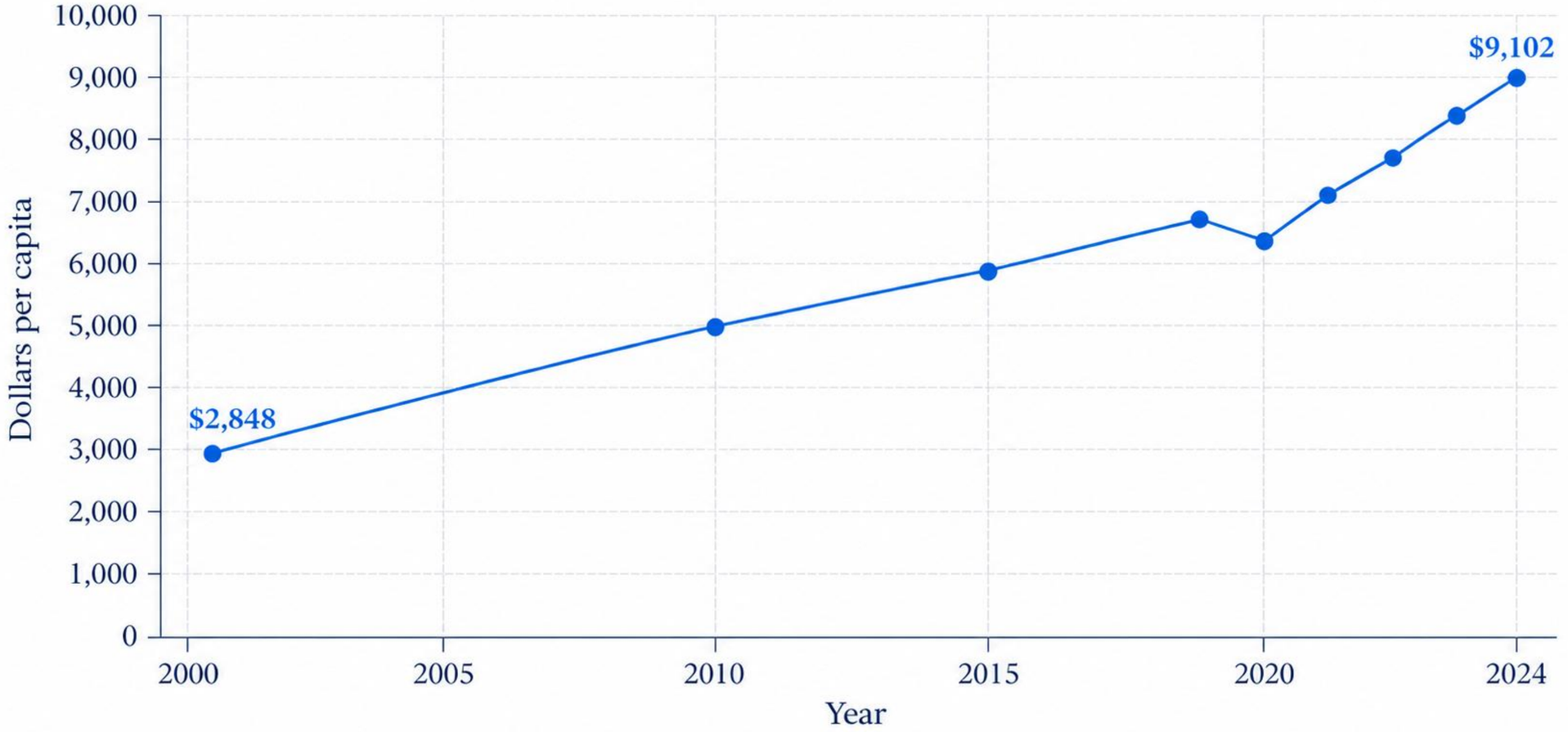
Oklahoma Health Care:
Costs, Access, and Medicaid Program Integrity

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Oklahoma Health Care PCE Per Capita, 2000–2024

