ARTICLE

Use Of Area-Based Socioeconomic Deprivation Indices: A Scoping Review And Qualitative Analysis

Stephen Trinidad, Cole Brokamp, Andres Mor Huertas, Andrew F. Beck, Carley L. Riley, Erika Rasnick, Richard Falcone, and Meera Kotagal

AFFILIATIONS

PUBLISHED: DECEMBER 2022 Full Access https://doi.org/10.1377/hlthaff.2022.00482

THE MILBANK QUARTERLY

A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Original Scholarship

Assessment of Population-Level Disadvantage Indices to Inform Equitable Health Policy

KAMARIA KAALUND, ANDREA THOUMI, NRUPEN A. BHAVSAR, AMY LABRADOR, RUSHINA CHOLERA

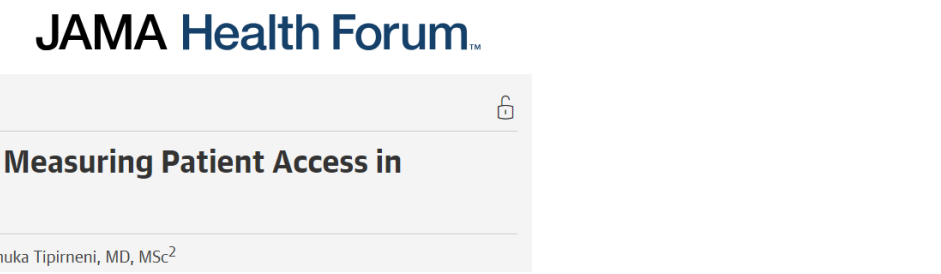
First published: 01 December 2022 | https://doi.org/10.1111/1468-0009.12588 | Citations: 21

Research Questions:

1. How does the CDC's Social Vulnerability Index (SVI) explain geographic variation in Medicaid primary care use?

Utilization doesn't necessarily = Access

But, maybe it can be a good proxy.



Actual patterns of health care use reflect access to care. Even though the quality of Medicaid claims collected and reported by states has improved in recent years, the data they provide are not always comparable across states or with other payers; research using all-payer claims databases can put Medicaid use patterns in context with other types of insurance.[8]

Research Questions:

1. How does the CDC's Social Vulnerability Index (SVI) explain geographic variation in Medicaid primary care use?

2. How do **federally qualified health centers (FQHCs)** contribute to closing access gaps in socially vulnerable areas?

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The Community Health Center Story

https://www.chcchronicles.org/histories

The Earliest Days

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Outreach worker with child at Las Cruces Migrant Health Project, Las Cruces, New Mexico, 1963 Courtesy of the National Center for Farmworker Health

American Economic Review
ISSN 0002-8282 (Print) | ISSN 1944-7981 (Online)

The War on Poverty's Experiment in Public Medicine: Community Health Centers and the Mortality of Older Americans

Martha J. Bailey

Andrew Goodman-Bacon

AMERICAN ECONOMIC REVIEW
VOL. 105, NO. 3, MARCH 2015
(pp. 1067–1104)

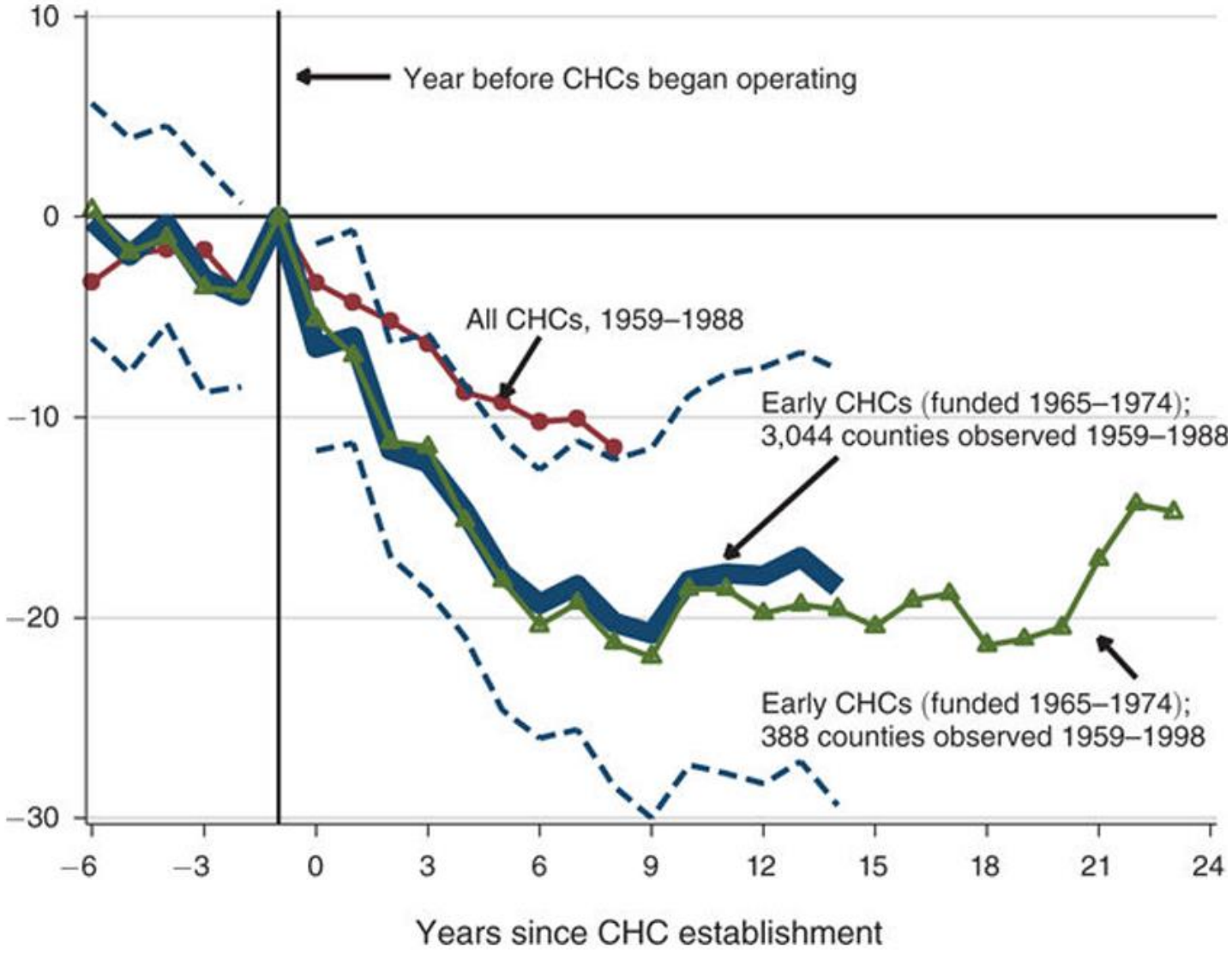

Figure 5.
The Relationship between Community Health Centers and Mortality Rates

American Economic Review
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This paper uses the rollout of the first Community Health Centers (CHCs) to study the longer-term health effects of increasing access to primary care. Within ten years, CHCs are associated with a reduction in age-adjusted mortality rates of 2 percent among those 50 and older. The implied 7 to 13 percent decrease in one-year mortality risk among beneficiaries amounts to 20 to 40 percent of the 1966 poor/non-poor mortality gap for this age group. Large effects for those 65 and older suggest that increased access to primary care has longer-term benefits, even for populations with near universal health insurance. (JEL H75, I12, I13, I18, I32, I38, J14)

