Cardinal Health, Inc. Dublin Day

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Sally Curley: Okay, good morning everyone. Hopefully this is working on the webcast as well.

I'm Sally Curley. I am SVP of Investor Relations for Cardinal Health. Welcome to our Dublin Day. As you can see, we are trying to keep this informal. Many of you have actually participated in Dublin Day in the past so you know that this is largely a Q&A.

One thing that we're going to do this morning is actually have a little bit of a focus on some of the smaller businesses within Cardinal Health that you don't get to hear about that much but that we are very, very excited about. So I will go into that in a moment. But on behalf of the Investor Relations team and the Cardinal Health management teams, I would just say welcome and thank you for joining us. For those of you in the room, thank you for making the trip. For those of you on the webcast, thank you for listening in today.

With me here I have our Chairman and CEO, George Barrett. I have our Chief Financial Officer, Mike Kaufmann; Jon Giacomin, the CEO of our Pharmaceutical segment; Don Casey, the CEO of our Medical Segment; and CEO of naviHealth, our special guest today is Clay Richards.

I also have who is going to join us later in the program, Joe DePinto, the President of our Cardinal Health Specialty Solutions. So maybe Joe for those in the room, just kind of wave.

As I mentioned in my email invitation in lieu of hosting a large investor day, we are actually moving to hosting two Dublin Days a year here at our headquarters and that has given our global investor base -- we are going to be webcasting the events. We started that last year when we announced Harvard Drug, happened to be serendipitous at the same time. So I will be keeping us all on track throughout the day so that we can adhere to the webcast.

Many of you or let me just say before I get started just the introduction, we will be making forward-looking statements. I need to remind everybody that actual results may differ materially. You can find information in our SEC filings on the IR section of our website.

So without further ado, just a reminder of our mission statement. Today, this is our agenda. So in the beginning, George, I'm going to turn it over shortly here to George. He's going to make some introductory comments. Don will actually provide some context and a quick introduction to medical and provide some context for Clay. Clay is actually going to present. We do have a few slides. You will be able to follow along here in the room and on the webcast.

We are going to break for lunch at about 11:45 for about 15 minutes. For those of you the webcast, we will be pausing that for 15 minutes. We will come back right at noon and we will do kind of a working lunch for those in the room and then in the last hour, we will be focused on the Pharmaceutical segment, and that's when we invite Joe to join us up here on stage as well. So we will adjourn at 1:00PM. We think you for your time and your questions today.

There will be a mechanism for those of you the webcast to be able to ask questions. The members of the Investor Relations team will periodically ask them if there any questions from the webcast. So please feel free to submit those. If we don't get to your questions on the webcast, I apologize. Just feel free to reach out to anybody on the Investor Relations team and we will try to follow up with you.

Without further ado, I will turn it over to George.

George Barrett: Great. Thanks, Sally. Good morning, everybody. Thanks for coming here and seeing us in Dublin. For those of you who have not been here before, I think most of you have but possibly one or two of you have not. This is essentially our worldwide headquarters. We have somewhere in the range of 2,800 people I think in this campus. We have some off-site activities here so this is probably our largest collection of Cardinal employees.

Some of you know this area is a little bit of a new entry into our facility and so often we bring people in here and we have some things that we can do in exhibits and with customers. It's not unusual for us to bring them in here. So anyway welcome. Glad to have you here.

Today is largely yours in a way. We're going to provide some broad overviews and then make sure that we are here to address some of the questions. We will try to make sure that we are clear about areas that are high-priority businesses for us, how we are doing, a little bit of color in the markets we are experiencing. As Sally

mentioned, we've got a couple of businesses you hear less about that are smaller but actually can have important strategic implications for our positioning. And so we are glad to be able to do that today and give you some chance.

One thing we will not do so I will get this out at the beginning, we are not providing today a fiscal FY17 guidance just so we can get that off the table and everybody is okay with that. Customarily we do this in August when we wrap our year and that's our game plan. We will try the best that we can and you also know that we are sort of closing in on the end of our quarter and our fiscal year so we have to be little bit careful but we will try to give you as much color as we can on the world as we see it, what is happening around us and we've got a talented team here to do that. So thanks for being here.

Let me just start with a couple of things. There has been so much discussion obviously around the environment that we are in and what's happening particularly in the US not just for us but around healthcare. So let me start with sort of just a very qualitative observation. I'm not sure as an enterprise, at least during my tenure, we've been better positioned, both in terms of being able to compete in the markets that we traditionally operated in but positioned to compete in world that is really going through some changes that we are going to talk about today.

We are competing very effectively. Most of our lines of business right now are having very, very good momentum in the sense of our value proposition with our customers. That is as an important a thing as I can describe to you. So I wanted to make sure I started with that very qualitative observation.

We are in a very interesting time in healthcare. It's not just the moving chess pieces that all of us see every day in the acquisitions and the mergers and the moves but it's also a time where there is so much discussion about how we will as a system try to adapt to different kinds of models. The discussion about a fee for value or fee for outcome, these are buzzwords but they really do actually mean something, there is sort of an underlying premise behind this which is that we've had a system for all these years that has primarily been a fee-for-service and it's been a fee for activity. And we are in the middle or maybe even in the early stages of some of that change.

And the description of how far we are along that change depends a lot on who you talk to even within our customer base. We have customers who have really, really taken some very assertive moves to try to position

themselves to compete in a different way where they may get paid for it differently or financed differently and others that are at a very different stage of that journey.

I think you guys cover the industry broadly and I imagine that that's what you hear, people with very different perspectives on where we are as a system and probably it's because of where they are. There's just a huge amount of movement.

But we do see this general direction occurring. The great challenge for us in every business and we try to keep incredibly mindful of it is that we have to be able to both. We have to compete in the world as we know it in a fee-for-service world with the customer base that we know and do it incredibly efficiently with a value proposition that is very clear and very focused, very disciplined. And at the same time, we have to have a point of view on some of these changes and where they are going to go and make some of the right moves to position ourselves as an enterprise to do that.

