Premier, Inc. (Nasdaq: PINC)

COVID-19 Expert Call Hosted by BofA Securities

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Operator: This call is not for media representatives or Bank of America securities, investment bankers or commercial bankers, including corporate and commercial FX. All such individuals are instructed to disconnect now. A replay will be available for Bank of America securities investment bankers and commercial bankers, including corporate and commercial FX. The replay is not available to the media. Good day and welcome to our real-time update on the Healthcare market with Premier. Today's call is being recorded and I would now like to turn the call over to Michael Cherney. Please go ahead.

Michael Cherney: Great, thank you Savannah and thank you so much for joining us. I guess you can call this a series, since this is the third call we have done with Premier since COVID first kicked off. It's my pleasure to have with us president of Premier, Mike Alkire, as well as Premier senior VP of supply chain, David Hargraves. Along with me, co-host in the call, are a number of my healthcare colleagues Derek Brown, Kevin Fischbeck, Bob Hopkins and Jason Gregory. All of whom will chime in with their specific subject matter expertise as we go. I'm going to kick off the call with questions, but just before we get going, two quick things. One as always, any conflict disclosures relating to the individual company or security discussed on the call can be found on the invitation that we sent out. And then two, we all have a number of topics that probably will take us through the hour. But as we're going, if there's any questions that you'd like for any of my Bank of America colleagues to ask, please feel free to email, or send me a Bloomberg message and we will address them as best we can. With that, again, Mike, David and I know Angie McCabe from the IR team, thank you all for joining us. I guess, just to start as topical as we can, in the last 24 hours, your members have started the vaccination process within their facilities. Maybe just give us a quick view on very simply how it's going.

Mike Alkire: Thank you, Michael and I appreciate you having us on the set this morning. Yeah, as you said, our healthcare systems have been receiving the vaccine. They've got their first shipments yesterday, many of them are expecting them today and tomorrow as well. So, a lot of that obviously is making its rounds on YouTube with the first patients being inoculated. So, we're incredibly excited. Just as a reminder, this is the Pfizer vaccine, that has some pretty substantial requirements in terms of, you know, keeping the product cold in transit and those kinds of things. And so, I would tell you so far, so good, in terms of our ability to dispense that product.

And just as a quick reminder, Pfizer is committed to producing 20 million doses here up to the end of the year. And then an additional 100 million doses through the first quarter of next year. And just again as a reminder, every patient will require two doses. So, you can split those numbers in half to determine the number of people that would be able to be vaccinated. But so far, you know, the handling of the product has been exceptional, and our healthcare systems are sort of stepping up to the task of vaccinating the population. So, we're really excited. Just as a quick sidebar, the Moderna emergency use authorization, conversation at the FDA is happening on Thursday. And we're hoping for quick approval and hopefully we'll be able to get that vaccine out into the population as well.

Michael Cherney: And can you give us a sense Mike, there was clearly a timeline that we were looking at that, is roughly in line with what I assume your member organizations were expecting? Can you tell us what your member health systems were doing to prepare, to make sure that starting yesterday morning, they could start vaccinating their own workers as fast as possible? What type of incremental investment data to make around storage, anything to make around supplies, in order to make sure they handle the vaccines once they came in?

Mike Alkire: Yeah, so that's a great question. So, I will tell you over the last couple of months, Premier has stood up a number of calls with our healthcare systems to really talk about, you know, that this both the distribution and the dispensing of the products. And it really was sort of a

brainstorming session in terms of how they were thinking through, you know, the dispensing of the therapy. And so, back then, obviously we knew that the Pfizer product needed to be maintained at -70 degrees Celsius. And so, we knew that that ultra-cold storage requires very special freezers. And so, we in fact, you know, we actually have those freezers actually on contract. And basically ensured that they-the organizations- that needed those freezers got access to them. They are at some point in time, Michael what's really interesting, there was these various commitments by various organizations to say, well, we'll ensure the cold storage from point A to point B. Meaning from the factory to the point of dispensing, but somebody is going to have to sort of step in and ensure that the product is kept at the appropriate temperatures, you know, post that. And so, lots of conversations occurred, federal government again step back up. And specifically, as it relates Moderna, they're going to provide a mechanism to do-I'm sorry, the-yeah, so the federal government is going to have a mechanism to do remote temperature probing, to ensure that the Pfizer product stays at that -70 degrees.

And then, if it stays within the container that it's shipped in, that pro bono work and again, the healthcare systems will be able to log that they were able to keep it to -70 degrees. And then if the member actually takes the vaccine and puts it into cold storage, and then they're going to be on the hook to have the probes and to do the logging of the information. But the point of all of that is, all of that logistics sort of had to be worked through over the last couple of months in terms of who was going to, you know, who was going to ensure the chain of custody, ensure that the products were appropriately stored and then obviously appropriately utilized. So, a lot of incredible planning went into this. And quite frankly, I'm very, very proud of how they all came together.