Research Questions:

1. How does the CDC's Social Vulnerability Index (SVI) explain geographic variation in Medicaid primary care use?

2. How do federally qualified health centers (FQHCs) contribute to closing access gaps in socially vulnerable areas?

Research Approach

- Data
  - 2019 Medicaid claims from TAF for 36 states; SVI replicated at zip code level from Franchi et al.
  - Beneficiaries <65 years old, non-dually eligible for Medicare, enrolled in Medicaid all calendar year
- Primary Care Identification
  - Adapted activity-based classification approach from O'Reilly-Jacob et al. to identify primary care clinicians – count all visits with these clinicians as primary care visits
- FQHCs
  - Identified organizational NPIs corresponding to FQHCs – taxonomy codes, matching algorithms, and a lot of manual matching
  - Count all E&M services at FQHCs as primary care

Table. Descriptive Statistics of the Analytical Sample of 34 890 932 Medicaid or Children Health Insurance Plan Beneficiaries[a]

Characteristic	%	% With a primary care visit		
		Any	Non-FQHC	FQHC
Total (N = 34 890 932)	100.0	68.1	61.1	12.7
Sex				
Female	54.2	69.4	62.3	13.5
Male	45.8	66.4	59.6	11.8
Disability				
No disability	89.5	67.5	60.6	12.5
Has disability	10.5	72.5	65.6	14.6
Age group, y				
1-9	29.7	79.1	72.4	12.0
10-19	29.0	69.1	62.0	11.9
20-29	12.1	52.3	46.0	12.0
30-39	11.5	56.4	50.0	13.1
40-49	7.7	61.8	54.6	14.4
50-59	7.1	69.0	60.5	16.5
60-64	2.9	71.5	62.7	16.4

Research Approach

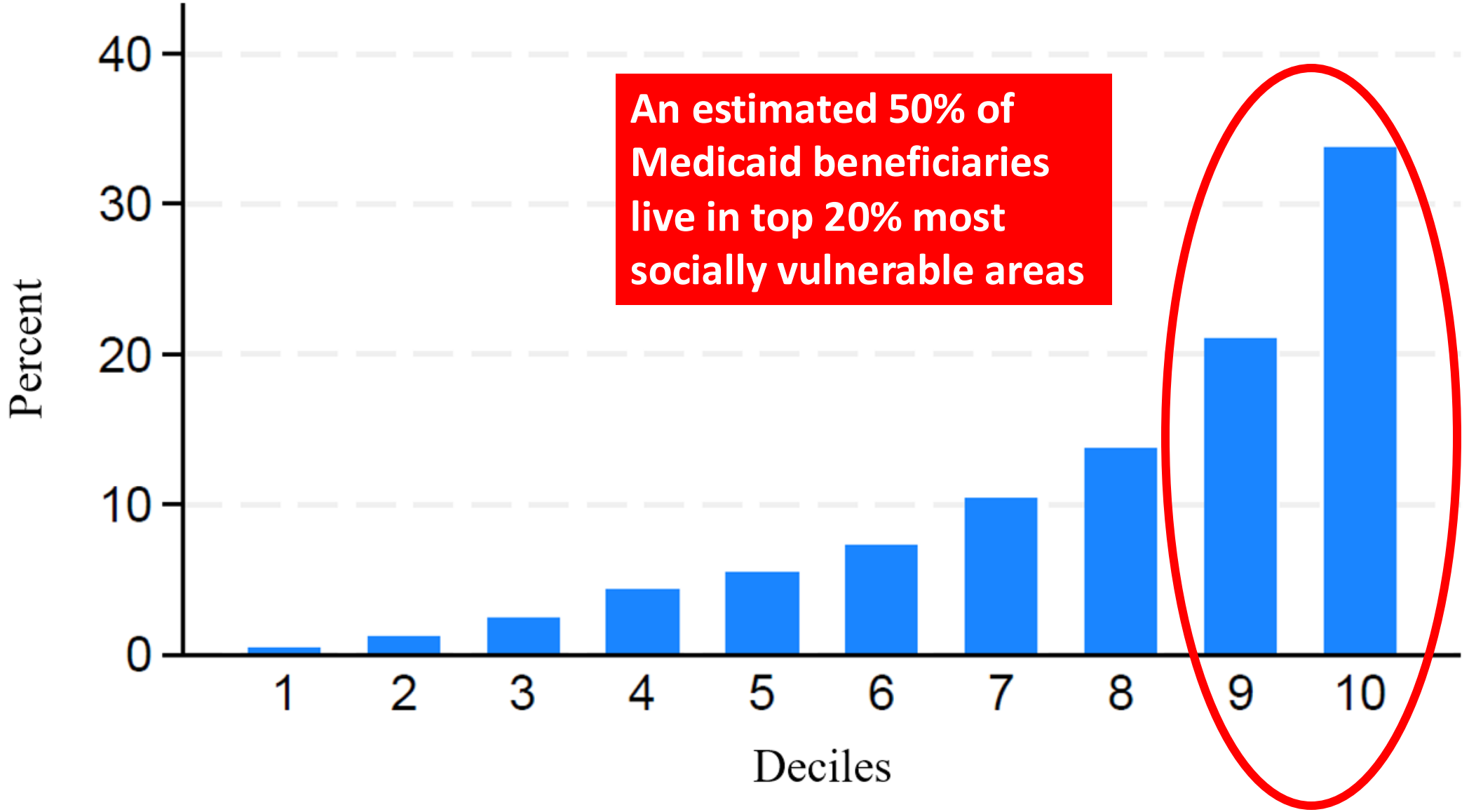
- Statistical Analysis
  - Sorted beneficiaries into SVI deciles based on zip codes (using zip code-based SVI from Franchi et al.)
  - Calculated distribution of beneficiaries across SVI deciles
  - Regression approach to calculated adjusted access gaps by SVI deciles

  - Outcomes (probability)
    - Having any primary care visit (non-FQHC and FQHC)
    - Having a primary care visit at non-FQHC
    - Having a primary care visit at an FQHC

  - Controlling for beneficiary-level sex, age, and diagnoses of chronic health conditions

