Aligning Sales to the Field Force – Increasing Complexities with Change in the Pharma Landscape

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Introduction

The pharmaceutical industry landscape is dramatically changing as it shifts from primary to specialist care. Increasing cost pressures and multiple factors influencing customer buying decisions has prompted the pharma companies to promote their specialty drugs more efficiently. Hence, there is a need for sales representatives (reps) to incorporate increased clinical knowledge, patient focus, managed care fluency, and understanding of territories when detailing.

These increasing complexities have pushed the companies towards designing a more effective and efficient incentive compensation plans for their sales forces.

To motivate sales reps to deliver stronger results with improved efficiency, their performance needs to be accurately measured and their reward aligned to their effort. But how do you ensure accurate sales crediting?

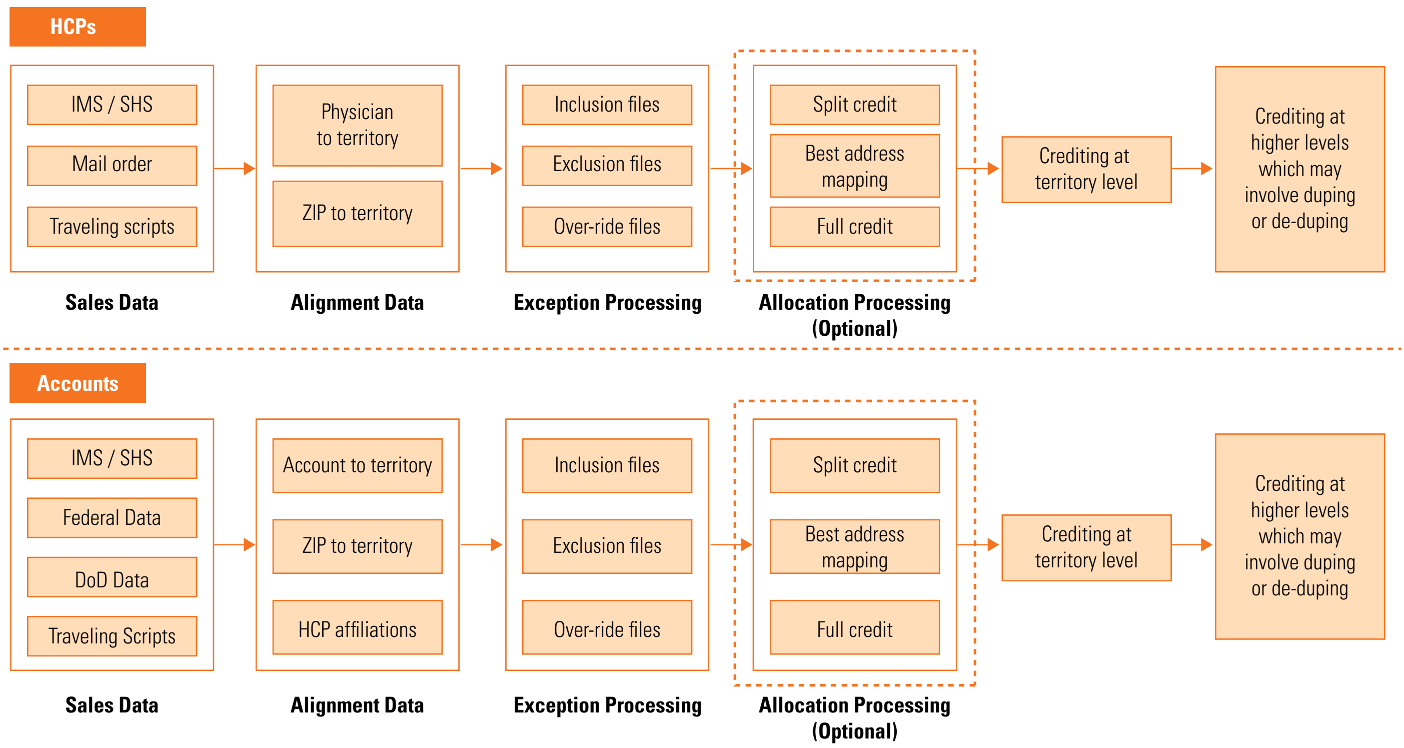
Incentive sales crediting process overview

