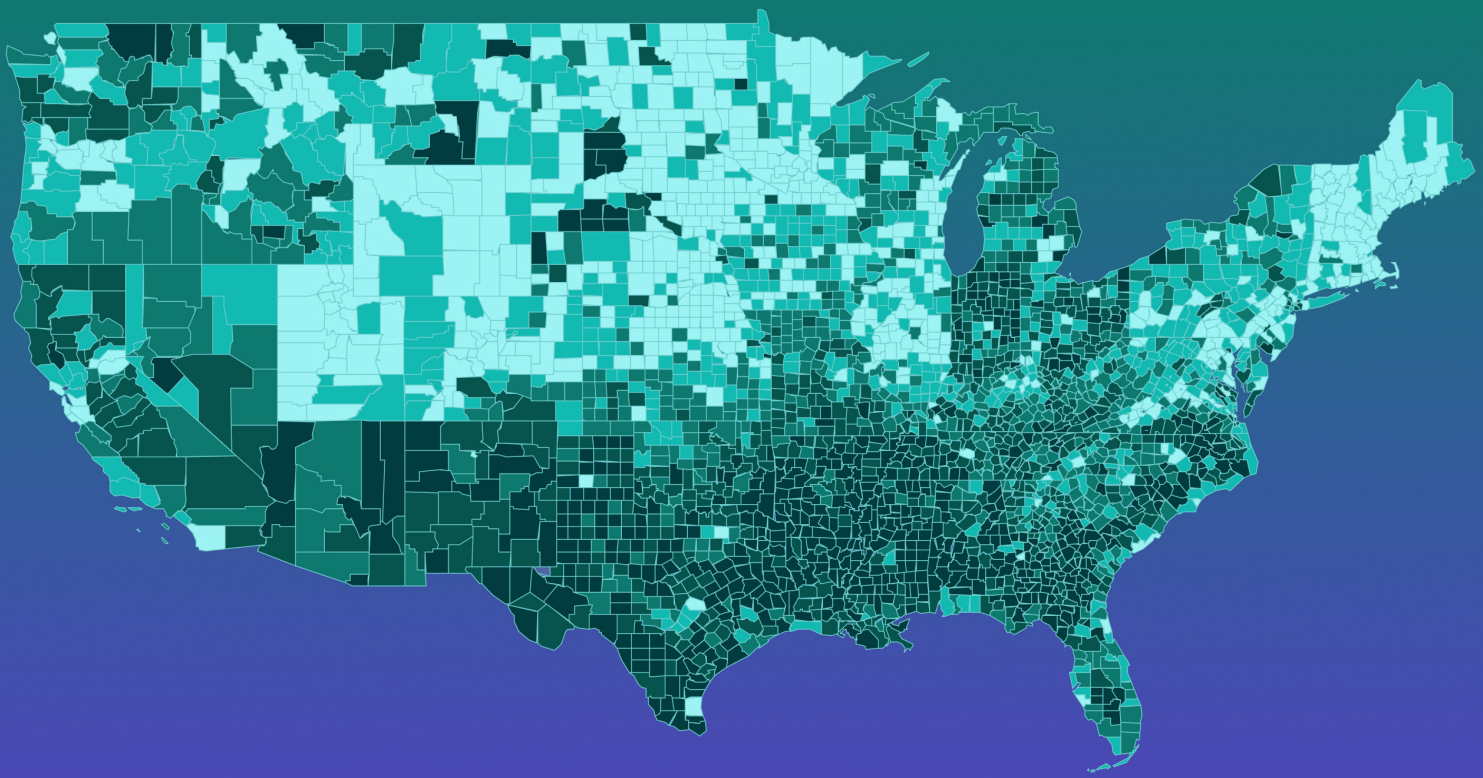
Youth Mental Health Tracker
SURGO HEALTH

Fractured Futures:

ThriveAtlas™ Maps the Risk to Youth Mental Health Amid Looming Medicaid Cuts



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Executive Summary

Every young person deserves a chance to thrive, no matter where they live.

But risks to youth mental health and wellbeing are not evenly distributed. Surgo Health's survey of over 4,500 youth aged 10-24 across the United States identified key upstream factors that influence young people's ability to thrive, including physical health, financial hardships, negative life experiences, social support and belonging, and barriers to care when youth do need help[1]. ThriveAtlas™ brings together eight existing data sources, outside of the survey, to measure how prevalent these factors are in every community across the U.S. This report provides the **first congressional district-level view of youth mental health and wellbeing risk** in the U.S., offering Members of Congress a critical tool to understand the needs and advocate for targeted resources in their own districts.

Why Now

The strength of our nation tomorrow depends on how we support young people's mental health today. Medicaid is one of the most important tools we have to address this, covering nearly half of all children in the U.S.[2] and funding clinical treatments, school-based care, community services, and early intervention. But as Congress debates deep cuts to federal spending[3] Medicaid and related supports are on the line, and many of the most vulnerable districts in the country risk losing the already limited infrastructure they have.

At the same time, demand for youth mental health support is surging and in most places, the system is already strained. ThriveAtlas™ comes at a pivotal moment. By mapping six upstream risk factors that influence youth mental health and wellbeing across all 435 congressional districts (and Washington, D.C.), this tool **provides congressional leaders with the data they need to protect what works, shore up what's missing, and match solutions to the real conditions young people face in their own communities.**

This is a **bipartisan issue** that should concern all political leaders. Democratic-led districts are more likely to face individual and economic hardships, while Republican-led districts struggle with broader system-level deficits: fewer providers, weaker support networks, and limited access to care. **Medicaid cuts will have deeply harmful consequences across the political spectrum but ThriveAtlas™ is a tool that can be used to better understand how funds can be distributed for mental health care.**

To learn more about ThriveAtlas™, the data behind these findings, or how to apply these insights in your local community, contact Surgo Health. We're here to support leaders in making data-driven decisions that protect and strengthen youth mental health and wellbeing across the country.

[1] Surgo Health. (2024). The Youth Mental Health Tracker: Uplifting Youth Mental Health and Wellbeing from Crisis to Empowerment.
[2] Heller et al., 2023
[3] Center on Budget and Policy Priorities, 2025

Key Findings

Insight 1: Medicaid Cuts Threaten Already-Strained Systems, and Risk Varies Widely by Congressional District Profile

- ThriveAtlas™ shows that **three out of four congressional districts** face serious challenges to youth mental health and wellbeing across 6 key themes: Limited Wellness Practices, Provider Shortages, Accessibility Barriers, Socioeconomic Hardship, Negative Life Experiences and Limited Support & Belonging. Each theme highlights a **different point of system failure** and a **different way Medicaid, especially Section 1115 Waivers, helps hold those systems together.**
- Each congressional district presents a unique risk profile, falling into one of four key categories: **Multi-Burden Districts (23.9% of districts), Personal Hardship Districts (23.9%), Underserved Districts (23.6%) and Low Burden Districts (28.7%).** The **South faces the most acute challenges**, with 43% of its districts classified as Multi-Burden, marked by overlapping issues across all themes. States like Mississippi, Tennessee, and Alabama face especially high risk across all themes. Even in regions with stronger conditions, like the Northeast and Midwest, states such as New York, Indiana, and South Dakota contain high-need districts that face persistent hardship or weak infrastructure, underscoring the urgent need for localized interventions.
- **Medicaid cuts would hit districts unevenly.** In Multi-Burden and Underserved Districts, Medicaid helps fund the few available services and support systems. Reductions in funding could deepen provider shortages, increase unmet need, and erode critical access points, especially in states already underinvesting in youth mental health infrastructure.

Six Themes of ThriveAtlas™

Limited Wellness Practices
Focuses on the behaviors that impact physical and mental wellness, such as exercise and sleep.

Provider Shortage
Addresses the capacity of a community's mental health infrastructure by examining the availability and variety of mental health providers and organizations.

Accessibility Barriers
Addresses the barriers that youth encounter when seeking mental healthcare, including obstacles related to language and insurance coverage.

Socioeconomic Hardship
Explores the socioeconomic factors, such as poverty, education, and employment, that influence mental health outcomes and access to mental healthcare.

Negative Life Experiences
Addresses experiences that impact mental health, including factors such as family structure, adverse childhood experiences, and neighborhood safety.

Limited Support and Belonging
Explores the quality and nature of relationships within families and peer groups, and social support networks.

Insight 2: Heightened Challenges Exist for Trigger Law and Mandate States

- **Trigger law states are highly vulnerable to Medicaid cuts given that 74% of their congressional districts fall into high-need segments** (32% Underserved, 29% Personal Hardship, 13% Multi-Burden). Yet these states are positioned to roll back coverage swiftly if federal funding drops.
- South Dakota, Missouri, and Oklahoma are constitutionally required to maintain Medicaid expansion. These states face steep youth mental health challenges: South Dakota is 100% Underserved while Missouri and Oklahoma have high shares of Multi-Burden Districts (38% and 60%, respectively). Without federal support, they may be **forced to cut other vital services like education, infrastructure, or public safety** to maintain Medicaid expansion, further straining already fragile systems and compounding risk for youth mental health and wellbeing.

Insight 3: Risk is Shaped by Both Geography and Governance

- **Rural districts are twice as likely to be Multi-Burden Districts** (35% vs. 18% urban). Given that Medicaid and Children's Health Insurance Program (CHIP) cover 47% of children and 18% of adults in small towns and rural areas[4] cuts to these programs would hit rural districts especially hard.
- **Democratic-led districts are more likely to be Low Burden or face Personal Hardships** (with better care access), while Republican-led districts are more likely to be Multi-Burden Districts or Underserved, refl ecting critical differences in provider availability, support systems, and negative exposures.
    - Republican districts are more than **2x as likely to experience provider shortages and face barriers to accessing care**: 55% and 57% of Republican districts hit high risk for these issues compared to just 25% and 23% in Democratic districts.
    - **Limited Support and Belonging is a greater concern in Republican districts** (46%), suggesting weaker social cohesion and available support networks compared to Democratic districts (34%).
    - Democratic-led urban districts are **2.5 times more likely to be at high risk for Socioeconomic Hardship** than Republican-led urban districts, showing that the challenges differ not just in degree, but in type as well.
    - **These partisan patterns intensify when looking within Urban-only and Rural-only districts.** This underscores that the differences between Democratic- and Republican-led districts are not simply the result of a rural-urban divide, but reflect a deeper political gap in youth mental health risk and infrastructure.

[4] Georgetown University CCF, 2023

Introduction

Thriving youth should be the ultimate goal, defined not just by the absence of mental health challenges, but by the presence of both good mental health and good mental wellbeing. Mental health and mental wellbeing is foundational to how young people learn, grow, and engage with the world around them. When youth thrive, they are more likely to succeed in school, contribute meaningfully to the workforce, and avoid costly long-term challenges. But when mental health and mental wellbeing needs go unaddressed, the impacts ripple across education, healthcare, and economic systems, affecting not just individuals, but entire communities. Our aim is to identify **where youth, defined as those aged 10-24, are most at risk of falling short of thriving, and why those risks exist.**

Congressional district leaders have a unique opportunity and responsibility to address these threats to youth mental health and wellbeing by ensuring that local youth have the support and care they need. Surgo Health's survey of over 4,500 youth across the U.S. identified key upstream factors that influence young people's ability to thrive, including physical health, financial hardships, negative life experiences, social support and belonging, and the barriers to care when youth do need help[5]. ThriveAtlas™ brings together eight existing data sources outside of the survey to measure how prevalent these factors are in every community across the U.S. By mapping these factors to congressional districts, this report exposes **sharp disparities in how well systems and communities are supporting their young people** and provides **critical insight for Members of Congress** about the challenges facing youth in their own districts.

As youth mental health needs grow and debates around Medicaid funding intensify, this data equips leaders with the insights needed to move **from broad concern to targeted data-driven action.** Thriving demands more than one-size-fits-all solutions; it requires local focus and tailored investment.

[5] Surgo Health. (2024). The Youth Mental Health Tracker: Uplifting Youth Mental Health and Wellbeing from Crisis to Empowerment

Key Findings

INSIGHT 1

Medicaid Cuts Threaten Already-Strained Systems, and Risk Varies Widely by Congressional District Profile

Medicaid is not just a safety net, it's the backbone of how many youth actually access care. It funds providers, covers essential treatments, and removes barriers like cost, distance, and digital access. Cuts to Medicaid, including potential rollbacks of Section 1115 Waivers that support housing, occupational therapy, and other social determinants of health, could destabilize already fragile systems. ThriveAtlas™ pinpoints youth mental health risk across six key themes, offering a clear view of where and how Medicaid reductions could hit hardest[6,7]. **Three out of four congressional districts face major challenges** in at least one critical area[8]:

1. **Limited Wellness Practices:**
   Youth in districts such as New York's 15th (Congressman Ritchie Torres), North Carolina's 1st (Congressman Don Davis), Tennessee's 9th (Congressman Steve Cohen) and Arkansas's 4th (Congressman Bruce Westerman) face significant gaps in wellness practices such as sleep and physical activity, which are critical for fostering mental health resilience.