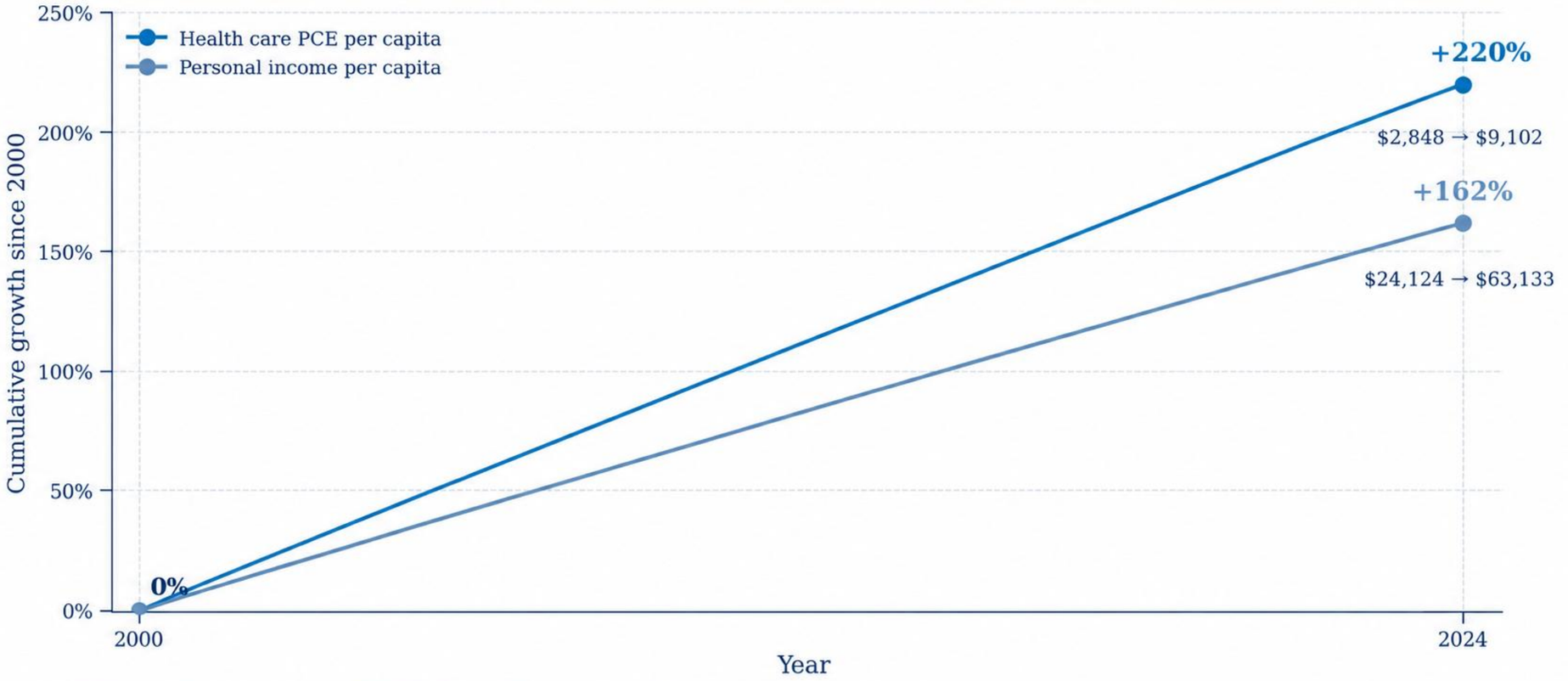
(Dollars per capita, nominal)



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Oklahoma Health Care Spending and Income Growth, 2000–2024

(Cumulative growth since 2000)

