STRATUM HEALTH ADVISORS

CASE STUDY N° 19 · DECISION ANALYSIS

The Same Repeal, Two Different Markets

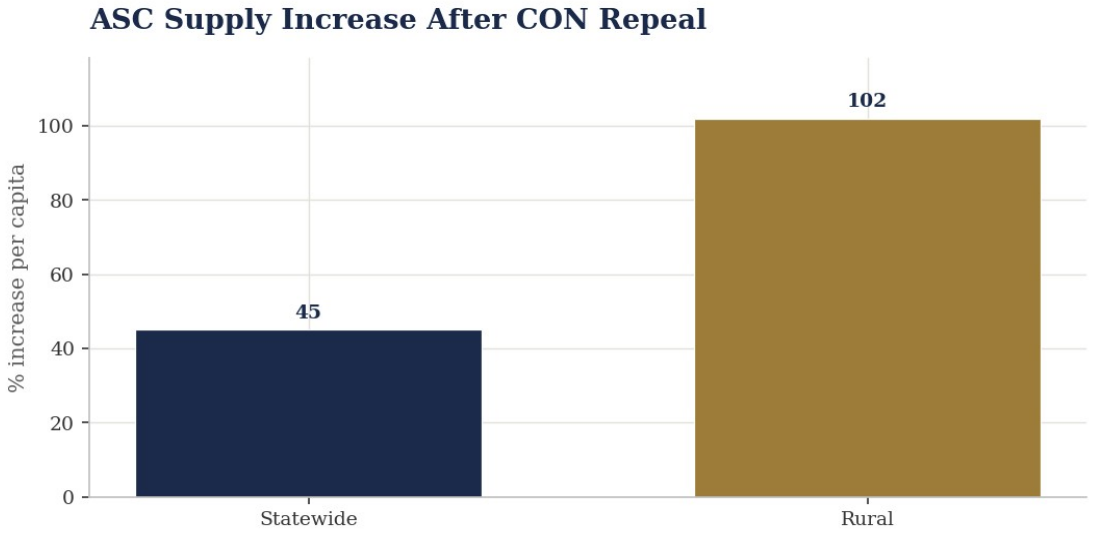
When a state lifts its certificate-of-need barrier, rural ASC supply jumps twice as much as urban — and the economics of the two markets diverge. What that teaches an operator choosing where to build. A rural-versus-urban ambulatory-surgery analysis.

1. The Fork

An ambulatory-surgery operator entering a newly-opened certificate-of-need (CON) state must decide where within that state to build: the urban and suburban markets where volume is dense and competition will be fiercest, or the rural markets where a single center can serve a wide catchment but per-center volume is lower. The same regulatory change that opens the state affects these two geographies very differently. This is an analysis of the rural-versus-urban ASC decision inside an opening market.

2. The Landscape Before the Decision

CON repeal increases ASC supply far more in rural areas than statewide: a causal study found repeal raised ASCs per capita by 44–47% statewide but 92–112% in rural areas — roughly double the effect — with the increase compounding for about a decade before leveling off, and no associated rise in hospital closures[1].



Illustrative midpoints | Source: Stratmann, Southern Economic J. (2025).

The reason rural sees a larger proportional jump is that rural markets were the most under-served under CON: the barrier suppressed supply where access was already thinnest. When the gate lifts, rural pent-up demand releases proportionally harder — which is both the opportunity and the warning, because a 92–112% increase means rural markets can go from under-served to competitive quickly[1].

3. The Decision Logic — Steelmanned

Both the urban and rural plays are defensible, and they are genuinely different businesses. The urban ASC bets on volume: dense population, high procedure counts, deep surgeon supply, and the ability to run high-acuity, high-margin cases — accepting that competition will be intense and differentiation on quality and payer contracting is essential. The rural ASC bets on catchment and access: a single well-placed center can serve a wide geography with little nearby competition, capturing a whole region's outpatient surgical demand — accepting lower absolute volume and thinner surgeon supply. In an opening CON state, the rural first-mover can lock up a catchment before the 92–112% supply surge fills it; the urban operator competes in a race where being early matters less than being differentiated.

4. The Landscape After

The evidence resolves the old fear that ASCs harm rural hospitals: CON repeal was not associated with rural hospital closures, and the likely reason is that ASCs and hospitals serve complementary roles — ASC entry lets hospitals focus on the complex cases that must stay inpatient, and can even help hospitals by relieving staffing pressure[1]. That removes the strongest political objection to rural ASC development.

The strategic asymmetry is in the timing. Because the rural supply increase is roughly double the urban one and compounds over a decade, the value of being an early rural entrant decays faster in proportional terms — the rural first-mover who secures a catchment in year one holds a position that a 100%+ supply increase would otherwise erode. In urban markets, where the proportional increase is smaller and the market larger, timing matters less than differentiation on acuity, quality, and payer relationships. The operator should therefore treat rural and urban entry as two different clocks: rural rewards speed and catchment capture; urban rewards durable differentiation. Building the same playbook in both is the error — a rural strategy in an

urban market leaves volume on the table, and an urban strategy in a rural market races too slowly to capture the catchment before it fills.

5. The Strategic Read — For Any ASC Operator in an Opening Market

Rural and urban ASC entry respond to the same repeal on different clocks and different economics. The tradeoff space:

DIMENSION	URBAN / SUBURBAN	RURAL
Volume	High — dense population	Lower — but wide catchment
Competition	Intense — differentiate or lose	Sparse — first-mover can lock catchment
Supply surge after repeal	+44-47% (slower fill)	+92-112% (fills fast)
Winning move	Durable differentiation on acuity/quality	Speed — capture catchment before the surge
The failure mode	Racing when you should differentiate	Differentiating when you should race

6. The Stratum Outlook

> **IN PLAIN TERMS**
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> Strip away the mechanics and it is this: when a state finally lets people open surgery centers freely, the number of centers jumps about 45% in the cities but doubles in rural areas — because rural was starved for them under the old rules. That difference changes your whole strategy depending on where you build. In a city, everyone rushes in, so being first matters less than being clearly better. In a rural area, one well-placed center can own a huge region — but only if you get there before the flood, because rural fills up twice as fast in percentage terms. Two different markets, two different clocks. Run the city playbook in the country and you are too slow to grab the territory; run the country playbook in the city and you leave money on the table.

7. Where Stratum Fits

An ASC operator entering an opening state needs its candidate markets scored rural-versus-urban on catchment, surgeon supply, competitive fill-rate, and the timing window each geography allows. Stratum builds that market-entry map. Start a conversation at stratumhealthadvisors.com.

References

All figures in this analysis are drawn from the following public sources, current as of publication (July 2026).

[1] Stratmann, T. “The causal effect of repealing Certificate-of-Need laws for ambulatory surgical centers.” Southern Economic Journal, 2025. (44–47% statewide vs. 92–112% rural increase; decade-long compounding; no rural hospital closures; ASC-hospital complementarity.)

Figures reflect the most recent public sources available and may change as ownership and market conditions evolve. This reference list is provided for transparency and does not constitute an endorsement by the cited parties.