Pharma companies promote their products through two primary channels -

- **Retail Sales:** provides view of the country's retail and mail order pharmacy prescription activity. These sales are reported at a physician level.
- **Non-Retail Sales:** provides view of wholesaler and manufacturer sales activity. These sales are reported at account level.

The process of aggregating this physician and account level data at the territory level is called sales crediting. The incentive sales crediting process helps to align sales with the various people involved in the selling process. Sales are aggregated for different periods and at various hierarchy levels. The sales crediting process requires merging sales and alignment data based on company-specific business rules and exceptions (Figure 1).

FIGURE 1: Various business rules involved in sales crediting process



With several exceptions, inclusions, and exclusions, complications may arise as the apportioning/allocation process is introduced. Arriving at the correct methodology to allocate fair sales to multiple people is a challenging task.

With years of incentive compensation experience, the team at Axtria has uncovered several challenges and nuances involved in the sales crediting process.

Key Challenges

1. **Assigning the correct address:** Health Care Practitioner (HCP) demographic information is available from a variety of internal and external sources. Derivation of addresses is essential to ensure accurate alignment of customers.
2. **Shared targets:** A typical HCP works out of multiple locations and is targeted by multiple field personnel.
3. **Data unavailability at the required granularity:** In the world of Health Care Outlets (HCOs), data may be available for a parent account. As reps promote brands to child accounts, it is necessary to allocate sales for large accounts to multiple geographies containing the child orgs.
4. **Traveling script:** Hospital outflow converted to retail, or a non-reporting pharmacy, may fulfill a prescription in a different territory than where it was to be credited.

Some additional complications also arise due to the transition from mass-market medicines to specialty medicines, such as:

1. Multiple indications associated with a single specialty drug
2. Missing account data from specialty pharmacies leading to data gaps during the measurement period
3. Off-label promotion of the drug
4. Tighter coordination with managed care reps
5. Increased patient focus

Considering the cumulative effect of these intricacies can help assess the increasing complexities involved in the sales crediting process. Over the years, Axtria has implemented several different methodologies to ensure accurate sales crediting and, therefore, reduce pitfalls in incentive payouts. This white paper will explore some of them and explain its pros and cons.

How to determine the best address for an HCP

Correct identification of the HCP address is an important step in determining who should be detailing the HCP and who will be compensated for the detailing efforts. Many a times, reps raise concerns on the validity of a practitioner's address, which can become a major source of disgruntlement, especially with high-value HCPs. Accurate HCP addresses are essential not only for effective personal and non-personal promotions, but also for incentives and multiple sales ops processes.

But determining the correct address comes with challenges:

- Multiple data sources: There are multiple external and internal data sources available. The key question is, which data sources should be trusted. Some of the external sources include:
  - External sales data providers like IMS, SHS, etc.
  - Third party demographic aggregation agencies like Medpro
  - License and demographic information sources, such as AHA, NPA, DEA, AOA, etc.
  - Third party aggregators that act as call centers and directly call on HCP offices to verify demographic information

  Some internal sources include:
  - Call activity data
  - Internal verification cells that calls upon HCP offices for sample and journal drop verification
  - CRM system where reps enter information on address changes, retirement and deceased HCP information
- Customer movement: It is important to accurately capture the information of HCPs who may have retired, relocated, or deceased.