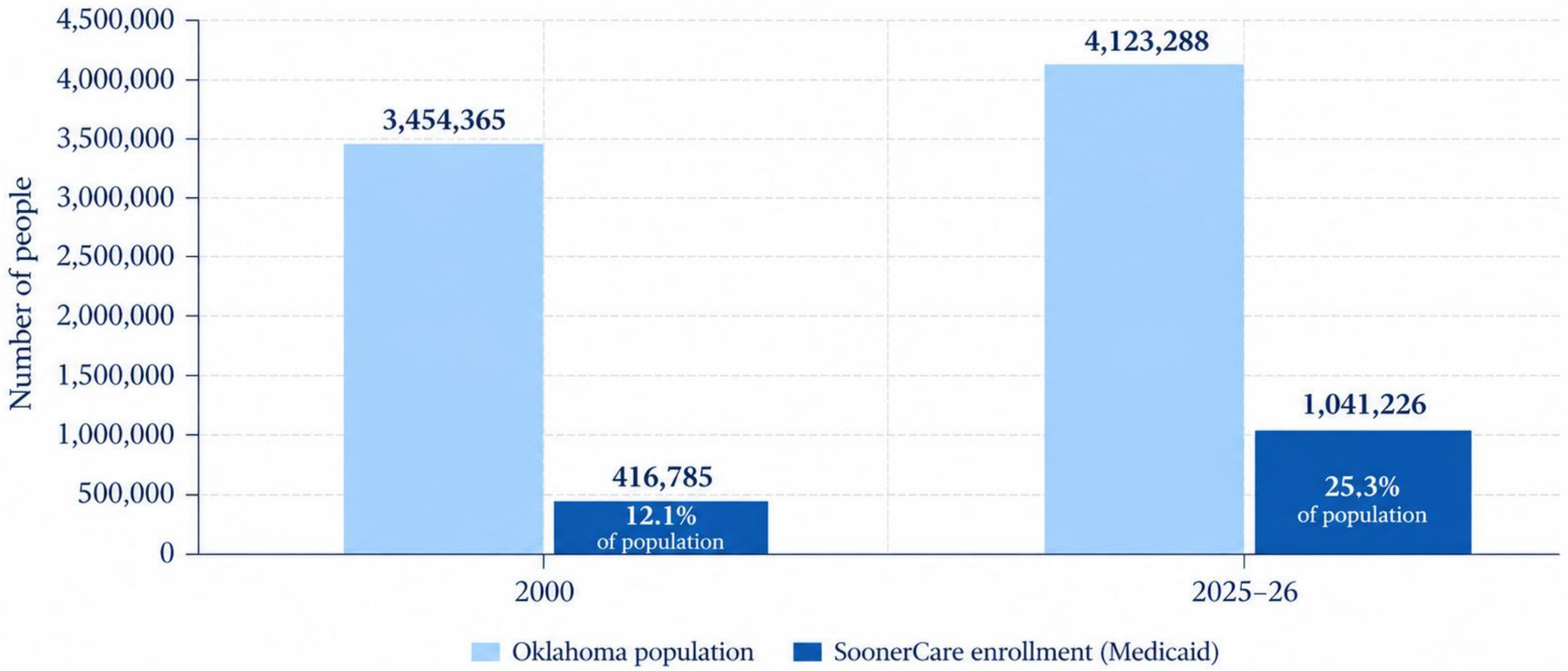


Source: U.S. Bureau of Economic Analysis via FRED. Health care PCE per capita and BEA personal income per capita.

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Oklahoma Population and SoonerCare Enrollment, 2000–2026

(Number of people, nominal)



Sources: Oklahoma Health Care Authority, Annual Report SFY2000; Oklahoma Health Care Authority, *SoonerCare Fast Facts*, August 2026; U.S. Census Bureau, Annual Estimates of the Resident Population for Oklahoma (July 1, 2025).

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Policy Framework for Health Care Access

Health care spending can largely be simplified as:

Health Care Spending ≈ Price x Utilization

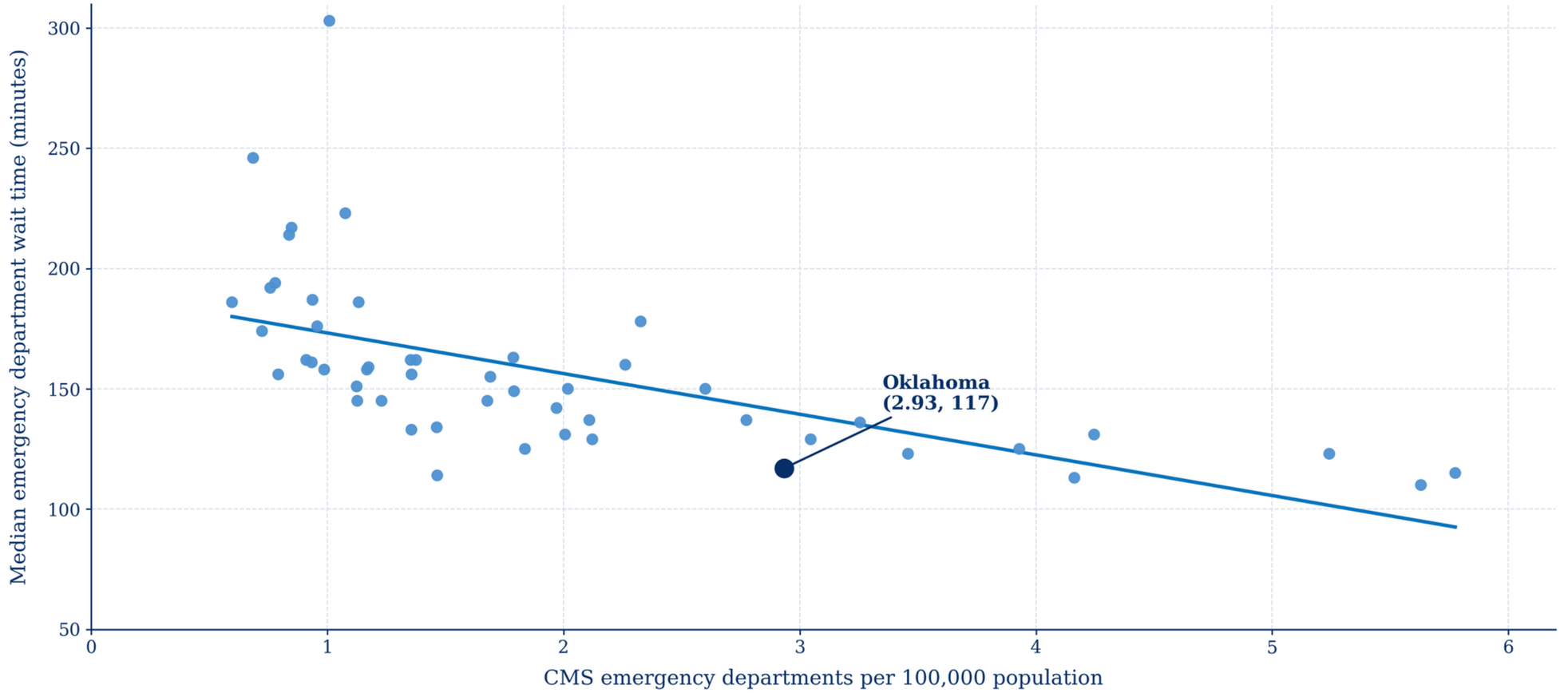
In public policy, access can largely be summarized as the relationship between price, capacity, utilization, and capacity allocation.

Health Care Access ≈ Price, Utilization, Capacity, Allocation

Price determines how expensive each unit is.
Utilization determines how many units are demanded or consumed.
Capacity constrains how many units can be supplied.
Allocation or efficiency determines how much of that finite capacity reaches appropriate patient care.

Emergency Department Facility Density and Wait Times

Median emergency department wait time and number of CMS emergency departments per 100,000 population, by state, 2024–2025



SOURCE: CMS, Timely and Effective Care – State (OP-18b: median time from emergency department arrival to departure for discharged patients); CMS Hospital General Information dataset; U.S. Census Bureau population estimates.