   - Cuts to Medicaid could reduce access to **preventive and community-based services** that support wellness behaviors, particularly for low-income youth who rely on Medicaid-funded programs for **routine checkups, chronic condition management, and behavioral health counseling**. While impacts may unfold more gradually than in other themes, over time **this erosion of preventive care infrastructure may contribute to worsening mental and physical health outcomes**, particularly in areas where wellness-promoting services are already scarce.

[6] Maps showing the distribution of these themes as well as tables which list the top 10 districts at greatest risk in each theme are presented in Appendix

[7] See brief methodology on pg. X. For full methodology, see Methodology report

[8] See Appendix Table 7 for a breakdown of ThriveAtlasTM themes in each congressional district

2. Provider Shortages:

Mental health provider shortages are particularly severe in districts like Alabama's 3rd (Congressman Mike Rogers) and 4th (Congressman Robert Aderholt) , Florida's 18th (Congressman Scott Franklin) and Tennessee's 4th (Congressman Scott DesJarlais).

- Medicaid reductions may lead to **lower provider reimbursements**, worsening existing shortages by **driving providers out of the Medicaid network** and **reducing service availability**. Many Republican-led congressional districts already face provider shortages (see below), which would likely be exacerbated by funding reductions. This theme is likely to **show immediate and visible impacts following funding cuts.**

3. Accessibility Barriers:

Districts like Georgia's 8th (Congressman Austin Scott), and Texas's 15th (Congresswoman Monica De La Cruz), 28th (Congressman Henry Cuellar) and 34th (Congressman Vicente Gonzalez Jr.) highlight significant accessibility barriers that prevent many youth from receiving timely mental health care, including insurance coverage and transportation.

- Medicaid is one of the most powerful tools for breaking down access barriers, whether through **expanding health care coverage** for youth, making the care they need more **affordable, enabling digital access in rural areas,** or **covering transportation to appointments.** Youth without reliable internet, consistent transportation, or alternative coverage options would be disproportionately affected. The effects of Medicaid cuts on this theme are likely to be immediately felt.

4. Socioeconomic Hardship:

In districts such as California's 22nd Congressional District (Congressman David Valadao), Louisiana's 6th Congressional District (Congressman Garret Graves), Michigan's 13th (Congressman Shri Thanedar) and New York's 15th (Congressman Ritchie Torres), the persistent socioeconomic hardship youth face is closely linked to their mental health challenges.

- Medicaid serves as a **critical financial buffer** for families facing hardship, covering healthcare costs that might otherwise become unmanageable. Cuts to Medicaid could lead to **increased out-of-pocket expenses**, which may force families to delay or forgo treatment entirely. This not only erodes a vital safety net but can hinder recovery, worsen long-term health outcomes, and compound stress in already vulnerable households.

5. Negative Life Experiences:

Youth in districts like Michigan's 12th (Congresswoman Rashida Tlaib) and 13th (Congressman Shri Thanedar), Mississippi's 2nd (Congressman Bennie Thompson), and Tennessee's 9th (Congressman Steve Cohen) face heightened exposure to trauma and safety concerns that deeply affect their mental health.

- **Medicaid plays a critical role in responding to negative life challenges by funding trauma-informed care and intensive case management, often delivered through schools, community health centers, and child welfare systems.** These services help buffer the long-term effects of trauma, promote emotional regulation, and connect families to stabilizing supports. Medicaid also provides access to **early and periodic screening, diagnostic, and treatment services**, which are essential for identifying concerns early and ensuring children get the care they need before issues escalate. While the effects of reduced trauma-informed services may not be immediately visible, they are likely to emerge over time through rising rates of behavioral issues, chronic mental health conditions, and deeper involvement in the child welfare or justice systems.

6. Limited Support & Belonging:

Social isolation and weak community ties are a significant concern in districts such as Florida's 20th (Congresswoman Sheila Cherfilus-McCormick) and Nevada's 1st (Congresswoman Dina Titus), 3rd (Congresswoman Susie Lee), and 4th (Congressman Steven Horsford).

- Medicaid supports many of the systems that nurture youth development and belonging, including **early childhood programs**, and **school-based and community-based supports that promote youth wellbeing**. Cuts to Medicaid could weaken these touchpoints, **diminishing the sense of connection youth feel to family, school, and peers**. Reductions in these wrap-around services could increase feelings of isolation and disconnection over time, particularly in communities where social infrastructure is already fragile, and deeper involvement in the child welfare or justice systems.

To further characterize the landscape of youth mental health risk, Congressional Districts can be segmented[9] into four distinct profiles based on their underlying challenges. Understanding these categories helps us determine the most effective interventions for communities at a granular level.

1. Personal Hardship Districts (23.9% of all districts, 24% of 10-24 year old youth):

In these districts, youth face multiple challenges to their mental wellbeing due to **limited engagement in wellness behaviors, significant socioeconomic challenges**, and **high exposure to negative life experiences**. These conditions create an environment where both prevention and recovery are more difficult to achieve.

- The **personal hardship segment**, shows the highest reported prevalence of poor youth mental health and wellbeing[10] with **54.8% of districts in this segment falling into the high prevalence category**. This underscores the strong link between personal adversity and youth mental health struggles.

2. Underserved Districts (23.6% of all districts, 23% of 10-24 year old youth):

Youth in these districts face a **dual challenge**: systemic obstacles like **provider shortages and accessibility gaps** that make care difficult to obtain, as well as **weak social support networks.**

- In **Underserved Districts**, 41% of districts are categorized as having high prevalence of poor youth mental health and wellbeing. This figure may reflect not a lower level of need, but rather **lower detection and underreporting**. In these communities, youth are less likely to access care, receive diagnoses, or have supportive systems around them who can help them receive help, in particular parents and caregivers, suggesting the true burden may be underestimated.

3. Multi-Burden Districts (23.9% of all districts, 26% of youth ages 10-24):

These districts face a convergence of **overlapping risk factors** across all themes, including **limited engagement in wellness activities, shortages of mental health providers, significant barriers to care, economic instability**, high exposure to **negative life experiences**, and **weak community support systems.**

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[9] A weighted k-medoid partitioning around medoids (PAM) clustering algorithm (with a Gower distance metric) was used to identify clusters of districts based on the 6 themes of our index

[10] High prevalence refers to Congressional Districts that fall within the top 40% nationwide of poor youth mental health (covering reported anxiety, reported depression, reported mental health not good and life dissatisfaction).

- 32% of Multi-Burden Districts had high prevalence of poor mental health and wellbeing. Similar to Underserved Districts, many youth may not access services due to provider shortages and accessibility issues leading to underdiagnosis, while the lack of supportive systems and personal hardships may lead to underreporting.

4. Low Burden Districts (28.7% of all districts, 27% of youth ages 10-24):

While not immune to mental health challenges, these districts benefit from better support systems and infrastructure and could **serve as models for best practices** that could be adapted and scaled in higher-risk areas.

- 34% of Low Burden Districts had high mental health prevalence.

Table 1. Percentage of districts within each segment that are High or Very High Risk for each theme

	Multi-Burden Districts	Low-Burden Districts	Personal Hardship Districts	Underserved Districts
Limited Wellness Practices	67%	7%	71%	21%
Provider Shortage	92%	7%	15%	52%
Accessibility Barriers	87%	2%	26%	53%
Socioeconomic Hardships	77%	4%	78%	9%
Negative Life Experiences	76%	5%	79%	7%
Limited Support and Belonging	89%	1%	30%	49%

Figure 1. Congressional District by Risk Segment

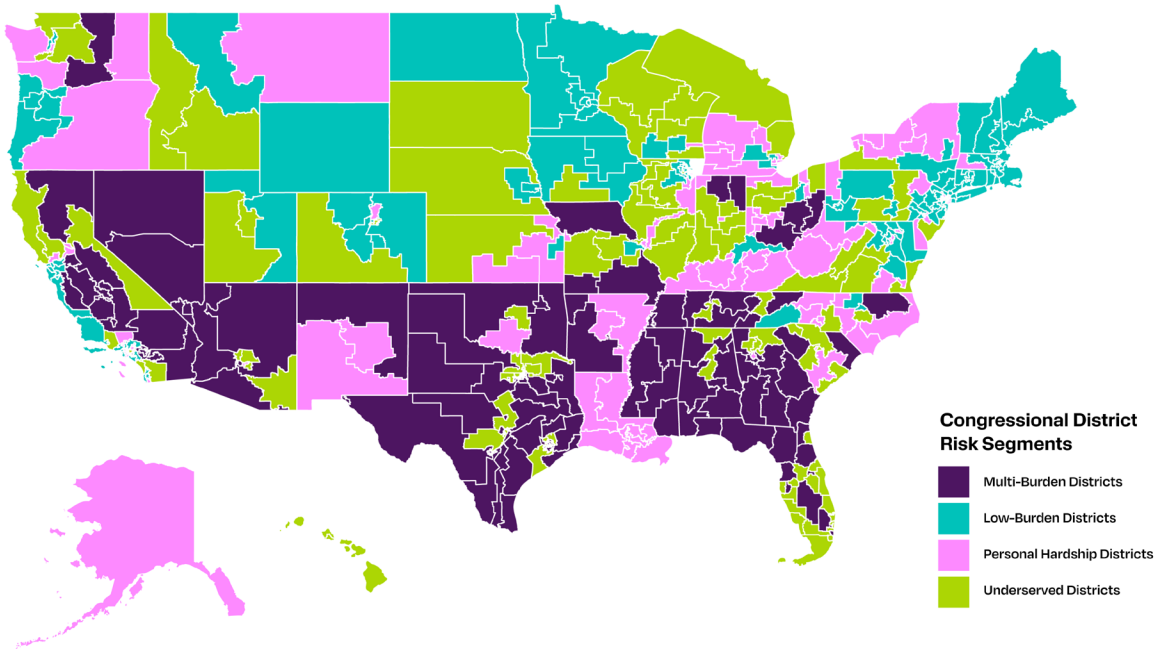


Table 2. Percentage of districts in each segment, by census region[11]

	Multi-Burden Districts	Low-Burden Districts	Personal Hardship Districts	Underserved Districts
Midwest	9%	32%	31%	29%
Northeast	0%	64%	28%	8%
South	43%	9%	19%	29%
West	24%	32%	22%	22%

It is well known that the South faces many health and economic challenges, which is also reflected in our findings with 43% of Southern states having the highest proportion of Multi-Burden Districts. But ThriveAtlas™ reveals wide variation in the types of challenges Southern youth face. While some states struggle on almost all fronts, such as **Tennessee and Mississippi** where 78% and 100% of districts, respectively, are Multi-Burden Districts) other states in the region, like **Kentucky and North Carolina primarily struggle with personal hardship** where 83% and 57% of districts, respectively, are Personal Hardship districts. Still other states, like **Florida and South Carolina are largely Underserved (61% and 57% of districts are Underserved Districts respectively).** These patterns point to a pressing need for both social and structural investment across the region. ThriveAtlas™ provides the localized, data-driven insights needed to prioritize youth mental health investments where they are most urgently needed and most likely to make an impact.

The **Western states present a mixed picture. California,** for example, mirrors its geographic and economic diversity, with districts spanning the spectrum: 33% Low Burden, alongside 29% Multi-Burden and 23% Personal Hardship districts. Arizona (44% of districts are Multi-Burden District, 44% are Underserved) and Nevada (100% are Multi-Burden District) emerge as particularly vulnerable.

Midwestern states present a balanced risk profile, with 32% of districts at Low Burden and the rest split between hardship and resource challenges. But within a region with stronger overall conditions, states such as **Indiana** (22% of districts in this state are Multi-Burden Districts, 56% are Underserved, and 22% are Personal Hardship districts) and **South Dakota** (100% are Underserved) still face significant hardship and/or structural gaps, emphasizing the importance of **localized policy responses**.

The **Northeast** stands out as a region of relative strength, with **64% of districts** falling into the **Low Burden** category. States like **Connecticut, Maine, Rhode Island, Vermont, and Massachusetts** demonstrate **strong social infrastructure, broad healthcare access, and greater socioeconomic stability**. However, this success story also casts a spotlight on geographic inequity: the sharp contrast between these Low Burden regions and high-risk regions in the South and West underscores how policy choices, funding priorities, and local investments can dramatically shape youth mental health outcomes. The Northeast offers models worth studying—but also a reminder that gains are not equally distributed. Even within the Northeast, there still exist districts experiencing higher risks (e.g. 46% of districts in New York are Personal Hardship districts and 8% are Underserved).

[11] States falling into each census region are displayed in Appendix Table 8

Mismatch in Medicaid: Underserved States Have the Greatest Gaps—But the Least Investment

Despite facing significant structural barriers to youth mental health care, **Underserved states** are associated with the **lowest Medicaid investment levels**[12]. On average, states with predominantly Underserved Districts allocate just **25.6% of their budgets to Medicaid**—less than any other segment, including Multi-burden states (31.3%). The gap is even more striking when looking at child-level investment, where **Medicaid spending in Underserved states is just $3,398 per child**, compared to **$4,292 in Multi-burden states and $3,794 in Low Burden states.** This shortfall in funding in Underserved states suggests a critical mismatch between need and investment. With further Medicaid cuts, these under-resourced communities risk falling further behind.