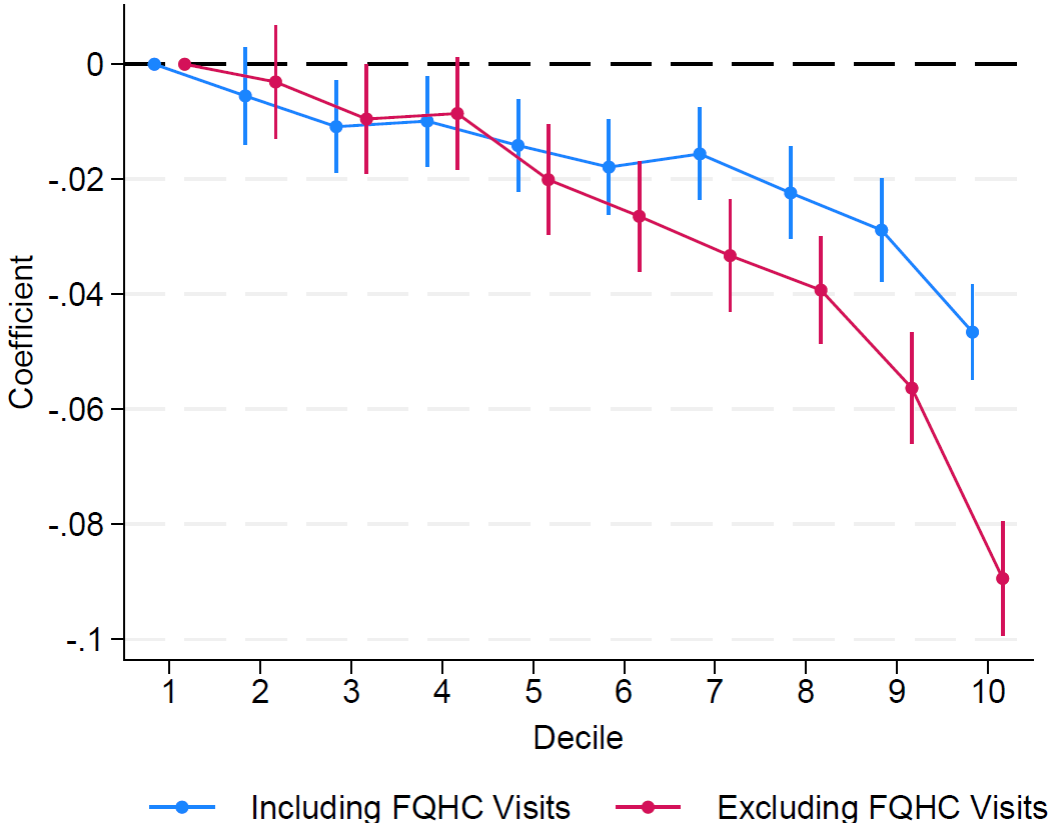
  - Main exposure: SVI deciles (omitting 1st decline/least vulnerable for reference in the regressions)

