Report

Evidence review

First edition
October 2026

How US hospitals buy new medical devices: who decides, through whom and on what evidence

An evidence review of GAO, AHA, CMS, MedPAC, KFF and peer-reviewed studies

Three purchasing groups serve about 84% of US hospitals, seven in ten community hospitals sit inside a system, and buyers want credible clinical evidence made in their own budget. No public source shows how long a purchase takes.

Download the report (PDF) **Key findings →**

How it was done →

Published
October 2026

Sources
11, all primary or peer-reviewed

Data window
2008 to 2026

Sources checked
22 October 2026

Licence
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Saroj Jha
AAJ Research

12 min read **7** chapters **8** figures **11** references

Selling a device to a US hospital is rarely one decision. I set out to find what public data shows about who buys, through whom, under what financial pressure and on what evidence, and what it does not show, because for a founder planning a sales cycle the gaps matter as much as the figures.

Key findings

Each finding is tagged with the strength of the evidence behind it.

01 **One measured study**

84.1%

of 4,760 US hospitals were served by Vizient, HealthTrust or Premier in 2024.

Chapter 2 →

02 **AAJ's calculation**

about 82%

of hospitals were already with the large groups in 2014 once MedAssets is counted, so most of the rise is one merger.

Chapter 2 →

03 **Reference data**

70%

of community hospitals are part of a health system: 3,567 of 5,121.

Chapter 3 →

04 Preliminary

−12.1%

was hospitals' preliminary fee-for-service Medicare margin in fiscal 2024, against 6.5% across all payers.

Chapter 4 →

05 One peer-reviewed study

5.7 years

was the median time from FDA authorization to Medicare coverage for novel technologies.

Chapter 5 →

06 Gap

0

public sources with a stated method measure how long a value analysis committee takes.

Chapter 7 →

How this report was made

An evidence review: the sources are the sample. I used government reports (GAO, CMS, MedPAC), the AHA's statistics, KFF, the Kaufman Hall flash report and peer-reviewed studies, 11 sources in all, published between 2010 and 2026. I left out figures whose method or sample could not be checked. Every source was opened on 22 October 2026 and every number checked against it.

Full method and limits →

Executive summary

The contract route is close to universal and concentrated. Purchasing groups reach nearly every hospital, three of them dominate, and the public numbers on their contracts and fees are more than a decade old.

Hospitals buy inside systems and inside tight budgets. A win at one site is a reference across its system; a device's price comes out of a Medicare payment that does not change with it, and new payment routes are narrow and slow.

On evidence, the two best studies agree that clinical evidence comes first and that the case has to work in the hospital's own budget. On timing, nothing public is reliable, so a founder has to measure their own cycle.

Read this if

You are planning the first hospital sales of a medical device and need to know who decides and what they weigh.

Use it to

Pick a contract route, build a value analysis case in the hospital's budget, and set honest expectations for your board.

It will not tell you

How long any one hospital takes, or what a specific committee requires. No public source measures either.