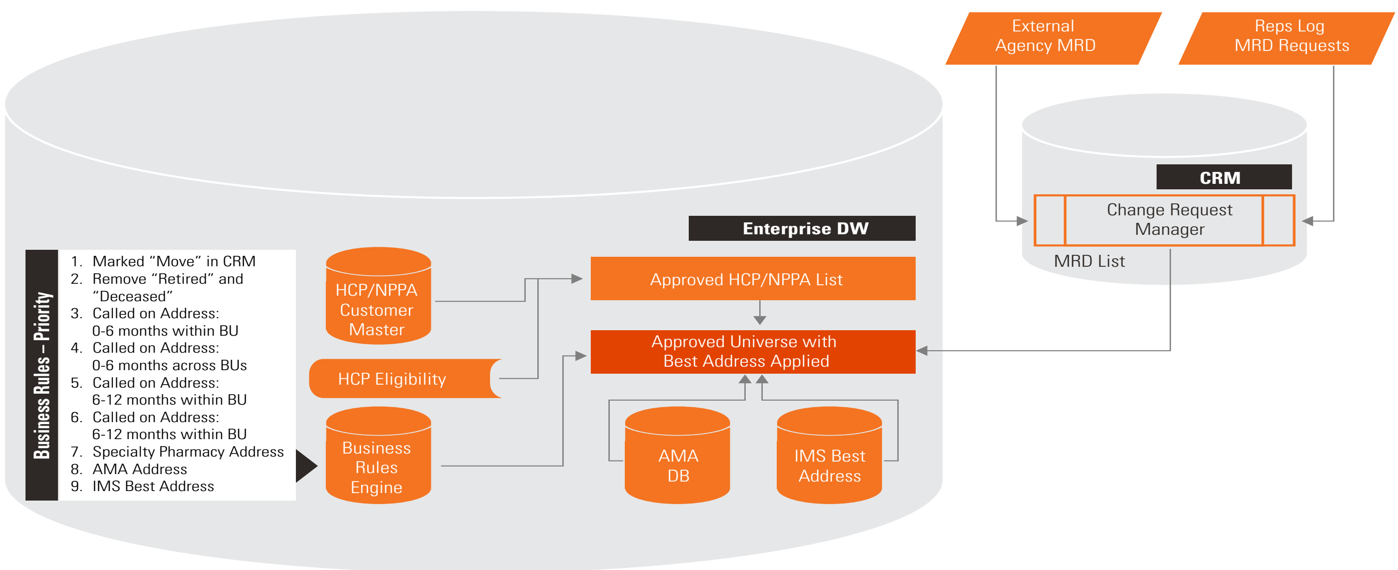
- Multiple addresses: HCPs may practice out of different locations depending on the therapeutic area(s) they are catering to. The same product may warrant different addresses for different indications due to the different facilities associated at the time of prescribing the drug.

A typical best address process involves:

1. Consolidation -The process starts off with aggregation of all demographic information from external and internal data sources. At this stage, there may be multiple addresses assigned to a single HCP.
2. Assigning "trust scores" – Assigning different "trust scores" to various data sources. Organizations generally give higher scores to internal data sources.
3. Determining business rules -The business rules depend on the "trust scores" assigned to various data sources. Once determined, the business-rule engine will begin scrubbing data to assign the correct address(es). Some steps are illustrated below:
   a. Update the address information using the "Move" change requests submitted by the field personnel. The records is updated after proper validation.
   b. Remove the "Retired" and "Deceased" HCPs from the universe. This will ensure that any existing scripts that a rep has no influence over are not inaccurately included in the crediting of sales.
   c. Reference the internal call activity data to determine the best address allocation. Typically, the most recent call activity is the primary factor in determining the correct address.
   d. If an HCP has multiple addresses relevant to different therapeutic areas, priority is given to the call in the therapeutic area with the pre-determined best address. Cases where the call activity data for the relevant therapeutic area is unavailable, call activity from other therapeutic areas can be picked up to determine the correct address.