I guess the last observation I would make and I will just give you a couple of quick -- a number of bullet points, is that our effectiveness as Cardinal Health the enterprise has probably never been more clear because if the system is sort of going through a kind of convergence and so the different -- the distinctions between channels and players in the market is actually in some ways blurring. And so for us to be able to go to our customers who now look quite different than they did 10 years ago with the value proposition that touches a number of lines of business for them is really important.

So we will finish up 2016 in a few weeks. You know that we have provided guidance on that. Just again for context, the midpoint of that guidance will imply the growth rate of non-GAAP EPS for FY16 of 18% to 20%. So not a bad year and a year in which we've seen some important areas of growth for us and in particular we're going to start with medical. We're starting to see some of the things that we've talked about over the last couple of years come to fruition.

So in the interest of time, just a couple of other data points just to give us -- if you go back to the spin of CareFusion, so we are now looking at six years or so. We have had a compound annual growth rate in the teens. It's been I think encouraging numbers. We have had a 220% cumulative dividend increase. We have repurchased

about $3 billion in shares. As you know, we have done this opportunistically but we when think that our cash position is a certain way and the stock price is right and that's the most effective way to deploy capital, and we deployed somewhere in the range of $9 billion in strategic acquisitions both enhanced scale in some places and to increase capability in others.

So it has been a busy and exciting number of years. But today we are here again to talk a little more about the present and the future rather than the past but I just want to provide that context.

So with that, I would welcome you. We are going to start this morning with Don, talk to you a little bit about our medical segment, but let me just tee it up for a second. As you guys know and we've talked about a lot, over the last five or six years we have really had to sort of reposition. We've always believed that if you think about the United States particularly, 87% of our spending is actually not pharmaceuticals; it's in the medical area, the medical spend and we know that that's an area that our value proposition in terms of our ability to bring efficiencies, enhanced outcomes, improved safety is very, very important to our customers. And we've had to go through this transformation where the traditional medical surgical business, which was in many ways the primary footprint of the business seven or eight years ago is being supplemented by other areas that take advantage of that footprint. So medical surgical continues to be actually really important to our business. We touch in the next 24 hours, we'll probably touch throughout this group, 75% of the hospitals in the United States. But those pipes into the system, those touch points enable us to bring other drivers of value to the system. And Don and his team have done I think a really great job of really beginning to drive that transformation in terms of how we create value, how we take advantage of those touch points and that footprint.

So with that, I will turn it over to Don Casey, who is the CEO of our Medical Segment, and we will take questions along the way. Don?

Don Casey: Great. Thanks, George. Just to build on that theme, the evolution that we have been on really is reflected in the evolution that the marketplace has undergone. So if you have been doing this as long as I have, you remember when a hospital was a hospital, a doctor's office was a doctor's office, there was no such thing as an urgent care clinic or a surgery center and now you start talking about an integrated delivery network. And as you see integrated delivery networks where a hospital will now span multiple hospitals, they will now span the

continuum of care, they are now trying to get ready for fee for value, which in some cases might look like risk sharing or capitation. What they are looking for from strategic partners has evolved and changed and that's really reflected in how we have approached the business.

To George's point, we think we've got a terrific set of pipes that go into that in our base distribution business. We think we are operating that business better today than we were yesterday and that is certainly better than we were two years ago just in terms of operational efficiency, how we manage cash, looking at inventory.

But more importantly, that relationship has allowed us to build a couple growth pillars that begin to allow us to have a different conversation. So when we go into an IDN today, we can go in as an enterprise where we can talk about managing the continuum of care and that's going to tee up where we are going to go with Clay. And managing a continuum of care is if you think through it, if you are discharged from a hospital and you are going to go home after a procedure, you are going to need medical supplies. That's our Cardinal Health at home business. As you are looking at how that discharge is managed, that is a business that we have begun to build.

And as we've talked to you guys in the past, we bought naviHealth and we bought a company called Curaspan. And we are beginning to look at that as part of our offering to manage this continuum of care. Once we get done, Clay will come back and talk to you. Some of the other growth pillars that we've talked about, our physician preference items, we can give you an update on Cordis and we can also talk about where we are in Cardinal branded and some of the other services we are doing.

But to George's point, as you begin to look at an evolved set of customers and you begin to look at the impetus that fee for value is creating, it has required us to reposition the business. We were very happy with our third-quarter results but more to the point, we are not here to talk about the past. It is about how we are positioned for the future.

One of the areas that we are very excited about is post-acute discharge and one of the pleasures of acquiring companies is you get great talent that comes along with this and Clay is now leading our post-acute discharge business and I'm happy to turn it over to him.

Clay Richards: Good morning. I am Clay Richards. I am the CEO of naviHealth and as George and Don mentioned, we became part of Cardinal in August of 2015. So what I thought I would do today is just introduce you into our business. I think a few of you we may have met before but talk about our market, our capabilities, and where do we see this market going forward.

So we have a couple of slides that we will just hit on and then we can go through some questions.

So when you think of naviHealth, we are in the business of managing post-acute care on a value basis or fee for value. I think if you look at post-acute care in general over the last decade, you have seen this has been an increasing area of spend, and an increasing amount of variance in what's driving that spend. So we started the business with the goal of really putting the patient in the center and managing it on a fee-for-value basis versus fee-for-service.

Primarily we have really three customer sets. We work with payers where we will manage the post-acute spend on a capitated risk basis. We will work with health systems, whether that is at an ACO or a bundled payment environment. Or we will work with hospitals and other post-acute providers in providing our technology or our analytics to them in order to manage discharge or manage post-acute care.

Just a couple of stats we will get into more of the business. We manage today about a little over 1.5 million Medicare Advantage lives that I spoke about. We are one of the larger participants in CMS's bundled payment program as a convener. We work with several different hospital systems in managing that episode of care. And then today we work with over 1,000 hospitals both with our technology and our services model and then about 10,000 post-acute providers. So that's a little bit of the landscape of where we are in our business model.