Medicaid beneficiaries are concentrated in socially vulnerable areas

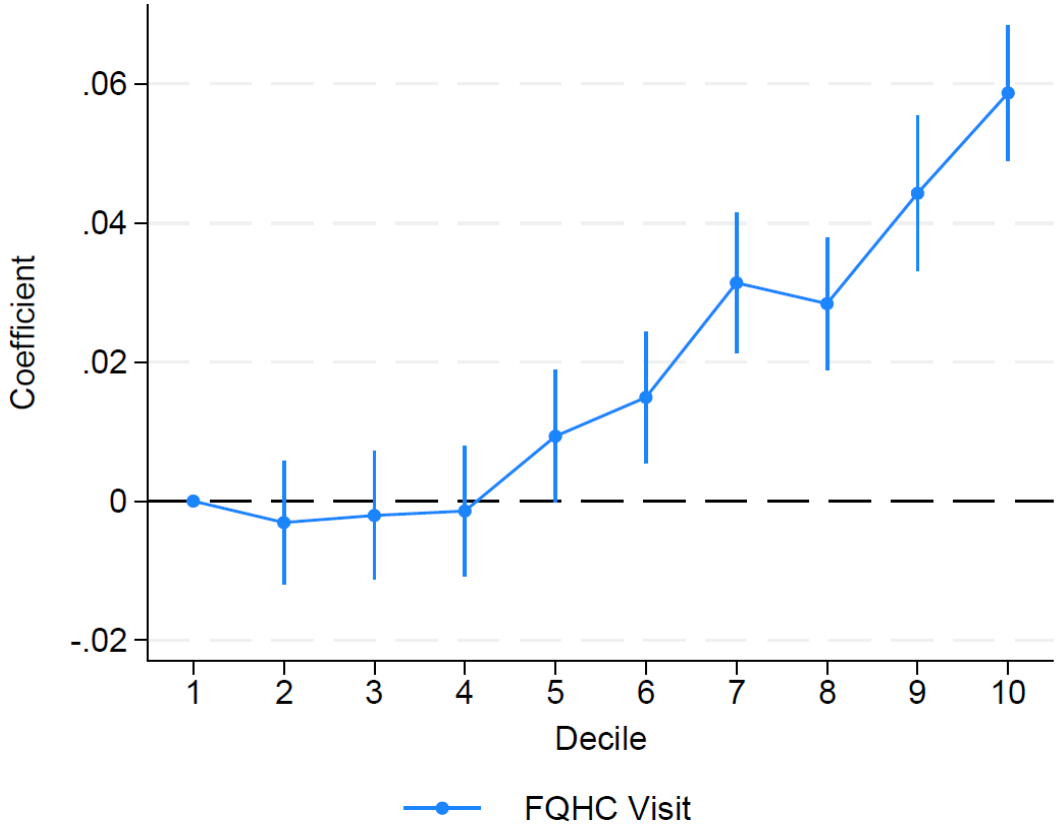


Main Results: Variation in primary care by SVI

Probability of primary care visit decreases with social vulnerability



Probability of FQHC visit increases with social vulnerability



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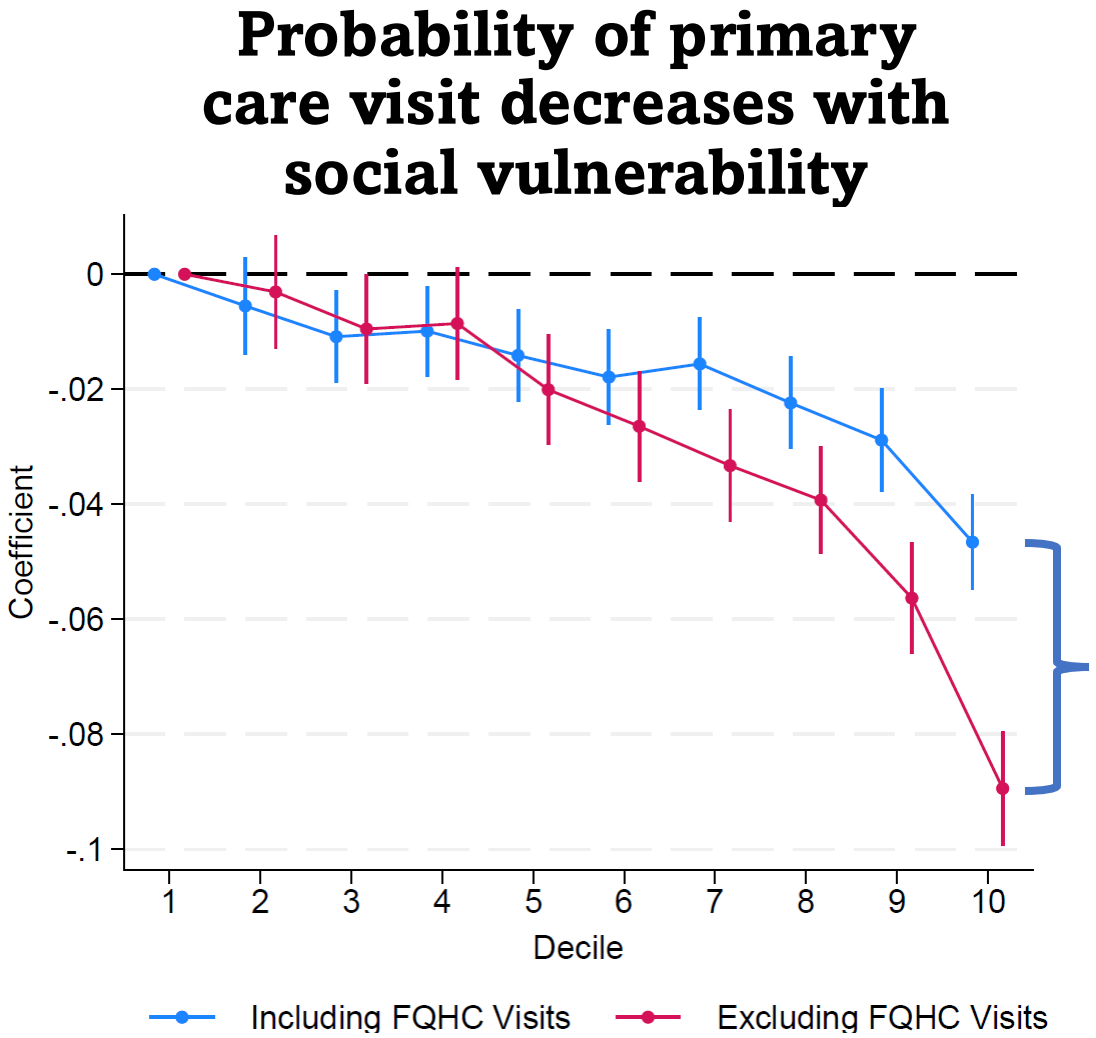

Bridging the access gap:

- **FQHCs essentially reduce the disparity between the most and least socially vulnerable areas by over 50%**

Summary of Findings

- SVI explains part of the substantial geographic variation in utilization – **highly vulnerable communities have lower probabilities of having a primary care visit**

- FQHC utilization increases with SVI
  - Non-FQHC utilization disparity: 8.9 pp
  - Including FQHCs disparity falls to 4.7 pp – reducing disparity by over half

- SVI also identifies higher concentrations of beneficiaries than the simple income-based poverty rate, and a slightly higher disparity in magnitude

Discussion

FQHC finding consistent with and builds on prior literature


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RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 36, NO. 1: COVERAGE EXPANSION, ACCOUNTABLE CARE & MORE

At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality Of Care

Megan B. Cole, Omar Galárraga, Ira B. Wilson, Brad Wright, and Amal N. Trivedi

AFFILIATIONS

PUBLISHED: JANUARY 2017 Full Access https://doi.org/10.1377/hlthaff.2016.0804


HSR Health Services Research

Research Article

Expanding Federal Funding to Community Health Centers Slows Decline in Access for Low-Income Adults

Stacey McMorrow, Stephen Zuckerman

First published: 18 December 2013 | https://doi.org/10.1111/1475-6773.12141 | Citations: 13


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RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 31, NO. 8: CHALLENGES FACING THE SAFETY NET

Integrating Community Health Centers Into Organized Delivery Systems Can Improve Access To Subspecialty Care

Katherine Neuhausen, Kevin Grumbach, Andrew Bazemore, and Robert L. Phillips

AFFILIATIONS

PUBLISHED: AUGUST 2012 Full Access https://doi.org/10.1377/hlthaff.2011.1261


American Journal of Preventive Medicine

RESEARCH ARTICLE

Screening for Social Risk at Federally Qualified Health Centers: A National Study

Megan B. Cole, PhD, MPH,[1] Kevin H. Nguyen, PhD,[2] Elena Byhoff, MD, MS,[3] Genevra F. Murray, PhD[4]


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RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 34, NO. 1: VARIETY ISSUE

Community Health Centers Employ Diverse Staffing Patterns, Which Can Provide Productivity Lessons For Medical Practices

Leighton Ku, Bianca K. Frogner, Erika Steinmetz, and Patricia Pittman

AFFILIATIONS

PUBLISHED: JANUARY 2015 Full Access https://doi.org/10.1377/hlthaff.2014.0098

FQHC finding consistent with and builds on prior literature

RESEARCH BRIEF

HSR Health Services Research

Mental health care provision in community health centers and hospital emergency department utilization

Kathleen Carey PhD | Megan B. Cole PhD

Principal Findings: CHC mental health utilization increased approximately 100% during 2012–2019. Increased CHC mental health provision was associated with small reductions in ED mental health utilization. An annual increase of 1000 CHC mental health care visits (5%) was associated with 0.44% fewer ED mental health care visits ($p = 0.153$), and an increase of 1000 CHC mental health care patients (15%) with 1.9% fewer ED mental health care visits ($p = 0.123$). An increase of 1 annual mental health visit per patient was associated with 16% fewer ED mental health care visits ($p = 0.011$).

The Development of Today's FQHC/CHC Landscape

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Federally Qualified Health Centers Established In Medicaid, Medicare

1987 - 1992: Medicare and Medicaid "Federally Qualified Health Centers" and FTCA Coverage

President George H. Bush proposes health center expansion, increasing federal funding by more than $150 million. Congress centralizes health centers' grants administration, establishes Federally Qualified Health Centers (FQHCs) in both Medicaid and Medicare (making services a guaranteed benefit and requiring cost-based payments), and extends malpractice coverage

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Prospective Payment System

2000: Medicaid FQHC Payments Preserved; Health Center Funding Reaches $1 Billion

Congressional health center supporters stave off the phase-out of Medicaid FQHC payments, replacing it with a Prospective Payment System (PPS) that establishes a per-visit payment syststem to avoid huge revenue losses. NACHC and its members introduce the REACH initiative proposing to double health center funding over 5 years. Both Presidential candidates - Bill Bradley and George W. Bush - embrace REACH and more than 60 percent of Congress support the initial steps. Federal funding for health centers surpasses $1 billion.

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Health Center Program Reauthorization

2001 - 2002: Health Centers Programs Reauthorized and Expanded

President George W. Bush fulfills his campaign pledge by calling for 5-year initiative to increase health center funding by $700 million. Congress unanimously reauthorizes the Health Center Program (S. 1533), boosting federal funding for health centers by $175 million in first year, exceeding President Bush's request

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Health Center Program Reauthorization

2001 - 2002: Health Centers Programs Reauthorized and Expanded

Investment And Bold Expansion

2009: Historic Health Center Investment as an Economic Stimulus

Within the first month of new President Barack Obama's term, Congress reauthorizes (and renames) CHIP; expansion reaches 4 million additional children and incorporates FQHC payment rules. The American Reinvestment and Recovery Act (ARRA) delivers the single largest investment in health center history, providing $2 billion in direct CHC funding to cover the costs of caring for new patients and the capital expenditures required to support expansion, and $300 million for NHSC, Medicaid funding expansions that include assistance to health centers approaching an additional $1 billion for HIT adoption.