If the preceding rules are unable to deliver satisfactory results due to data unavailability, varying time periods or external data sources are then considered. Every organization gives different priority rating to external data sources. Commonly, if a specialty pharmacy is engaged in administering or dispensing drugs for a specialized therapeutic area, their information is considered more accurate than other data sources as they are constantly involved with the practitioner. If the address is not determined from the preceding step, license data is then used as an alternate. Using sales data to determine the address for a HCP is the last resort.

FIGURE 2: A sample best address process is illustrated below



An organization's strategy determines whether a HCP has a single best address or multiple best addresses. If a HCPs has multiple addresses, sales crediting logic will determine how a rep is credited with the sales.

Credit HCP with multiple addresses

Multiple addresses for a HCP implies that one or more reps will receive credit for these sales. More than one rep receives credit if the HCP's offices fall into more than one rep's geographical span of control.

There are two major ways to credit sales for a HCP with multiple addresses:

1. Apportioning (*also interchangeably referred to as allocations in the life sciences industry*) – It implies splitting sales equally or basis a pre-determined split percentage between all the addresses assigned. When aggregated, these split sales equal the actual volume as dispensed by the practitioner.
2. 100% equal credit – Complete sales is allocated to the rep who has the HCP in his geographical span of control. There is a nuance involved here, if a HCP may have two offices (two best addresses) in the same geographical territory, care must be taken to avoid double crediting to the rep. Further, the sales must be de-duplicated to avoid double credit while aggregating data at a higher level such as the rep's managing district.

The table below highlights the pros and cons associated with the above two methods of crediting sales for HCPs with multiple addresses:

	Pros	Cons
Apportioning – equal or unequal sales split across multiple territories	• No double counting of sales • Sales allocated to multiple reps and territories • Limits over-utilization of budget • Promotes teamwork - if done in the right way	• Low field comprehension of methodology • Difficult to determine the right effort put in by individuals. It's not just effort but influence and management which drives this. Quantifying indirect contribution is challenging
Full credit to all addresses	• Field comprehension is high • Less inquiries related to sales • Budget utilization can be controlled by designing appropriate plan metrics. This is optimal for mature brands • Promotes collaborative work environment	• Needs to be controlled financially. Limits the options for plan metrics. Metrics that are not directly based on territory volume are preferred. Examples: quotas, rank, market share • May not be fair to reps who actually drive sales as it can impact their motivation to do better

Axtria has, over the course of multiple engagements, worked on several different approaches to determine apportioning ratios. Highlighted below are some examples of apportioning methodologies:

Approach 1	Approach 2	Approach 3
Define allocation percentages based on feedback from the field. Minimize ambiguity by taking allocation recommendations from the First Line Managers, while the Regional Heads can review, modify, and approve them	Using other data sources like claims data, APLD, or using special tie with Pharmacy Benefit Managers (PBMs) for specialized TAs such as Oncology, etc. to allocate sales to various territories using advanced analytical techniques	Define allocation percentages based on the roles of different people involved in sales. This can be based on inputs from home office (HO). *Example: a managed care personnel in a territory may be receiving equal sales credit but split between two reps may be different*
Pros • This takes into account the local conditions • Minimizes ambiguity as inputs are derived directly from the field	**Pros** • Data driven approach – can be utilized for large purchasers • One time set-up cost with minimal ongoing cost	**Pros** • This takes into account the role of a sales personnel and local conditions. • Minimizes ambiguity as inputs are derived from HO.
Cons • It requires an automated system to take inputs from the field • It can be cost prohibitive, as the set-up cost and ongoing cost could run high • This method cannot be employed to allocate sales of very large accounts	**Cons** • Other data sources availability could be a challenge and could also be cost prohibitive • This could demotivate reps, as it does not take into account their inputs and local intelligence • Difficult to understand for reps	**Cons** • It can be cost prohibitive, as the set-up and ongoing costs could run high. • This may raise a lot of questions from the field as they may not find it fair.

The above apportioning methodologies can also be used to allocate sales for a large non-retail outlet distributing data to multiple child accounts.

