STRATUM HEALTH ADVISORS

CASE STUDY N° 21 · DECISION ANALYSIS

The Scan Moves to the Cheaper Room

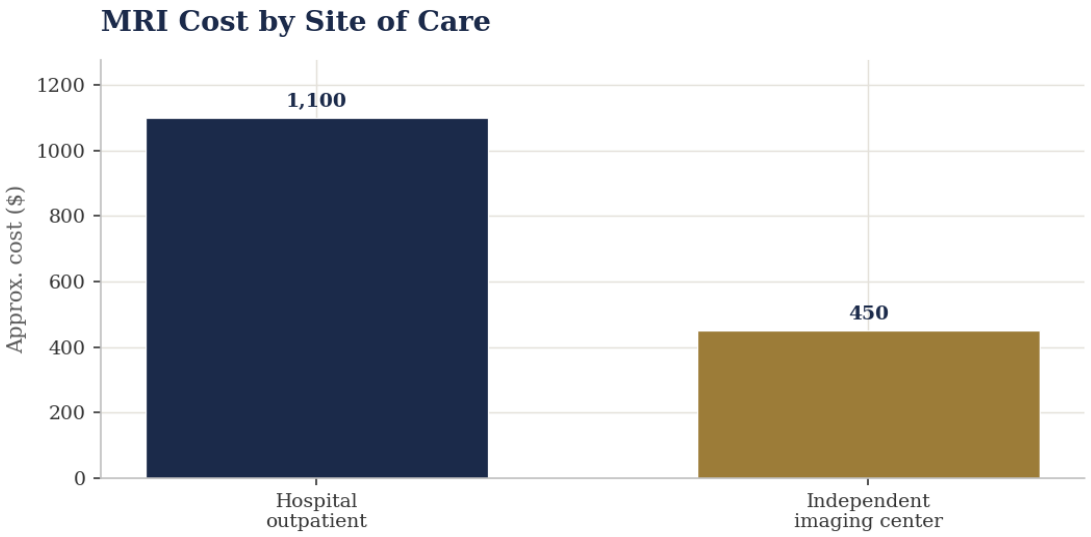
Imaging is shifting from hospital departments to freestanding centers on a cost gap payers are actively steering toward — but the shift plays out differently by market density. An imaging site-of-care and geography analysis.

1. The Fork

An imaging operator or a health system with imaging assets faces a site-of-care shift analogous to the ambulatory-surgery migration: scans are moving from higher-cost hospital outpatient departments to lower-cost freestanding imaging centers, pushed by payers steering toward the cheaper site. The decision is where and how to position for that shift — and, as with ASCs, the answer differs sharply between dense metro markets and thinner ones. This is an analysis of the imaging site-of-care shift through a geographic lens.

2. The Landscape Before the Decision

The cost differential driving the shift is large and consistent: the same scan performed in a hospital outpatient department typically costs far more than in a freestanding imaging center, and payers — commercial and increasingly Medicare through site-neutral policy pressure — are steering volume toward the lower-cost setting[1].



Illustrative | Source: Illustrative of documented HOPD vs. freestanding differentials.

The economic logic mirrors the ASC story earlier in this series: a lower-cost site of care that payers actively prefer captures migrating volume, and the operators positioned in that lower-cost setting benefit as the shift accelerates. Freestanding imaging, like the ASC, is the structurally advantaged setting as payment policy moves toward site-neutrality.

3. The Decision Logic — Steelmanned

Positioning for the freestanding shift is the obvious play, but the health system's instinct to defend hospital-based imaging has a real argument in specific geographies. In a dense metro with strong commercial payer mix and high scan volume, the freestanding center wins clearly: volume supports the fixed cost of the equipment, competition rewards the low-cost site, and payer steering is strongest. In a thin or rural market, the calculus flips — scan volume may not support a dedicated freestanding center's equipment economics, and the hospital's imaging department, cross-subsidized by other services and serving as the only regional option, may be the more sustainable model. The site-of-care shift is not uniform; it is a metro-first phenomenon.

4. The Landscape After

The strategic insight is that the imaging shift, like the ASC shift, rewards operators who match the setting to the market's density rather than applying one model everywhere. In dense markets, the freestanding center is the growth vehicle and the migrating volume plus payer preference make it the right bet; the operator who builds or acquires freestanding capacity in high-volume metros captures the shift. In thin markets, freestanding economics are fragile, and the durable position may be a hospital-affiliated or hybrid model that aggregates a wide catchment's volume into a single sustainable site.

The parallel to ambulatory surgery is exact: both are lower-cost sites of care that payers steer toward, both benefit from site-neutral payment pressure, and both see the shift concentrate first and hardest in dense markets while thin markets lag or resist[1]. An operator who understands imaging as the same structural story as ASCs — a volume-and-density-dependent migration — can read which of its markets will shift fast and which will not, and position accordingly.

The failure mode is treating the national site-of-care trend as uniform. Building freestanding capacity into a thin market because “imaging is moving freestanding” ignores that the equipment economics require volume the market cannot supply; defending hospital-based imaging in a dense metro because “we've always done it here” ignores that payers will steer the volume away regardless. Density decides which mistake an operator is at risk of making.

5. The Strategic Read — For Any Imaging Operator or System

The imaging site-of-care shift is real but density-dependent, exactly like ambulatory surgery. The tradeoff space:

MARKET DENSITY	WINNING POSITION	THE FAILURE MODE
Dense metro, commercial-heavy	Freestanding center — capture migrating volume	Defending hospital imaging payers will bypass
Thin / rural	Hospital-affiliated or hybrid, wide catchment	Building freestanding capacity volume can't support
Mixed system footprint	Match setting to each market's density	Applying one national model everywhere

6. The Stratum Outlook

> **IN PLAIN TERMS**
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> Strip away the mechanics and it is this: the same MRI costs a lot more in a hospital than in a standalone imaging center, and insurers are now pushing patients toward the cheaper one. So the scans are migrating out of hospitals — but not everywhere at the same speed. In a big city with lots of volume, the standalone center wins and the hospital imaging department will lose that business whether it likes it or not. In a small rural market, there may not be enough scans to justify a standalone center's expensive machines, and the hospital stays the sensible option. The mistake is believing the national trend applies evenly: do not build a fancy standalone center where there is not enough volume, and do not defend your hospital scanner in a city where insurers will route around it. Density decides.

7. Where Stratum Fits

An imaging operator or system needs each market classified by density and payer mix to know where the freestanding shift wins and where a hospital-affiliated model is more durable. Stratum builds that site-of-care 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] Site-of-care cost differentials and site-neutral payment policy are widely documented (industry compilations of CMS and commercial-payer data); MRI cost figures shown are illustrative of typical HOPD-vs-freestanding differentials and vary by market. Parallels to ASC site-of-care migration per Stratmann (2025) and CMS ASC policy.

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.