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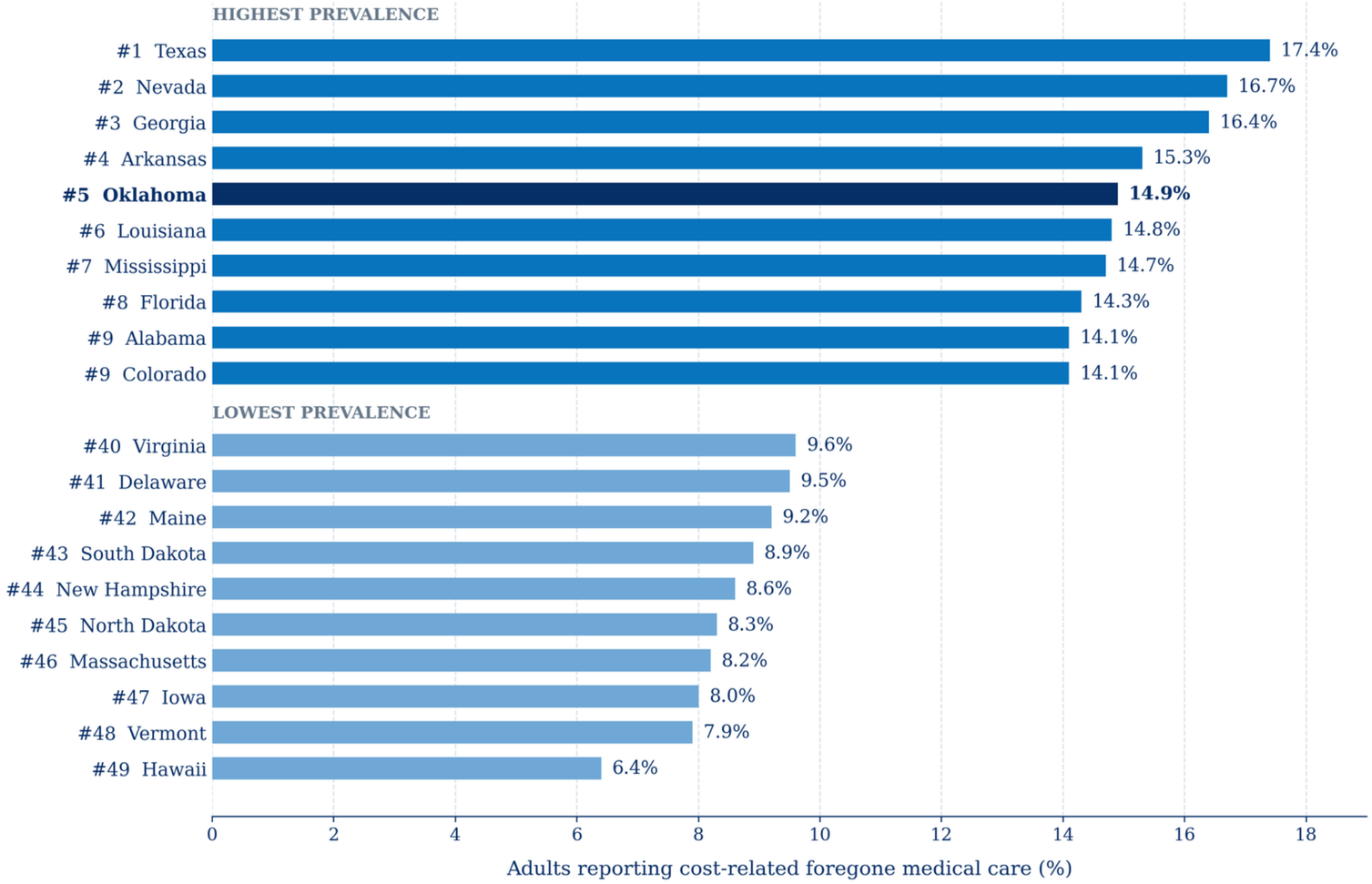
Key Factors for Access

Cost-Related Forgone Care
The Centers for Disease Control and Prevention (CDC) managed Behavioral Risk Factor Surveillance System (BRFSS) survey asks respondents:

“ Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it? ”

