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Account affiliation and hierarchy management

A unified POV for life sciences and medtech

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Introduction

Decision-making power in U.S. life sciences organizations is shifting away from individual healthcare providers (HCPs) and toward organized customers—health systems, payers, group purchasing organizations (GPOs) and pharmacy benefit managers acting as consolidated entities.

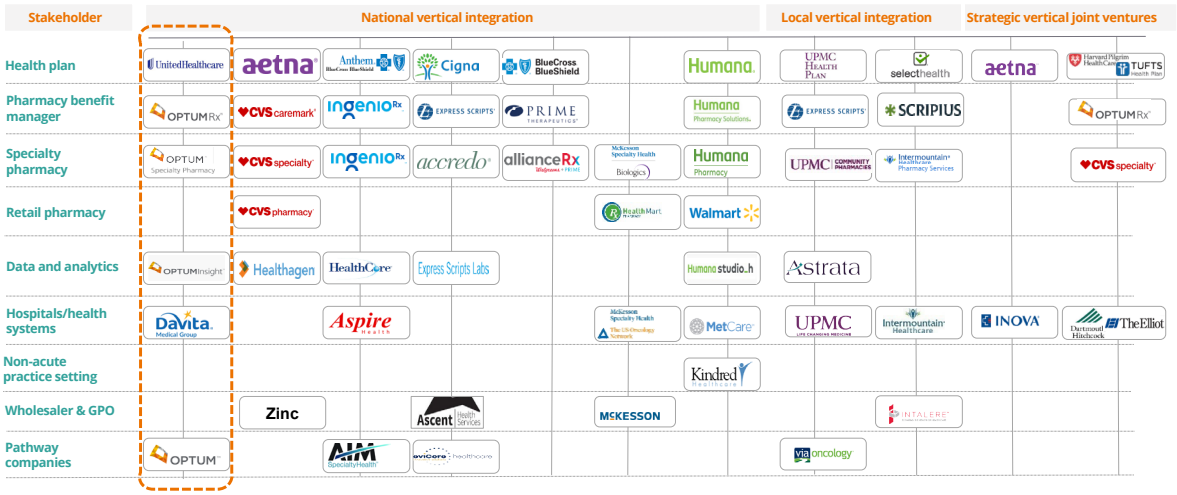
Today, an estimated 40%-70% of business flows through organized customers rather than individual HCPs, and this figure continues to rise as health systems and market-access functions position themselves at the center of value-chain negotiations.

The COVID-19-era rise of new care models—including a marked increase in urgent care and mobile health utilization—also has accelerated this consolidation.

This is compounded by a parallel wave of vertical integration among organized customers. Health plans, pharmacy benefit managers, specialty pharmacies, retail chains, hospital systems and pathway companies are increasingly integrating—nationally, locally and through strategic joint ventures—to capture value that would otherwise be lost to "double marginalization" across the supply chain.

FIGURE 1:

Organized customers are vertically integrating across national, local and joint-venture structures to capture value across the care-delivery chain



For pharmaceutical companies, this means the traditional HCP-centric go-to-market model is no longer sufficient. Influence now sits with organizations, not individuals, and that influence is not evenly distributed: the relative importance of payers, providers, GPOs and specialty pharmacies shifts depending on therapy area (TA) and how a product is reimbursed (pharmacy benefit, medical benefit or drug).

Engaging organized customers effectively requires a commercial model built around organizational relationships and hierarchies—not just clinician-level detail.