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Health Center Program Reauthorization

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Investment And Bold Expansion

2009: Historic Health Center Investment as an Economic Stimulus

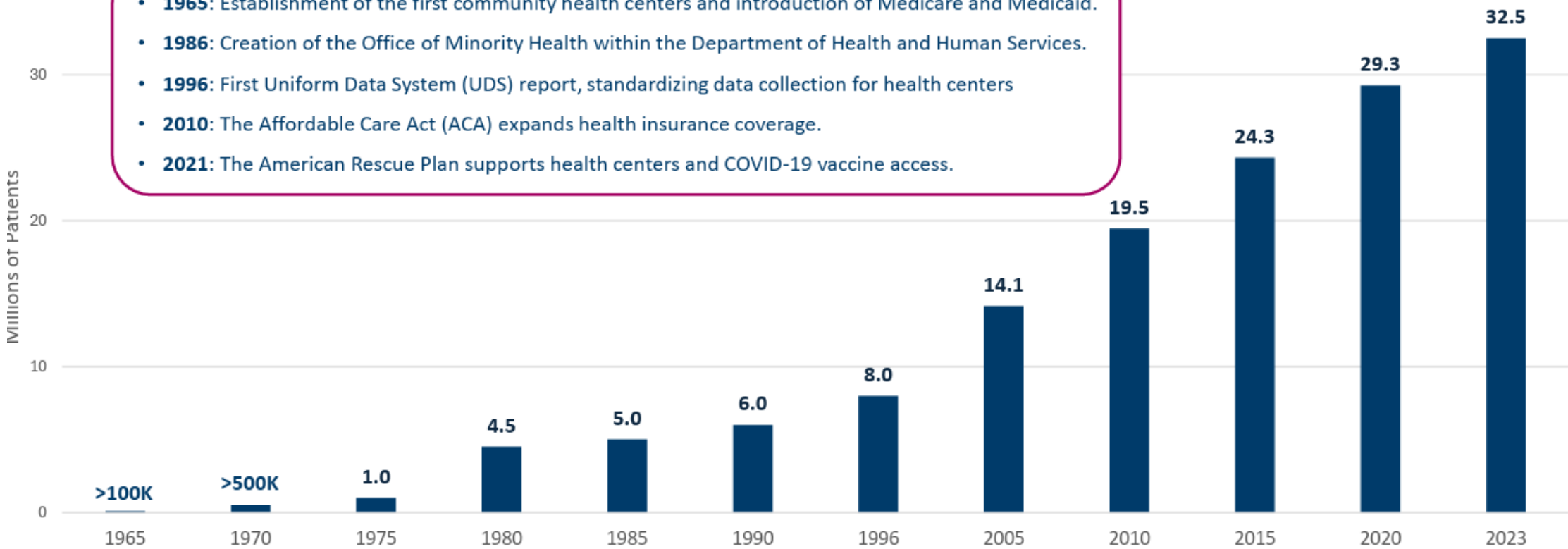
Health Reform

2010: Celebrating 45 years of CHC History as Historic Health Reform is Approved

Health reform becomes law in March 2010 with the passage of the Affordable Care Act (ACA), and community health centers feature prominently in a landmark program to expand access, improve quality, and reduce the cost of care for all Americans. In addition to key Medicaid expansions and payment protections, the ACA provides for $11 billion in increased CHC funding over the next five years, to enable health centers to double capacity, and $1.5 billion for National Health Service Corps over five years to substantially expand the number of clinicians in underserved areas.

Growth of Health Centers: From Under 100K Patients in 1965 to Over 32 Million in 2023

- **1965**: Establishment of the first community health centers and introduction of Medicare and Medicaid.
- **1986**: Creation of the Office of Minority Health within the Department of Health and Human Services.
- **1996**: First Uniform Data System (UDS) report, standardizing data collection for health centers
- **2010**: The Affordable Care Act (ACA) expands health insurance coverage.
- **2021**: The American Rescue Plan supports health centers and COVID-19 vaccine access.