We recently did a survey, 78 of our health care systems and of those 78 systems, 79% were identified that they were the ones that were going to be receiving the vaccine. And this survey took place a week or two ago. 62% of them said they had the ultra-low freezers. 18% said they had them on order and in terms of getting the access to the freezers, now there's a bit of a

backlog in terms of folks getting them by maybe a month or two. But a number of them obviously we're planning far enough ahead that they got access to those freezers if they needed them. But the good news is that, at least the Pfizer vaccine is shipped in a container that can be utilized to store that product.

Michael Cherney: Thanks Mike, one quick follow up on that. Having known you in the company since before you came to public, I know how widespread your contracting is on various different supplies and equipment. I never would have guessed that you had ultra-cold freezers within the supply contract. Has anything changed about whichever manufacturers? I don't know if there's one or two that do it, but how you contracted out on those freezers as you saw the potential need in highly increased need for freezers? And is there anything you can say about how much more demand versus a typical year there would be for an ultra-cold freezer?

Mike Alkire: Yeah, I'll let see if David Hargraves has some of those details. But at-just at the highest-level question Michael, there are products that require ultra-low temperatures. So, we've had those on contract obviously support those products. So, the good news is, you know, they've been in production and they've been utilized for other products and now they're able to be used for the vaccine. But David, I'm not sure if you're aware, go ahead,

David Hargraves: I can get the little cover. So yeah, I appreciate the question Michael. So, early in the pandemic, we came up with some new processes for what we call our expedited sourcing process. So, you know, our standard sourcing processes long existed, it's very rigid and robust and comprehensive. But we found that we needed to, without sacrificing any of the benefits of this source you put by the way, to be able to get new products on vetted and on contract quickly. So, you know, we did that early on when we had the mask shortages here and then now when the freezer issue came up, we were able to utilize all these processes that we've put in place to do exactly that. So, we had existing contracts and suppliers that we had great relationships with and we had all the same conversations about their production capacity and the expected

demand. And then we were able to bring new suppliers onto contract as well. And it's one thing I want to make sure that I put out as, you know, the collaborative nature of the membership also works. Then as we harnessed to their collective knowledge through different calls, where one of them had a source, we made that information available for it.

So, just like ventilators spike at the beginning of it, sales and expectations of these freezers spiked as well. We identified some new sources, we worked with our existing sources and I'd say overall, the membership has been able, they have been-it's been handled. So the spike in demand, the corresponding the new suppliers that are found, there are certainly issues with lead times and things like this. But for the most part, it was really, I think assuring with our membership to know that we had the mechanisms all in place to be able to rapidly respond, if that news broke.

Michael Cherney: Got it, I'll pull on that for a little bit more and it's interesting that you mentioned the change in processes. When we did this first call, I remember you gave some, I almost call them jarring stats. About the shortfall you were seeing in particular on both PPE and ventilators. Something that was very widely known among common person, just in terms of big picture. But they were obviously more detailed in terms what you're seeing. Whether it's those two products and some other areas, can you just give us a sense on when you're seeing some of the current shortfalls on products and then along the other lines in particular for PPE, how the supply chain, which also included a lot of hard work from Premier has evolved in terms of meeting the excess demand on PPE?

Mike Alkire: Yeah, David I'll take the first highest level and please add any colour. So currently there's 7,500 products that are on allocation. And just as a reminder to the investors, allocation means that if you were ordering a specific amount before, the suppliers are typically allocating a certain number, depending on how much you had ordered. Either prior to COVID or over some period of time. So that just means they're limiting the amounts of products that they're

distributing. So, 7,500 products on allocation. And that compares to roughly 11,000 products that were on allocation at the height of the pandemic in the April, the March, April, May timeframe. So, it's down pretty close to 30% or so. In regard to products that are experiencing shortages, I will tell you the biggest issue we're dealing with as an industry, is exam gloves. And the reason is, again and you've heard me talk about this incredible demand, supply and balance. Well, you know, there's been a significant jump in the demand for exam gloves, especially the nitrile gloves, where you have organizations historically that had never used gloves are now using gloves. You've had countries that historically had never used gloves are using gloves. There are caregivers who were historically for various procedures, weren't using gloves that are now using gloves.

So, the demand is up, you know, 30 to 50%, depending on the part of the world that you are in. So substantial increase in the demand. And then versus the supply, that it's really struggling to keep up. But there's one major producer, Top Glove, that's experiencing some manufacturing issues in terms of producing products. We're working very, very feverously with entities to both stand up additional production, both in Southeast Asia, near shore and domestically. Because we do think we need to have a very balanced approach to exam gloves, but that's one area that we're seeing. And we can get into more detail if you have more detailed questions. But that's an area that we're seeing shortages and obviously, if the products are in short supply and prices are going up and to kind of give you some perspective, some exam gloves typically sold in heart-based just check my math on all this. But between two or three cents, prior to COVID. And today, you're seeing the price of gloves going up to the high teens and even into the mid-20 cent kind of range. So, those prices are going up substantially because of that supply, demand and balance.