Summary of Medicaid Measures by ThriveAtlas™ Segmentation

Medicaid Measure	Multi-Burden States[13]	Low-Burden States	Personal Hardship States	Underserved States
State expenditure toward Medicaid	31.3%	26.7%	28.5%	25.6%
Medicaid per capita: total population[14]	$8019.59	$9659.58	$8646.73	$7610.48
Medicaid per capita: children[15]	$4292.13	$3793.89	$3829.83	$3398.21
Enrollment as % of state population[9]	16.0%	24.4%	23.7%	18.5%

[13] For this analysis, states are categorized as Multi-burden, Low Burden, Personal Hardship, or Underserved based on the most prevalent ThriveAtlas™ segment among their congressional districts. Each state is assigned to the segment that represents the largest share of its districts. To maintain clarity in the comparisons, states with an equal proportion of districts across two or more segments are excluded from this categorization and analysis.

[14] The average across segments was weighted by total state population size.

[15] The average across segments was weighted by the total number of children under 18 in a state.

INSIGHT 2

Heightened Challenges in Trigger and Mandate States

Trigger Laws and the Most Vulnerable Districts

As Congress considers sweeping cuts to Medicaid, **nine states have automatic trigger laws**[16] (Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah, and Virginia) that would swiftly **terminate or weaken Medicaid expansion if federal funding falls below 90% (80% for Arizona).**

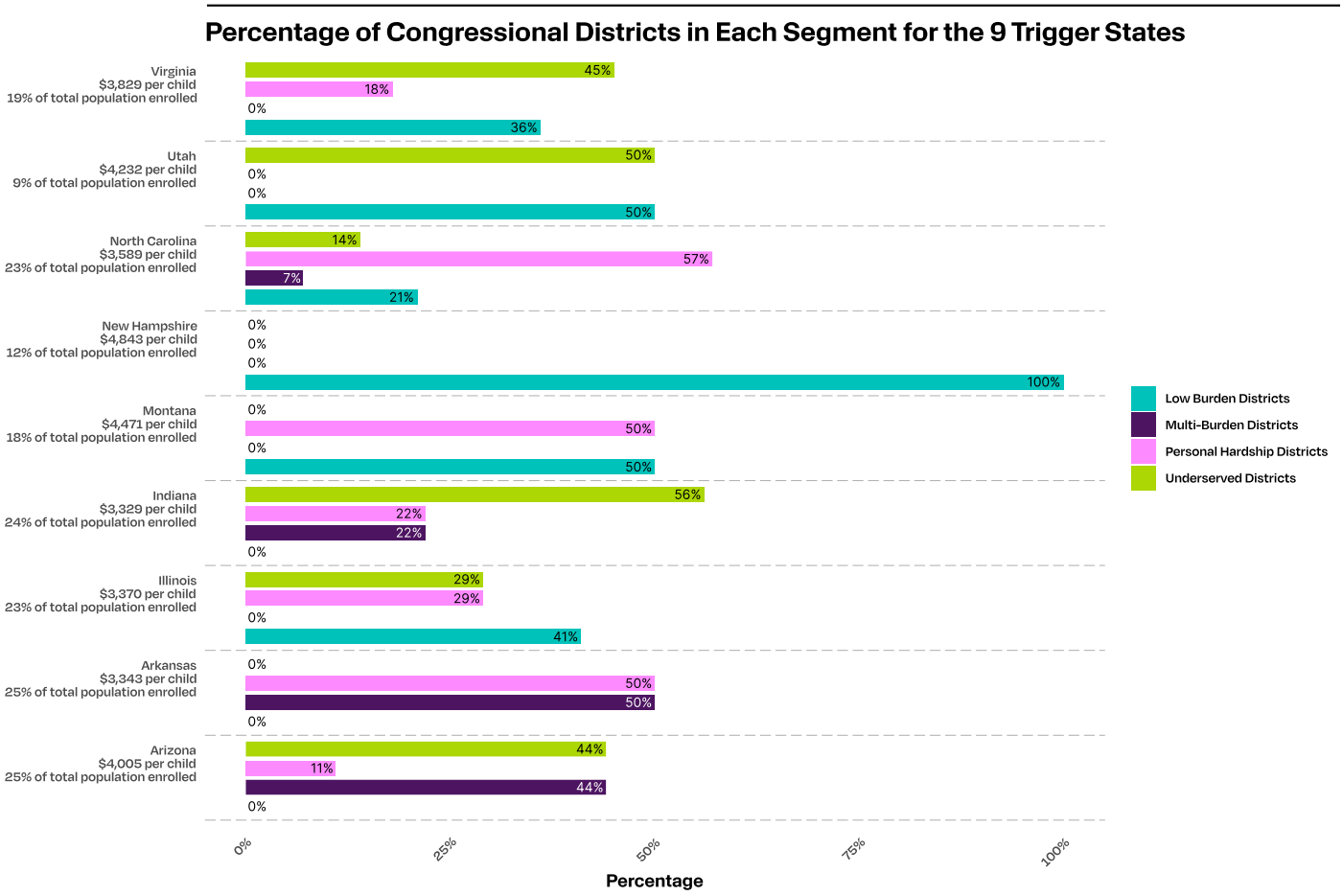
- **32%** of congressional districts across these 9 states fall into **Underserved Districts**, where care access is limited and community support is fragile.
- **13%** of congressional districts across these 9 states are **Multi-Burden Districts**, facing multiple overlapping barriers to youth wellbeing.
- **29%** are **Personal Hardship Districts**, marked by socioeconomic strain and adverse life experiences.
- **26%** of districts are **Low Burden**, offering little systemic buffer if federal Medicaid support is reduced.

This distribution highlights that some states most at risk of Medicaid rollbacks have some of the **least resilient** districts to absorb the fallout.

- For example, **8 out of the 9 congressional districts in Arizona** fall into either **Multi-Burden (44%)** or **Underserved (44%)** Districts. Despite **relatively high Medicaid enrollment (25%)** and **child-level investment ($4,005 per child)**, serious gaps in access and support remain. As a trigger law state, Arizona is legally positioned to automatically roll back Medicaid expansion if federal funding drops. The consequences would be severe: **even with robust current investment, the state's youth mental health system is already at risk.** Cuts could deepen provider shortages, reduce care access, and leave vulnerable youth without the support they need, highlighting the urgent need for sustained funding and targeted, district-level solutions.

[16] KFF Dec 2024

Figure 2.
Percentage of districts within each of the 9 trigger law states that fall into each risk segment. Under each state name, Medicaid per capita expenditures on children only (2022) and proportion of population enrolled in Medicaid (10/ 2024) are displayed.



Constitutional Mandate States: Trapped in a Fiscal Bind

On the other side, **South Dakota, Missouri,** and **Oklahoma** are constitutionally obligated to maintain Medicaid expansion, even if federal funding drops[17]. That leaves these states with only **two options**: fill the gap by cutting other state services or raise taxes.

These states face steep challenges of their own:

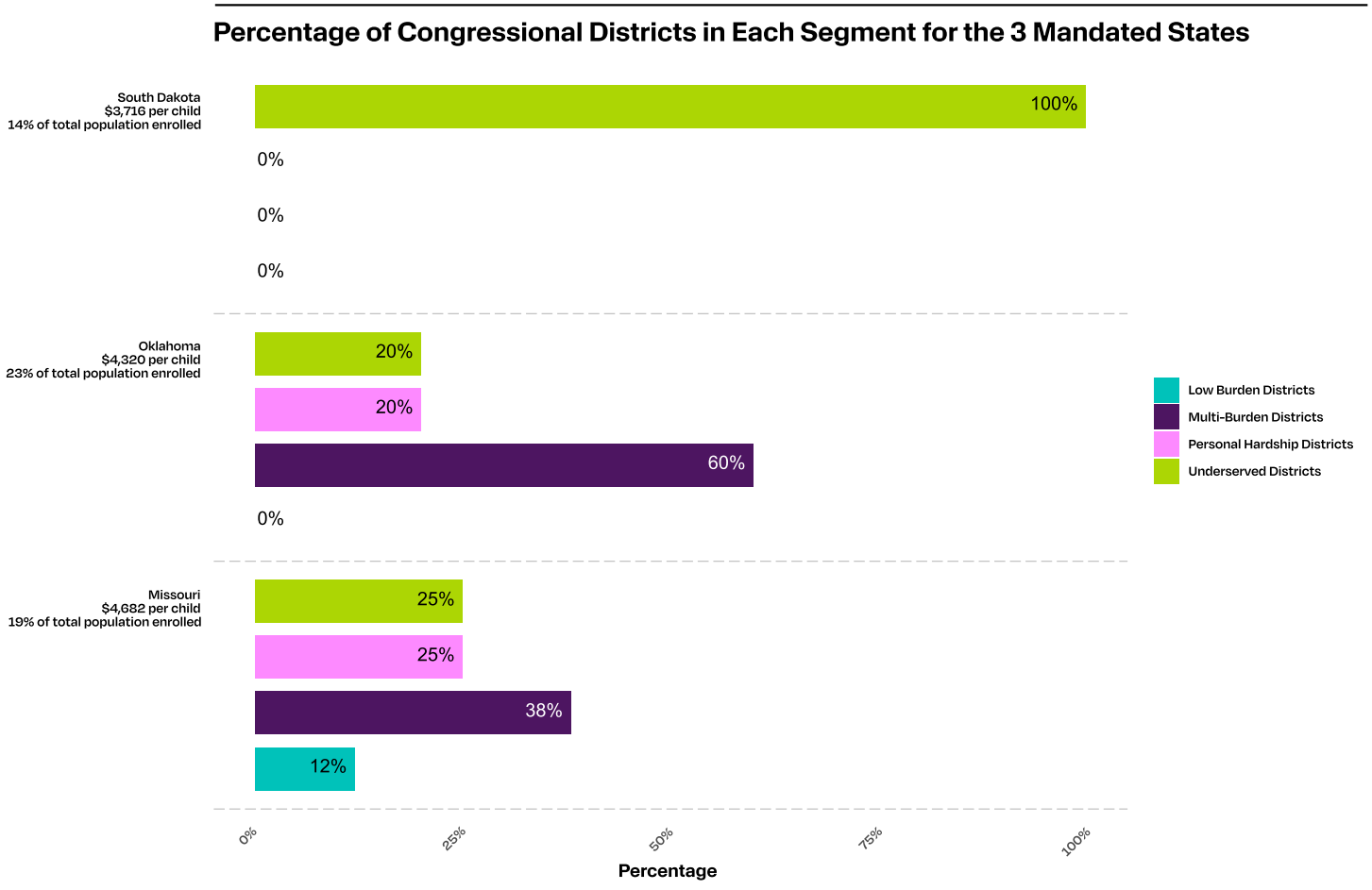
- **South Dakota is 100% Underserved**, suggesting low coverage and fragile infrastructure. Fortunately, its constitutional mandate preserves Medicaid expansion, a critical backstop in an otherwise fragile system. But if the state is forced to cut elsewhere, essential services like education, transportation, or housing could suffer. Programs that support **youth safety**, such as law enforcement training, school resource officers, and community-based prevention initiatives, could also be on the chopping block, putting vulnerable young people at greater risk. In underresourced districts, even small funding losses can have outsized impacts on the systems that protect and stabilize youth.

[17] New York Times, 2025

- **Missouri** includes **38% Multi-Burden, 25% Underserved districts and 25% Personal Hardship**. These overlapping challenges mean that Medicaid must work in concert with other public investments. Cuts to school funding, public safety nets, or child welfare services could further destabilize families and communities, worsening the underlying conditions that put youth at risk.
- **Oklahoma** faces a similarly high share of **Multi-Burden (60%), Underserved (20%) and Personal Hardship (20%)** districts. For a state already struggling to meet the needs of vulnerable youth, any diversion of resources away from education, mental health, housing, or workforce development could compound risk and weaken the broader ecosystem young people rely on to thrive.

Unlike trigger law states, these three cannot reduce coverage with a single vote. But without additional federal support, they may be forced into difficult trade-offs that compromise other critical systems. In high-need segments, cutting beyond Medicaid, whether in schools, community programs, or family supports, could unravel already fragile safety nets and deepen inequities in youth mental health and wellbeing.

Figure 3.
Percentage of districts within each of the 3 mandated states that fall into each risk segment. Under each state name, Medicaid per capita expenditures on children only (2022) and proportion of population enrolled in Medicaid (10/ 2024) are displayed.