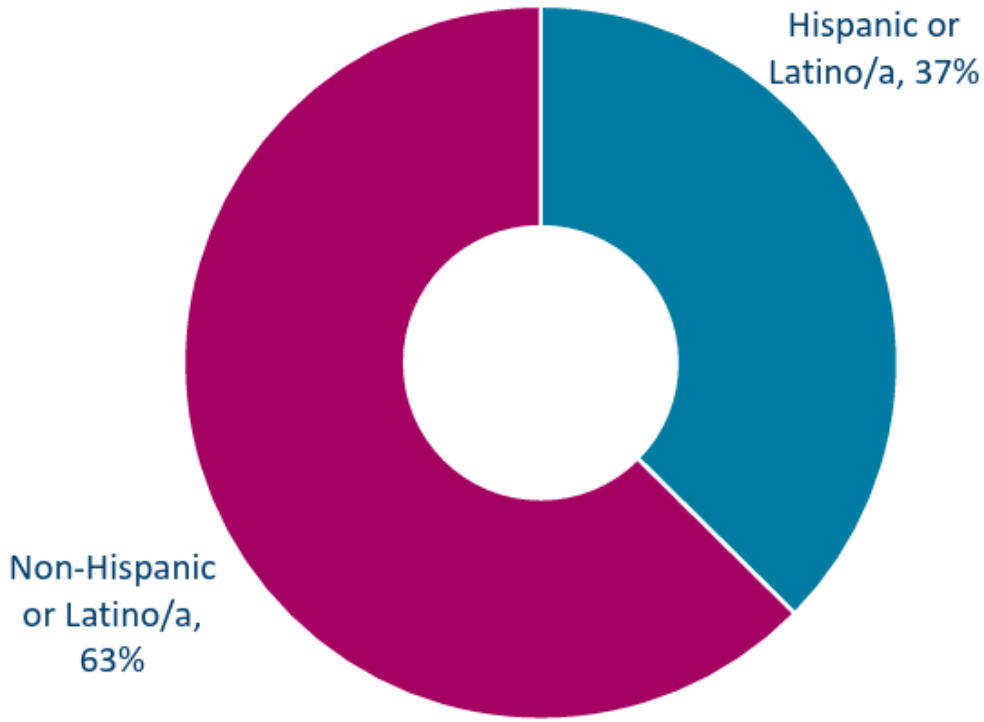


NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

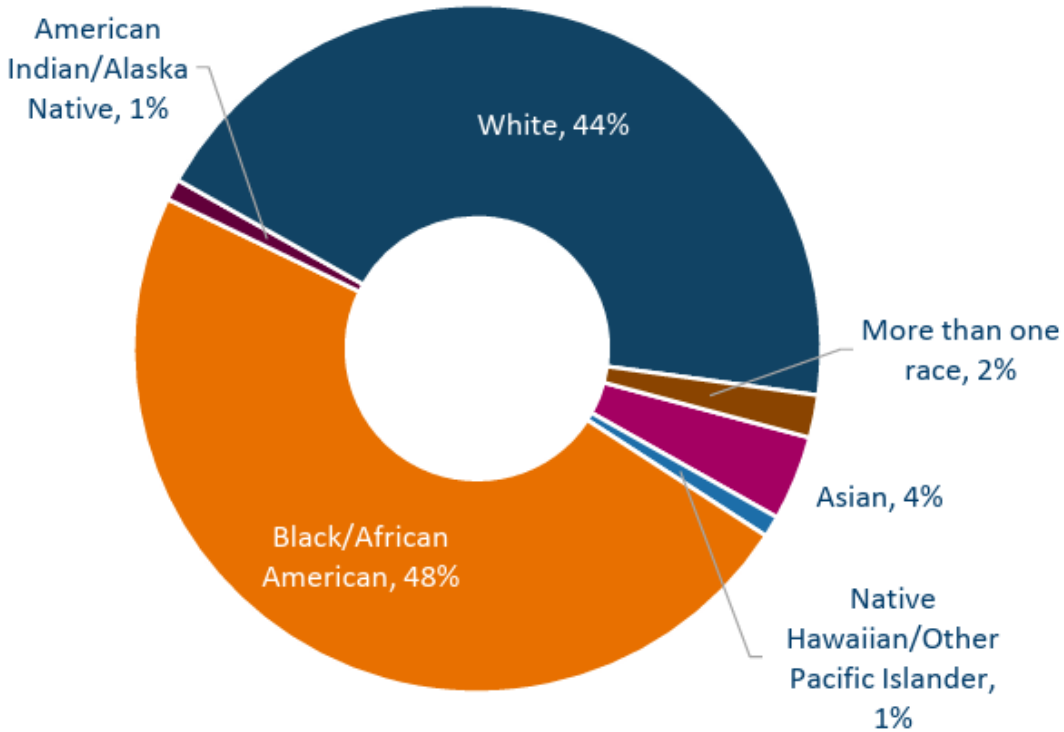
https://www.nachc.org/resource/2025-uniform-data-system-chartbook-analysis-of-the-2023-uds-data/

Health Centers Serve a Diverse Patient Population

Patient Ethnicity



Patient Race



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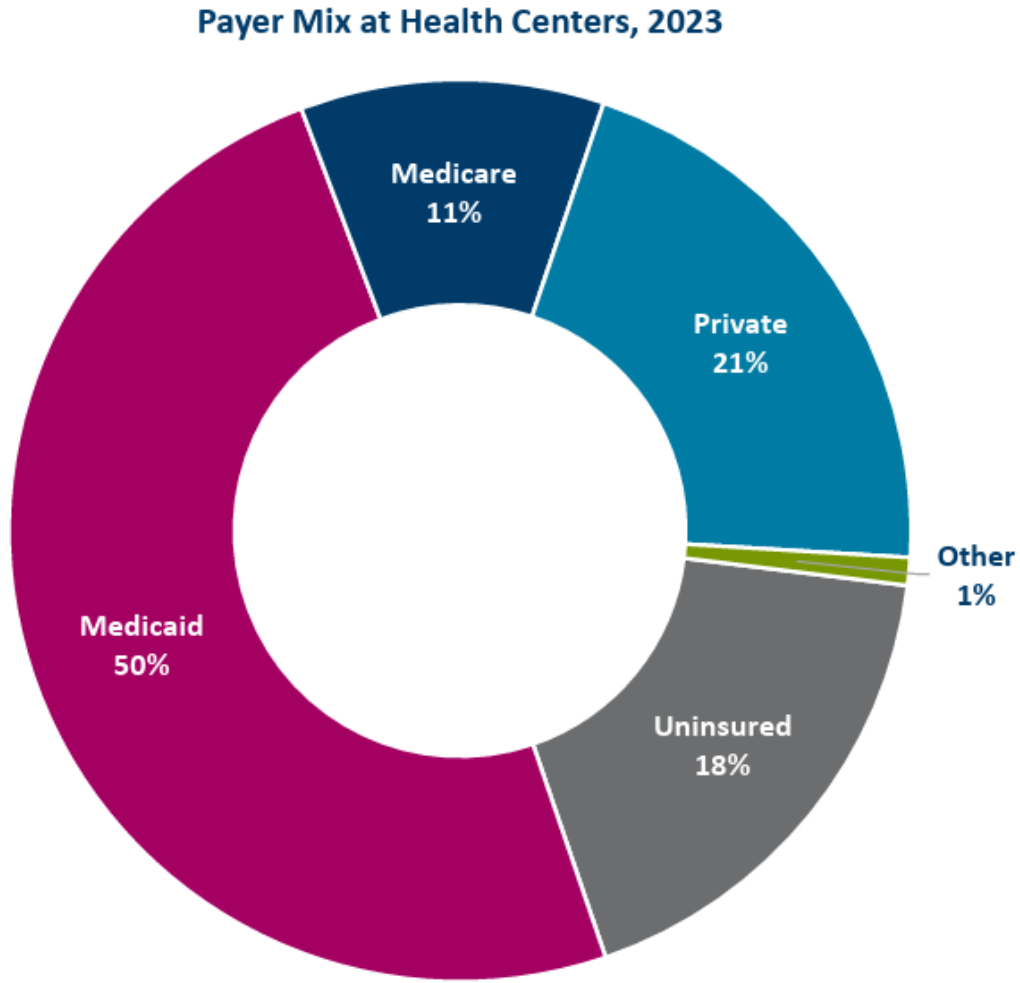
https://www.nachc.org/resource/2025-uniform-data-system-chartbook-analysis-of-the-2023-uds-data/

Health Centers Heavily Rely on Federal and State Funds for Revenue in 2023

- Medicaid's 50% Share Highlights Heavy Dependence on Public Funding.

- With an 18% Uninsured Rate, Health Centers Face Potentially High Costs for Uncompensated Care.