Handling data granularity complications for HCOs

Unlike HCPs, HCOs do not have the problem of multiple addresses, but the level of data granularity in the non-retail world has its own challenges:

- Chain HCOs buy centrally and redistribute inventory from multiple branches. Here, credit may be attributed only to the geography/rep that is aligned to the central purchasing unit. Example, Florida Cancer Center (FCC) buys at one address and then re-distributes to the branches. When looking at account sales, all sales to FCC will be attributed to a single corresponding territory. This is not a true reflection of FCC sales as the demand is being generated through multiple branches.
- Long term care sources, such as Omnicare or large wholesalers (e.g., Diamond Cardinal/ Morris-Dickson, PA) may not provide data at a granular level. Further processing is warranted to distribute sales across all contributing territories.
- Sales data from federal accounts and the Department of Defense is received last as they need additional time to provide information due to the administrative effort required. This data contains mostly shared accounts. Due to the overall high sales volume, it is key to align these accounts correctly.

Sales for shared accounts can be credited across territories in multiple ways:

1. Use of an outlet to account for territory mapping / ZIP to territory file -This will provide a direct mapping of accounts to each territory where two types of mappings are possible:

a. One to one mapping - this is straightforward and involves no complexities.

b. One to many mapping - these are shared accounts mapped to multiple territories. **Allocation % of these accounts is computed using secondary sales data or through field intelligence.** Some of the processes used in the industry to determine the allocation of non-retail sales are illustrated below:

Process	Axtria Point of View	
	Pros	Cons
Utilize field feedback to determine allocations. First Line Managers provide split % while Region Heads review	• Considers local conditions • Minimizes ambiguity as inputs are derived from the field themselves	• Requires automated system to receive inputs from field • Can be cost prohibitive as set-up and ongoing costs may be high • Cannot be employed to allocate sales of very large accounts
Utilize other data sources (e.g., claims, APLD, etc.) with advanced analytics to determine share %. For example, use IDN data to determine allocation % for FCC.	• Data driven approach – can be utilized for large purchasers • One-time set-up cost with minimal ongoing cost	• Availability and costs of other required data sources may be prohibitive • Does not utilize local intelligence • Difficult for the field to understand

2. If direct outlet to account mapping is not available (typically seen in smaller clients), the following approaches may be considered:
   a. Alternative data sets such as Dartmouth Health Atlas data can be used to provide a ready mapping of ZIPs to hospitals.
   b. A physician affiliation file provides the list of physicians affiliated to the desired hospital. Common addresses for these physicians can be identified and mapped to the territory accordingly. However, in scenarios where the physician mapping file has many missing physicians, or an account has only a handful of affiliations, this methodology will not work.

How to handle a traveling script

A ***traveling script*** provides a constant challenge when determining the correct territory responsible for a prescription. The most common scenarios where we encounter this problem are:

1. A prescription may be filled by a non-reporting retail pharmacy. The sales data is received as non-retail data reported against a non-retail outlet filling the prescription.
2. Hospital outflow may be converted to retail channel sales.

There are multiple ways to attribute these scripts to correct HCPs/geographies. However, adjustments for these scripts are advisable only when the spillover percentage is high, as these cause field disruptions.

- Simple approach - This is cost friendly. We can seek data from PBMs or doctors' offices (especially for low volume, high value products such as Oncology) to determine the adjustments to be made to the non-reporting pharmacy data.
- Analytical approach - This is a costly and cumbersome process. Spillover analysis can be conducted to determine impact and adjust accordingly. This will involve:
  – Analyzing and integrating multiple datasets, such as **APLD, Dartmouth Health Atlas, hospital claims, discharge data, affiliations data, etc.**
  – Determining key focus areas for pharmacy and hospitals, based on Medicare claims data.
  – Deducing percentage of ***traveling scripts*** using APLD data and adjust.