Cost-Related Foregone Medical Care by State, 2024

Ten highest and ten lowest state prevalence rates; Oklahoma highlighted

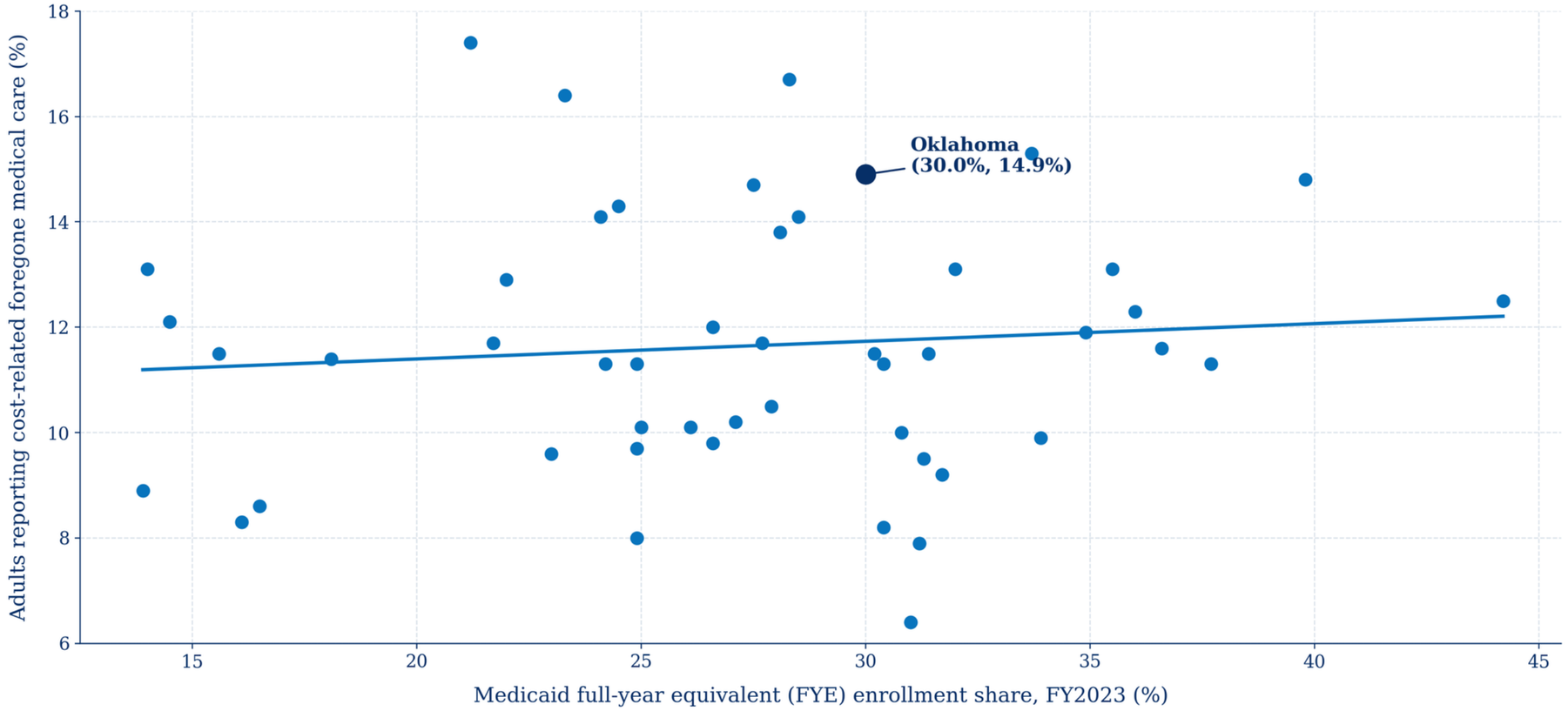


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2024.

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Medicaid Enrollment Share vs. Cost-Related Foregone Care, 2024