So post-acute has gotten a lot of attention in the last 24 months, certainly much more than when we started the business. It's in the bull's-eye of CMS, MedPAC, certainly commercial payers and there's really two drivers. One, post-acute is a lot more expensive than people realize. In total it's about $60 billion on an annual basis is what CMS pays out for post-acute care. When we think of post-acute care, it's really the services that are provided post discharge from a hospital, four big buckets, skilled nursing facilities care, that's the biggest bucket; inpatient

rehab; long-term acute care; and then home health services. There's also some ancillary Part B and outpatient therapy but that is a much, much smaller percentage of the care.

That's really how we define post-acute care. As I mentioned it is about $60 billion on an annual basis that CMS pays for and as you look at -- there's a lot of talk around bundling and whether it's post-acute bundling, CMS's mandatory bundling initiatives with joints, on average post-acute accounts for greater than 50% of the cost of that bundle.

So as we talk about why do hospitals care about this, to win in bundles you have to be effective in managing what happens when patients leave the hospital.

The next thing I will talk about is one, it's expensive. Two, it's been growing at about twice the rate of inpatient hospital spend over the last decade. And what you have seen is as the spend has grown, you haven't seen the outcomes improve so that goes to my next point around variance.

This was first highlighted in the Institute of Medicine study in 2013 where the Institute of Medicine was looking at what's driving regional variance across Medicare. As you can see here, almost three-quarters of the variance could be eliminated if you could just eliminate unnecessary variance in post-acute care. Post-acute care accounts for about 10% of Medicare spend but they could say the study revealed that you could reduce that variance by 75% if you could manage post-acute care, which tells you it is the wild wild west of healthcare.

Largely that has been because it has been an area that has been driven by volume. If you look at the payment models in post-acute, when a patient is discharged, every time they stop at a different provider, there is a different payment mechanism. If you go to a skilled facility, you are being paid on per diem which is driven by your therapy levels. If you are then discharged to home health, you are paid in episode rate. And then if you readmit back to the hospital, you are paid another DRG.

So it was an area where you had increasing spend and really no one entity or person was thinking about how do you manage this care more effectively to get better outcome for the patient? So again higher costs, great variance, and unfortunately no better outcomes for patients over the last decade.

Sally, if you would move to the next slide.

So probably the biggest area where we see opportunity to mitigate the variance is in discharge planning. So historically hospitals have thought of discharge planning really in two ways. As you know, hospitals are paid on a DRG so they are paid a set amount for different conditions where patients admit. The role of the discharge planner was one, make sure they were meeting the Medicare compliance rules from a patient choice standpoint and make sure patients were flowing through the system fast enough and they weren't keeping patients longer than they needed to.

Discharge planning is probably the area that has more turnover in the hospital than any other area from a human capital standpoint. And then over the last two or three years, you have really seen the rules change for hospitals, how they think about discharge planning.

So about four years ago you started seeing readmission penalties for hospitals on the three core conditions which made it important for hospitals to think about what happens when patients leave their hospital. You saw the introduction of value-based purchasing penalties which hospitals could get paid more or less depending on the cost of care outside of the hospital.

And then more recently, you've seen the introduction of mandatory bundles, the first one being comprehensive of joint replacement, hips and knees where hospitals are responsible for that cost of care for a 90 day episode post discharge.

So hospitals now have to care about what happens when patients leave their hospital and really the three areas that we think about are important, one is understanding your patients. What's the risk level? What are their needs? Two, how do you match those needs to the right level of care? So do they need to go to a skilled facility? Do they need to go home health? Do they need to go to a higher level of care? How do you match their needs with the right level of care and then how do you match those needs to the high-quality providers?

A lot of talk around how do you get preferred narrow higher-quality networks, probably post-acute is the biggest opportunity to match needs of the patients with those higher-quality providers.

And then finally, how do you stay connected to patients and providers throughout the continuum? Again, patients discharged from the hospital, how do patients -- the hospitals have continued engagement with those providers and those patients throughout that 90 day episode.

So if you think about next slide, Sally, if you think about our solutions, we have bucketed them really in three and I will start on the left. First is technology solutions. Don mentioned this. Over the last really nine months we've acquired two different companies that we think are the market leaders in discharge planning solutions where we provide not just workflow for discharge planners and connectivity into the post-acute providers but we've also acquired clinical decision support capabilities to address that issue of matching patients' needs with the right level of care and the right providers.

So today we are partnering with about over 600 hospitals leveraging this technology and workflow solution and about 8,000 post-acute providers and that spans 15 different types of providers. So that's DME, that's dialysis all the way to skilled nursing facility and patient rehab etc.

On the far right is what we refer to our managed services and this is really more traditionally how we have serviced the payer market where we are a fully outsourced solution. So if you think about payers, traditional benefit management type solutions, that's essentially what we have done with post-acute. We created one category of spend that we would manage on a risk basis. We would deploy our technology, our analytics and we would deploy clinicians in the market working both with hospitals and post-acute providers to manage the care for patients.

We do this with about 1.8 million Medicare Advantage lives across the country where our fee is based on the value we create. Similarly we do this in the bundled payment program, which is one of CMS's bundling initiatives where we partner with hospital systems in a very similar model except CMS is the payer rather than other commercial payers.

On the far left is more of a fee-based model where we are selling technology analytics into providers and on the far right is where we are really risk partners in creating the value and then sharing in that value back.

This is just somewhat of a scatter plot of where we are the market representing both post-acute in blue and then our acute care partners in the orangest color.

Just to give you a sense, a little over 20% of the discharges across the country we touch. Either that's through our technology, our analytics, or through our managed services. And then as I mentioned, about 1.8 million Medicare Advantage lives we manage on a risk basis with our health plan partners.

And then the last slide and then we can take questions, what's our value proposition when we go into these markets? It's really three things. One, we can engage our patients better in the episode of care. Two, we can deliver better quality outcomes. Three, we can do it in a way that lowers cost for the system.