FIGURE 2:

The relative importance of payer, provider, GPO and specialty stakeholders varies by TA and reimbursement pathway

OC stakeholder	Pharma benefit Key stakeholders are payers, but provider contracting important for hospital initiations, 340B	Medical benefit Control is largely driven by provider, but payer management is beginning to increase	Hospital/DRG In-patient hospital products that are reimbursed through DRG payments	C&G therapy/precision medicine Risk-based reimbursement by payers; providers help support logistics
Payer	✓✓✓	✓✓		✓✓✓
Provider	✓	✓✓	✓✓✓	✓✓✓
GPO	✓	✓✓✓	✓✓✓	✓✓✓
Specialty	✓✓✓	✓✓✓		✓✓✓

This is fundamentally a data problem. Key account management (KAM) depends on knowing who these organized customers are, how they're structured and how affiliated entities roll up into a single hierarchy. In practice, most organizations lack this foundation. Without a primary source of truth for customer hierarchy, companies duplicate analytics efforts, misattribute sales activity, under-capture revenue and build reporting on outdated affiliations data. As organized customers grow larger and more complex, these gaps compound—and without clean, governed hierarchy data, the customer engagement model cannot scale. This paper discusses how adapting to the shift toward organized customers requires solving the underlying data challenge first. We propose a framework for the account hierarchy and affiliations infrastructure needed to support pharma commercial models going forward.

Key challenges in setting up a customer data foundation for pharma

Pharmaceutical commercial data is inherently fragmented. Organizations consume external datasets (such as third-party data—IQVIA Onekey, Veeva Open Data, Komodo, syndicated sales/DDD, claims, 844 chargebacks, 867 shipments and GPO rosters) alongside internal sources (including CRM platforms, field spreadsheets and manual overrides). Each source carries its own affiliation signals and they rarely agree.

This matters most for account-model customers, high-value customers that often span multiple colocated treatment sites listed as unrelated records in vendor data. When these sites are fragmented or misaffiliated, the impact is immediate: distorted sales attribution, incorrect incentive compensation (IC) payouts, misaligned contracting, incomplete KAM insights and poor targeting precision.

FIGURE 3:

There are four persistent challenges that result from healthcare organization/account data

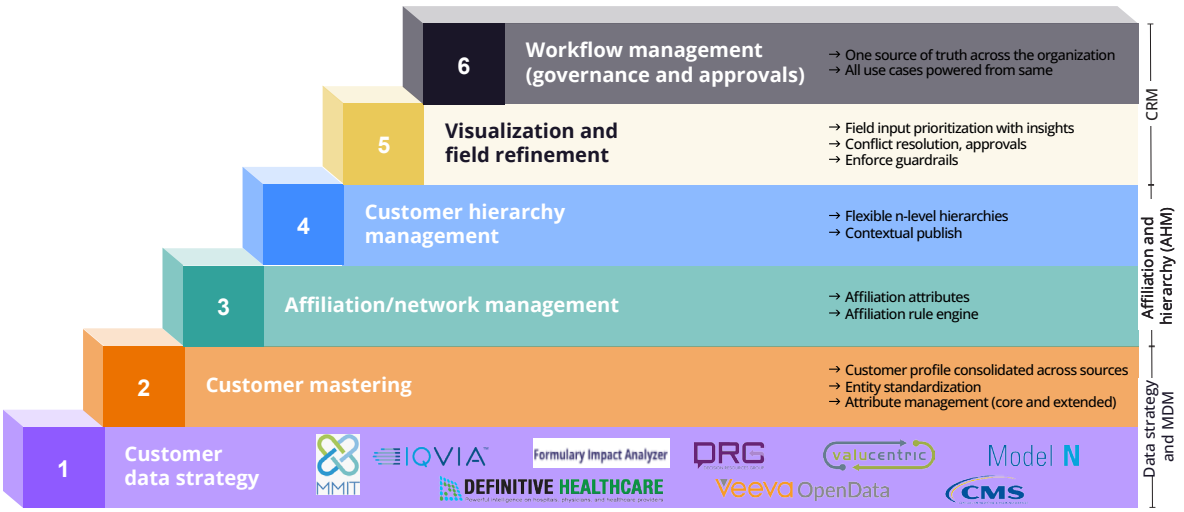
Challenge	Description
No single source of truth	Affiliation data differs by source. A facility may appear under one IDN in a vendor dataset but under a different parent in CRM, and GPO contracting relationships operate on a separate axis entirely. These misalignments cascade into targeting, IC, analytics and contracting.
Incomplete hierarchy and geospatial gaps	Most MDM systems support only two hierarchy levels, while real-world ecosystems operate across five or more. Hierarchies also fail to capture proximity-based clustering, which is critical in specialty markets where colocated clinics function as a single operational unit.
Governance and stewardship gaps	Feedback processes for hierarchy updates vary across brands, therapeutic areas and regions. Without standardized workflows and defined SLAs, stewardship is inconsistent, updates are delayed and changes lack auditability
Limited visualization and usability	Flat CRM hierarchies can't represent multilevel ownership, referral patterns or prescriber clustering. KAM and market access teams lack intuitive tools to navigate complex structures and validate changes.