Each dot represents a state; Oklahoma highlighted

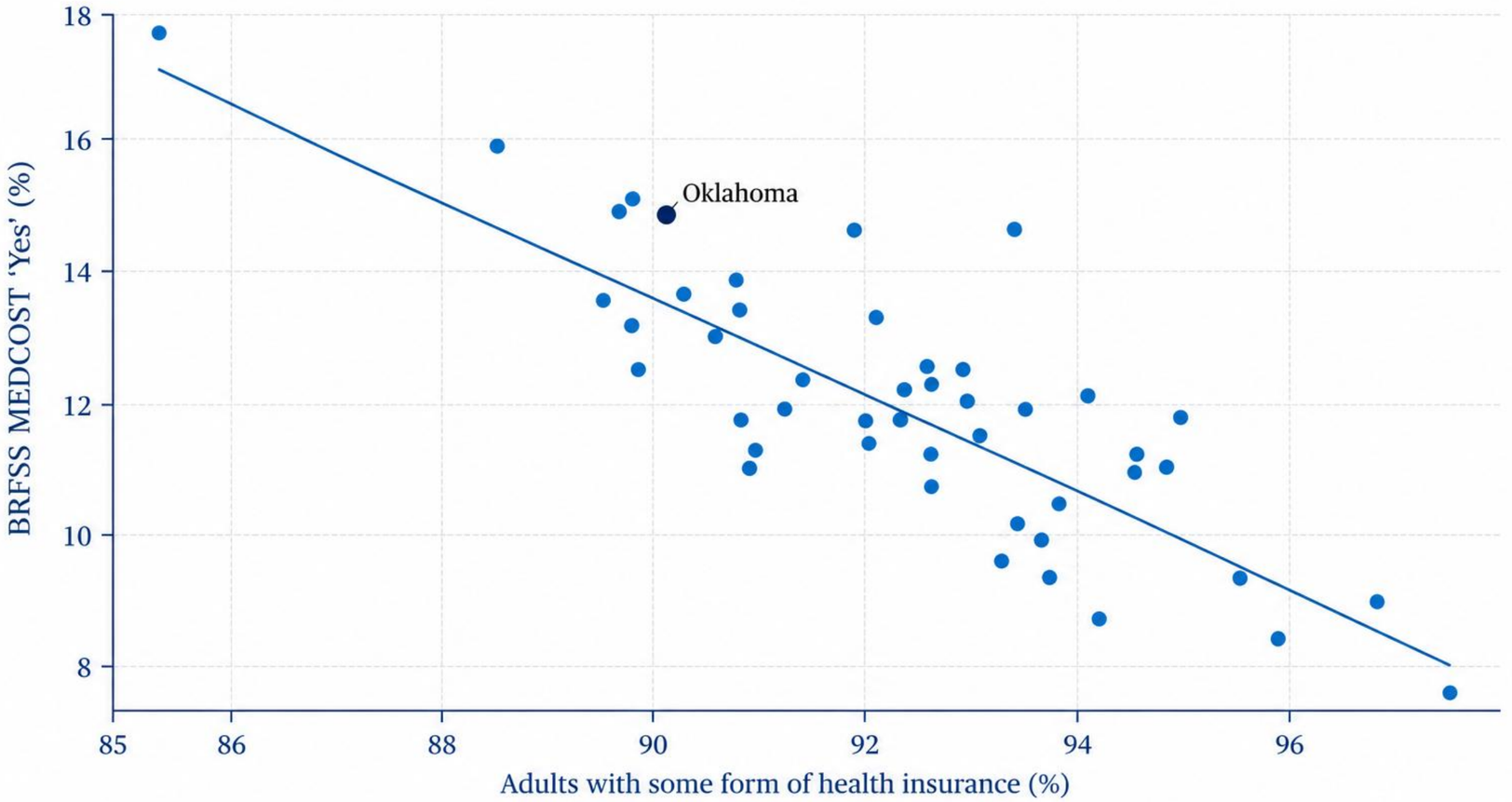


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2024; Medicaid and CHIP Payment and Access Commission (MACPAC), Exhibit 15, FY2023.

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Health-Insurance Coverage vs. Cost-Related Foregone Care, 2025