The other areas that include disinfecting wipes. I know that that doesn't seem like a significant product, if you think about our healthcare systems and our caregivers providing care to patients. But disinfectant wipes is another area that we're very much focused on. And then there are about

20 critical drugs to include, painkillers and sedation products like Propofol, blood thinners, drugs for low blood pressure that we're keeping an eye on that are needed, obviously for COVID patients. But you know, those obviously go in and out of various States of shortages or not. So, we're keeping an eye on those and ensuring that we've got capacity. If in fact, we need to produce additional pharmaceuticals in those areas that we're able to stand that up. David, please add any colour.

David Hargraves: Thanks Mike, no changes to anything you said for sure. All of those are true. If you are trying to make a comprehensive list right now, the other things that are in short supply, you'd also add in the testing area, the reagents primarily, but the instruments secondarily. And one that luckily has come off the list that was on our last call we had was at the time, the swabs were on short supply. We've worked with the manufacturers that supply has come back and they're now available. But you've got the reagents and the test equipment, then just two others, one is relatively minor syringes and needles. You know our government's ordered a lot to be used for the vaccination, I'd call that in a constrained supply right now, not shortage.

But, you know, gosh, forbid if something happened to the supply, you've got them. They're sort of in the yellow. And then the big one though, that I'm not sure how well reported is, is the staffing shortage. The clinical staffing shortage. So not a supply, it's on the labour side, but very material right now. That the normal staffing requests that we would see with our members might be 9,000 per week, we've seen recently with our supplier AMN healthcare, they've received 19,000 requests. And so, there's a big strain on availability of temporary clinical staff. And then as a result, the wages that are needed to be paid in order to fill those openings have increased significantly.

Mike Alkire: And to give you Michael some context on the staffing numbers. Again, we do these surveys pretty regularly. And the most recent survey we asked, what's the number one issue that you're struggling with from a shortage perspective? And the number one issue and you could

only answer once. 53% of the membership said, staffing was the number one issue and versus 16% that said gloves. And so, you've kind of already heard our perspective on what's happening in the glove market. But I wanted then again the investors to appreciate the significant stress on the healthcare systems, as it relates to staffing shortages.

Michael Cherney: And before I turn it over to some of my teammates, one last follow-up for me. One item that you did not mention on the PPE shortage is actually masks. Which I know was a big focus point during especially the first call we did. Can you give us a little sense on how that has progressed and also any colour now that you're invested in Prestige Ameritech, the mask manufacturer, how Premier has been able to come to the aid so significantly in this area for its members?

Mike Alkire: Yeah, so just to give you some numbers, you know, at the height of the virus, the demand for N95 stood about 350 million masks. Prior to COVID, the US demand for N95 stood somewhere between 22 and 24 million masks. So that gives you again some perspectives and some context for the scale of the issue. We did along with 16 of our healthcare systems make an investment, a minority investment of Prestige Ameritech. The reason behind that investment really was to get access, number one. Number two was to provide needed capital to help Prestige America tech expand their production footprints, make the needed investments in raw materials as well as machinery. And so, Prestige Ameritech obviously took those investments. Took that capital infusion and stood up in additional, a couple of three lines, we're really excited obviously with the production output that they are providing us. Not only are they obviously providing the demand that our healthcare systems have for current needs, but they're also building out some pretty substantial stockpiles for the membership. And they'll be doing that for the foreseeable future. At least the next few months. David Hargraves, please add any colour.

David Hargraves: I think you've covered it well Mike, thank you.

Michael Cherney: And now I think is my last follow up on that. Is it safe to say that your members are still in buying what we need? And then if for some reason we can still stockpile stuff, so be it. But for now, especially for some of the hard to find PPE it's still a need based purchase that they're making?

Mike Alkire: Yeah, I will tell you right now, you know, as it relates to masks, there are across just because of how big we are. You'll periodically hear that somebody needs some small masks or some large masks or whatever. But you're hearing issues associated with just sizing and those kinds of things. But for the most part, that's getting resolved very, very quickly. I mean, we now have the flexibility to get production up and running within days and weeks to get those things solved. So, that seems to be getting solved from a current demand standpoint. But we're also, again, Michael, to your point, we want to make sure we're never in a scenario like this again. So, we do want to build up appropriate stockpiles of products that they can have and they can draw upon as they see fit. In a way that as you can think about it, the way that we're doing this is, the most recent production actually goes on the stockpile. And then we're buying the products back out of the stockpile to ensure that the stockpile remains as fresh as possible.

