

**Statement of Richard W. "Rick" Snyder II, M.D.  
President, HeartPlace**

**Before the Subcommittee on Health, House Committee on Energy and Commerce**

May 20, 2026

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to testify today.

My name is Dr. Rick Snyder. I am an interventional cardiologist, and I serve as President of HeartPlace, one of the largest independent cardiology practices in Texas. Every day, my colleagues and I care for Medicare patients in ten counties across the Dallas-Fort Worth metroplex -- patients with heart attacks, heart failure, blocked arteries, and other serious cardiovascular conditions.

The Medicare Physician Fee Schedule is not just an accounting formula. It is one of the most important forces shaping where patients receive care, what that care costs, and whether independent physicians can continue serving the people who rely on them.

Right now, the system is completely broken. Hospitals receive automatic annual inflationary updates from Medicare. Physicians do not, even though the costs of operating a medical practice -- staffing, rent, insurance, technology, and supplies -- continue to rise dramatically.

After adjusting for inflation, Medicare physician reimbursement has declined [33% since 2001](#).



Credit: [American Medical Association](#)

This divergence in how hospitals and medical practices are paid by Medicare is reshaping our healthcare system in ways that directly affect patients.

Independent practices are disappearing. Many physicians, especially in primary care, cannot keep absorbing rising costs while reimbursement falls further behind. Some are retiring early. Some are shifting to concierge models. Many are selling to hospitals and large health systems because owning and operating an independent practice is no longer financially viable.

Medicare's reimbursement structure offers hospitals an additional advantage. It pays them more than independent physician practices for identical care.

That disparity harms patients, who end up paying more out of pocket for healthcare services in the hospital outpatient setting than they do for the same services in the independent practice setting.

Consider an example from my own practice. My clinic is on the campus of a major hospital in Dallas. When I perform an echocardiogram -- an ultrasound of the heart that helps diagnose and manage heart disease -- in my office, Medicare pays my practice a technical fee of about \$123. My patient's co-pay for that fee through Medicare is roughly \$24.

If a patient walks out my door and takes the elevator down one floor to a hospital outpatient lab in the exact same building, the cost of that echocardiogram to Medicare and to the patient more than quadruples.

That's what I call a magic -- and very disturbing -- elevator ride.

Physicians across the country have shared similar stories with me at gatherings convened by the American Independent Medical Practice Association, where I serve as vice president. [AIMPA](#) represents more than 14,000 physicians caring for more than 40 million patients across 48 states.

My independent physician colleagues and I have watched these payment disparities accelerate hospital acquisition of physician practices and the consolidation of local healthcare markets.

Hospitals acquired [nearly 33,000 physician practices](#) and added [more than 181,000 physicians](#) to their employment rolls between 2018 and 2026. In 2012, [about 60%](#) of physicians practiced independently. Today, [almost 60%](#) are employed by hospitals.

Patients and taxpayers are paying the price for this wave of hospital consolidation.

When an independent practice closes, patients don't just lose a doctor. They lose a trusted, convenient entry point to the healthcare system -- which forces them to wait longer for an appointment or, especially in rural areas, travel [hours](#) to see a provider.

Many seniors would much rather receive care in a familiar community practice than navigate a large hospital system for routine outpatient care.

And given how much more expensive care is in the hospital setting, taxpayers lose out, too. If my own practice were to become part of a hospital system, the increased annual cost to Medicare for just two common, outpatient, office-based cardiovascular tests would be more than \$25 million. Nothing about the care would change -- just the amount taxpayers and patients pay.

Our practices are being bought with the government's money!

HOPPS APC	HCPCS (Dallas Payment Amount)	Short Descriptor	2025 Medicare & Medicare Advantage Volume*	2025 Impact			
				HOPPS	Physician	Difference	Impact
0377	78452	Nuclear stress test (Ht muscle image spect, mult)		1,305.48	338.79	966.69	
	93015-93018	Nuclear stress test** (Cardiovascular stress test)		311.40	37.37	274.03	
			11,633	1,616.88	376.16	1,240.72	14,433,296
0269	93306	Echocardiogram	26,271	548.30	123.33	424.97	11,164,387
							<u>25,597,683</u>

\*2025 Medicare Volume Based Upon The Twelve Months Ended December 31, 2025.

\*\*Compares against reimbursement for the technical component only (i.e. 93017).

HOPPS APC rates reflect January 2025-updated 01/02/2025, available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>

*Credit: HeartPlace Data*

If we want to preserve the viability of independent physician practice -- if we want to make sure that patients can seek timely access to high-quality, lower-cost care in their communities -- then we must reform the Medicare physician payment system.

At a minimum, Medicare physician reimbursement should include a permanent inflation-based update tied to the Medicare Economic Index, just as many other parts of the healthcare system already receive. Physicians cannot continue absorbing rising practice costs while reimbursement keeps declining in real terms.

[H.R. 6160](#) -- which has been led, on a bipartisan basis, by two members of this subcommittee, Dr. Ruiz and Mr. Bilirakis -- addresses this disparity. I commend and appreciate their leadership.