Building the right infrastructure and data foundation for organized customers and accounts is the answer

Setting up the right data and analytics foundation for organized customers means solving this end-to-end: consolidating and mastering customer data, mapping true affiliations and networks and building flexible hierarchies—that's the core data infrastructure work. CRM, field visualization and workflow governance are downstream consumers of that foundation, not the foundation itself.

FIGURE 4:

Key steps in setting up account data foundation



MDM: Master data management (No. 2 from Figure 4): The primary objective of MDM is to bring together disparate data sources and establish a trusted, consistent customer record and identifier. It provides a unified way to manage customer profiles, demographics, attributes and identifiers across sources, ensuring that the organization has a consistent view of who the customer is.

In essence, MDM answers: "Who is this customer?"

AHM: Affiliation and hierarchy management (Nos. 3 and 4 from Figure 4): At first glance, AHM can be mistaken for an extension of MDM. Both involve customers, identifiers and data quality; however, they address fundamentally different layers of the commercial data ecosystem.

AHM goes beyond identifying individual customers to establish how customers and healthcare entities are connected, and how those relationships matter to the business. It links HCPs, sites of care (SOC), hospitals, health systems, integrated delivery networks (IDNs), practices, GPOs and other entities and organizes these relationships into business-relevant hierarchies.

Third-party data vendors provide an important starting point for these affiliations and relationships, but vendor data alone does not provide the complete business context required for effective hierarchy management. Organizations need to augment vendor data with internal sources such as CRM, sales, claims, contracting, GPO data and field intelligence, while also applying business rules and governance.

This is particularly important because the way relationships need to be structured can vary by therapeutic area, commercial strategy and business function. Commercial, KAM, medical, market access and contracting teams may need different views of the same underlying healthcare ecosystem.

AHM therefore captures not only who is connected to whom, but also the nature, context and business relevance of those connections including ownership and parent-child structures; employment and practice affiliations; campus relationships; purchasing and contracting relationships; and other business-relevant associations. It also determines how these relationships should be structured, prioritized and rolled up into a hierarchy that reflects how the business operates.

AHM can then provide different contextual views of the same underlying ecosystem based on the needs of a therapeutic area, business function or commercial strategy, while maintaining a common relationship foundation across the enterprise.

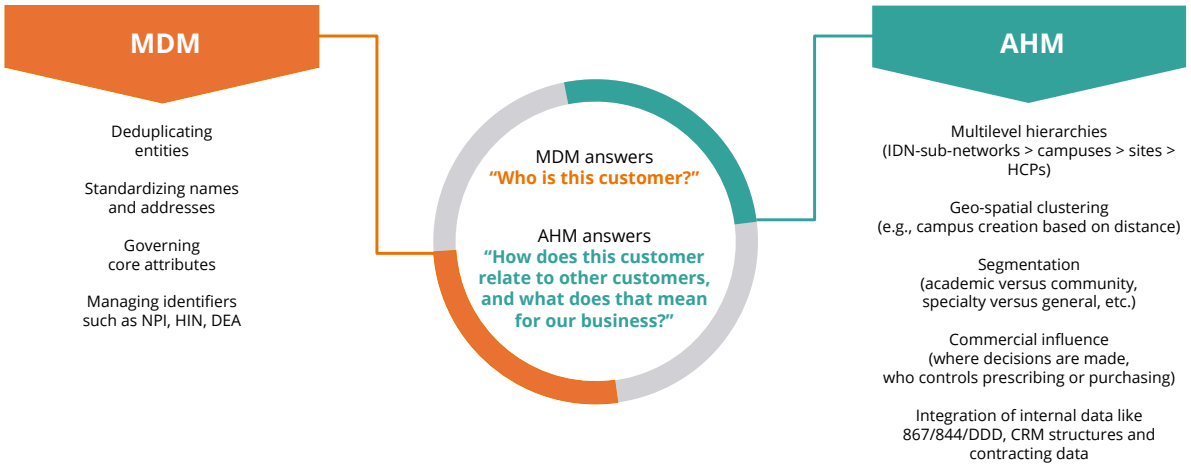
In essence, AHM answers: "How are these customers connected, and how should the business use them?"