INSIGHT 3

Risk is Shaped by Both Geography and Governance

Urban vs. Rural Disparities

Youth mental health challenges exist in both urban and rural areas[18], but rural communities face significantly greater barriers to care and well-being. Rural districts are especially overrepresented in the **Multi-Burden segment (35%) compared to urban districts (18%)**, pointing to more widespread challenges in rural regions. Medicaid cuts would likely intensify these challenges, especially in communities already experiencing severe provider shortages and geographic isolation. In fact, **Medicaid and CHIP cover 47% of children and 18% of adults in small towns and rural communities**[19], where residents are more likely to be uninsured and face additional barriers to care. Conversely, urban districts are more likely to fall into the **Low Burden segment (35% vs. 16% rural)**, while the Personal Hardship and Underserved segments are more evenly distributed across urban and rural lines. These patterns reflect the complex geography of youth mental health risk, with rural areas facing heightened overall vulnerability. While Medicaid reductions would still strain services in cities, especially for low-income families in Personal Hardship Districts, the consequences in rural areas could be far more severe and enduring, widening the geographic divide in youth thriving.

Table 3. Proportion of Urban and Rural Congressional Districts by Segment

	% of urban congressional districts in overall index and each segment	% of rural congressional districts in overall index and each segment
Multi-Burden	18%	35%
Low Burden	35%	16%
Personal Hardship	25%	22%
Underserved	22%	27%

Key Differences Between Republican- and Democratic-Led Districts

Despite youth mental health challenges being a nationwide issue, stark disparities exist in risk levels and access to care between Republican- and Democratic-led districts. **Democratic districts are more likely to be classified as Low Burden (41% of Democratic districts vs. 16% of Republican districts) or have a higher proportion of communities facing Personal Hardship (31% vs. 17%)**, meaning that while individual economic and societal struggles are present, these areas tend to have stronger mental health infrastructure. In contrast, **Republican districts are significantly more likely to be of Multi-Burden (30% vs. 18%) or Underserved (37% vs. 10%)**, reflecting widespread shortages in providers and critical support services.

[18] Congressional Districts are classified as either urban or rural based on the percentage of the population living in urban-designated census blocks, aggregated from county-level data. Districts where more than 75% of the population resides in urban blocks are classified as urban.

[19] Georgetown University CCF, 2023

- Republican districts are **more than 2 times as likely to experience provider shortages and face barriers to accessing care**, 55% and 57% of Republican-led districts hit high risk for these issues compared to just 25% and 23% in Democratic-led districts.
- Limited Support and Belonging is a greater concern in Republican districts (46%), suggesting **weaker social cohesion and available support networks** compared to 34% of Democratic districts.
- Democratic-led urban districts are **2.5 times more likely to be at high risk for Socioeconomic Hardship** than Republican-led urban districts, showing that the challenges differ not just in degree, but in type as well.

These patterns persist and are exacerbated when examining within Urban-only districts and Rural-only districts (Table 4). These disparities highlight that the issue is **not just a rural-urban divide but also a political gap**. The combination of higher resource deprivation and fewer providers in Republican districts means that youth in these areas are more likely to experience untreated mental health conditions, leading to long-term consequences for education, employment, and overall wellbeing.

Table 4. **Proportion of Democrats and Republican Congressional Districts by Segment, for Urban and Rural Districts**

	Urban Democratic Districts	Urban Republican Districts	Rural Democratic Districts	Rural Republican Districts
Multi-Burden	17%	20%	27%	36%
Low Burden	42%	21%	36%	13%
Personal Hardship	31%	10%	23%	22%
Underserved	10%	48%	14%	29%

Partisan Patterns, Uneven Risks: How Medicaid Cuts Would Hit Districts Differently

Democratic-led districts are more likely to fall into the "Personal Hardship" segment, where economic and social stress is present, but mental health infrastructure is comparatively stronger. In these areas, Medicaid cuts may primarily impact individuals and families, **forcing difficult trade-offs between health care and basic needs**. The consequences would be immediate and tangible for many households.

Republican-led districts, by contrast, are significantly more likely to be "Underserved," marked by broad shortages in providers, services, and system-level support. Here, Medicaid cuts would likely **exacerbate already fragile healthcare ecosystems**, deepening provider deserts, shuttering local programs, and further isolating rural communities. This extends beyond youth mental health: Medicaid also funds critical services for opioid and substance use recovery. Cuts could derail treatment, increase relapse risk, and strain already overburdened families, law enforcement, and emergency systems. The impact would ripple beyond individual households, undermining entire care networks.

Policy, Funding, and Program Implications

ThriveAtlas™ equips Congress with a district-level roadmap to act with urgency and precision. The data reveal clear mismatches between need and investment, especially in districts that are Underserved or Multi-burden.

By revealing the largest care gaps, ThriveAtlas™ allows policymakers to see where investments can have the greatest impact and prioritize limited resources. Rather than distributing funds evenly across all districts, Congress can use ThriveAtlas™ to target the areas with higher need and ensure that the dollars are being spent efficiently. As mental health demands rise and debates over federal funding escalate, especially around Medicaid, the cost of inaction will only grow.

To ensure young people have a real shot at thriving, Congress should:

- **Protect Medicaid as a cornerstone of youth mental health care, and ensure continued funding of treatment, breaking of access barriers, and enabling trauma-informed, preventive, and school-based services**
  - **Ensure Medicaid reimbursement for school-based mental health services:** It is important for states to allow school-based mental health providers to be reimbursed for all Medicaid-eligible students. States can submit State Plan Amendments (SPAs) that align with federal guidance to allow reimbursement for mental health services delivered to all eligible students. SPAs allow for the implementation of a tiered payment system, where reimbursement is based on the level of service needed. By providing lower reimbursement rates for less intensive services, such as counseling, and higher rates for more intensive services, states can optimize spending while ensuring that services are appropriately meeting the needs of youth. At the federal level, easing licensure barriers can further support workforce growth by allowing qualified providers to practice across state lines, particularly in underserved areas.
  - **Reduce administrative burdens related to reimbursement systems:** Many districts do not have the administrative staff or resources to adequately prepare the paperwork that is required for Medicaid reimbursement. Thus, streamlining the billing processes can ensure providers are properly reimbursed and increase the overall mental health workforce.
- **Prioritize upstream solutions like community-based programs, wellness supports, and early intervention to reduce long-term system strain**
  - **Partner with local community organizations:** To build holistic well-being programs, districts must foster strong partnerships between schools and community-based organizations, such as faith-based organizations and cultural centers. Integrating services within the community helps youth develop trust and a sense of belonging which are key factors that support improved mental health outcomes. Additionally, leveraging existing community partnerships reduces overall program costs and also streamlines coordinated care.

- **Expand school-based supports through flexible funding and targeted grants:** Expanding grants like Project AWARE can further promote youth safety and resiliency by supporting mental health services in schools and strengthening community partnerships. The federal government can also increase flexibility in how states use Department of Education funds to hire school-based mental health professionals and provide substance use disorder (SUD) services tailored to youth needs.

- **Integrate mental health into primary care to expand early access:** Incentivizing integrated care models, like the Collaborative Care Model, can further expand access by embedding mental health support into primary care. Programs such as the Pediatric Mental Health Care Access (PMHCA) Program show how supporting pediatricians and other frontline providers with training, resources, and consultation can dramatically improve early identification and coordination of mental health care for children and adolescents.

- **Promote bipartisan, place-based strategies that recognize regional diversity in risk, and reject one-size-fits-all approaches**

  - **Strengthen the mental health workforce in underserved areas:** The federal government can incentivize the expansion of integrated care models and support the training of pediatricians and other frontline providers to help fill workforce gaps in underserved communities. Programs that train providers in Screening, Brief Intervention, and Referral to Treatment (SBIRT) can further expand early identification and access to care especially for youth at risk of substance use disorders.

  - **Advance telehealth services in Underserved areas:** In many rural areas, there is a significant provider shortage which is why utilizing telehealth services can reach youth and their families that are in need. Advancing telehealth services can help bridge this gap by connecting individuals to licensed professionals regardless of barriers. To support this, the federal government should ensure that Broadband Equity, Access, and Deployment (BEAD) funding is maintained and quickly distributed to areas most in need, so that digital infrastructure is not a limiting factor in care access.

  - **Prioritize culturally appropriate trauma-informed services in urban areas:** It is important for districts at high risk of Negative Life Experiences to expand access to culturally responsive, trauma-informed services that acknowledge the complex realities youth navigate daily. Equally important is equipping mental health providers, educators, and school staff with specialized training to recognize and address the unique mental health needs of these students. The earlier these mental health needs are identified and addressed, the sooner districts can reduce the long-term costs associated with untreated trauma, such as chronic absenteeism, disciplinary actions, and the need for intensive costly interventions.

Congressional leaders have a narrow window to make strategic, equitable investments in youth wellbeing. ThriveAtlas™ offers the data to guide them and create sustainable solutions for enhancing mental health outcomes.

Methodology

ThriveAtlas™ is a powerful, geographically granular tool to measure the upstream factors at a community level putting young people at risk of not thriving.

The index assigns one risk score between 0 (lowest risk) and 100 (highest risk) to each Congressional District. Districts at High or Very High Risk fall within, respectively, the top 40% and 20% nationwide in terms of youth mental health burden.

ThriveAtlas™ data comes from 8 sources and contains 25 indicators capturing a wide range of factors, leveraging publicly available data as well as Surgo Health's proprietary data. Indicators were carefully selected based on the results from our representative nationwide youth survey, existing literature and available datasets to ensure relevance and accuracy. For some indicators, we applied Small Area Estimation methods to generate census tract level estimates.

ThriveAtlas™ scores were calculated for all districts in the 119th U.S. Congress. To generate these scores, we used geographic relationship files to crosswalk data from the census tract level up to congressional districts. Because census tracts do not align perfectly with district boundaries, we developed an allocation factor based on both the proportion of each tract's land area and its population within a given congressional district. These factors were used to weight tract-level data and accurately aggregate it to the district level.

ThriveAtlas™ demonstrates positive correlations with youth mental health prevalence (up to r = 0.25 for the correlation between Limited Wellness Practices and reported poor youth mental health at the census tract level). At the congressional district level, core themes such as Negative Life Experiences (r = 0.18), Limited Wellness Practices (r = 0.14) and Socioeconomic Hardship (r = 0.13) are significantly correlated with reported mental health challenges. At the congressional district level, correlations are weaker and not significant for Provider Shortage, Accessibility Barriers and Limited Support and Belonging due to factors such as underdiagnosis, underreporting and geographic aggregation.

To identify the four district segments, we applied a k-medoids clustering algorithm (Partitioning Around Medoids, or PAM) using the Gower distance metric across the six themes of our index, using the index scores of 0 to 100. The optimal number of clusters was determined by evaluating silhouette width and the elbow method, balancing cohesion and separation among groups.

Congressional Districts are classified as either urban or rural based on the percentage of the population living in urban-designated census blocks (Census, 2020), aggregated from county-level data. Districts where more than 75% of the population resides in urban blocks are classified as urban. Congressional Districts are classified as either Republican or Democratic based on results of the 2024 House elections.

Medicaid expenditure and enrollment data were obtained from KFF (2023), Medicaid and Children's Health Insurance Program (CHIP) Scorecard (2022) and Data. Medicaid (2024). Our Medicaid analyses are conducted at the state level since Medicaid data is provided at the state level. States are categorized as Multi-burden, Low Burden, Personal Hardship, or Underserved based on the most prevalent ThriveAtlas™ segment among their congressional districts. Each state is assigned to the segment that represents the largest share of its districts. To maintain clarity in the comparisons, states with an equal proportion of districts across two or more segments are excluded from this categorization and analysis.

[20] Reported youth mental health prevalence used here is a ranked score, based on an aggregate of depression, anxiety, mental health not good and life dissatisfaction measures for youth aged 10-24.

Appendices

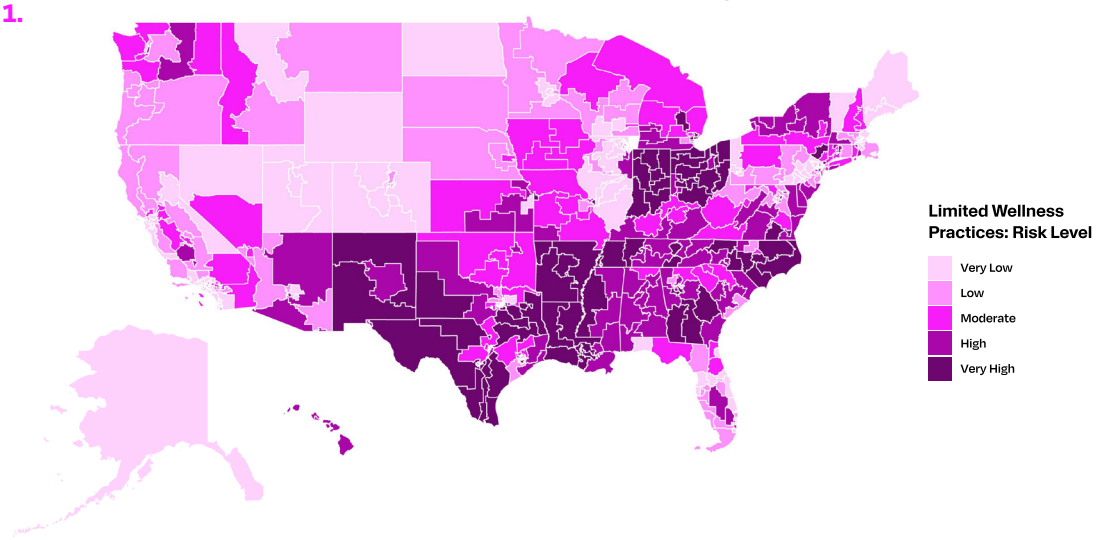
ThriveAtlas™ Theme Maps and Top 10 High Risk Congressional Districts

Limited Wellness Practices

Focuses on the behaviors that impact physical and mental wellness, such as exercise and sleep.