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Key findings

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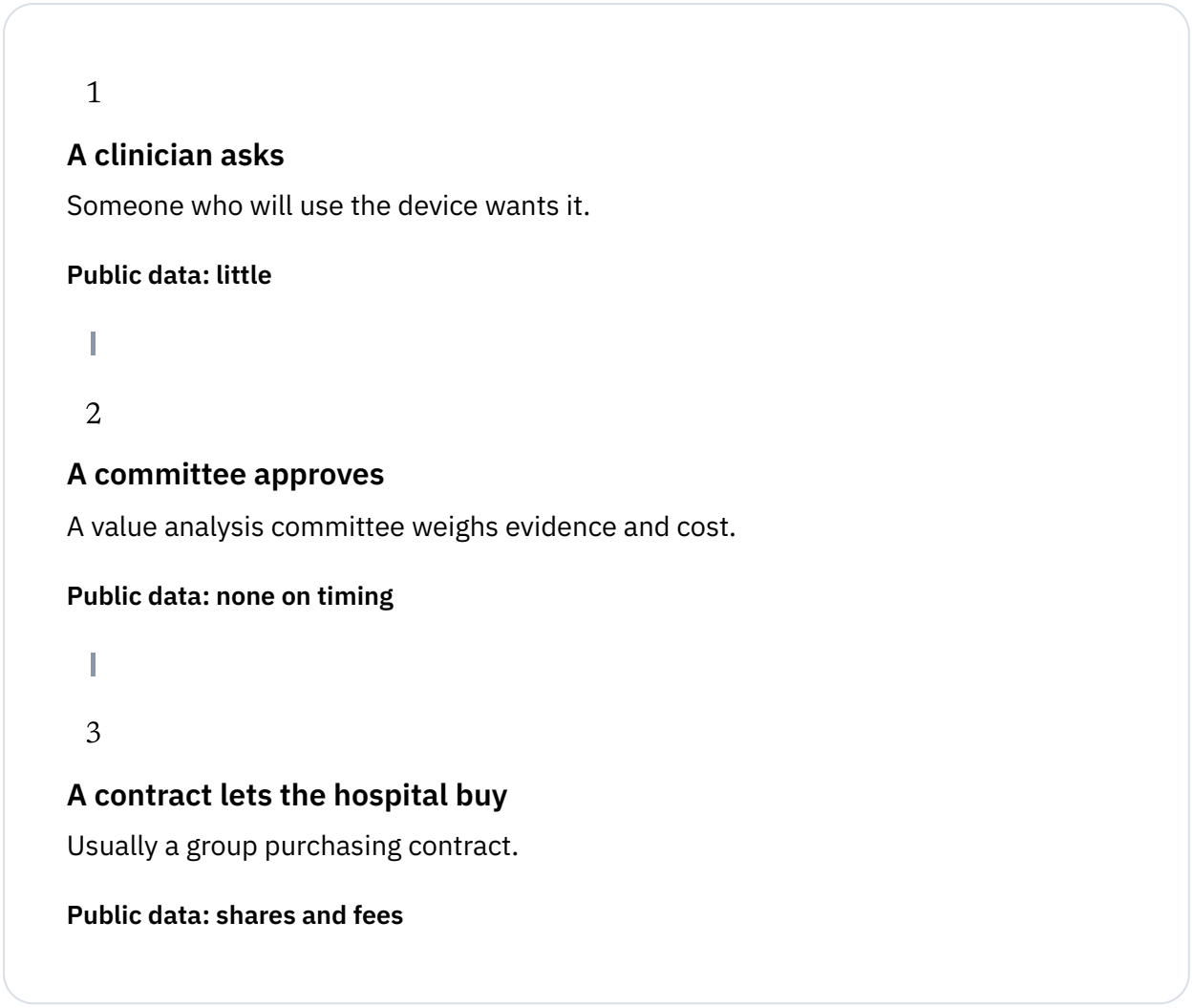
Chapter 1 of 7

Three yeses stand between a device and a hospital order

In my working model, a new device needs a clinician who asks for it, a committee that approves it, and a contract that lets the hospital buy it. The public data is strongest on the contract, so most of this report is about contracts, money and evidence rather than committees.

Figure 1

A new device usually needs three yeses, and the public data is strongest on the third



AAJ's working model of a purchase, not a finding from the sources in this report. Where public data exists is AAJ's assessment.

Read the chain from left to right: a clinician has to want the device, a value analysis committee has to approve it, and a contract has to exist before anyone can place an order. The note under each step says how much public data exists, and only the third step, the contract, is well measured. In my view, that is why a founder's own records of the first two steps are worth more than any published benchmark.