Together, MDM and AHM provide complementary foundational capabilities: MDM establishes the trusted customer record, while AHM connects those records into a meaningful, business-ready view of the healthcare ecosystem. This foundation enables downstream capabilities such as targeting, account ownership, KAM planning, coordinated engagement, contracting,

analytics and AI-driven decision-making.

FIGURE 5:

MDM and AHM each address different layers of the commercial data ecosystem



Where third-party data falls short

A key reason MDM cannot fulfill the AHM mandate is its dependence on third-party data as the primary source of affiliations. While vendors deliver essential healthcare organization and HCP demographics and identifiers, they are not equipped to provide a complete, commercial-grade hierarchy on their own.

FIGURE 6:

Relying on MDM alone exposes many gaps in data affiliation

Gap	Description
Legal ownership ≠ commercial behavior	Vendor datasets document corporate ownership structures, but commercial influence and clinical decision-making do not always follow the legal tree. Two hospitals under the same health system may act independently in different therapeutic areas; an outpatient center may be formally independent yet tightly integrated with an academic medical center.
No colocated campus identification	Syndicated datasets treat every physical location as a separate record. They cannot calculate distances between sites, identify when multiple locations function as a single campus or recognize shared clinical teams and capacity. Capturing this requires geo-coding, distance calculations and therapeutic-area context, all outside the remit of vendor data.
No visibility into commercially important sites	Vendor records do not indicate which sites drive product volume, where the majority of treatment activity occurs or which address should serve as the roll-up point for sales, calls and IC. These are inherently brand- and client-specific business rules, not vendor attributes.
Slow refresh cadence	Vendor updates are typically monthly or quarterly. But the real world moves faster. IDNs acquire new systems, clinics relocate or consolidate, new treatment sites open and network relationships shift after contracts go live. These changes are visible to field teams and in transactional data long before they appear in syndicated reference files.

FIGURE 7:

Beyond vendor data, a realistic view of the customer ecosystem must integrate multiple internal signals that no third-party provider can supply

Data Source	Role in AHM
867 Shipments	Product distribution by ship-to location; key input for campus representative selection and sales attribution
844 Chargebacks	Billing entity identification; contracting eligibility validation and revenue leakage analysis
DDD/outlet sales	Outlet-level demand data; market share analysis and competitive benchmarking
CRM account data	Local affiliation edits, field-maintained relationships and account structures
GPO rosters	Membership, eligibility and chargeback relationships for contracting alignment
Field feedback	Real-time intelligence on new sites, closures, ownership changes and operational shifts

The case for a unified AHM framework

A unified AHM framework combines external data, internal business signals, configurable business rules and governance to create a trusted, business-relevant view of the healthcare ecosystem. It provides a common relationship foundation while allowing different functions to apply the context required for their specific decisions.

1. Connected data ecosystem

A unified AHM layer brings together third-party affiliations, MDM, CRM, sales, claims, contracting, GPO and field-generated intelligence to create a more complete and current view of customer relationships.

This common foundation can be consumed by downstream platforms and processes for targeting, reporting, IC, CRM, analytics and other commercial use cases, reducing reliance on fragmented hierarchies maintained independently across systems and teams.

2. Multilevel hierarchy model

Healthcare relationships are multidimensional and cannot always be represented through a single hierarchy. Organizations may need to be viewed through different lenses, including ownership, operational, contracting, purchasing, clinical and other relationships.