Appendix Figure 1.

Subtheme 1: Limited Wellness Practices Across Congressional Districts



Appendix Table 1.

The top 10 congressional districts with the greatest risk for Limited Wellness Practises are:

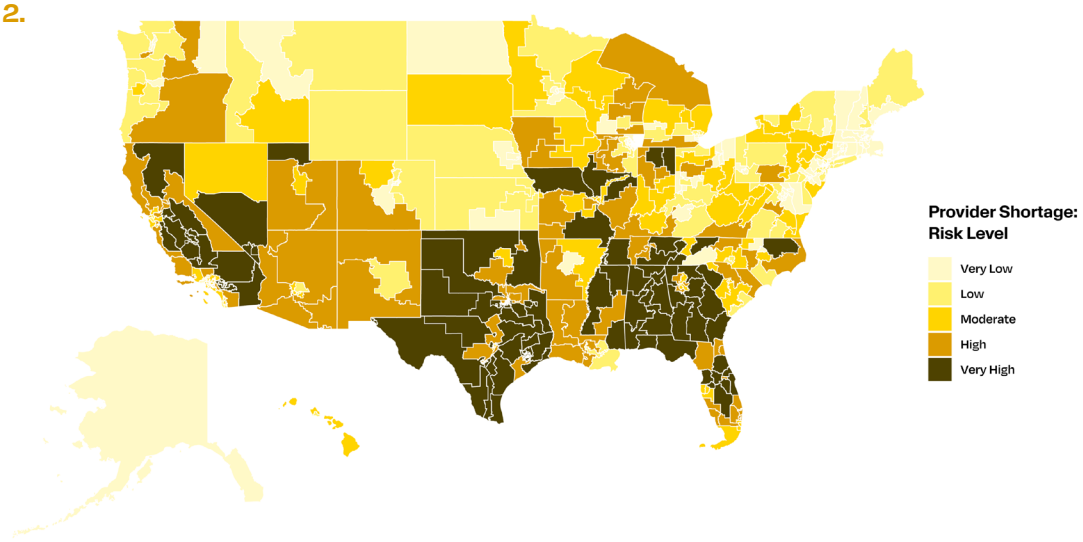
Map	District	Congressperson	Party
Limited Wellness Practices	New York's 15th Congressional District	Ritchie Torres	Democrat
	North Carolina's 1st Congressional District	Don Davis	Democrat
	Tennessee's 9th Congressional District	Steve Cohen	Democrat
	Arkansas's 4th Congressional District	Bruce Westerman	Republican
	New York's 14th Congressional District	Alexandria Ocasio-Cortez	Democrat
	Indiana's 2nd Congressional District	Rudy Yakym	Republican
	New York's 8th Congressional District	Hakeem Jeffries	Democrat
	Ohio's 11th Congressional District	Shontel Brown	Democrat
	Arkansas's 1st Congressional District	Rick Crawford	Republican
	Louisiana's 2nd Congressional District	Troy Carter	Democrat

Provider Shortages

Addresses the capacity of a community's mental health infrastructure by examining the availability and variety of mental health providers and organizations.

Appendix Figure 2.

Subtheme 2: Provider Shortage Across Congressional Districts



Appendix Table 2.

The top 10 congressional districts with the greatest risk for Provider Shortage are:

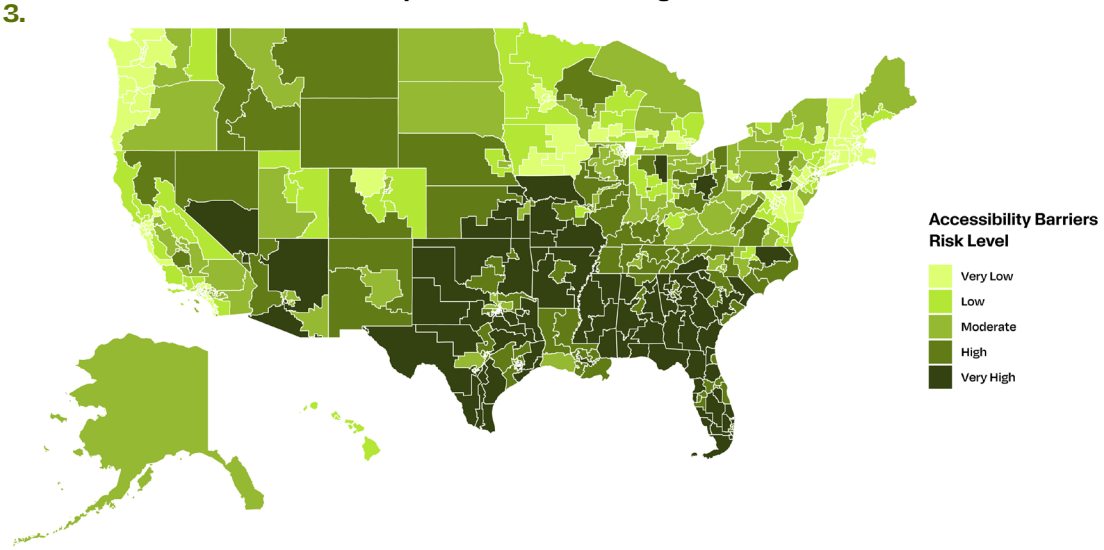
Map	District	Congressperson	Party
Provider Shortage	Tennessee's 4th Congressional District	Scott DesJarlais	Republican
	Alabama's 3rd Congressional District	Mike Rogers	Republican
	Alabama's 4th Congressional District	Robert Aderholt	Republican
	Florida's 18th Congressional District	Scott Franklin	Republican
	Alabama's 2nd Congressional District	Shomari Figures	Democrat
	Texas's 11th Congressional District	August Pfluger	Republican
	Texas's 28th Congressional District	Henry Cuellar	Democrat
	Alabama's 1st Congressional District	Barry Moore	Republican
	Texas's 1st Congressional District	Nathaniel Moran	Republican
	Georgia's 3rd Congressional District	Brian Jack	Republican

Accessibility Barriers

Addresses the barriers that youth encounter when seeking mental healthcare, including obstacles related to language and insurance coverage.

Appendix Figure 3.

Subtheme 3: Accessibility Barriers Across Congressional Districts



Appendix Table 3.

The top 10 congressional districts with the greatest risk for Accessibility Barriers are:

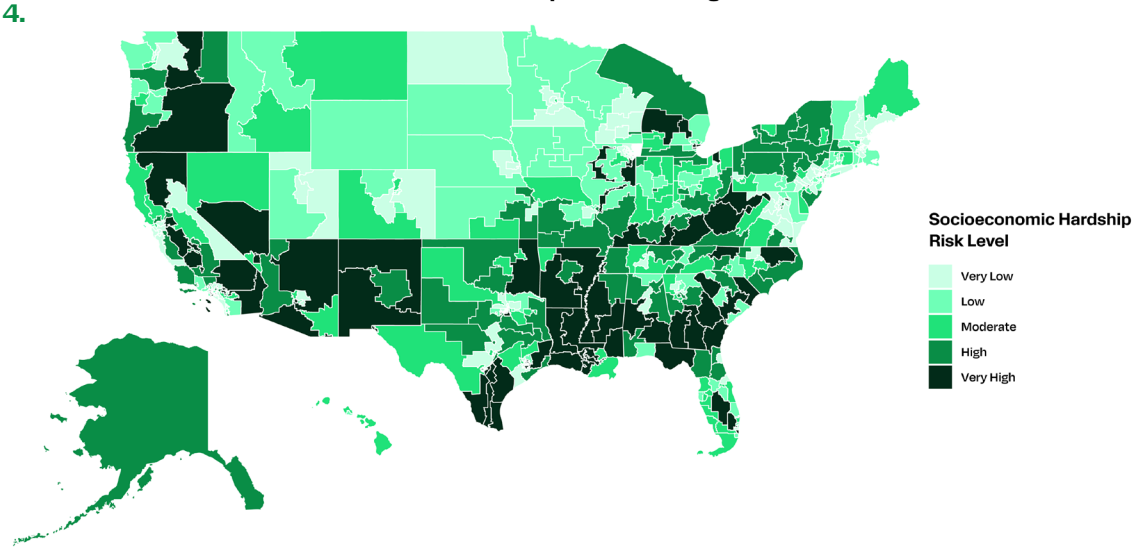
Map	District	Congressperson	Party
Accessibility Barriers	Texas's 15th Congressional District	Monica De La Cruz	Republican
	Texas's 34th Congressional District	Vicente Gonzalez Jr	Democrat
	Texas's 28th Congressional District	Henry Cuellar	Democrat
	Georgia's 8th Congressional District	Austin Scott	Republican
	Texas's 1st Congressional District	Nathaniel Moran	Republican
	Florida's 18th Congressional District	Scott Franklin	Republican
	Georgia's 2nd Congressional District	Sanford Bishop	Democrat
	Mississippi's 2nd Congressional District	Bennie Thompson	Democrat
	Texas's 23rd Congressional District	Tony Gonzales	Republican
	Mississippi's 3rd Congressional District	Michael Guest	Republican

Socioeconomic Hardships

Addresses the barriers that youth encounter when seeking mental healthcare, including obstacles related to language and insurance coverage.

Appendix Figure 4.

Subtheme 4: Socioeconomic Hardship Across Congressional Districts



Appendix Table 4.

The top 10 congressional districts with the greatest risk for Accessibility Barriers are:

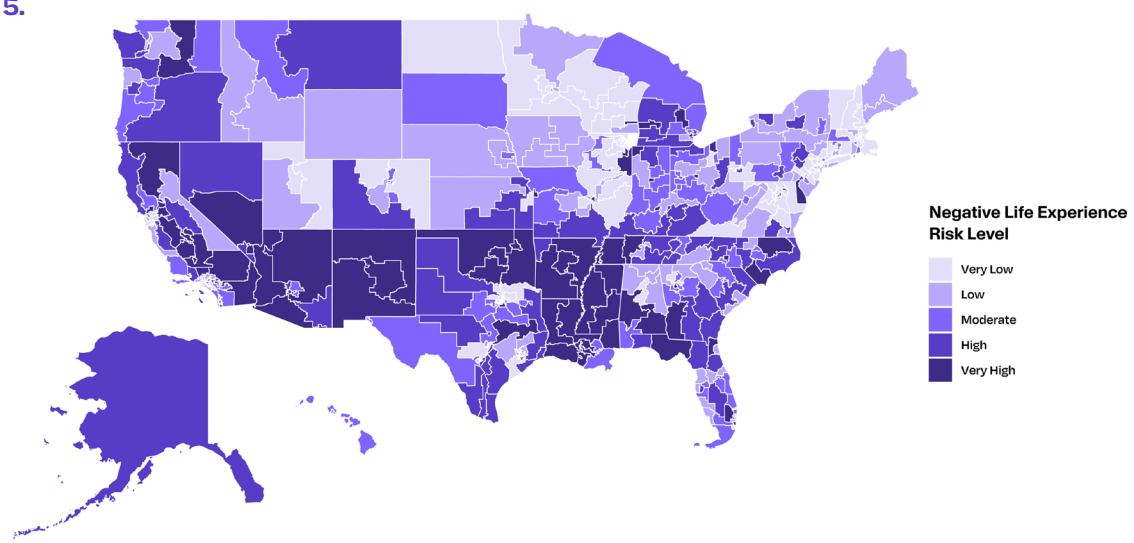
Map	District	Congressperson	Party
Socioeconomic Hardship	Michigan's 13t Congressional District	Shri Thanedar	Democrat
	New York's 15th Congressional District	Ritchie Torres	Democrat
	California's 22nd Congressional District	David Valadao	Republican
	Louisiana's 6th Congressional District	Cleo Fields	Democrat
	Pennsylvania's 2nd Congressional District	Brendan Boyle	Democrat
	Mississippi's 2nd Congressional District	Bennie Thompson	Democrat
	California's 21st Congressional District	Jim Costa	Democrat
	Georgia's 2nd Congressional District	Sanford Bishop	Democrat
	Texas's 29th Congressional District	Sylvia Garcia	Democrat
	Texas's 34th Congressional District	Vicente Gonzalez	Democrat

Negative Life Experiences

Addresses experiences that impact mental health including factors such as family structure, adverse childhood experiences, and neighborhood safety.

Appendix Figure 5.

Subtheme 5: Negative Life Experiences Across Congressional Districts



Appendix Table 5.