So anyway, we're really happy with the overall program. We're doing very similar stuff with our partner in isolation gowns. So, we should have isolation gowns stood up and produced here in the next few months. And why we're so excited about that opportunity, and again, minority investments, that's roughly 34 of our health systems. The reason we're so excited about that is, it is a domestic manufacturer of isolation gowns. In long-term, we believe there will be viability for the production of those products. Because, we spent a number of weeks and again, David Hargraves can get into some detail on this. Working with our clinicians to design an isolation gown that could be almost 100% automated. And so, we believe obviously given that it has very, very low labour costs, that long-term, it will be first competitive with products that are produced outside this country. And David, please add any context or comments.

David Hargraves: I appreciate Mike. Well, one thing on the gowns and then one earlier comment on the overall PPE Market and the stock line. But on the gowns, just a slight correction Mike on that one. It's the real sort of strong production for the gowns can be more sort of late summer, versus early spring. Just one minor thing on that, on the talking point. And that is because of that, just a phenomenal engineering that's been gone into, which is Mike's core point. That there was proper engineering US-based and the design work with our members. This is going to be-and it's an incredibly automated process and that does allow us to be cost competitive. And so, it's really, really strong and its exciting project for that.

The-on the other point, just for US, what's important to know is, you know, it's tough and Mike alluded to this. And the actual questions of what people are stockpiling, or are they sort of buying hand them out? Just one thing I'd point out is, just where as Mike said, you know, if you're in the core, the main part numbers, right? The availability is improving like in masks, but you might have where you have a very small size or a very large size, you'll see them in shortages. You can carry that concept over as well to the members themselves, right? If you're a large ID and that has some physical space to be able to stockpile or you've rented some offsite warehousing, your situation can be different then and you've been able to build stockpiles. Different than let's say a critical access hospital, a rural, a community hospital who may have some difficulties in holding that space. So we need to give great care to monitoring the members of all sizes and of all types and across all points of care to make sure that the smaller ones really don't get left behind, but we're ensuring that they're-that we've got solutions for them as well.

Mike Alkire: Perfect. I'm going to turn it over now.

Michael Cherney: All right, great. Thanks. We've got a couple of questions here. I guess about how you're looking at the, kind of the core volume of the hospital? You know, if you were to kind of strip out COVID from the overall occupancy and give a sense of kind of where that normalized volume is and how far back to normal we are right now?

Mike Alkire: Yeah, so I'm going to take a first pass. This is really regional dependent, right? So, it's kind of all over the board. I've had conversations with healthcare systems in Pennsylvania, that are limiting elective procedures, you know, by as much as 50%. So, you know, that I know there are instances of that occurring. I had some conversations with health systems here in Texas, that the COVID census is starting to climb, they are probably two or three weeks away from making a decision as to whether or not they will be limiting elective procedures. But if the trajectory stays on the same track, they will be having to consider that.

So that kind of gives you a perspective, I will tell you up North, you're going to-you're seeing elective procedures pinched a bit and then, again, at least what I'm aware of in Texas is the implications in terms of reducing electric procedures, aren't quite there. But they're still worried that these numbers are going to peak here in the Christmas kind of timeframe and that it's going to be pretty tough and go as to whether or not they're going to have to cut back on elective procedures. I hope that answers your question. But it's very, very hard for me to give specifics, given that we-you just have a myriad of systems that are dealing with this virus in different ways.

Michael Cherney: Yeah, no, that's definitely helpful. I mean, we do our own surveys of hospitals every month and the earliest ones just came out today. And we asked when companies would the hospital stuff volumes would be coming back. And now half of the respondents are saying March, but that's always been a moving target every month we do it. It gets pushed back a month or two, versus the last time we asked them, I don't know if you guys have a sense for when your customers think that kind of, you know, we'll get back to kind of normalize volumes.

Mike Alkire: No, that sounds pretty close. I think with this vaccine, obviously, if we can get as many people, you know, vaccinated as possible. I think obviously the quicker we're going to be able to get back to it. The dates that sort of the ranges that you threw out there, in the first quarter through second quarter, I would guess that that's what I'm hearing as well. Although again, if

you're in state that, you know, you haven't seen the big surge, you probably are going to experience getting back to normal quicker.

Michael Cherney: Yeah and then I guess when we think about that return to normal, is there anything that you kind of see on the horizon if you're preparing for and say, okay, when core volumes come back up, we're going to need a whole lot more of X, Y, Z? Is there anything you're preparing for anything that you might be worried about that might stop that normal volume from coming on as quickly as it might otherwise?

Mike Alkire: Yeah, there are three things that we really, really worry, we think about and a couple of more worries. And the other is, you know, just the, sort of the extension of virtual health and telehealth. And we're preparing for the potential that virtual on tele-health are going to be reality is going forward. And so, we're thinking through our strategies to align our data assets, to think about technologies and capabilities that we're going to need the contract for and those kinds of things. So, we do believe that that's going to be something that is going to be prevalent going forward. Things that we're worried about is that, given that the scenario that's been playing out with the viruses' folks haven't been going and getting their screens, they haven't been doing it. You know, their normal procedures, and we are worried that we're going to see sicker patients. And so, we're thinking through what that looks like. Specifically, in the areas of oncology, you think about those areas and other elective procedures.