For this paper, we focus on two commonly used business views: commercial and market access.

The commercial view typically emphasizes organizational ownership, operational structure and sites of care to support account planning, targeting, territory alignment and customer engagement. The market access view emphasizes contracting relationships, GPO membership, purchasing structures, eligibility and other factors that influence access and pull-through.

These views should remain connected through a common AHM foundation rather than being maintained as independent hierarchies. This allows the organization to understand both the underlying organizational structure and the commercial relationships that influence access, purchasing and pull-through.

3. Bridging the gap across business functions

Connecting multiple hierarchy views enables business functions to work from a consistent understanding of the customer ecosystem while retaining the relationships relevant to their specific decisions.

For example, commercial teams can understand where care is delivered and how accounts are organized, while market access teams can assess contracting coverage, GPO relationships, purchasing influence and eligibility in the context of those same organizations.

This connected model creates greater visibility across account ownership, contracting, access and pull-through, and strengthens the foundation for processes such as 340B management and incentive compensation.

4. Governance and trust

A hierarchy is only valuable when the organization can trust how it was created and how it changes over time.

A governed AHM framework establishes clear ownership, data stewardship, feedback and approval workflows and traceability for hierarchy changes. Field intelligence and business-driven overrides can be incorporated through a structured process, with periodic reviews to validate, retain or retire changes.

This creates transparency into why relationships exist and reduces the proliferation of conflicting, locally maintained hierarchies.

5. Build once, configure for scale

AHM should be a shared enterprise capability, not a series of brand-specific builds. A common hierarchy core, supported by configurable rules and business views, allows organizations to scale across brands, therapeutic areas and markets—maintaining consistency while accommodating business-specific needs.

FIGURE 8:

The ideal way to build this solution is to set up a common shared base and contextualize with brand- and TA-specific rules.

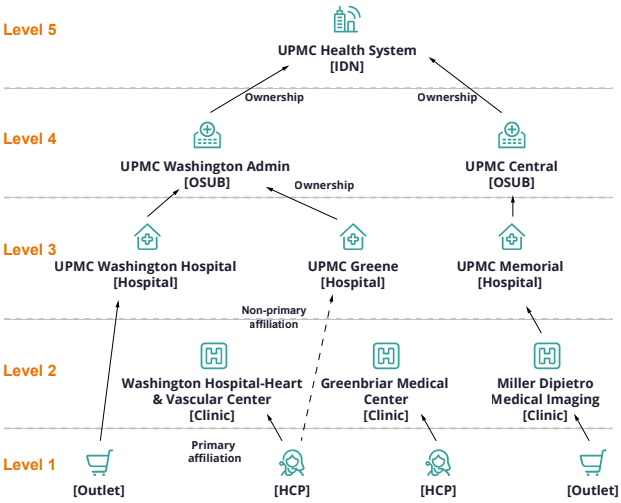
Layer	Techniques	How it scales
Shared base hierarchy	The five-level structure (IDN > OSUB > Hospital > SOC > HCP), master IDs, crosswalk and core affiliation logic	Built once, reused across all brands and TAs. Changes to ownership, campus groupings and entity records propagate automatically to every downstream consumer.
Configurable rule layer	Colocation thresholds, campus representative selection priorities, academic/community classification rules, HCP primary affiliation methodology and override governance	Configured per brand or TA depending upon the key customer types each brand/TA engages with.
Brand-specific overrides	Field-driven adjustments, local account exceptions and brand-level business rules	Managed through the governance workflow. Overrides apply only to the requesting brand's view without affecting the shared base hierarchy.

Example: A pharmaceutical company with both an oncology portfolio and a rare disease launch shares the same five-level hierarchy and mastered customer data. The oncology brand configures its rule layer with tighter campus thresholds, prioritizes infusion-capable sites for representative selection and applies National Cancer Institute/National Comprehensive Cancer Network-based academic classification.

The rare disease brand uses wider campus thresholds, prioritizes HCP density and applies keyword-based classification for specialist centers. Both brands consume the same underlying hierarchy, only the rules differ.