The top 10 congressional districts with the greatest risk for Negative Life Experiences are:

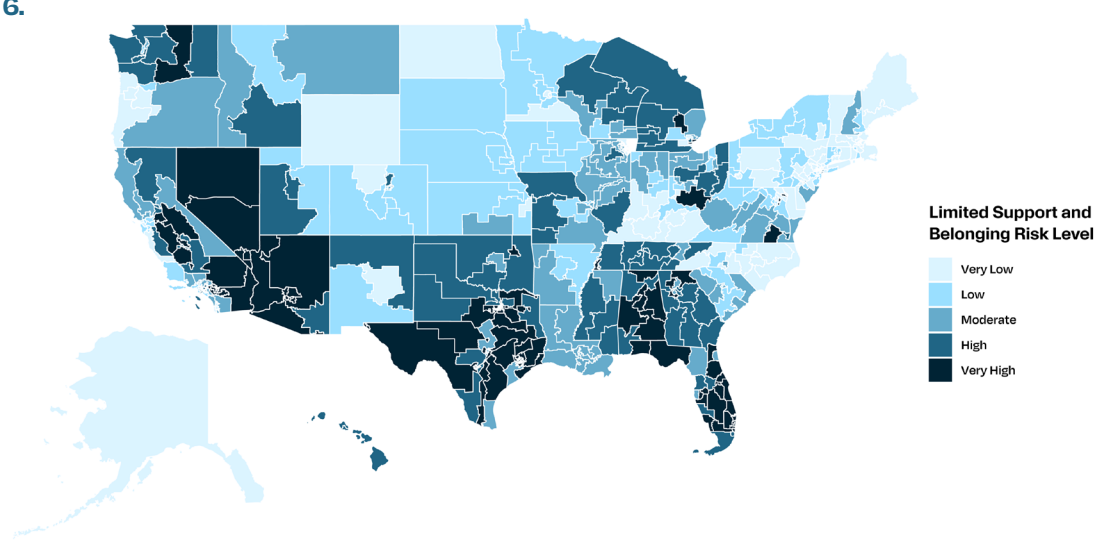
Map	District	Congressperson	Party
Negative Life Experiences	Michigan's 13t Congressional District	Shri Thanedar	Democrat
	Mississippi's 2nd Congressional District	Bennie Thompson	Democrat
	Tennessee's 9th Congressional District	Steve Cohen	Democrat
	Michigan's 12th Congressional District	Rashida Tlaib	Democrat
	Louisiana's 6th Congressional District	Cleo Fields	Democrat
	Louisiana's 2nd Congressional District	Troy Carter	Democrat
	New Mexico's 3rd Congressional District	Teresa Leger Fernandez	Democrat
	Missouri's 1st Congressional District	Wesley Bell	Democrat
	Pennsylvania's 3rd Congressional District	Dwight Evans	Democrat
	Indiana's 7th Congressional District	André Carson	Democrat

Limited Support and Belonging

Explores the quality and nature of relationships within families and peer groups, and social support networks.

Appendix Figure 6.

Subtheme 6: Limited Support and Belonging Across Congressional Districts



Appendix Table 6.

The top 10 congressional districts with the greatest risk for Limited Support and Belonging are:

Map	District	Congressperson	Party
Limited Support and Belonging	Nevada's 1st Congressional District	Dina Titus	Democrat
	Nevada's 4th Congressional District	Steven Horsford	Democrat
	Nevada's 3rd Congressional District	Susie Lee	Democrat
	Florida's 20th Congressional District	Sheila Cherfilus-McCormick	Democrat
	Arizona's 2nd Congressional District	Eli Crane	Republican
	Arizona's 9th Congressional District	Paul A. Gosar	Republican
	Tennessee's 9th Congressional District	Steve Cohen	Democrat
	Arizona's 5th Congressional District	Andy Biggs	Republican
	Arizona's 3rd Congressional District	Yassamin Ansari	Democrat
	Texas's 33rd Congressional District	Marc Veasey	Democrat

Appendix Table 7.

Congressional District Segment Types and ThriveAtlas™ Theme Risk Levels

Legend

- **Segment Types:**
  MB: Multi-Burden, **LB:** Low Burden, **U:** Underserved, **PH:** Personal Hardship
- **ThriveAtlas™ Theme Risk Levels:**
  VH: Very High Risk, **H:** High Risk, **M:** Moderate Risk, **L:** Low Risk, **VL:** Very Low Risk

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Alabama's 1st	MB	H	VH	VH	H	M	H
Alabama's 2nd	MB	H	VH	VH	VH	VH	VH
Alabama's 3rd	MB	H	VH	VH	H	L	VH
Alabama's 4th	MB	H	VH	VH	H	L	H
Alabama's 5th	U	M	VH	H	L	L	VH
Alabama's 6th	U	H	VH	H	VL	VL	VH
Alabama's 7th	MB	H	VH	VH	VH	VH	VH
Alaska (At-Large)	PH	VL	VL	M	H	H	VL
Arizona's 1st	U	VL	L	M	VL	M	VH
Arizona's 2nd	MB	H	H	VH	VH	VH	VH
Arizona's 3rd	MB	H	M	VH	VH	VH	VH
Arizona's 4th	PH	L	L	M	M	VH	VH
Arizona's 5th	U	VL	M	M	VL	M	VH
Arizona's 6th	U	L	H	M	M	H	H
Arizona's 7th	MB	H	H	VH	VH	VH	VH
Arizona's 8th	U	L	M	M	M	H	VH
Arizona's 9th	MB	L	H	H	H	VH	VH
Arkansas's 1st	PH	VH	M	VH	VH	VH	L
Arkansas's 2nd	PH	VH	VL	H	H	VH	L
Arkansas's 3rd	MB	VH	H	VH	M	H	M
Arkansas's 4th	MB	VH	H	VH	VH	VH	M

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
California's 1st	MB	L	VH	H	VH	VH	H
California's 2nd	U	L	H	L	M	H	M
California's 3rd	U	VL	H	L	VL	L	M
California's 4th	U	L	H	L	M	M	M
California's 5th	MB	L	VH	L	M	H	VH
California's 6th	PH	L	H	VL	H	VH	H
California's 7th	PH	M	H	VL	H	VH	H
California's 8th	PH	M	M	L	H	VH	M
California's 9th	MB	M	VH	M	VH	VH	VH
California's 10th	LB	VL	H	VL	VL	VL	L
California's 11th	LB	VL	M	VL	L	VL	VL
California's 12th	LB	L	L	VL	M	M	L
California's 13th	MB	M	VH	M	VH	VH	VH
California's 14th	LB	VL	M	VL	VL	VL	L
California's 15th	LB	VL	L	VL	VL	L	VL
California's 16th	LB	VL	M	VL	VL	VL	L
California's 17th	LB	VL	H	VL	VL	VL	L
California's 18th	MB	L	VH	L	H	H	H
California's 19th	LB	VL	H	VL	VL	L	VL
California's 20th	MB	L	VH	M	H	VH	H
California's 21st	MB	M	VH	M	VH	VH	VH
California's 22nd	MB	H	VH	H	VH	VH	VH
California's 23rd	MB	M	VH	M	VH	VH	VH
California's 24th	LB	L	H	L	H	M	L
California's 25th	MB	M	VH	M	VH	VH	VH
California's 26th	U	VL	M	L	L	H	M
California's 27th	PH	L	H	L	H	VH	M
California's 28th	LB	VL	M	VL	VL	L	M
California's 29th	PH	M	L	M	VH	VH	H

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
California's 30th	LB	L	M	L	M	L	L
California's 31st	PH	L	M	M	H	H	H
California's 32nd	LB	VL	VL	L	L	L	L
California's 33rd	MB	M	VH	M	VH	VH	VH
California's 34th	PH	M	M	H	VH	VH	VH
California's 35th	MB	M	VH	M	H	H	VH
California's 36th	LB	VL	M	VL	L	VL	L
California's 37th	PH	H	M	M	VH	VH	M
California's 38th	U	L	M	L	L	M	H
California's 39th	MB	M	VH	M	VH	H	VH
California's 40th	LB	VL	H	VL	VL	VL	M
California's 41st	MB	L	VH	M	M	M	VH
California's 42nd	PH	M	M	M	VH	H	H
California's 43rd	PH	H	M	M	VH	VH	H
California's 44th	PH	M	M	M	VH	VH	H
California's 45th	U	VL	H	L	L	M	M
California's 46th	MB	M	H	M	H	H	H
California's 47th	LB	VL	M	VL	VL	L	L
California's 48th	U	VL	H	L	L	M	M
California's 49th	U	VL	M	VL	VL	M	M
California's 50th	LB	VL	L	VL	VL	L	VL
California's 51st	LB	VL	M	VL	L	M	VL
California's 52nd	PH	L	L	M	H	VH	M
Colorado's 1st	LB	L	VL	L	L	H	L
Colorado's 2nd	LB	VL	M	VL	L	VL	VL
Colorado's 3rd	U	VL	H	H	M	H	L
Colorado's 4th	LB	VL	L	L	VL	VL	L
Colorado's 5th	LB	VL	L	L	L	M	L
Colorado's 6th	U	L	VL	M	L	M	M
Colorado's 7th	LB	VL	VL	L	VL	L	L

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Colorado's 8th	PH	L	L	M	M	M	H
Connecticut's 1st	LB	H	VL	VL	M	M	L
Connecticut's 2nd	LB	L	VL	VL	M	VL	VL
Connecticut's 3rd	LB	M	VL	VL	L	L	VL
Connecticut's 4th	LB	M	VL	VL	L	VL	L
Connecticut's 5th	LB	M	VL	VL	L	VL	L
Delaware (At-Large)	PH	H	L	VL	M	VH	VL
District of Columbia (At-Large)	PH	L	VL	VL	H	VH	VL
Florida's 1st	MB	VL	VH	VH	L	H	VH
Florida's 2nd	MB	M	VH	VH	VH	VH	VH
Florida's 3rd	MB	L	H	VH	H	H	M
Florida's 4th	MB	M	H	VH	H	VH	VH
Florida's 5th	U	VL	H	H	VL	L	M
Florida's 6th	MB	M	VH	VH	H	H	VH
Florida's 7th	U	VL	VH	H	VL	L	VH
Florida's 8th	U	VL	VH	H	M	M	VH
Florida's 9th	U	L	VH	VH	L	M	VH
Florida's 10th	MB	L	H	H	M	M	VH
Florida's 11th	U	VL	VH	H	L	L	H
Florida's 12th	MB	VL	VH	VH	M	L	H
Florida's 13th	U	VL	M	VH	L	L	M
Florida's 14th	MB	L	M	H	M	H	VH
Florida's 15th	U	L	VH	H	M	M	VH
Florida's 16th	U	L	M	H	M	M	VH
Florida's 17th	U	L	H	VH	M	L	H
Florida's 18th	MB	H	VH	VH	VH	H	VH
Florida's 19th	U	L	H	VH	M	L	VH
Florida's 20th	MB	H	H	VH	VH	VH	VH
Florida's 21st	U	VL	H	VH	L	M	VH

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Florida's 22nd	U	L	H	VH	M	M	VH
Florida's 23rd	U	VL	H	H	L	L	VH
Florida's 24th	MB	H	M	VH	VH	VH	VH
Florida's 25th	U	VL	M	H	VL	L	VH
Florida's 26th	U	L	H	VH	M	M	VH
Florida's 27th	U	VL	M	VH	L	VL	H
Florida's 28th	U	L	M	VH	M	M	H
Georgia's 1st	MB	H	VH	VH	VH	H	H
Georgia's 2nd	MB	VH	VH	VH	VH	VH	H
Georgia's 3rd	MB	H	VH	VH	H	M	H
Georgia's 4th	MB	VH	M	VH	H	M	H
Georgia's 5th	PH	H	M	H	H	VH	M
Georgia's 6th	U	H	M	H	L	M	M
Georgia's 7th	U	VL	H	H	VL	VL	H
Georgia's 8th	MB	VH	VH	VH	VH	H	H
Georgia's 9th	U	M	VH	VH	L	L	VH
Georgia's 10th	MB	H	VH	VH	H	M	H
Georgia's 11th	U	L	H	VH	VL	VL	VH
Georgia's 12th	MB	VH	VH	VH	VH	H	H
Georgia's 13th	MB	VH	H	VH	M	M	VH
Georgia's 14th	MB	H	VH	VH	M	L	H
Hawaii's 1st	U	M	L	L	L	L	H
Hawaii's 2nd	U	H	M	L	M	M	H
Idaho's 1st	U	M	L	H	L	L	M
Idaho's 2nd	U	L	M	H	M	L	H
Illinois's 1st	PH	H	L	M	VH	VH	M
Illinois's 2nd	PH	H	L	H	VH	VH	M
Illinois's 3rd	U	M	VL	H	L	L	M
Illinois's 4th	PH	H	VL	H	VH	L	M
Illinois's 5th	LB	VL	VL	L	VL	VL	VL