Each dot represents a state; Oklahoma highlighted

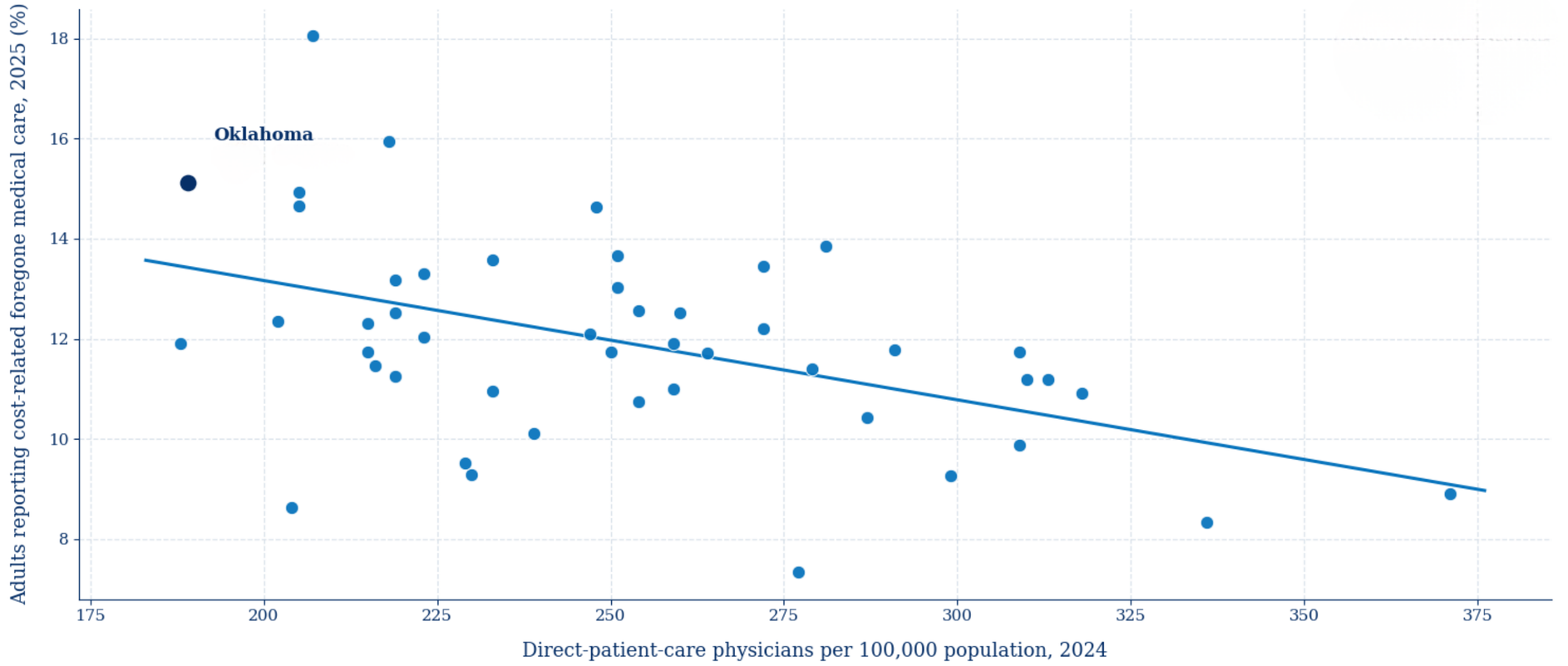


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2025; and U.S. Census Bureau, American Community Survey, 2025.

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Physician Supply vs. Cost-Related Foregone Care, 2025

2024 direct-patient-care physician supply matched to 2025 BRFSS MEDCOST; each dot represents a state



Source: Association of American Medical Colleges (AAMC), U.S. Physician Workforce Data Dashboard, 2024; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2025.

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The Relationship of State Medicaid Integrity with Access & Capacity

Fraud: CMS reports have defined Medicaid fraud as “the intentional providing of false information to get Medicaid to pay for medical care or services.”

Improper payments: According to CMS, improper payments are those “that do not meet program requirements.” Improper payments are not synonymous with fraud.

National Service-Equivalent Translations

We reframed Medicaid fraud and improper payments into real-world health care service equivalents.

FY2024 detected MFCU recoveries ($1.368 billion) were translated into roughly:
13.68 million physician-visit equivalents
21.05 million prescription fill equivalents
171,009 full-year enrollee equivalents

FY2024 Medicaid improper payments ($31.10 billion) were translated into approximately:
311 million physician-visit equivalents
479 million prescription fill equivalents
3.89 million full-year enrollee equivalents

Using a blended service-cost sensitivity range, the paper estimated that improper payments were equivalent to roughly:
10,000 to 25,000 physician-equivalent years for FY2024 and 12,000 to 30,000 for FY2025.

*These figures express scale and do not assert that every improper dollar displaced a patient visit or that every improper payment involved unnecessary clinical care.

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The Implications of Medicaid Integrity on System Capacity

Medicaid fraud and improper payments can affect health care capacity through two forms of displacement that may occur independently or concurrently:

- Clinical Capacity Displacement
- Administrative Capacity Displacement
- Combined Clinical & Administrative Displacement

>>> Medicaid fraud and improper payments can impose capacity costs beyond the value or utilization represented by the improper payment or fraud itself.

Current Oklahoma Program Integrity System

A. Program Scale

- $9 billion in FY2024 benefit spending - program integrity relevant even when error or fraud rates are comparatively small.

B. Managed-Care Reporting Structure

- Contracted entities required to refer credible allegations of fraud to OHCA within three business days of discovery.

C. Regular HHS OIG Review of Oklahoma MFCU

- The OIG report found that the Oklahoma MFCU took steps to maintain adequate referral volume and quality but received few fraud referrals from the OHCA and MCO's during the review period, calling it "a continuing concern."
- The OIG report recommended that the MFCU increase the volume and quality of referrals from those sources.

D. National MFCU Context

- Across all MFCUs, OIG reported approximately $3.46 recovered for every $1 spent in FY2024, and $4.64 for every $1 spent in FY 2025.

Potential Pillars for Medicaid Integrity Reform in Oklahoma

Pillar	Core Policy Reform	Primary Legislative Objective
1. Referral & Enforcement	Statutorily mandate the dual referral of credible fraud allegations simultaneously to OHCA & the Attorney General's MFCU.	Could reduce referral bottlenecks, respond directly to HHS OIG findings, and accelerate fraud enforcement.
2. Eligibility Integrity	Statutorily ban income self-attestation to the full extent permitted under federal law (specifically for MAGI), combined with mandatory quarterly cross-agency electronic data matching.	Verifies income, residency, incarceration, and death records using existing state databases, supplementing periodic renewals with quarterly cross-agency verification.
3. Oversight	Statutorily mandate joint annual legislative oversight report.	Ensures direct legislative visibility into enforcement and tracks clinical capacity preserved alongside dollar recoveries.

QUESTIONS?

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