For commercial, a typical hierarchy has anywhere between three to six levels with five levels being a commonly accepted structure. This five-level model enables organizations to represent real-world complexity—from the broadest IDN umbrella down to individual prescribers—while supporting clean roll-ups for IC, targeting, reporting and contracting.

FIGURE 9A:
Provider hierarchy



Level 5

Corporate parent: Organization with direct responsibility for centraliz ing the treatment, purchasing or contracting decisions of its affiliated healthcare facilities.

Level 4

Owner subsidiary/child IDN: A legal, incorporated entity that serves as a corporate parent within a larger parent organization, either a corporate owner or an IDN.

Level 3

Hospital: Healthcare facilities that deliver a wide range of medical services to employers and patients, including urgent care, occupational medicine, physical therapy, primary care and wellness programs.

Level 2

Site of care: Site of care is a physical location of infusion administration. Sites of care include clinics, long term cares, physician office, ambulatory infusion suite or home-based setting.

Level 1

Outlet: Point of sale location where drugs are shipped to and sold from.

HCPs: Provide healthcare treatment and advice based on formal train- ing and experience.

FIGURE 9B:
A typical commercial hierarchy

Layer	Techniques	How it scales
Level 5	Corporate parent/IDN	The top-level health system or integrated delivery network that holds ultimate organizational control. Drives systemwide clinical, financial and strategic decisions.
Level 4	Owner subsidiary	A regional or functional subsidiary within the IDN that manages a cluster of facilities. Reflects operational management rather than just legal ownership, which is critical for understanding how decisions are delegated within large systems.
Level 3	Hospital	Hospitals are sites of care that provide inpatient medical care and related services, they usually have departments/clinics/pharmacies as a part of them.
Level 2	Site of care (SOC)	Individual facilities such as clinics, infusion centers, physician offices, specialty pharmacies or ambulatory surgery centers.
Level 1	HCPs and outlets	HCPs: Individual prescribers and practitioners affiliated with the SOC. Links clinical activity to the organizational hierarchy. Outlets: Point of sale location where drugs are shipped to and sold from.

Governance and operating model for AHM

Without governance, even the best hierarchy model will decay over time. A robust AHM operating model should establish clear ownership, structured feedback mechanisms, defined decision rights and continuous monitoring to ensure the hierarchy remains accurate and business relevant.

Field feedback integration

Field teams are often the first to identify real-world changes such as new facilities, closures, ownership transfers and operational shifts. A structured feedback process should enable these insights to be captured consistently and incorporated into the AHM process:

- Standardized feedback templates to capture specific change requests
- Defined cutoff schedules (such as weekly submission windows) to batch and process changes efficiently
- Automated override creation for high-confidence changes
- Stewardship validation for complex or ambiguous requests
- Transparent feedback closure summaries so field teams know the outcome of their submissions

AI-enabled stewardship and approval workflows

AI can augment the stewardship process by analyzing incoming feedback, assessing the supporting evidence and recommending the appropriate hierarchy action while keeping final accountability with designated AHM stewards.

The workflow can include:

- **AI-powered intake and classification** to interpret field submissions, identify the entities and relationships involved and categorize the requested change
- **Evidence aggregation and validation** by comparing feedback against MDM, third-party data, CRM, claims, contracting, GPO and other available sources
- **Confidence scoring and recommendation** to assess the likelihood that a proposed relationship change is valid and recommend approve, reject or escalate actions
- **Human-in-the-loop approval** where stewards review AI recommendations and supporting evidence before material hierarchy changes are implemented
- **Auditability and explainability** by maintaining a traceable record of the source information, AI recommendation, steward decision and resulting hierarchy change
- **Continuous monitoring and improvement**

Governance should extend beyond individual change requests to ensure the AHM model continuously improves as the business and healthcare ecosystem evolve.

Regular monitoring should include hierarchy quality audits, analysis of feedback trends and recurring exceptions, evaluation of AI recommendation accuracy and periodic refinement of business rules, matching logic and stewardship thresholds. This creates a closed-loop AHM operating model in which field intelligence is captured, AI-supported analysis accelerates stewardship, human owners retain decision rights and outcomes continuously improve the underlying hierarchy.