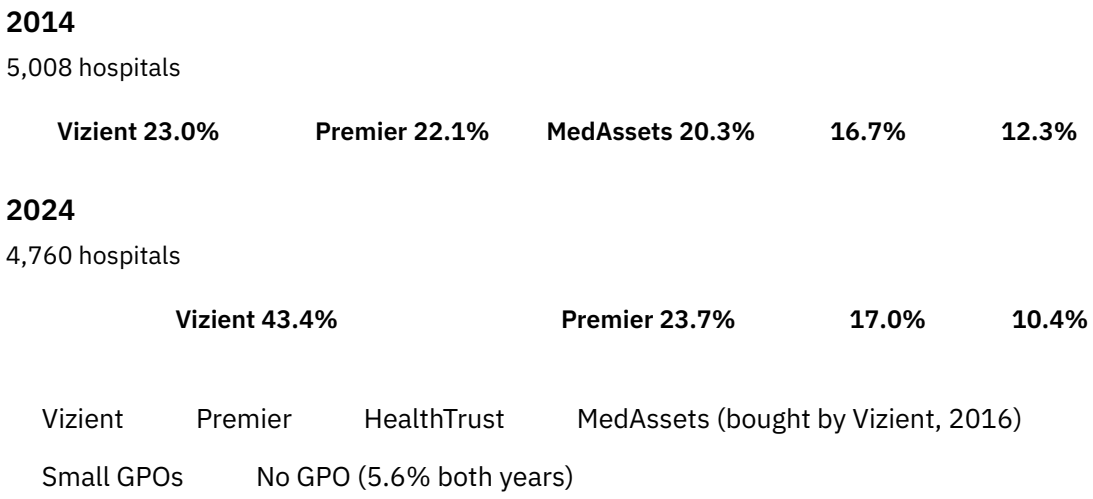
Purchasing groups reach nearly every hospital, and three dominate

A group purchasing organization (GPO) negotiates contracts with vendors for many hospitals. GAO's 2014 review quotes a trade association, the Healthcare Supply Chain Association, estimating that "approximately 96 percent to 98 percent" of US hospitals buy through GPO contracts[1]. That is an industry estimate GAO reports rather than measures.

The most recent measurement is a 2026 research letter in JAMA Health Forum, using AHA survey and IQVIA data. Vizient, HealthTrust and Premier together served 84.1% of 4,760 hospitals in 2024, up from 61.7% of 5,008 in 2014, and 5.6% had no GPO in either year[2].

Figure 2

Vizient's jump from 23% to 43% of hospitals is mostly its 2016 purchase of MedAssets



Big three, 2014 to 2024

61.7% → 84.1%

Vizient, HealthTrust and Premier combined

Large groups in 2014, counting MedAssets

about 82%

AAJ's sum of the letter's counts: 4,113 of 5,008

Hospitals with no GPO

5.6%

In both years

Show the numbers as a table

Vizient

2014 (hospitals)	23.0% (1,152)

2024 (hospitals)	43.4% (2,066)
Premier	
2014 (hospitals)	22.1% (1,109)
2024 (hospitals)	23.7% (1,128)
MedAssets	
2014 (hospitals)	20.3% (1,019)
2024 (hospitals)	Part of Vizient
HealthTrust	
2014 (hospitals)	16.7% (833)
2024 (hospitals)	17.0% (807)
Small GPOs	
2014 (hospitals)	12.3% (616)
2024 (hospitals)	10.4% (493)
No GPO	
2014 (hospitals)	5.6% (279)
2024 (hospitals)	5.6% (266)

Source: Tseng, Bond and Dean (2026), research letter in JAMA Health Forum, using AHA survey and IQVIA data; each hospital's primary pharmaceutical GPO.[2] The "about 82%" is AAJ's sum (3,094 + 1,019 of 5,008).

> Compare the two bars segment by segment. The gold MedAssets block from 2014 is gone in 2024 because Vizient bought it in 2016, and Vizient's 2024 share (43.4%) is almost exactly what the two held together in 2014 (43.3%); most of the big three's rise came from Vizient absorbing MedAssets, while Premier and HealthTrust held roughly steady. The shares describe each hospital's primary pharmaceutical GPO, and the authors report that pharmaceutical and medical-surgical affiliations agree in 94% of cases[2]. In my view, a device company should still ask each hospital

which group covers its category, but should expect the answer to be one of three names.

Contract terms matter as much as membership

Vendors pay the fees, which is why a GPO contract is a commercial negotiation for a device company. Administrative fees made up about 92% of the five largest GPOs' revenue in 2012, and nearly 70% of the roughly $2.3 billion in fees was passed on to customers or owners[1]. The federal Anti-Kickback safe harbor lets GPOs collect these fees if, among other conditions, the written agreement states that fees are 3% or less of the purchase price or specifies the amount[1].