How to handle additional complications with specialty market

Specialty market share is only going to increase in the future and the specific considerations governing this market also impact the sales crediting process, bringing in a new set of challenges.

Multiple indications associated with specialty drugs

Specialty drugs, at times, are approved for multiple indications. The disease states associated with these drugs may be aligned to the same or different prescribers. Appropriate specialty inclusion and apportioning rules need to be applied to ensure the accurate alignment of sales to the reps.

1. Physicians with different specialties are prescribing this drug - The scripts can be split by specialty for sales crediting.
2. Same physician prescribes for multiple indications - For accurate sales crediting, it is important to split the sales by indication, which is difficult unless we use additional data sources, such as patient level data or claims data. However, this makes the process complex and the administrative cost high. An alternate route may be to not split sales and instead provide full credit to all reps involved. Designing an appropriate incentive plan will help ensure this method does not have a financial implication to the company.

Missing data from specialty pharmacies

Specialty drugs are increasingly dispensed through specialty pharmacies. Specialty pharmacies, which once occupied only a small niche in the marketplace, is becoming a developed industry. Collaborations between specialty pharmacies, retail settings, hospitals, payers, and manufacturers have become common. These collaborations can improve patient care by enhancing patient access to specialty pharmacies and the high-touch services a specialty pharmacy can provide. However, there are challenges when it comes to the timely delivery of data.

The contracts between pharmacies, hospitals, manufactures, and payers are revised periodically that leads to delay in data reporting during the performance period. Sales crediting as a result requires frequent adjustments to ensure each rep's performance is adequately captured and rewarded.

Off-label promotion of the drug

Specialty drugs are approved for multiple indications and, at times, are used for treating diseases not approved by the FDA. While crediting the sales, it is important to look for off-label promotion or usage of this drug and exclude these sales from the credit to the sales rep.

Tighter coordination with managed care representatives

Specialty reps need to integrate with management protocol of leading managed-care plans directing the medical treatment. There has been a significant shift in influence and authority over treatment choice between the provider and the payer community. Without a doubt, payers have assumed far greater influence. Hence, it is important for the specialty and managed care sales reps to work together to be successful and more effective in their respective roles.

From an incentive standpoint, it is imperative for the payers and providers to tie their interests together. Sales crediting rules are defined to ensure that the sales for specialty drugs are accounted fairly to both the reps.

Increased focus on patients

The specialty drug market requires a shift from product-centric orientation to a patient-centric orientation. Patient

adherence and persistence is critical, but specialty drugs can potentially have severe side effects. A patient is not going to finish treatment and enjoy the outcome unless they understand the potential adverse effects.

Specialty reps have an opportunity to serve as a resource and as an advocate for patients.

Measuring effectiveness of the specialty rep and incentivizing them should not be prescription driven, but based on the entire treatment lifecycle. The total number of scripts needed to complete a treatment should be considered instead of a single script, which only represents partial treatment. Few companies follow this logic today but it will become the standard approach to measure sales rep effectiveness in the coming years.

Conclusion

We have discussed some of the intricacies involved in the sales crediting process throughout this paper. To keep the sales force motivated, credit must be given where due. As the quantitative measures are highly transparent and visible to the field, it is essential to ensure accuracy of the sales crediting process. This requires that the attributes associated with HCPs/HCOs are accurately captured or determined, especially addresses and specialties.

The sales crediting exercise is a highly-evolved process and is not limited to determining the best address or setting up an allocation/apportioning process. Other elements include setting up business rules per the brand strategy, compliance/off-label promotion requirements, call plan and targeting requirements, alignment set-ups, unit of measures, and more. At Axtria, we have assisted several clients in set-up and delivery of various complex sales crediting processes. Reach out to our expert today to understand the process for accurate sales crediting to motivate your sales team to deliver better results.

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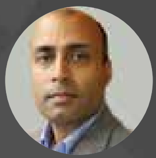

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