So, you know, for us, it's-we're out having conversations with our healthcare systems, providing advisory services with them as well around how did do you take the assets that they already have and improve throughput? And organize themselves in a much more efficient way, than they were organized prior to the virus? So, we have different conversations that are occurring is if you're a large IDN and you have multiple facilities that actually provide multiple procedures, doesn't make sense. To more align each of these facilities and get much more productivity out of each of these facilities based upon a specific procedure. And so, a lot of those conversations are happening as

we speak. Surely there are given what's been happening with COVID, I will tell you. Our healthcare systems really are, taking a really strong work at corporate allocations, corporate overhead. And how they create a more dynamic cost structure? That gives and takes, you know, when issues like pandemics arise. And so, we've been working with a number of our very, very large ideas, creating sort of the technology underpinning, the benchmarks in the advisory services to really help them sort of think through how to become a bit more nimble with that corporate overhead structure?

Michael Cherney: That's helpful. I guess another question, you know, I guess when you think about what's going on now, as far as vaccine distribution, I really like I think it was our last call that we did with you. We kind of highlighted some things that we weren't thinking about, like alcohol swabs that you mentioned today, things that might be shortages. Is there anything within the supply chain where you say, everyone's rushing to get the vaccine out and distributed? Does that push anything to the back of the line that therefore might be a problem?

Mike Alkire: The biggest issue that we're seeing and if I could kind of make a public service announcement is, you know, are we using PPE appropriately when we are dispensing the vaccines? So again, I'm not a clinician, but I do think there needs to be some debates around glove utilization and the usage of a glove and do you think that the gloves or change gloves for every, be in between every shot and those kinds of things. So, I just think from a sense that the impact of the pressures that provided the vaccines on potentially PPE, that they have create some constriction of other services that can be provided. But outside that, I can't think of anything off the top of my head. David, can you?

David Hargraves: There's a couple ones that we continue to monitor and what I mean, is we put them on our list early in the pandemic and they sort of come close to the allocation issue, but then faded, that you could call the needles and syringes would be one. Another one is respiratory therapy disposables, you know, as you put people on ventilators and then you wean them off

ventilators, they need to have those types of others, sterile water that's used in those ventilators for humidification. Some categories like that, so we monitor them, we watch them closely, we track them weekly with the manufacturers. None that are really approaching the red zone. They're all dark. But after the secondary wave, if you will, of the potential ones. And so that's why we monitor them and we look and see if there's things we can do to ensure that supply and encourage excess production.

But unquestionably, I know we hit it here. The one that is top of mine, but two that just jockey for first place position are the temporary labour and then the gloves and the gloves are going to be sustained. The rest of them again but there is a list of a dozen costs that we are looking at and working on weekly. Just to make sure that we're ahead of the curve for that. And then actually Mike, example in the disinfectant wipes was a great one, right? And we did that followed by survey the members, gathered their requirements, placed an order for that because we have some concerns over availability. So did that far by ahead of it.

Mike Alkire: David that brings up a really good point. I think this the issue with labour is something that can be constraining to the health care systems going forward. You know, the metaphor that was given to me is that if typically, a nurse works three, 12 hour shifts and what had been happening over the course of the last number of months, is nurses have been taking on a second or a fourth and a fifth shift. And so you're seeing a lot of burnout. And so, I do think, I do worry that from a labour standpoint, are we going to be able to have enough of the nurse staffing to ensure that we get back to normal as quickly as possible, given that you've got a very, very tired workforce?

Michael Cherney: Yeah, actually I was just talking to AMN yesterday and they were saying the same thing that the demand right now is through the roof. They could have 30% fewer requests and they still wouldn't be able to fill everything. And they're very worried about burnout lengthening this well into next year. I guess maybe my last question would be, you know, you mentioned

gloves and kind of using some equipment approach as you do the vaccinations. And I guess in some ways you think, okay, with, as long as you turn back to normal, then equipment utilization returns back to normal, but is that not the case? You expect a high level of utilization, like a statue. Something that's not throw away our masks for the next few months. So if you are at hospital can it to be just having this above average elevation, even when COVID dies down, there's going to be one quarter, two quarter, three quarters, more elevated utilization, or how do you think about that?

Mike Alkire: Yeah, I will tell you, we have been obviously planning for that surge, right? So, when after the sort of the first high watermark for the virus, we were expecting and we saw some pretty, pretty significant surges for elective procedures in the summer. And then obviously the virus came back in the second wave. But I would tell you, I think, the search, you know, the-I'm sorry. The growth in elective procedures and I think should potentially resemble what was happening in the summer. Where you're going to get some outsides growth for a period of time. So, people making up those procedures. But again, I think, I'm just not sure when that date's going to be. And when we-the virus is going to be under controlled enough that the healthcare systems are going to feel comfortable obviously planning for those additional procedures and making sure that ICU's have availability and PPE and those kinds of things.