Figure 3

The public numbers on GPO contracts and fees date from 2008 and 2012

Contract fact	What GAO found	Year and source
Typical contract term	Mostly 3 years; some 5 years or more	2012, GA 15-13
Most frequent vendor fee	3% of the purchase price	2012, GA 15-13
Average vendor fee, weighted by volume	Around 1 to 2%	2012, GA 15-13
Average fees by GPO	1.22% to 2.25% of purchases; single contracts from 0.09% to 10%	2008, GA 10-738
Share of GPO revenue from vendor fees	About 92% on average (83% to 98%)	2012, GA 15-13
Fees passed on to customers or owners	Nearly 70% of about $2.3 billion	2012, GA 15-13

Source: GAO surveys of the five largest GPOs.[1,3] AAJ found no newer public source for today's terms and fees.

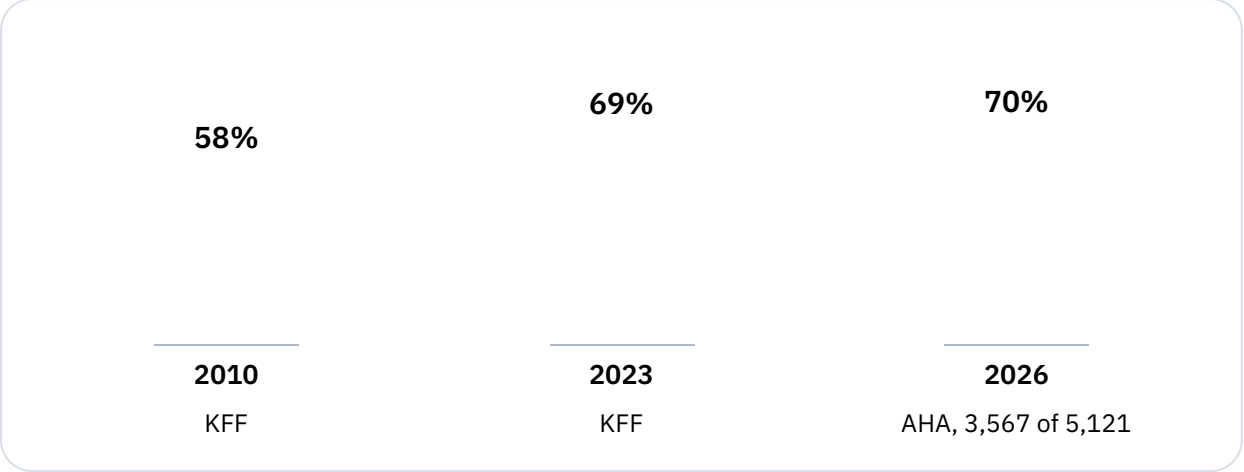
Each row is one contract fact, with the year GAO measured it. The newest figures are from 2012, so they describe the market before the MedAssets merger and before most of today's system consolidation. In my view, treat them as the shape of a GPO deal (a multi-year term, a vendor fee of a few percent, most of it passed back to members) rather than as today's numbers, and confirm terms with the group itself.

Most hospitals buy as part of a system

The AHA counts 3,567 of 5,121 US community hospitals as part of a health system[4]. KFF reports the share of hospitals affiliated with a system rising from 58% in 2010 to 69% in 2023[5].

Figure 4

Seven in ten community hospitals now sit inside a health system



Show the numbers as a table

2010

Share in a system	58%
Source	KFF

2023

Share in a system	69%
Source	KFF

2026

Share in a system	70% (3,567 of 5,121 community hospitals)
Source	AHA

Sources: KFF, share of hospitals affiliated with a system, 2010 and 2023 [5]; AHA Fast Facts 2026, community hospitals in a system. [4] The two sources define the base differently, so read them as one trend, not a precise series.

> The columns rise from 58% in 2010 to about 70% today, but they come from two sources with different bases, so read them as one direction of travel rather than a precise series. What matters for a seller is the direction:

most hospitals now decide inside a system. In my view, a win at one hospital is a reference inside its system, and a loss at the system level can close several hospitals at once, so plan the first site as a case for the system's committee, not as a one-off sale.