So when we look across all of our markets, those are the things we measure. As you can see, we have really high member satisfaction. Patients view what we do as a concierge service. If you've ever had a family member or loved one go through post-acute, it is an area that is really complex with not a lot of information. So we provide a lot of data, a lot of information and then we work with the patients and the family through this episode.

Two, we have been able to improve outcomes both patient functional outcomes so that means how the patient is able to recover, lower readmission rates.

And then finally, we have been able to do this in a way that significantly reduces the cost of care. So as we think about CMS's triple aim in this area. How do you engage members? How do you get better outcomes? And how you get do it in a more efficient manner? That's really our value proposition whether we are working with a payer, provider or a health system.

George Barrett: So again, think about for Cardinal Health, and I will come back to our broad priorities because they really are the ones we've talked about actually pretty consistently. In doing that, having some part of our business that is really attentive to these emerging and very powerful trends that are going on. naviHealth is a small business economically for Cardinal Health. The implications of that capability for us and our discussions with our customers has actually been really profound and to some extent even more surprising than we thought.

I just got back from a meeting with a number of leaders of large health systems. This area is incredibly important to them. Again now some of them are further along the path in capability of thinking about this. Some are just

wrestling with it, which is how -- if we are going to be responsible, let's call it pre-op to post-op, what does that look like? When we have tools that enable that, it changes the discussion between Cardinal Health and our customers. And then we can talk about pharmaceuticals and our generics programs and our other services and product lines that we bring to them. So our consumables.

This has been a really interesting move for us because it is a capability that we think is so relevant and really relevant across many areas in healthcare. So again, a small business but one that we are really excited about and I think that brings capability.

I'm going to add one more piece and then we will -- I will let you guys ask some questions. This also goes back to sort of the capabilities and composition of our workforce. The number of people in Cardinal Health taking out a larger acquisition let's say like Cordis, which brought more people, over the last five years has been relatively stable, the number of people. The composition of that group has actually been changing in interesting ways. We have several thousand people that we would describe as clinical-oriented folks, the number of data scientists we have.

So it has sort of been an interesting evolution and these kinds of capabilities are really important to us. Just to give another context.

So Don, things you want to add before we take some questions?

Don Casey: I mean I started when a hospital used to be a hospital, they didn't really have to manage an episode of care. They were basically going to perform a surgery and then somebody was going to leave. And the whole idea of an integrated delivery network and thinking about fee for value where you are going to have to manage pre-op to post-op for a 90 day occurrence, it's not as if these institutions have had two decades of experience where they can really begin to manage post-acute discharge.

So the demand for services as George said of something like what Clay and his team are bringing just create a whole different conversation because you are not necessarily going in and saying hey, we really want to talk to you about pharmaceutical distribution into the acute care setting or this. It is look, you are now facing an entirely different environment. And once you go in and have a conversation about the solutions you can provide, it

certainly provides a broader umbrella in which to have conversation about a number of different things. So with that questions. Yes, Dave?

Audience Member: Thanks, Dave Larsen, Leerink Partners. Clay, can you talk a bit more about the market overall? We've been hearing about fee-for-value for a long time. I kept hearing about capitation in the 90s. And what is different about today versus the 90s and the 80s? What percentage of the market do you think about risk bearing sort of environment now and what do you think that percent will be say five years from now?

Clay Richards: First of all, CMS came out and said they want 50% of their payments in 2018 to add to value. Currently they are at 30%, slightly ahead of schedule of where they thought they would be. I think you are going to continue to see CMS through these voluntary programs like BPCI, ACOs etc. push more of their payments to value-based. But at the same time, CJR was really important, not the size is not that big, there's probably 100,000-150,000 episodes in the mandatory joint replacement. But the first time CMS has ever put in place a mandatory change in payment policy for hospitals. When you think about it, hospitals are now taking insurance risks for 90 days, mandatory. In all those MSAs where CJR applies, CJR is the comprehensive joint replacement program that CMS started on April 1 of this year.

So I think the momentum is getting greater and what we've seen is that's what's happening from a policy standpoint. Commercially, you are seeing more and more payers look to mimic that. So how do they get their hospital systems, their physician groups in a fee for value world?

And then even this week, MedPAC, I don't know if you guys saw this, MedPAC released their June report, which basically was the first step towards a prospective payment system for post-acute, which would essentially create a post-acute DRG on a prospective basis, which was pretty important. And their step was I think the secretary is mandated to review this again in 2022, their view is we have to move faster than that.

I would just say whether it's on the government side or commercially, I think you are seeing a lot of tailwinds towards managing value-based care and you really can't get at those goals, the 50% goal that CMS is after unless you tackle post-acute care.

Audience Member: So naviHealth has solutions that will enable providers basically function effectively amidst a macro world also bundles orthopedics and how about the recent Part B rule on drug reimbursement? Does naviHealth have a solution there?

Clay Richards: Our focus to date has really been working with the hospitals on the Part A and the Part B spend. We do think that's obviously an opportunity with Cardinal longer-term is how do we look at those capabilities together?

George Barrett: You actually touched on something I was going to comment on here. These are -- I think this is very real. This is happening. The gravitational pull is there and the push from CMS is pretty clear directed and specific. Having said that, there are areas where identifying the outcome, measuring the outcome, the value that we want to pay for is going to be clearer. And there are areas where it's really hard because over what time?

So for example, in the pharmaceutical areas, this is a much more challenging question in many ways and as you know as people talk about these pay-for-value programs, it has been really hard to put those into fruition because they require an agreement on a prospective on time dimension which is very hard.

So I think what we ought to be thinking about is this is directionally where things are going. We will probably come back a little bit when you talk about pharma and specialty, but it's happening systemically but I think we are going to see pockets where there are clearer disease areas where you can say we have alignment on what the outcome is that we are looking for and how we define value and there are areas where there's going to be much more ambiguity there, disagreement about over what time horizon.