Derek Brown: Great. Hi, this is Derek Brown. I do diagnostics and love [inaudible] tools. So, a couple of questions. And the first one I want to bring up is, you mentioned that there was still shortages on the instrumentation for diagnostics. I think one of the questions we've been getting from investors is, you know, all these hospitals, all these organizations are buying new diagnostics equipment. And then the question becomes once the COVID crisis is over and volumes drop back down, do these just become expensive paperweights that don't get you to use? How are your members sort of thinking about diagnostics utilization and equipment purchases, you know, in the context of what the future looks like?

Mike Alkire: Yeah, so David, I'll take that. I'll take a high-level pass at this and then please provide some details. So, you know, just as we sort of think about the diagnostic and the testing for COVID, so this last week set another record in terms of the number of tests being conducted and it has doubled since September. So, we've conducted over 10.8 million tests in the past 70-I'm sorry, the past seven days. 40% of our members still are reporting shortages of tests and testing supplies. And we have been all over this for the last, I don't know, say three or four months. We have a testing advisory panel that's made up of very, very senior executives from our healthcare systems to sort of give us perspective on this. I don't think we've actually talked to them specifically about post COVID, you know, what's happening with the testing equipment. But having said all of that, I think everybody saw this on 12, nine that Lab Corp got in EU and home test kits that were for the molecular PCR tests. And that once the-obviously the tests were sent in as about one to two-day turnaround. So, I do think that obviously to your point, you know, diagnostic organizations continue to sell the products and creating new capabilities to do more home testing. And I think you're probably going to see more of that. But David, I don't know if you have any comments around the utilization post COVID.

David Hargraves: I do have a few. There's one I'd say if I looked at the most summary statement, as it relates to the diagnostic equipment, it would be this. So, our members tell us that what they're doing right now, if they're load balancing a combination of between four and six different testing platforms. And they're no longer standardized to a single platform. And so, I think that'll be one of the bigger structural changes as you go through this. Is that if they continue to rely on the major diagnostics manufacturers, they are generally not adopting some of the new market entrants that have come in I think generally once again, take care of so many thousands of hospitals. But then, it's because they're already managing these between four and six platforms. They're using multiple platforms because they've got some unreliable supply issues right on the reagents for them. And they definitely continue to show a preference that, you know, a lot of the new point of care tests just aren't reliable enough in their minds for regular patient care. And so their molecular PCR just continues to be the gold standard inside there. But so, you know, will

there be excess equipment at the end of it? You can ask the same question for ventilators if you wanted to. But the major thing I see of a shift is I'd move from standardized to a single platform to having multiple platforms so that you have multiple sources of supply. This is probably the most notable change.

Michael Cherney: Great, that's really helpful and it's funny. I mean, just this morning there was another E-way for an OTC antigen test that just came out. So, for asymptomatic was sort of the label on it. And some of you had started wondering and a couple of weeks ago there was a E-way on a home PCR test, that prescription only PCR tests. I'm sort of wondering, it's like, what is sort of the appetite for these point of care systems and sort of like how do you think that's these new entries to these at home in OTC episodes are going to sort of change the demand?

Mike Alkire: You know, so interesting. And David, I'll just take a quick overview and then I thought for your details overviews as well. It's interesting. I actually think, what this is going to do is it's going to sort of disrupt the market. I do believe longer term that, you know, if somebody can do testing at home, I think folks are going to want to, especially those that have chronic conditions. They're going to want to figure out ways to do that. And we've moved a lot of testing. Be it for diabetes or for your INR or whatever. We've moved a ton of that stuff to the home. I would say, I think this is just another one of those opportunities that folks are going to innovate around that they're sort of building up a mechanism now to do, you know, some of this molecular testing at home. Just think of additional of these cases that can potentially be developed on that platform. So I do think, obviously, especially for chronic diseases. So, I do think that, again, this is just another innovation that will drive additional innovation into degree that folks want to do more home testing. There will be that availability for them to do that. But David, go ahead.

David Hargraves: Actually, I was going to echo those comments in the [inaudible] ad, say this again, this isn't my view. This is these laboratory clinical experts that we have inside here. What they'd like to see is that, the over use of the very important, the hospital, Medicare PSCR tests are

there. And so, they look forward to the availability of ones to be used in the more areas of, you know, screening at sports or travel or social gathering, outside there. Where in their minds, the lesser reliability could actually, it's okay for that populist, for the purpose of that pre-screening for those asymptomatic patients. And maybe then would lessen some of the burden on them at the core hospitals so that they could use their scarce resources for those patients that are more truly in need. I hope that comes out across directly. It's not that those tests are no good or maybe they've got more of a use outside there, if you care once the patient is brought in. Does that make sense?

Michael Cherney: Yeah, actually it does. That works well. And just one final thing, you mentioned reagent shortages. I'm picking up from some of the scientific Twitters, their labs, academic labs and research labs are running short of pipette tips and plastics, because a lot of it's being shunted to diagnostic laboratories. You've seen any sort of plastic shortages that you're hearing of as well?