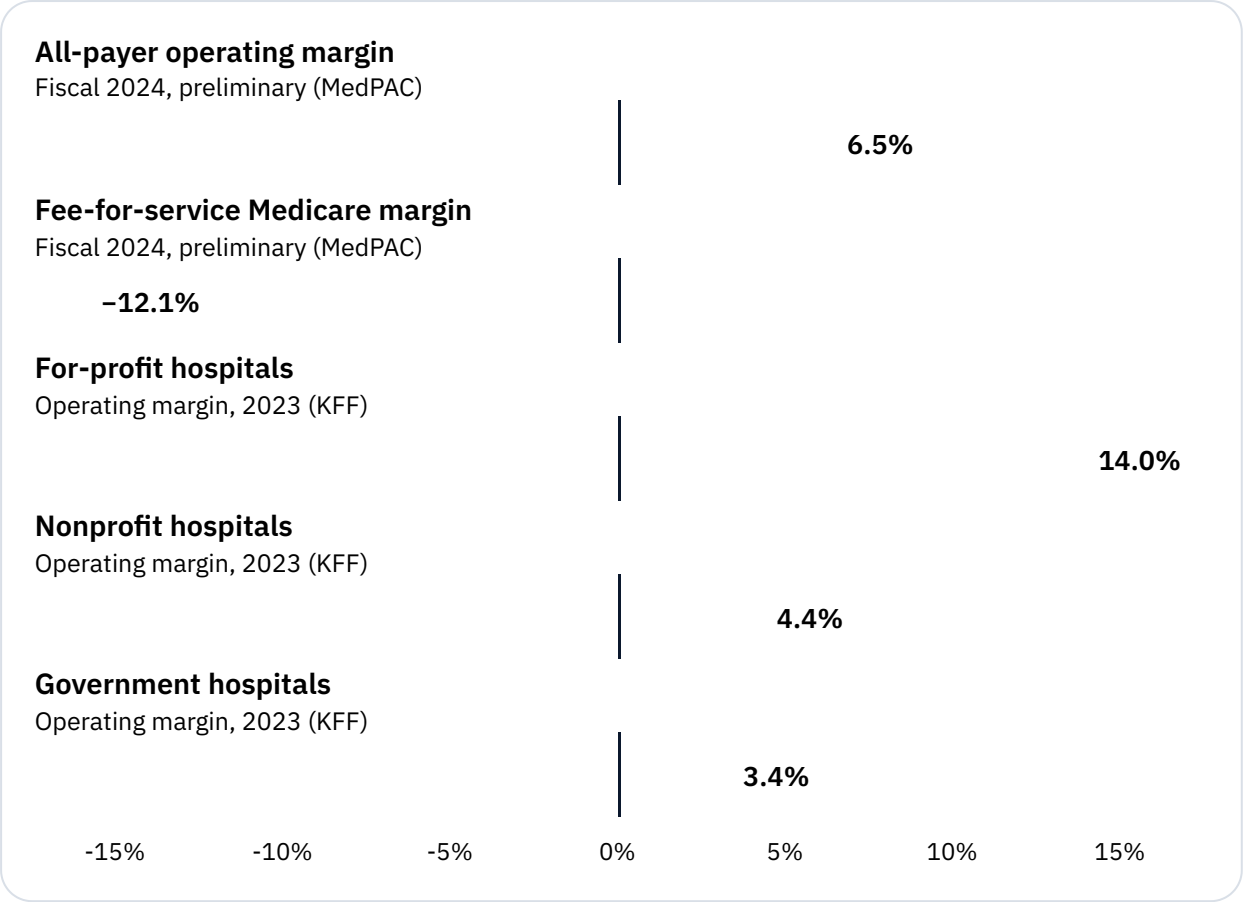
Chapter 4 of 7

Hospitals buy under financial pressure, and Medicare pays a fixed rate

The picture depends on the measure and on who owns the hospital. MedPAC's January 2026 slides give a preliminary fiscal 2024 all-payer operating margin of 6.5% and a fee-for-service Medicare margin of −12.1%[6]. KFF finds for-profit hospitals earned much higher operating margins in 2023 than nonprofit and government hospitals[5].