Roles and accountability

Successfully operationalizing the governance framework above requires clear ownership and accountability across teams.

FIGURE 10:

The following RACI matrix defines who is responsible for each key AHM activity

AHM activity	Governance council	Stewardship team	Field teams	IT/data management
Hierarchy rule change	A (Approve)	R (Recommend)	C (Consulted)	I (Informed)
Field feedback submission	I (Informed)	R (Process)	R (Submit)	I (Informed)
Override approval	A (Escalations)	R (Apply)	C (Evidence)	I (Informed)
Hierarchy refresh execution	I (Informed)	C (Validate)	I (Informed)	R (Execute)
SLA monitoring and reporting	A (Review)	R (Track)	I (Informed)	C (Metrics)
Periodic hierarchy audits	A (Commission)	R (Execute)	C (Validate)	C (Data)

Illustrative case studies

FIGURE 11:

The following anonymized examples illustrate the impact of a well-implemented AHM capability across different organizational contexts

	Case A: Specialty biotech	Case B: Specialty pharma	Case C: Large pharma manufacturer
Challenge	Inconsistent IDN roll-ups across 40+ facilities led to misattributed sales and IC disputes	Significant mismatches between 867 shipment and DDD outlet-level sales data, causing unreliable market share reporting	Unclear OSUB structures across regions made it difficult for KAMs and contracting teams to assess account relationships and coverage
AHM capabilities applied	Five-level hierarchy model, geospatial colocation logic, standardized affiliation rules	Fuzzy matching (Jaro-Winkler), name/address standardization, XREF creation	OSUB mapping integrated with AHM engine, GPO affiliation layering for unified contracting and ownership view
Outcome	Consolidated network into 16 accurate campuses; improved targeting precision, IC fairness and KAM planning	87% reduction in mismatched sales records; significantly improved data reliability for analytics and field teams	Improved KAM planning, contracting visibility and cross-functional alignment between sales, market access and analytics
Key AHM section	Multilevel hierarchy model, colocation rules	Data mastering and standardization	Affiliation rules, GPO affiliation management

Each case demonstrates that AHM is not a theoretical framework. It produces measurable improvements in data accuracy, commercial alignment and field effectiveness when implemented with clear rules and governance.

How a dedicated AHM capability provides a competitive advantage

Modern pharmaceutical commercial models cannot rely on fragmented or static customer relationship structures. As healthcare organizations consolidate and relationships evolve, companies need an AHM capability that can **connect data, apply business context, adapt to changing commercial needs and maintain governance at scale.**

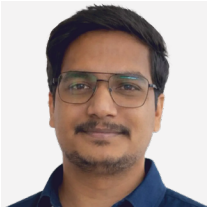
A dedicated AHM capability brings together foundational data, business context, configurable hierarchy and affiliation logic and governance to create a trusted view of the healthcare ecosystem. This enables organizations to support diverse commercial needs while providing a consistent foundation for downstream functions, including targeting, account planning, field execution, contracting, reporting, analytics and AI.

Organizations that invest in a dedicated AHM capability gain a measurable competitive advantage through:

- A trusted data foundation: Integrates MDM, third-party affiliations, internal business signals and field intelligence to create a consistent view of customer relationships.
- Business flexibility: Supports a common foundation while enabling TA- and function-specific views across commercial, KAM, medical, market access and contracting.
- Commercial precision: Improves targeting, account planning, sales attribution, IC, contracting and downstream analytics.
- Scalability: Configurable capabilities can adapt to new brands, TAs, markets and evolving commercial models.
- Governance and trust: Structured stewardship, feedback, approval and override processes keep relationships current and traceable.
- Field enablement: Gives teams a clear view of account relationships and SOC to support more effective engagement

AHM is more than a data management exercise. It is a foundational commercial capability that translates relationships into business context and enables downstream teams to make better decisions, execute more effectively and adapt faster as the market evolves.

About the authors



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