Mike Alkire: Yeah, plastic shortages, if they were down there, there are one that we have seen. It was a little surprising for sure, because those are things that can be made in the US and are available. We have, they're just like we looked at these swabs early on. A couple of those have come up on the radar screen again. So yes, we can confirm that smaller isolated, for sure. Honestly, they both in a few part numbers in a few regions and things like this, but I can confirm a couple of those did come onto our radar screen.

Michael Cherney: Great, thanks very much.

Mike Alkire: Thank you.

Jason Gregory: Hey, it's Jason. I guess I can jump in Mike?

Mike Alkire: Yeah, go for it Jason.

Jason Gregory: Okay, hi everybody, Jason Gregory. I cover the biopharma stocks. And so I'm probably a little less topical amongst the various talking points. But just hearkening back to our prior calls, we've had with you guys, any noteworthy points you'd want to call out as it pertains to drug shortages? I think the last time we convened there was concerns about EPI and excipient shortages. And there was political rhetoric around drug on shoring, disrupted the manufacturing supply chain. But we haven't heard a lot on those topics of late and I'm just wondering if that's a topic that's largely in the rear-view mirror.

Mike Alkire: I really, really appreciate you asking this question and I'm not I'm not kidding. I really appreciate it. So, a couple of things. There are the facts are indisputable. In that we've got this overdependence on the production of these drugs, especially generic drugs in both India, China and Southeast Asia. And you know, the FDA does a wonderful job of tracking the API and where those are actually being produced. And so, you know, what we're asking the FDA to do is actually track where the raw materials are being produced. They go into the APIs, as well as where the excipients are actually being produced. There is a pretty significant movement, to continue to produce products, especially those that have long-term viability from a cost standpoint, to do those both in domestic, domestically in nearshore. But I've actually been talking about this since for ever. But certainly since 2011, we have got to lessen our dependence. Specifically, in Southeast Asia and specifically on China long-term.

So, while there is a lot of political rhetoric, while there is a change for an administration standpoint, we cannot let our guard down. Because quite frankly, we're putting our population at risk when we have such a narrow supply chain that is so dependent on just a couple of few countries. And I think we dodged a significant board, in that we were able to create additional capabilities in short periods of time, vis-a-vis still compounding other things, other strategies. But I do think longer term, we are going to have to look for creating a much more resilient supply

chain. And I think that includes, it certainly can include low cost country production. But it also has to include nearshore and domestic production. To answer your question more specifically, there's 117 drugs that are on the FDA shortage list. But we are continuing to work through those, through our provided GX program. And just as a quick reminder, our provided GX program has about 136 health systems or 850 hospitals that participate in it. And it really, the reason we stepped that up was really to provide capital to domestic, but also some non-domestic manufacturers of drugs that were chronically in short supply. And so that program continues to grow. Today we have about 46 products that are in the-provide a GX portfolio and we're going to want to continue to grow those out and ensure that we get after these drugs that have been chronically in short supply.

Jason Gregory: And those 46 products are all domestically sourced? [inaudible] is it still finished?

Mike Alkire: Yeah, a majority are finished here, but we still have a huge issue. You know this, with API production. We do very little API production here. So I do think that once we get to a level of comfort on from a provide GX standpoint on the finished fill and how we're doing, I do think we're going to have to double back and look at the APIs, where those APIs are coming from. But to answer your question, no. There's a number are domestically produced, but then we are also sourcing across the globe for various products. But what we needed to do initially was it's, if there was a monopoly or duopoly that existed, we pretty much, you know, our goal was really to create a healthier market. And if we had to go to Italy or we had to go to a European country or to South America or wherever to produce the product we did.

Jason Gregory: And then, just on generic drug pricing, I think in the past, when we've talked, your contractual agreements have insulated you from any exposure to price spikes. But you know, in the context of shortages or just what you're seeing in the generic drug pricing environment, it can provide any colour in terms of the generic drug pricing front. Is that what you're saying?

Mike Alkire: Yeah, I-and David, I don't have the most recent data. I don't know if you do. And if not, I can certainly get you the specifics. But David, do you have the-

David Hargraves: Yeah, I don't have that. I don't have it [inaudible] Just right for this call, I get just a week or so ago. And it was actually-well, let's follow up with that one if we would, rather than give conjecture, yeah.

Mike Alkire: I think what David was going to say is we've not seen substantial inflation in the markets. But let us get very-let us get the specifics and you can get it all back out to your investors.

Jason Gregory: Got it, great. I'll turn it back over to Mike or whoever's next.