More broadly, Congress should pursue site-neutral payment reforms. Medicare should pay identical rates for identical services, regardless of where those services are delivered.

Medicare policy should encourage site-of-care optimization, wherein care is delivered in the lowest-cost setting where it can be provided safely and effectively -- whether that is a physician office, an ambulatory surgery center, or a hospital outpatient department.

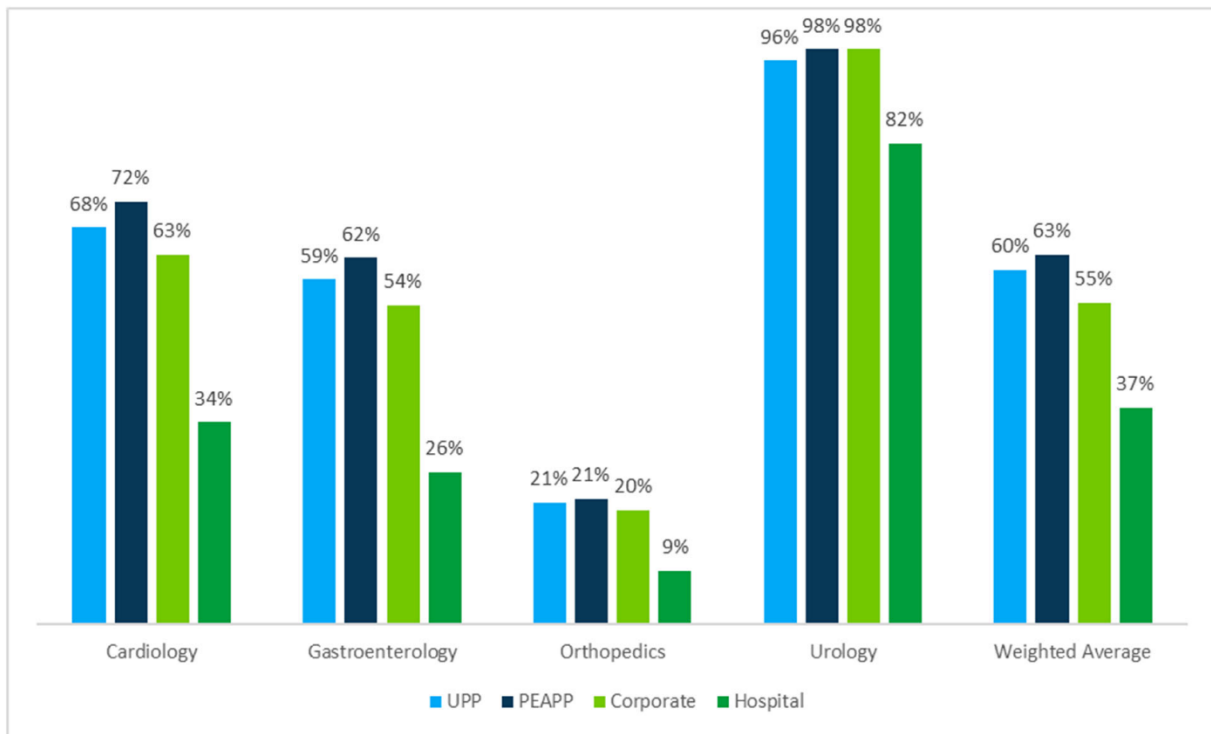
Congress and Medicare officials have already taken some important incremental steps in this direction for certain services. But more work remains.

Today's payment disparities encourage hospitals to acquire independent physician practices and shift care into higher-cost settings, which increases costs for both patients and taxpayers.

[Peer-reviewed research](#) published last year by several of my AIMPA colleagues found that hospital-affiliated physicians were much more likely than their independent physician counterparts to deliver care in the higher-cost hospital outpatient department.

Across 32 common procedures and services, Medicare beneficiaries treated by hospital-affiliated physicians had just a [37%](#) chance of receiving care in the lower-cost office or ambulatory surgery center setting.

Independent physicians were much more likely than their hospital-affiliated counterparts to deliver care in the lower-cost office or ambulatory surgery center setting. Across those same 32 procedures and services, patients cared for by independent physicians had a roughly [60%](#) chance of receiving care in the lower-cost setting.



*Credit: [Journal of Market Access & Health Policy](#)*

Those decisions about where to deliver care have serious implications for patients and taxpayers. The difference in out-of-pocket costs can be thousands of dollars for patients -- and billions of dollars for taxpayers.

The question is not whether a physician should be incentivized or penalized for their decision to refer a patient to a higher-cost site of care. It's whether the patient should be forced to bear the cost burden of that choice.

There is something fundamentally broken about a payment system in which the cost of a service more than quadruples when a beneficiary takes a "magic elevator ride" from my office down one floor to a hospital outpatient department in the same building for the very same service.

If we fail to act, we will continue moving toward a healthcare system dominated by larger and more expensive institutional providers. That will mean higher costs for taxpayers and beneficiaries, fewer options for patients, and less access to community-based care.

Thank you again for the opportunity to testify today. I look forward to your questions.

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