So again, we have to recognize this as sort of an episodes of care are going to look quite different I think.

Clay Richards: Just one other point. I failed to mention this, MA, which is Medicare Advantage, which is the biggest fee for value program out there has consistently grown. So there is a 20% three years ago now it's that 31% of Medicare seniors are in Medicare Advantage programs and I think you are going to continue to see that number rise. We think is a great area for us just because that is where we cut our teeth on the Medicare Advantage population.

Audience Member: Garen Sarafian, Citigroup. Thank you for hosting. Clay, one of your slides are those three buckets on the right side is the managed services bucket. Could you first just give us a couple of common examples of what

type of contracts? Is it just on the absorbing admissions side? If that's the case, then just ballpark what do you sort of commit to? Overall, how is that coming in the last two to three years? How are your clients buying? Are they buying that more? Are they sort of saying, no I don't want that risk or I don't want to pay that way? Or are they saying we want to see more visibility in which to pay?

Clay Richards: Let me answer your last question first. To George's point, I think that varies by market and you have some clients that have greater capabilities and investments in this area and really need help. They want us to enable them. They want to use some of our analytics, some of our technology but they feel like they've made investments and they can manage that risk but they need our help. That's where we would look at more of a technology analytics solutions.

You have others that don't have those capabilities and are looking for a risk partner, somebody that will do it for them, whether that's technology analytics as well as the clinical services. When I say clinical services, care management. We are not a provider. I should've mentioned that earlier. We are not a provider. We provide care management services, where we will be their full risk partner for that.

And I'd say the demand both on the Medicare Advantage side for that service is continuing to grow at a pretty strong rate and on the health systems side again, I think there's both. We want you to manage it for us and in some cases we just want some capabilities and some tools to help us manage it.

Audience Member: So the clients that are within the buckets aren't changing buckets? They are just buying more of it once they commit to those buckets?

Clay Richards: Largely I think right now that's the case. I think you will see some evolution of that over time but this is still pretty nascent. Then the first question is of course contractual structure. Obviously on our fee-based model, it's a typical fee-based model where we are providing solutions and we are getting paid a fee. In our value-based model, we carve out a certain subset of the spend if you think about it skilled nursing, inpatient rehab, long-term acute care. We basically agree on what that historical cost would be and then we share in the value we create from reducing that cost from what the historical spend was.

So it's very defined as to what the buckets of spend we manage and obviously we have been doing this a long time so our ability to underwrite and know what the opportunities are, we go in, we feel pretty good about what discount we can give the plan and then how much we can save.

Audience Member: Kristen Stewart, Deutsche Bank. I was wondering, Don, if you could give an update on just the PPI initiative with -- and also the integration of Cordis? And the maybe also talk about how you plan integrating naviHealth with PPI because it seems to be the perfect program obviously to go hand-in-hand as you are going into the hospitals with value-based products. I'm talking about shared savings particularly starting off with orthopedics and then ultimately the discussion is for CMS rolling to cardiology, how that may work out this quarter?

Don Casey: Let's discuss just for a point of order, we're going to finish kind of Clay's section and then I was literally going to do a preamble, this is where we are on Cordis, this is where we are on a couple things. Your macro premise and we talked about how are we being relevant across the care continuum? Obviously when we look at PPIs and naviHealth as well as Curaspan, you are thinking along the same ways we are.

But why don't we stay a little focused on Clay and actually the question on Curaspan is one that is certainly pertinent here and maybe we would just take a second and explain what Curaspan is and then why we're excited about what capabilities that will enable with naviHealth as well as the other acquisition we mentioned, which was a smaller one, which was RightCare.

Clay Richards: So if you think about Curaspan, I mentioned before one of the big challenges in post-acute is just start explaining, matching patients' needs to the level of care and then to the right providers. What we were so excited about Curaspan is Curaspan is integrated into the workflow of over 600 hospitals and not only are they integrating the workflow from intake through discharge planning, they have built the pipes and the connectivity into the post-acute ecosystem.

So if you think about in the market areas, a hub and spoke system where you are integrating into the hospital workflow and you have also built the connectivity to over 9,000 post-acute providers across the country. The network effect of being able to manage patients across that continuum for us increases significantly now because

of our ability to put our analytics, our clinical protocols on top of these pipes into the hospital and then far reaching into the different post-acute providers.

So for us we think it's a perfect complement for what we were really good at the clinical analytics, clinical protocols and the services but we weren't integrated into the workflow, so this opens up the ability to manage that across the continuum.

Don Casey: It kind of goes to a broader thesis that when we were looking at the space, we felt that we needed to have a couple capabilities and naviHealth, which was one, as well as Curaspan, which is a separate capability but when combined we believe advantages in the space and then when you put it under the overall Cardinal umbrella, it gives us a certain access to a different place within the acute care setting that we hadn't gotten to before.

So Jon's people will talk to the pharmacy manager. We have historically talked to the materials manager. Now we need to talk to the C-suite because we're going to begin to help them with bundle. So it kind of changes the direction of the conversation.

The other thing is just that -- and we will come back to this theme a couple different times, there are -- there is a significant part of our acute care services that are run under Jon's direction and it's like medication therapy management and other things that we are really excited about as we begin to take naviHealth, we begin to take Curaspan, we begin to take Medication Therapy Management and begin to look at an episode of care where it is not only the product, the medical surgical, the post-acute discharge, but it's how do we manage pharmacy along the way with that?

Jon will cover that off a little bit later.

George Barrett: Kristen, we will make sure that again we will try to do this but I will absolutely make sure we come back, give you a full discussion of Cordis and a little bit of our thinking around how this capability might be deployed in other areas. So we will absolutely to make sure to come back to that.

Don Casey: And it is relevant to the PPI as well so it's a very pertinent question.

Audience Member: Ross Muken, Evercore. Clay, maybe a few high-level questions. So naviHealth is a relatively nascent young business. Can you help us -- value-based here and the concept has been around for some time but your industry has not. And so help us understand how you've seen it sort of evolve? What does the competitor landscape look like? When you are going out and you are pitching your services, is there anyone else who offers anything similar in terms of the scale of the suite like you can provide to give us just an idea?