Michael Cherney: Great, I think Bob's questions were answered and across the various different areas. So, I guess in the couple of minutes we have left and they have a pretty hard timeline. I'll try to wrap this up. Mike, you mentioned an interesting comment regarding, I think it was around tele-health. But the dynamics around telehealth is that you're working with your health systems, working with your members to essentially optimize their operations in a new normal future, normal, whatever you want to call that term is for healthcare. Can you just give a sense? Whether it's through some of the platforms that Premier developed or other partners that you've worked with broadly on the technology side? How health systems have been responding in terms of positioning themselves for whatever that future state is? You know, obviously tele-health is one area, but are there ways where they're trying to best optimize their procedures and processes and where Premier as an organization, especially from a platform perspective can come in and really help there?

Mike Alkire: No, Michael, thank you. That's a great question. So, a whole bunch of stuff and David, if I miss anything, please, please jump in. So, I think from a technology platform, obviously we've been making investments in a wide variety of technologies to support the transformation to tele-

health. So, if you think about sort of like our stance and acquisition in our ability to both right protocols and those kinds of things right into the medical record. We believe that that's going to have a great application as caregivers are thinking of doing more tele-health. We also have technologies where as those tele-health visits are occurring, where we can read the unstructured data and create machine learning classifiers to truly understand from an authorization standpoint, whether a high-cost image is necessary or going to be required. So, we're working on that path of truly providing as much intelligence as possible at the point of care, by the way that application can work face-to-face as well as from a tele-health standpoint as well. So, the technologies, we think we've got some real strong technologies to support those kinds of transactions.

Secondarily, you know, we've been pretty much had significant capabilities to help manage labour costs. And so, in labour benchmarking and labour productivity and helping our healthcare system strides efficient operations. And so, obviously as we think about how care is going to be provided, we have the ability to look across. Across how care is being provided and create the new normal or the potentially the efficient model, you know, fight disease and those kinds of things. So, we'll continue to evolve our technologies to create those kinds of protocols and capabilities that our healthcare systems they can measure themselves and benchmark themselves against one another on. So that's the second area and there was a third area [inaudible] and I-but it was labour. And I guess the last one on the labour find is, again, looking at, are there more efficient ways? And oh, by the way, if it's not as efficient, could you be doing something from a tele-health standpoint by looking at quality outcomes and those kinds of things? We'll have the ability to help our healthcare systems with those kinds of measures as well.

Oh, I know what I was going to say, and then obviously the wraparound advisory services. So we've been really adding significant capabilities to the team over the last number of months. And a lot of those folks are, you know, thought leaders, in terms of appropriate utilization of labour. As it relates to traditional ways that care was being provided. But just as importantly, thinking through, you know, now that we've got these technologies and this chassis built, for doing more

virtual healthcare. What's the most efficient ways to do that by disease? And so, we're in a number of conversations as well as advisory engagements and having those conversations with the members.

Michael Cherney: And I think to wrap this up, Premiere as an organization has long had close ties across the federal government, clearly as an enabling entity to help with the vaccination process and the role of the federal government's playing that further grows. Can you just give us a sense on how that relationship of the federal government is changing? Is evolving and potentially is expanding within your member systems? And what that means for the role that Premier is playing with the government?

Mike Alkire: Yeah, I actually think with the COVID crisis, we became a lot more in tune with various agencies that are responsible for healthcare besides NCHS, think of FEMA CDC, FDA. And so, I think those open lines of communications are there now, where we can provide input into all forms of how to improve the healthcare system. I mean, a couple of things we are continuing to have discussions around is the need for syndromic surveillance. And while the CDC and others didn't take advantage of that capability, I think Premier has got real-time capability to really help healthcare officials with understanding the prevalent sort of surges of diseases. And I think that that's something that the federal government should give some very, very strong consideration to. Secondly, as this virus gets ruled out, we do believe real world evidence is going to be needed. A whole program around real-world evidence and looking at, whether there are issues with allergic reactions or just any kind of reaction to the vaccine. So, we do think the federal government needs to very quickly put together a program to do some real-world evidence research and ensure that the product is having the expected outcomes and to track any adverse events. So, we do think that's an area.

And then finally, the conversation says that with the new administration and depending on the direction, we are sort of assuming this Biden administration is going to go back down the path on

pay for performance and bundles and requiring quality scores and those kinds of things. So star ratings and [inaudible] scores and those kinds of things. And so, you know, we believe we're in a fantastic spot that if in the event those kinds of measures are going to be required going forward, from a health care delivery standpoint, that we're going to have the capabilities to support our health care systems.

Michael Cherney: Great. Well, we're just out of time. So, I guess on behalf of the BFA team, Mike, David, Angie, thank you so much for the time you spent today and obviously the entire Premier team. Thank you for all the hard work and helping your members manage through. What's been a very interesting nine months to put it mildly.

Mike Alkire: Yeah, thank you Michael and team for having us. We appreciate the time.

Speaker: Thanks [inaudible].

Mike Alkire: Yeah and happy holidays if you don't speak.

Speaker: You too, bye-bye.

Operator: And this concludes today's conference. Thank you for your participation and you may now disconnect.