Figure 5

Hospitals are profitable overall, but lose money on traditional Medicare patients



Show the numbers as a table

All-payer operating margin, fiscal 2024 (preliminary)

Margin	6.5%
Source	MedPAC, January 2026

Fee-for-service Medicare margin, fiscal 2024 (preliminary)

Margin	–12.1%
Source	MedPAC, January 2026

Operating margin 2023: for-profit, nonprofit, government

Margin	14.0%, 4.4%, 3.4%

Source	KFF

Sources: MedPAC, January 2026 hospital update slides (preliminary; the all-payer margin excludes investment and donation income)[6]; KFF.[5]

Bars to the right of zero are profits and bars to the left are losses, all on one scale. The all-payer margin of 6.5% looks healthy, but the same hospitals lose 12.1% on traditional Medicare patients, and nonprofit and government hospitals run margins of 3.4% to 4.4%, far below for-profit ones. In my view, most of the hospitals a startup will sell to have little room for a device that raises cost per case without a clear offset.

Kaufman Hall's most recent flash report says roughly 43% of hospitals are operating at a loss, against roughly 33% before the pandemic[7].

About this data

The Kaufman Hall flash report is published on the website of Vizient, which is also the largest purchasing group. Read it with that in mind.

A new device's price comes out of a fixed payment

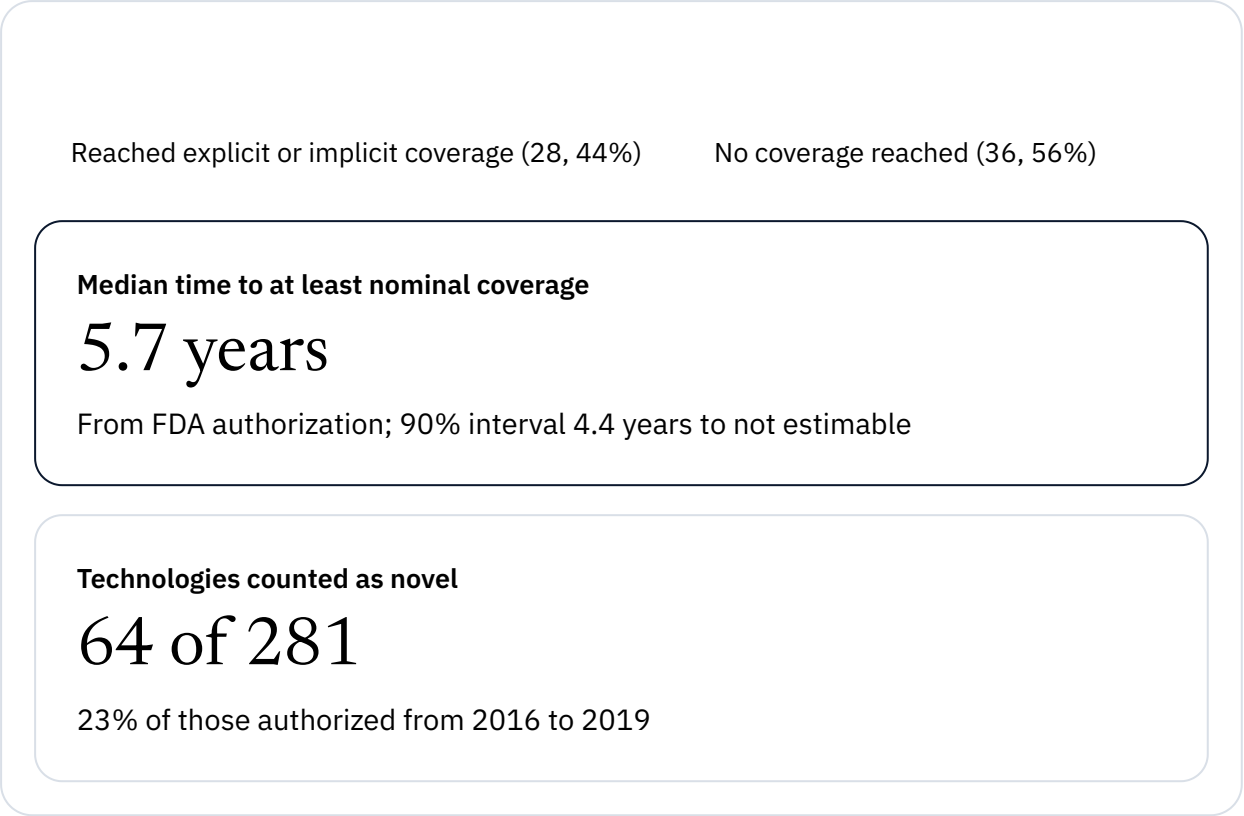
For inpatient stays, CMS pays "at predetermined, specific rates for each hospital discharge", so a new device's price comes out of a payment that does not change with it. A new-technology add-on payment can cover part of the extra cost, no more than 65% of the technology's cost (or of the amount by which the case cost exceeds the standard payment, whichever is lower), and only for technology that shows "substantial clinical improvement" over what exists[8].