And then secondarily, when you were -- you are obviously a very attractive asset, there were numbers of folks who would be interested or rightful owners of it other than Cardinal over time, what made Cardinal the right partner for you where you clearly saw the leverage of the enterprise or the vision to where you thought that in the promise of this asset could really come to fruition underneath this umbrella?

Don Casey: Well, let me answer it. No and is there any question?

Clay Richards: Let me answer again that question first. For us, we were young private equity-backed business growing fast so when we were looking at who was the right partner for us to scale? A couple of things we looked at. One, same values, meaning we wanted to be with a partner that we felt like had the same mission we did, which was to be on the right side of healthcare and really change things for the better. Cardinal certainly met that criteria.

Two, having a partner that could scale with us, we knew both Medicare Advantage is going to continue to be a growing market but also our ability to look at broader value proposition and a distribution network in the hospitals was key. Obviously with Cardinal's suite of products as well as the fact that three quarters of the hospitals as George said would be touched by Cardinal today was very, very attractive to us.

And then the third and fourth thing I would say is we knew we needed more capabilities and Cardinal certainly had the appetite to want to go invest around this transformative post-acute solution. We also wanted somebody that if we partnered with them we had not foreclosed a part of the market. So Cardinal is unique in that payers, providers, IDNs, are still -- view them somewhat as Switzerland, in a good way, as a partner to all and that was really important to us.

So those were the four main reasons. As far as competitive landscape, when we first started, we were only competing against status quo and really worked to convince people that they should even know or care about post-acute care. That has changed a lot.

However, our biggest competitor is still status quo, is still do nothing. We do see some technology solutions that we compete against on the hospital side and you guys -- there's a whole bunch of those. On the payer side, there's really not a lot. You see some other benefit managers that will compete for this. But we are not aware of anybody else and frankly don't run across a lot of other competitors in the Medicare Advantage market. It's still a do we do it ourselves or do we outsource it to somebody else?

George Barrett: That's one of the things we thought about a lot. From a strategy standpoint, when we think about moves into new areas, nascent areas, our view is if you're going to go there -- be early and be the best. We just made a decision, that's why we sort of combined these is three smaller moves together. We thought that that combination would be unlike anything that is available in the market. And we hope that's what we are achieving.

Again recognizing this as -- you used the word nascent. It is I think a perfect word for what's happening here. Not in the system but in terms of tools and I think that's right. A lot of the choices can be -- can we do this ourselves as an integrated institution or do we need somebody who can help us facilitate that? So we are really excited about this opportunity.

Mike Kaufmann: Also just real quick on this, this business while it's nascent is making money when we acquired it. So I don't want you to think we spent a lot of money on something like a lot of these internet companies are losing money, it is making money. It is incredibly capital-efficient the way they bill, collect and do that. So it's a low to no capital business. It's higher-margin rates, too.

So don't take nascent as losing money. It's very, very well-established for sure. Just the CFO part of me was starting to get a little hair on the back…

Don Casey: We said it was a strategic nascent investment.

Sally Curley: Before we move to the broader medical piece, any other questions for Clay on this component? On naviHealth?

Audience Member: You put up a slide, it's still up that talks about you declines in readmissions, double-digit declines in spend. So can you talk to us about how healthcare systems you work with are changing behavior in either discharge patterns or basically where are they able to improve these metrics?

Clay Richards: Sure, I would answer in the context of both health systems but also health plans because this is across the board. First is you are seeing a big push and a lot of discussion around how do we narrow our networks and really work with higher-quality, smaller number of providers? It would not be uncommon for us to go into a large Blue's plan and they would discharge to over 350 different skilled nursing facilities in a year. And so what you saw was wide variance in outcome. You didn't have constant care protocols. Patients were treated differently, tremendous variance.

With the data we collect as we are managing these services, we can really narrow in on what we call a risk-adjusted basis, meaning on a -- take into account the complexity of the patients to understand who is really good at managing hips? Who is really good at strokes? How do we match those needs to the right providers? So you have seen a big push towards higher-quality networks both on the payer side as well as on the health systems side.

The other area where we have been really successful is in length of stay management on the post-acute side. And we have been able to do that with -- this is really important for us is we've been able to reduce the length of stay significantly, double-digit reductions we've talked about. At the same time, our readmissions from skilled facilities have gone down double digits, meaning we are not squeezing the balloon. We are not discharging patients too quickly and then they are bouncing back. We're actually eliminating unnecessary utilization. So the outcomes are better and the cost of care is better, so those are the two primary areas.

George Barrett: In a very practical sense, again I don't know how many of you have experienced even an aging parent, if you discharge someone to the wrong side of care, someone let's say who should be doing some kind of therapy, rehabilitative therapy and you put them in a long-term care facility, they are going to decline. They're going to

decline. It's more dangerous. It's less effective for them, it costs more and there's a very good chance they are going to rebound back into the ER.

So a lot of this is using clinical data, and that base is growing to say what are the like clinical conditions that we can identify where we can help direct outcomes?

The other interesting thing that is happening, even within a system. So we are talking often about multiple systems but even within a system that are getting more big and complex, even inside their own system, they are looking for -- and I've talked to all of you looking for help as to where they have reached their variability even in their own systems and they are trying to figure out how do we improve that?

So a lot of what you're describing here again it's this change in behavior thing. The change in healthcare, unit cost pressure is sort of the situation we have all lived with and known. The real change is going to be behavior change, the right care and the right time, right context, right set of protocols by the right clinician. That's where the big action. That's where the big changes are going to take place and where the real savings and improvement in quality and safety are going to occur.

Don Casey: That's one of the reasons I think George mentioned it. If you are going to buy something in a new area and buy something with scale and something is proprietary advantage, we have run a lot of lives through this process. Therefore it turns into somewhat of a virtuous cycle. You run more lives through it, you gain more experience and that allows us to direct patients to the right care and you begin to validate that circle.