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Policy Implications

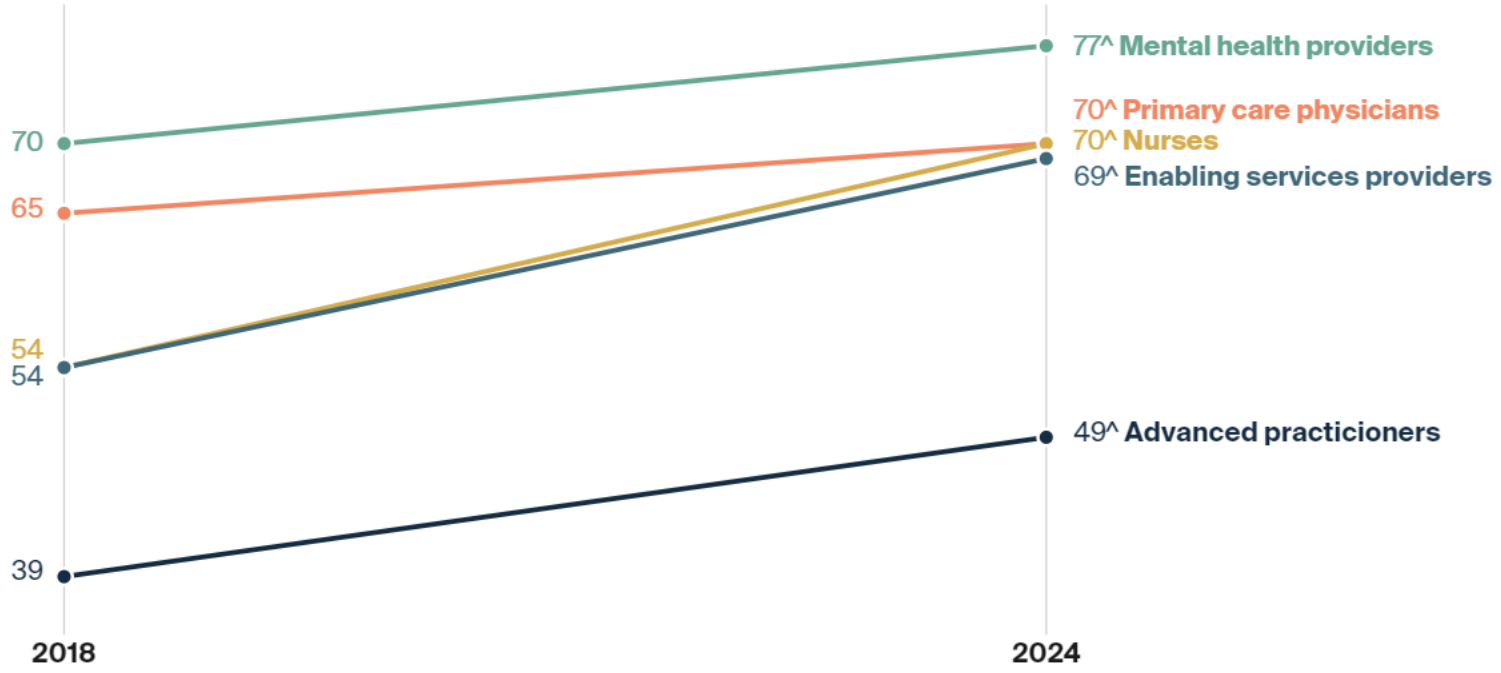
- Geographic inequities persists – even ***within*** the Medicaid population
  - Many discussions center on comparisons of Medicaid vs. other payers
  - But we focuses on within variation – showing that geography continues to shape health care access beyond payer type

- Addressing geographic inequities through policy with small-scale indexes
  - Value-based payment models – "bonus" payments for providing care to certain areas
  - Workforce policies – NHSC, loan repayment, incentive programs to practice in these socially vulnerable areas
  - **Simply expand the FQHC program**
    - Increase capacity at current FQHCs
    - Increase the number and distribution of FQHCs across the country
    - Adequately provide support for the FQHC workforce (wages/salaries, benefits, etc.)
    - **FQHCs strategically locate in underserved and vulnerable areas – let's get more of them to continue doing that!**

Addressing FQHC Challenges

Since 2018, community health center workforce shortages have increased for all types of providers.

Percent who responded "yes" when asked if there are currently shortages of the following types of personnel at their largest site:



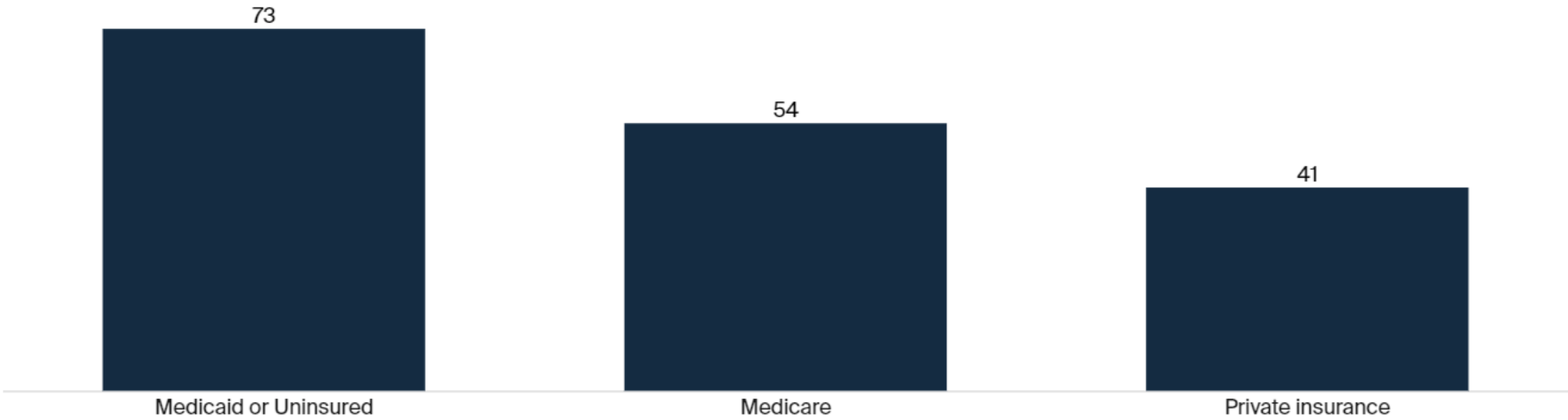
Source: Celli Horstman et al., *Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs: Findings from the Commonwealth Fund 2024 National Survey of Federally Qualified Health Centers* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/wmta-a282

The Commonwealth Fund

Addressing FQHC Challenges

In 2024, most community health centers struggle to obtain specialist or subspecialist appointments for uninsured patients and those enrolled in Medicaid.

Percent who responded that it was "somewhat difficult" or "very difficult" for providers to obtain timely appointments for office visits with specialists or subspecialists outside their health care organization, for patients with each of the following types of coverage:



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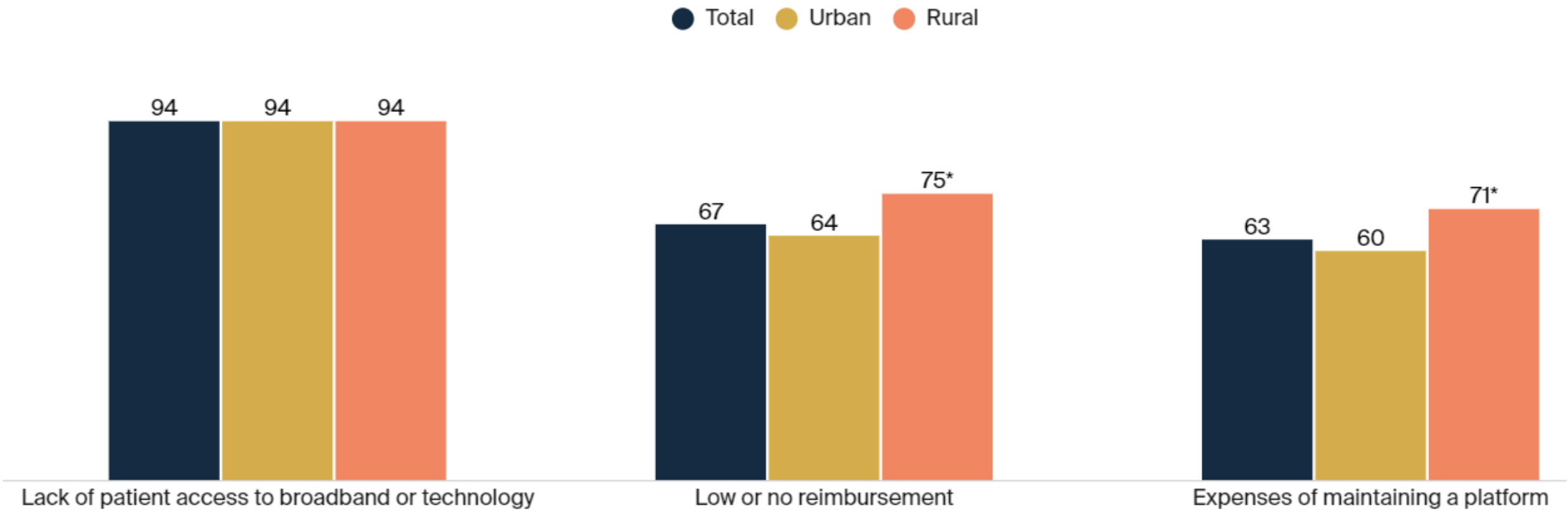
The Commonwealth Fund

Addressing FQHC Challenges

Lack of patient access to necessary technology is a challenge to community health centers providing telehealth in 2024.

Percent who responded that each of the following was a "major challenge" or "minor challenge" when using telehealth at their largest site:



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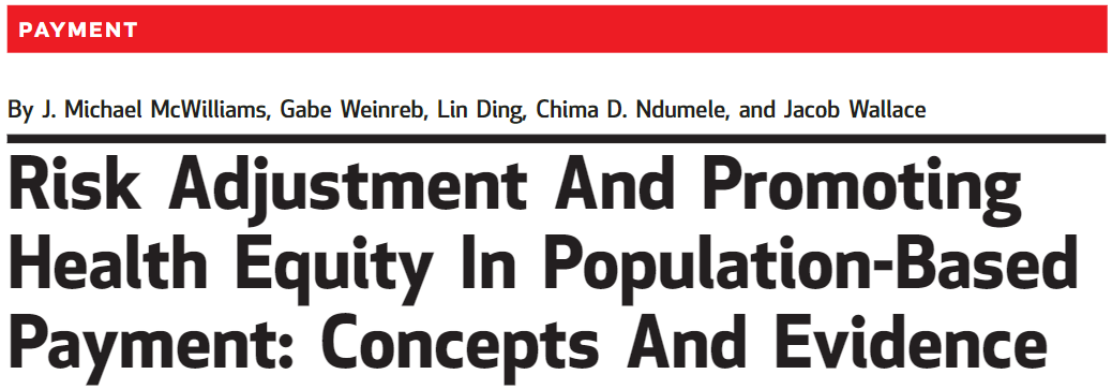
The Commonwealth Fund

Policy Implications

- Why target areas rather than individuals?


PAYMENT

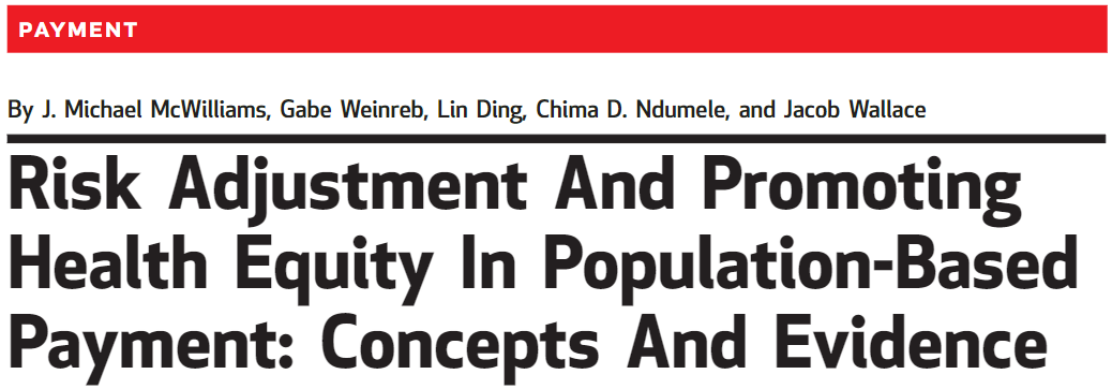
By J. Michael McWilliams, Gabe Weinreb, Lin Ding, Chima D. Ndumele, and Jacob Wallace

Risk Adjustment And Promoting Health Equity In Population-Based Payment: Concepts And Evidence

Although payment adjustments at the community level may be considered poorly targeted when the intention is to benefit a subgroup of residents, they may nevertheless be important complements to individual-level adjustments. The latter are critical to establish incentives for MA plans or ACOs to compete for underserved patients. For plans or ACOs to act effectively on those incentives, however, they must include providers serving those patients' communities. Payment reallocations at the area level may have greater influence on market entry and network inclusion decisions made by plans and ACOs.

Policy Implications

- Why target areas rather than individuals?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Policy Implications

- Why target areas rather than individuals?

Substantial implications for how we understand variation in health access and outcomes

JAMA Health Forum™

Original Investigation

Validating 8 Area-Based Measures of Social Risk for Predicting Health and Mortality

Aubrey Limburg, PhD; David H. Rehkopf, ScD; Nicole Gladish, PhD; Robert L. Phillips, MD; Victoria Udalova, PhD

CONCLUSIONS AND RELEVANCE In this cross-sectional study, area-based measures predicted health outcomes better than individual socioeconomic measures, and generally predicted health equitably across subpopulations; thus, their use should be considered in conjunction or instead of using individual-level measures for selected health policy applications.

Concluding Remarks

- We used zip code-level social vulnerability to help explain geographic variation in primary care utilization in Medicaid – finding a strong relationship

- Research innovation
  - Research with TAF is in its infancy – quantifying primary care utilization and identifying FQHC utilization highly novel
  - Primary care identification came from actual provider activity – broadening the definition of what we conventionally identify as “primary care”
  - Quantified the direct contribution of FQHCs to closing access gaps

- Many opportunities to address inequities
  1. Use small-scale indexes (eg, the SVI) in policy for incentives
  2. Increase FQHC support widely

Thank you!

Bridging the Gap: Community Health Centers and Geographic Inequities in Medicaid Healthcare Access

October 2025

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JAMA Health Forum™

Original Investigation

Medicaid Primary Care Utilization and Area-Level Social Vulnerability

Jordan Herring, PhD[1]; Yoon Hong Park, MPP[2]; Qian Luo, PhD[2] ;
Anushree Vichare, PhD[2]; Clese Erikson, MPA[2]; Patricia Pittman, PhD[2]

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