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Illinois's 6th	LB	VL	VL	L	VL	VL	VL
Illinois's 7th	PH	H	L	M	VH	VH	M
Illinois's 8th	LB	L	VL	M	VL	VL	M
Illinois's 9th	LB	VL	VL	L	L	VL	VL
Illinois's 10th	LB	VL	VL	M	VL	VL	VL
Illinois's 11th	LB	VL	L	L	VL	VL	M
Illinois's 12th	U	VL	H	H	H	VL	H
Illinois's 13th	PH	VL	M	M	VH	L	M
Illinois's 14th	LB	VL	L	M	M	VL	H
Illinois's 15th	U	VL	VH	H	L	VL	M
Illinois's 16th	U	VL	H	M	L	VL	M
Illinois's 17th	U	L	H	H	VH	M	M
Indiana's 1st	PH	VH	H	L	H	VH	L
Indiana's 2nd	MB	VH	VH	H	M	H	M
Indiana's 3rd	MB	VH	VH	VH	M	M	M
Indiana's 4th	U	VH	H	L	L	L	M
Indiana's 5th	U	VH	H	L	L	M	L
Indiana's 6th	U	VH	M	L	M	M	L
Indiana's 7th	PH	VH	M	H	H	VH	M
Indiana's 8th	U	VH	M	M	M	M	VL
Indiana's 9th	U	VH	M	M	M	M	VL
Iowa's 1st	LB	M	M	VL	L	L	L
Iowa's 2nd	LB	M	M	VL	L	L	L
Iowa's 3rd	U	M	H	VL	L	L	L
Iowa's 4th	LB	M	H	L	L	L	L
Kansas's 1st	U	M	L	H	L	L	L
Kansas's 2nd	PH	H	L	VH	H	H	L
Kansas's 3rd	LB	VL	L	M	VL	VL	VL
Kansas's 4th	PH	H	VL	VH	M	H	M
Kentucky's 1st	PH	H	H	H	VH	H	VL

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Kentucky's 2nd	PH	M	M	H	H	M	VL
Kentucky's 3rd	PH	H	L	M	H	VH	VL
Kentucky's 4th	LB	M	L	M	L	L	L
Kentucky's 5th	PH	H	L	M	VH	H	VL
Kentucky's 6th	PH	M	VL	L	H	H	VL
Louisiana's 1st	PH	H	L	H	M	M	M
Louisiana's 2nd	PH	VH	L	VH	VH	VH	M
Louisiana's 3rd	PH	VH	H	M	VH	VH	M
Louisiana's 4th	PH	VH	H	H	VH	VH	M
Louisiana's 5th	PH	VH	H	H	VH	VH	M
Louisiana's 6th	PH	VH	H	H	VH	VH	M
Maine's 1st	LB	VL	VL	L	VL	L	VL
Maine's 2nd	LB	VL	L	M	M	L	VL
Maryland's 1st	LB	H	VL	VL	L	VL	VL
Maryland's 2nd	LB	L	VL	VL	L	VL	VL
Maryland's 3rd	LB	L	VL	VL	VL	VL	VL
Maryland's 4th	PH	VH	VL	L	H	M	VH
Maryland's 5th	LB	L	VL	VL	VL	VL	L
Maryland's 6th	LB	M	L	VL	VL	VL	L
Maryland's 7th	PH	H	VL	L	VH	VH	VH
Maryland's 8th	LB	L	VL	VL	VL	VL	VL
Massachusetts's 1st	PH	H	VL	VL	H	M	VL
Massachusetts's 2nd	LB	L	VL	VL	L	VL	VL
Massachusetts's 3rd	LB	L	VL	VL	M	L	VL
Massachusetts's 4th	LB	VL	VL	VL	VL	VL	VL
Massachusetts's 5th	LB	VL	VL	VL	VL	VL	VL
Massachusetts's 6th	LB	VL	VL	VL	VL	VL	VL
Massachusetts's 7th	LB	M	VL	VL	M	M	VL
Massachusetts's 8th	LB	VL	VL	VL	VL	VL	VL
Massachusetts's 9th	LB	L	VL	VL	L	VL	VL

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Michigan's 1st	U	M	H	M	H	M	H
Michigan's 2nd	PH	M	M	M	VH	H	H
Michigan's 3rd	PH	H	VL	VL	M	VH	H
Michigan's 4th	PH	H	L	L	M	H	H
Michigan's 5th	PH	H	H	M	H	H	H
Michigan's 6th	LB	L	VL	VL	L	L	VL
Michigan's 7th	LB	M	L	VL	L	M	L
Michigan's 8th	PH	VH	M	L	VH	VH	VH
Michigan's 9th	U	M	M	L	L	M	M
Michigan's 10th	PH	VH	L	VL	M	H	M
Michigan's 11th	LB	M	L	VL	L	M	VL
Michigan's 12th	PH	VH	VL	VL	VH	VH	H
Michigan's 13th	PH	VH	VL	L	VH	VH	VH
Minnesota's 1st	LB	L	L	L	VL	VL	VL
Minnesota's 2nd	LB	VL	VL	VL	VL	VL	L
Minnesota's 3rd	LB	VL	VL	VL	VL	VL	VL
Minnesota's 4th	LB	L	VL	VL	VL	L	L
Minnesota's 5th	LB	VL	VL	VL	M	L	VL
Minnesota's 6th	LB	VL	L	VL	VL	VL	L
Minnesota's 7th	LB	L	M	L	L	VL	L
Minnesota's 8th	LB	L	L	L	L	L	L
Mississippi's 1st	MB	H	VH	VH	H	VH	M
Mississippi's 2nd	MB	VH	VH	VH	VH	VH	H
Mississippi's 3rd	MB	H	H	VH	VH	VH	H
Mississippi's 4th	MB	H	VH	VH	VH	VH	H
Missouri's 1st	PH	VH	M	H	H	VH	M
Missouri's 2nd	LB	L	H	L	VL	VL	M
Missouri's 3rd	U	M	M	H	L	L	L
Missouri's 4th	U	M	H	VH	H	M	H
Missouri's 5th	PH	VH	M	H	M	VH	H

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Missouri's 6th	MB	M	VH	VH	M	M	H
Missouri's 7th	MB	H	H	VH	H	H	H
Missouri's 8th	MB	M	VH	VH	H	H	M
Montana's 1st	LB	VL	VL	M	L	M	L
Montana's 2nd	PH	L	L	H	M	H	M
Nebraska's 1st	LB	L	VL	L	VL	L	L
Nebraska's 2nd	LB	M	VL	M	VL	M	L
Nebraska's 3rd	U	L	L	H	L	L	L
Nevada's 1st	MB	M	VH	VH	VH	VH	VH
Nevada's 2nd	MB	VL	M	H	M	H	VH
Nevada's 3rd	MB	L	VH	H	M	H	VH
Nevada's 4th	MB	M	VH	VH	VH	VH	VH
New Hampshire's 1st	LB	M	L	VL	VL	VL	L
New Hampshire's 2nd	LB	M	VL	VL	VL	VL	M
New Jersey's 1st	PH	M	VL	L	M	M	L
New Jersey's 2nd	U	H	M	M	H	L	M
New Jersey's 3rd	LB	L	VL	L	VL	VL	VL
New Jersey's 4th	LB	L	L	L	L	VL	L
New Jersey's 5th	LB	VL	L	L	VL	VL	VL
New Jersey's 6th	LB	M	L	M	L	L	L
New Jersey's 7th	LB	VL	VL	VL	VL	VL	VL
New Jersey's 8th	PH	VH	L	H	VH	M	M
New Jersey's 9th	PH	H	L	M	M	M	L
New Jersey's 10th	PH	VH	L	H	VH	H	M
New Jersey's 11th	LB	VL	VL	L	VL	VL	VL
New Jersey's 12th	LB	L	L	L	L	VL	L
New Mexico's 1st	PH	H	L	M	H	VH	VL
New Mexico's 2nd	PH	VH	H	H	VH	VH	L
New Mexico's 3rd	MB	VH	H	H	VH	VH	H

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
New York's 1st	LB	M	L	VL	VL	VL	VL
New York's 2nd	LB	H	L	L	L	L	L
New York's 3rd	LB	L	L	VL	VL	VL	VL
New York's 4th	LB	M	L	VL	VL	L	VL
New York's 5th	PH	VH	M	L	H	H	H
New York's 6th	U	VH	L	L	L	L	M
New York's 7th	PH	VH	L	L	VH	H	L
New York's 8th	PH	VH	M	L	VH	VH	H
New York's 9th	PH	VH	M	L	H	H	M
New York's 10th	LB	M	L	VL	M	L	VL
New York's 11th	LB	H	L	L	M	L	VL
New York's 12th	LB	VL	L	VL	VL	VL	VL
New York's 13th	PH	VH	L	L	VH	VH	M
New York's 14th	PH	VH	L	M	VH	VH	H
New York's 15th	PH	VH	L	L	VH	VH	H
New York's 16th	LB	VH	VL	VL	L	M	VL
New York's 17th	LB	M	VL	L	L	VL	VL
New York's 18th	LB	VH	M	L	H	L	VL
New York's 19th	LB	M	M	L	H	L	VL
New York's 20th	LB	M	VL	VL	M	M	VL
New York's 21st	PH	H	L	M	H	L	L
New York's 22nd	PH	H	L	L	H	H	L
New York's 23rd	U	M	M	M	H	L	L
New York's 24th	PH	H	M	M	H	L	L
New York's 25th	PH	H	L	L	M	H	L
New York's 26th	PH	H	L	L	H	H	L
North Carolina's 1st	MB	VH	VH	VH	VH	VH	VL
North Carolina's 2nd	LB	M	VL	L	VL	M	VL
North Carolina's 3rd	PH	VH	H	H	H	H	VL
North Carolina's 4th	LB	L	VL	L	VL	L	VL

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
North Carolina's 5th	PH	VH	H	H	VH	H	VL
North Carolina's 6th	PH	H	M	M	H	H	L
North Carolina's 7th	PH	VH	L	H	H	VH	VL
North Carolina's 8th	U	VH	M	H	L	M	VL
North Carolina's 9th	PH	VH	H	M	M	H	VL
North Carolina's 10th	PH	H	M	M	H	H	L
North Carolina's 11th	LB	H	VL	VH	M	L	VL
North Carolina's 12th	PH	H	L	M	M	VH	M
North Carolina's 13th	U	VH	M	H	M	M	VL
North Carolina's 14th	PH	H	L	M	M	M	VL
North Dakota (At-Large)	LB	VL	VL	M	VL	VL	VL
Ohio's 1st	PH	H	VL	L	M	M	VL
Ohio's 2nd	MB	VH	L	H	H	M	VH
Ohio's 3rd	PH	VH	VL	L	M	VH	VL
Ohio's 4th	U	VH	H	H	L	L	H
Ohio's 5th	U	VH	M	M	M	M	M
Ohio's 6th	MB	VH	M	H	H	H	H
Ohio's 7th	LB	H	VL	H	VL	VL	L
Ohio's 8th	PH	H	VL	L	M	M	L
Ohio's 9th	PH	VH	L	M	H	H	M
Ohio's 10th	PH	VH	L	M	H	M	L
Ohio's 11th	PH	VH	VL	M	VH	VH	L
Ohio's 12th	MB	VH	M	VH	M	L	H
Ohio's 13th	PH	VH	VL	L	M	M	M
Ohio's 14th	U	VH	VL	H	M	L	H
Ohio's 15th	PH	VH	VL	M	L	M	M
Oklahoma's 1st	MB	H	H	H	M	VH	VH
Oklahoma's 2nd	MB	M	VH	VH	VH	VH	H
Oklahoma's 3rd	MB	M	VH	VH	H	VH	H
Oklahoma's 4th	PH	M	H	H	H	VH	H

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Oklahoma's 5th	U	M	M	H	M	VH	M
Oregon's 1st	LB	L	L	VL	L	L	VL
Oregon's 2nd	PH	L	H	M	VH	H	M
Oregon's 3rd	LB	L	VL	VL	L	M	L
Oregon's 4th	LB	L	L	VL	H	M	VL
Oregon's 5th	LB	L	L	VL	L	M	VL
Oregon's 6th	LB	L	M	VL	M	H	VL
Pennsylvania's 1st	LB	VL	VL	VL	VL	VL	VL
Pennsylvania's 2nd	PH	VH	VL	M	VH	VH	M
Pennsylvania's 3rd	PH	H	VL	L	VH	VH	M
Pennsylvania's 4th	LB	VL	VL	VL	VL	VL	VL
Pennsylvania's 5th	LB	VL	VL	VL	M	H	VL
Pennsylvania's 6th	LB	VL	L	M	VL	L	L
Pennsylvania's 7th	LB	VL	M	L	M	H	VL
Pennsylvania's 8th	PH	L	M	M	H	H	L
Pennsylvania's 9th	U	L	M	H	H	M	L
Pennsylvania's 10th	LB	L	M	L	L	H	L
Pennsylvania's 11th	U	VL	L	VH	L	L	L
Pennsylvania's 12th	LB	VL	VL	L	M	H	VL
Pennsylvania's 13th	U	L	H	H	L	M	VL
Pennsylvania's 14th	LB	L	L	M	M	VL	L
Pennsylvania's 15th	LB	M	L	M	H	L	VL
Pennsylvania's 16th	PH	VL	L	M	H	M	L
Pennsylvania's 17th	LB	VL	VL	VL	VL	VL	L
Rhode Island's 1st	LB	H	VL	VL	L	M	L
Rhode Island's 2nd	LB	M	VL	VL	L	L	VL
South Carolina's 1st	U	L	L	H	L	L	M
South Carolina's 2nd	U	H	M	H	L	M	M
South Carolina's 3rd	MB	M	VH	VH	VH	L	M
South Carolina's 4th	U	M	M	VH	L	L	L