So it's almost a systemic advantage as you begin to go through that.

Why don't we -- Sally, I think we will kick it over to Medical and not to go through a long, long discussion, but when we have the opportunity to go out and talk to investors or analysts, the question we're getting recently is what has changed? I would say nothing has really changed. I think a lot of the things that we put into place, a lot of initiatives that we have been focusing on over the last couple of years are starting to come to fruition. And again I started off by saying the acute-care market has changed and we are now talking about IDNs that have a lot of different challenges. And Dave, you asked the question because we've always -- if you lived back through the HMOs is when were we really going to see fee for value? I don't know if we have hit the tipping point but

we've certainly hit the thinking tipping point where there isn't an institution that is not really beginning to say okay, I'm still getting a majority on fee-for-service but I can see the day where that is going to switch.

And basically we have been configuring the segment as well as total Cardinal to begin to address the needs of a very different customer. What are those needs? As you begin to think through a fee for value environment, it's going to be episodes of care and if you begin to look at an episode of care, it's going to have a product component. It is going to have a post-acute discharge component. It's going to have how do we actually manage beyond the walls of a hospital? It's not just going to be medical. It's going to be how do you look at medical, laboratory, as well as pharmaceutical?

So that's kind of what we have been focusing on and just an update on where we were, those of you that have been following Medical segment for a while we talked about an expansion of our product business and today we feel that we have begun to create a very effective product organization that is showing the growth that we wanted to see.

We've invested a lot of time, talent and treasure really expanding our portfolio and our portfolio today is probably twice as big as it was in terms of an absolute number of SKU basis from where it was three years ago.

This is something that we will come back -- so this is more kind of the branded commodity business that we feel we are extremely competitive there.

The PPI initiative and just to clarify this, the obvious focus is on the products. When are you going to get into an orthopedic product business or whatnot? We have always said that this solution that it's not going to be just about product, it's going to be product, services, and analytics and the question you asked feeds right into that which we always said there's going to be a product component and we're making investments in that. But there's going to be a service component as you begin to look at things like CJR, where naviHealth can play a role, but also analytics, which is we have invested in WaveMark, which we now refer to as Cardinal Inventory Management Solutions, CIMS, which is an RFID program that's going to enable us to create a totally we think more effective lean supply chain organization and that has applications in cardio. It has applications in ortho and others.

So our PPI initiative was not necessarily product, it was a broader portfolio of products, services and analytics. Just an update on that. Cordis is obviously the flagship on that but we have made a couple moves here. About 18 months ago we bought AccessClosure, which was kind of our first step into the cardiovascular area and with Cordis.

So where are we on Cordis today? We kind of think through Cordis in three phases, which was catch the business, run the business, and then optimize the business. And as you begin to look at the help we are getting from J&J, it has been significant as we begin to carve out what we say are day one versus day two countries. In some countries it takes a little longer to get product registrations and what not and we will use J&J there for a little longer. But we are in the process now the day we closed, we brought a lot of business right into us, US and China and other places. We took over the manufacturing facilities and that's going well.

As we begin to look at beyond the United States or China where we have infrastructure, we've spent a lot of time as well as focused effort on really beginning to take the commercial capabilities that come with Cordis and beginning to build an infrastructure underneath that. That has gone well.

At this point we feel that we filled key leadership positions all around the world, the most recent one was in Japan, where we think we've got a really good set of leaders there and team so we feel good about that. Some of -- Mike and I get to spend a lot of time together anyway but we get to spend even more time because the accounting issues obviously as you look at the inventory step-up as well as Johnson & Johnson runs a slightly different calendar than we do, so there is some lumpiness that goes along with when day one countries show up or day two countries show up and we think we are a couple quarters away from having that totally ironed out.

But what the lumpiness in accounting doesn't show is the business is performing about how we thought and that's important to us. Look, it's got some FX headwinds associated with it but as you look at almost by region by region, we are pretty comfortable that the business is performing that way.

Some red letter dates for us, we actually have put the AccessClosure and the Cordis salesforces together and that gives us an expanded presence in the US. We are -- that has gone well and I think everyone picked up on Biosensors, which was a distribution deal we did for a drug eluting stent. And I think that will be a pattern that you

will see going forward where George and Mike when they talked about Cordis have always been clear it's not an R&D, it's much more D.

You are seeing an evolution in the med device space where you are starting to see innovative companies that don't want to necessarily invest in the commercial capabilities. They would rather focus on how do I get my technology to market? And all of a sudden we now have a tailor-made cardiovascular salesforce that's operational in 60 countries and as such, we've become a very attractive partner.

So the model for us to help Cordis fill out its bag will be partnerships and we are proud to see Biosensors as the first one of those.

The next obvious question is what are the other partnerships and when are they going to show up? We are working through it but if you look at the bag that you are putting, particularly in Europe where you want to be able to compete on a tendered basis where it might be a broad portfolio, we think we can compete effectively today. We would like to add a few more things to that.

So that has gone reasonably well and if you go to -- we have had to learn a new language, PCR and PCT where you go to these meetings, our challenge is to actually meet all the people who want to talk to us. It's a great brand name.

And the last point I would make is incredibly proud of not only the Cordis organization under the leadership of David Wilson, but the Cardinal organization showed tremendous agility and flexibility because as we were saying, one day we inherited a business in a country we've probably not even traveled to and now we are operating something. So the combination of Cordis and Cardinal hasn't been seamless. There's been a lot of work going into it but the fact that we set a goal right at the beginning, we said we didn't want there to be a single patient around the world that wasn't going to get the Cordis product they needed when they needed it. To date, we are in it since October, we have been able to do that.

So we're excited about the opportunities. It's great. One of the privileges of working at a company like this is one minute we get to talk about how are we creating an amazing post-acute discharge business? The next is how do you really talk about creating a really powerful cardiovascular business that is not going to be just about product?