Medicare coverage for novel technology takes years

A 2023 study of 281 devices and diagnostics authorized through premarket approval, De Novo or breakthrough 510(k) from 2016 to 2019 found 64 (23%) were novel, meaning they lacked coverage decisions or relied on temporary billing codes. Only 28 of the 64 reached explicit or implicit Medicare coverage[9].

Figure 6

Only 28 of 64 novel technologies in the study reached Medicare coverage



Source: Sexton et al. (2023), JAMA Health Forum: devices and diagnostics authorized by premarket approval, De Novo or breakthrough 510(k) from 2016 to 2019.[9]

Each square is one of the 64 novel technologies; the 28 filled squares reached explicit or implicit Medicare coverage, and the dark card shows the median wait for at least nominal coverage, 5.7 years from FDA authorization. Fewer than half got there at all within the study's window. In my view, build the first hospital case on the payment the hospital already gets, count on new payment only if your evidence can meet the add-on

payment's "substantial clinical improvement" test, and budget for years, not quarters.

Chapter 6 of 7

Buyers want clinical evidence first, and a case made in their own budget

I found two directly relevant studies: a survey of hospital executives[10] and a systematic review of what hospital decision makers need to know[11].

Figure 7

Two studies point to clinical evidence first, and each has limits

Study	What it found	Limits
Li et al. (2015): survey of 34 North American hospital executives	Clinical evidence and cost effectiveness ranked most important. For new technology: enough evidence in the literature first, then key opinion leaders, then the device's cost.	34 respondents; abo orthopedic implants osteoarthritis
Ølholm et al. (2015): systematic review of 14 studies, 2000 to 2012	74 types of information that hospital decision makers found relevant; clinical, economic and political or strategic ones mentioned most. Cites earlier work finding budget impact mattered more than cost-effectiveness.	Studies from several countries; the budge impact point is cited earlier work, not a re of the review

Sources: Li et al.[10]; Ølholm et al.[11]

Read each row across: the study, what it found, and the limit that keeps it from being the last word. Together they support leading with credible clinical evidence. The review also points to earlier work finding that budget

impact, the cost to the hospital's own budget at its own volume, matters more to investment decisions than a cost-effectiveness ratio, although the executives in the survey ranked cost effectiveness among the most important factors. In my view, bring both: the clinical evidence first, then the effect on that hospital's budget in its own numbers, because neither study shows how much weight any one factor carries at a particular hospital.

Chapter 7 of 7

What the public data does not show

I looked for each of the following and found no source with a stated method and a representative sample.

Figure 8

Five things a founder planning a sales cycle needs that no public source measures

What AAJ found	
How long a value analysis committee takes	No source with a stated method and a representative sample
What share of hospitals run a formal committee, and who sits on it	No representative source found
Which kinds of evidence committees require	No representative source found
Share of hospital spending through GPO contracts today	Newest public figures are GAO's, from 2012
When hospitals' fiscal years end and budgets are set	No source with numbers found

AAJ's search of government, association and peer-reviewed sources, October 2026.

Each row is something a founder planning a sales cycle would want to know, with what my search turned up. None of the five has a public source with a stated method and a representative sample, and the closest one, the share of spending through GPO contracts, is from 2012. In my view, the practical answer is to collect these facts yourself: ask each target hospital for its committee's form, meeting dates and submission deadline, and record your own request, submission, decision, contract and first-order dates.