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
South Carolina's 5th	U	M	H	H	H	M	L
South Carolina's 6th	PH	H	M	VH	VH	H	L
South Carolina's 7th	MB	H	H	VH	VH	H	M
South Dakota (At-Large)	U	L	M	M	L	M	L
Tennessee's 1st	MB	H	VH	H	H	H	H
Tennessee's 2nd	U	H	M	H	L	M	M
Tennessee's 3rd	MB	VH	VH	H	H	H	H
Tennessee's 4th	MB	H	VH	H	M	H	H
Tennessee's 5th	U	H	H	M	VL	L	H
Tennessee's 6th	MB	H	VH	H	H	H	H
Tennessee's 7th	MB	VH	H	H	M	VH	H
Tennessee's 8th	MB	VH	VH	H	H	VH	H
Tennessee's 9th	MB	VH	VH	VH	VH	VH	VH
Texas's 1st	MB	VH	VH	VH	H	H	H
Texas's 2nd	U	M	VH	H	L	L	VH
Texas's 3rd	U	VL	H	M	VL	VL	H
Texas's 4th	U	M	H	H	L	VL	VH
Texas's 5th	MB	VH	VH	VH	M	M	VH
Texas's 6th	MB	VH	VH	VH	H	M	VH
Texas's 7th	MB	H	VH	VH	M	L	VH
Texas's 8th	MB	M	VH	H	M	L	VH
Texas's 9th	MB	VH	VH	VH	VH	H	VH
Texas's 10th	MB	M	VH	H	M	L	VH
Texas's 11th	MB	VH	VH	VH	H	H	VH
Texas's 12th	U	M	VH	H	L	M	VH
Texas's 13th	MB	H	VH	VH	M	H	H
Texas's 14th	MB	H	VH	VH	H	H	VH
Texas's 15th	MB	VH	VH	VH	VH	H	VH
Texas's 16th	MB	H	VH	VH	VH	M	VH
Texas's 17th	MB	VH	VH	VH	H	VH	VH

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Texas's 18th	MB	VH	VH	VH	VH	VH	VH
Texas's 19th	MB	VH	VH	VH	H	H	H
Texas's 20th	MB	H	H	H	VH	H	VH
Texas's 21st	U	M	H	M	VL	VL	H
Texas's 22nd	U	L	H	H	VL	VL	M
Texas's 23rd	MB	VH	VH	VH	M	M	VH
Texas's 24th	U	VL	H	M	VL	VL	VH
Texas's 25th	MB	H	VH	VH	H	M	VH
Texas's 26th	U	L	H	M	VL	VL	H
Texas's 27th	MB	VH	VH	VH	VH	H	VH
Texas's 28th	MB	VH	VH	VH	VH	H	H
Texas's 29th	MB	VH	VH	VH	VH	H	VH
Texas's 30th	MB	VH	VH	VH	VH	VH	VH
Texas's 31st	U	M	H	H	VL	M	M
Texas's 32nd	MB	H	H	VH	H	M	VH
Texas's 33rd	MB	VH	VH	VH	VH	H	VH
Texas's 34th	MB	VH	VH	VH	VH	H	M
Texas's 35th	MB	H	H	H	H	H	VH
Texas's 36th	MB	H	VH	VH	VH	H	VH
Texas's 37th	U	VL	M	M	L	VL	M
Texas's 38th	U	M	VH	M	VL	VL	VH
Utah's 1st	LB	VL	VH	L	VL	VL	L
Utah's 2nd	U	VL	H	M	L	L	H
Utah's 3rd	LB	VL	H	L	VL	VL	L
Utah's 4th	U	VL	M	L	VL	VL	H
Vermont (At-Large)	LB	VL	VL	VL	L	VL	VL
Virginia's 1st	LB	M	M	L	VL	VL	M
Virginia's 2nd	U	H	M	L	VL	L	M
Virginia's 3rd	PH	VH	M	L	H	H	H
Virginia's 4th	PH	VH	L	M	H	H	VH

District	Segment	Limited Wellness Practices	Provider Shortage	Access-ibility Barriers	Socio-economic Hardship	Negative Life Expe-riences	Limited Support and Belonging
Virginia's 5th	U	H	L	H	M	L	M
Virginia's 6th	U	H	M	H	M	L	M
Virginia's 7th	U	H	H	L	VL	VL	M
Virginia's 8th	LB	L	VL	L	VL	VL	L
Virginia's 9th	U	M	H	M	H	VL	L
Virginia's 10th	LB	L	L	L	VL	VL	L
Virginia's 11th	LB	VL	VL	VL	VL	VL	L
Washington's 1st	LB	L	VL	VL	VL	L	M
Washington's 2nd	U	M	L	VL	L	M	H
Washington's 3rd	PH	M	L	VL	H	H	H
Washington's 4th	MB	H	H	M	VH	VH	VH
Washington's 5th	PH	M	VL	L	H	M	H
Washington's 6th	PH	M	L	VL	L	H	H
Washington's 7th	LB	VL	VL	VL	VL	L	L
Washington's 8th	U	L	L	VL	VL	L	H
Washington's 9th	PH	H	VL	VL	L	H	H
Washington's 10th	U	M	H	VL	M	H	H
West Virginia's 1st	PH	M	M	M	VH	M	M
West Virginia's 2nd	PH	L	M	M	VH	L	L
Wisconsin's 1st	U	L	H	L	L	L	M
Wisconsin's 2nd	LB	VL	VL	VL	VL	VL	L
Wisconsin's 3rd	U	L	M	M	L	VL	M
Wisconsin's 4th	PH	M	L	L	H	VH	M
Wisconsin's 5th	LB	VL	L	VL	VL	VL	M
Wisconsin's 6th	U	L	H	L	VL	VL	H
Wisconsin's 7th	U	M	M	H	L	VL	H
Wisconsin's 8th	U	L	H	L	VL	VL	H
Wyoming (At-Large)	LB	VL	L	H	L	L	VL

Appendix Table 8.

Distribution of Congressional Districts in each Risk Segment by State, Medicaid Expenditure and Enrollment

State	Census Region	% of Multi-burden districts	% of Low Burden districts	% of Personal hardship districts	% of Un-derserved districts	Total CDs within state	Medicaid Expendi-tures as a Percent of Total State Expendi-tures by Fund (2023)	Medicaid per capita expen-ditures (2022)	Medicaid per capita expen-ditures (2022)22 [children only]	Propor-tion of population enrolled in Medicaid (10/ 2024)
Alabama	South	71%	0%	0%	29%	7	22%	$5,893	$2,680	15%
Alaska	West	0%	0%	100%	0%	1	17%	$9,992	$5,911	32%
Arizona*	West	44%	0%	11%	44%	9	23%	$9,109	$4,005	25%
Arkansas*	South	50%	0%	50%	0%	4	29%	$9,269	$3,343	25%
California	West	29%	33%	23%	15%	52	32%	$8,567	$3,419	31%
Colorado	West	0%	63%	13%	25%	8	36%	$7,687	$3,387	18%
Connecticut	Northeast	0%	100%	0%	0%	5	24%	$8,289	$3,763	25%
Delaware	South	0%	0%	100%	0%	1	21%	$10,744	$5,242	24%
Florida	South	39%	0%	0%	61%	28	31%	$6,536	$3,510	16%
Georgia	South	64%	0%	7%	29%	14	23%	$5,577	$2,747	16%
Hawaii	West	0%	0%	0%	100%	2	17%	$7,167	$3,394	26%
Idaho	West	0%	0%	0%	100%	2	33%	$7,879	$2,970	16%
Illinois*	Midwest	0%	41%	29%	29%	17	17%	$9,108	$3,370	23%
Indiana*	Midwest	22%	0%	22%	56%	9	33%	$8,509	$3,329	24%
Iowa	Midwest	0%	75%	0%	25%	4	26%	$8,856	$3,431	19%
Kansas	Midwest	0%	25%	50%	25%	4	23%	$10,089	$3,943	12%
Kentucky	South	0%	17%	83%	0%	6	33%	$9,160	$4,593	28%
Louisiana	South	0%	0%	100%	0%	6	38%	$8,167	$3,999	30%
Maine	Northeast	0%	100%	0%	0%	2	32%	$9,144	$4,144	24%
Maryland	South	0%	75%	25%	0%	8	21%	$9,719	$3,898	22%
Massachu-setts	Northeast	0%	89%	11%	0%	9	30%	$10,254	$4,118	21%
Michigan	Midwest	0%	23%	62%	15%	13	29%	$7,120	$2,884	22%
Minnesota	Midwest	0%	100%	0%	0%	8	33%	$12,823	$4,182	21%
Mississippi	South	100%	0%	0%	0%	4	25%	$7,029	$3,261	18%
Missouri+	Midwest	38%	13%	25%	25%	8	41%	$9,517	$4,682	19%
Montana*	West	0%	50%	50%	0%	2	23%	$8,141	$4,471	18%
Nebraska	Midwest	0%	67%	0%	33%	3	23%	$10,308	$3,777	16%

State	Census Region	% of Multi-burden districts	% of Low Burden districts	% of Personal hardship districts	% of Un-derserved districts	Total CDs within state	Medicaid Expendi-tures as a Percent of Total State Expendi-tures by Fund (2023)	Medicaid per capita expen-ditures (2022)	Medicaid per capita expen-ditures (2022)22 [children only]	Propor-tion of population enrolled in Medicaid (10/ 2024)
Nevada	West	100%	0%	0%	0%	4	32%	$5,495	$2,586	23%
New Hampshire*	Northeast	0%	100%	0%	0%	2	31%	$9,245	$4,843	12%
New Jersey	Northeast	0%	58%	33%	8%	12	25%	$10,569	$3,741	17%
New Mexico	West	33%	0%	67%	0%	3	34%	$8,991	$4,930	34%
New York	Northeast	0%	46%	46%	8%	26	38%	$11,203	$3,727	30%
North Carolina*	South	7%	21%	57%	14%	14	31%	$7,169	$3,589	23%
North Dakota	Midwest	0%	100%	0%	0%	1	19%	$13,097	$4,003	13%
Ohio	Midwest	20%	7%	53%	20%	15	39%	$9,520	$4,020	22%
Oklahoma+	South	60%	0%	20%	20%	5	34%	$7,380	$4,320	23%
Oregon	West	0%	83%	17%	0%	6	27%	$10,658	$5,199	26%
Pennsyl-vania	Northeast	0%	59%	24%	18%	17	40%	$12,115	$4,695	22%
Rhode Island	Northeast	0%	100%	0%	0%	2	26%	$9,002	$3,904	25%
South Carolina	South	29%	0%	14%	57%	7	22%	$5,245	$2,888	18%
South Dakota+	Midwest	0%	0%	0%	100%	1	19%	$9,773	$3,716	14%
Tennessee	South	78%	0%	0%	22%	9	31%	$7,077	$3,839	18%
Texas	South	71%	0%	0%	29%	38	42%	$9,637	$5,332	13%
Utah*	West	0%	50%	0%	50%	4	20%	$9,288	$4,232	9%
Vermont	Northeast	0%	100%	0%	0%	1	26%	$9,768	$5,843	24%
Virginia*	South	0%	36%	18%	46%	11	28%	$10,543	$3,829	19%
Washington	West	10%	20%	40%	30%	10	26%	$10,436	$3,822	23%
West Virginia	South	0%	0%	100%	0%	2	23%	$7,912	$3,518	26%
Wisconsin	Midwest	0%	25%	13%	63%	8	22%	$8,047	$3,020	19%
Wyoming	West	0%	100%	0%	0%	1	13%	$9,101	$3,821	10%

* 9 states that have trigger laws that would swiftly end their Medicaid expansions if federal funding falls (KFF 2024)

+ South Dakota, Missouri, and Oklahoma's state constitutions require Medicaid expansion, meaning they cannot simply roll it back if federal funding is cut. Instead, they would have to either amend their constitutions or offset the shortfall through tax increases or cuts to other critical services.

Appendix Table 9.

Proportion of Democratic-Led and Republican-Led Congressional Districts Exposure to Risk Themes

ThriveAtlas™ Theme	% of **Democratic-Led** Districts at High or Very High Risk of...	% of **Republican-Led** Districts at High or Very High Risk of...
Limited Wellness Practices	38%	42%
Provider Shortage	25%	55%
Accessibility Barriers	23%	57%
Socioeconomic Hardship	43%	38%
Negative Life Experiences	45%	35%
Limited Support and Belonging	34%	46%

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