Left out on purpose

Two figures that circulate widely are left out. One is the claim that 73% of hospitals' non-labor purchases go through GPOs, which GAO quotes from a 2009 study by an industry consultancy rather than finding itself. The other is value analysis survey results from a supply-chain software vendor and a professional association, whose percentages do not fit the stated sample sizes.

What this means for you

The evidence points to five moves. Here they are grouped by the stage at which each usually comes first.

Pre-seed

Find out the contract route before you price. Ask early clinical partners which group and contract they buy through, and whether a competitor already holds your category.

Seed

Build the value analysis case in this year's budget: clinical evidence first, then cost per patient and budget impact at the hospital's own volume. Do not lean on new payment.

Series A–B

Sell to the system, not the hospital, and measure your own cycle: request, submission, decision, contract and first-order dates at every site.

Method and limits

Design

Evidence review; the 11 sources are the sample

Sources

GAO (2), CMS, MedPAC, AHA, KFF, Kaufman Hall, and three peer-reviewed studies plus one research letter

Window

Published 2010 to 2026; data from 2000 to 2026

Inclusion

Primary sources with a stated method; industry estimates reported only as estimates

Checked

Every source opened and every figure checked on 22 October 2026

AAJ calculations

The "about 82%" share and the 43.3% combined share, from the letter's counts

Where a source quotes another (GAO quoting a trade association, the review citing earlier work), the report says so.

What this report cannot tell you

- The group shares come from a one-page research letter and describe pharmaceutical affiliations.
- GAO's contract data is from 2012 and 2008; today's terms may differ.
- The MedPAC figures are from preliminary slides and may change.
- The executive survey had 34 respondents and covered orthopedic implants; the systematic review covers studies from 2000 to 2012.
- The AHA is an advocacy organization, though its hospital counts are standard reference data.
- This report is general information, not legal or financial advice.

Data and citation

Every figure links to its source in the references. The tables behind each chart are under "Show the numbers as a table".

Full report
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Figure data
CSV, every number behind the figures

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Independence. No sponsor. AAJ sells marketing strategy services, including to medical device companies, so it has an interest in this topic. Every figure comes from a named public source so it can be checked.

Version history

October 2026

First edition published; sources checked 22 October 2026.

26 October 2026

Restructured as a report: key findings with evidence tags, method and limits, citation and data downloads. No figures changed.

Questions founders ask

How do US hospitals buy medical devices?

Most hospitals buy through group purchasing organizations (GPOs). A 2026 study found Vizient, HealthTrust and Premier served 84.1% of 4,760 hospitals in 2024, and 5.6% had no GPO. Inside a hospital, a committee usually weighs evidence and cost, but no public source shows how long that takes.

What share of hospitals use group purchasing organizations?

GAO quotes a trade association estimate that approximately 96 to 98 percent of US hospitals buy through GPO contracts. A 2026 research letter found only 5.6% of hospitals had no GPO affiliation in 2014 and in 2024.

How long does it take a hospital to approve a new medical device?

No public source gives a reliable figure. There is no study with a stated method and a representative sample on value analysis committee timelines, so record your own request, decision, contract and first-order dates at each hospital.

Does Medicare pay extra for a new medical device?

Not automatically. For inpatient stays Medicare pays a predetermined rate per discharge. A new-technology add-on payment can cover up to 65% of the extra cost, only for technology that shows substantial clinical improvement. A 2023 study found a median of 5.7 years to at least nominal Medicare coverage for novel technologies.

What evidence do hospital buyers want from a device company?

In the best public studies, clinical evidence ranked first, followed by key opinion leaders and cost. Make the case in the hospital's own budget, with the evidence behind it.

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Plan an evaluation backwards from the committee date

Marketing Compliance Checklist

Check the rule sets before a campaign goes live

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The superscript numbers in the report match this list. Every source was opened on 22 October 2026.

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Written by Saroj Jha

Founder of AAJ

Saroj has spent more than ten years in marketing strategy. He writes AAJ's reports in his own voice. Every figure is referenced, and where a report gives his view it says so.

About the founder →

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(510) 516-6170

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