All of a sudden we're taking WaveMark in, every presentation that you go in to Cordis, all of a sudden, WaveMark shows up, which is Cardinal Health Inventory Management Solutions. And now that we have naviHealth, we're talking about how are you going to manage a bundle?

So the conversation is very, very different. The Cordis team was surprised. They said we thought it was all going to be about product and now you sit with a group of advisers and you show them WaveMark. They said there and say my God, I'm under so much pressure to manage the inventory. When can we have this presentation? So that's gone well.

The rest of PPI is -- look, negative pressure we like our investment there. It's moving along. Ortho, again I think everyone is going to ask where is the product? I would tell you with CJR and you begin to look at the capabilities we just talked about and then you look at an inventory management system that might be transformative in terms of how you talk about trades, you can see that again it's a triangle for us. Its analytics, services, and product. And when we see the right product we will make the move on the right product.

But our strategy to help the orthopedic market transform itself is not reliant strictly on the product. We see good progress there.

Just last two points and then we can get into it. Our Cardinal Health at Home business is another example. As George said, if you are going to get into a space, buy an asset that is at scale and really has an advantage and that business since we have owned it has continued to grow at a good clip. It is proving to be much more important to the acute-care market than we originally thought because people are now -- Oh, I'm just discharging that patient, I'm now responsible for them. How do I get my stuff to them? So all of a sudden we're going in and saying, we have Edgepark and we have Independence Medical.

So that business and we've made some tuck-in acquisitions to help boost a urology or an ostomy area and that continues to be a growth pillar for us. So the proof is in the pudding.

I think the win that we had at Kaiser is kind of emblematic of the fact that we are now coming in not only as a great distribution company but with a full bag of products and innovative solutions around things like PPIs and we

are having a conversation where we take Jon's Medication Therapy Management as well and we combine that and sit there and say we are really coming in as a solution-oriented company.

So I didn't mean to be quite that long but I am incredibly proud of the work our team has done and sometimes it shows.

George Barrett: Don, roughly how many Cardinal label consumables do you think we've launched in the last say two years?

Don Casey: If you were to look at GHX and you would say there's roughly 950 categories that represent distribution. We have doubled the number of categories we participate in. We have launched over 2,500 SKUs under the Cardinal Health brand.

It's interesting, anyone who has come to the building if you begin to look in the back and you will see one of the reasons we built this place is there's a lot of Cardinal branded product coming in. And what is the WIIFM -- what's in it for me for a Cardinal branded product? If you go into a Kaiser and say look, we not only have distribution but some of these categories that are really more commodity-oriented or slightly more engineered, we can now advantage you because it's now riding on the Cardinal rails and it's now a Cardinal brand. So you are helping them with value and I think Kaiser represented a significant change for us because if you were to ask the people that work on Kaiser every day, yes, you are having conversations about when are you going to make that transition? But it's also now when we were pitching, you talked about A, B, and C, so it has proven to be an interesting conversation.

George Barrett: So we actually have if you sort of hear that language and then we will come back obviously to talk about pharma and then think about our generics business, there's a lot of differences and we can talk about those. But one of the common themes is sort of this flywheel, which it the ability to aggregate in a very fragment system, the ability to aggregate demand increases scale and improves our acquisition costs. We are able to provide value to the downstream from that additional scale, which gives us more scale, which allows the flywheel to get in motion.

That is true with capabilities as well. Again going back to Clay's work, the more data that we get, the more clinical lives we manage, the more valuable our work. So that is probably a theme you will hear sort of across our businesses even though there are some very interesting distinctions and we will come back to those as well.

Sally Curley: Did we get your question; did we get to the heart of your question? Anybody else?

Audience Member: Don, one of the things that clearly has evolved is the fact that not just the focus on products but really kind of like this suite of capabilities more than ever. Could you talk a little bit how you are structuring the sales force? And obviously assuming that this is kind of going to be an evolutionary process, how does kind of like Clay's sales, his product now and who are the different kind of points within the IDN that you reach out to? So that's question one.

Question two, just if you can comment around the Medtronic announcement around the generics in hips and knees? If this is something you can potentially do? It seems like you have the capability to do it. Is there a desire to do so?

Don Casey: Sure, Ricky, I know you have followed us for a while and you could probably go back about two years. We talked about some of the restructuring we did. At that point we changed literally how we go to market. And Jon and I, we now go into the acute-care market at the larger customers. We call it our executive selling organization where we've gone and transformed that. So large accounts and strategic accounts now have a single very senior Cardinal person to do that. Their job is to create opportunities for all of Cardinal Health and then what will go on is we will come into Clay and say Account XYZ is really interested in post-acute. So his sales force would follow that up.

The other change that we made as part of that -- again if you think about -- and we refer to strategic accounts a fair amount, we began to stratify those and we moved to what we would refer to as a big bag rep that carries all of Cardinal and then we simplified the number of expert sales forces behind that. We again two years ago, we had probably about 11 of them and we moved it down to five.

How it's now structured is again you will go to Account XYZ and if they have particular interest in, say, negative pressure wound, a negative pressure wound expert will go do that. And we wrapped it all up into what we call the

Cardinal 360 program, which has proven to be important to us, which is if you buy one set of products from us, you get one price. If you buy and perform against a second, third, fourth category, you have an opportunity to earn additional discounts across the entire business.

So that bundle if you will begins to when you can add naviHealth, you can add inventory management systems to it, it becomes progressively more attractive. So as you partner and create more opportunities to do that, the Cardinal 360 program, which is again something we introduced about 18 months ago, has proven important. So think of it as strategic accounts, executive selling at the top, experts behind it supported by a bundle underneath it.

George Barrett: That content capability is really important because this is a really important concept I think. The idea of saying we can provide you a lot of things is only valuable if you are best-in-class at those things. So to try to convince you -- we do a lot of things for you but one of these things is quite mediocre and ordinary. Once you get into the content experts on the other side, you are not going to make progress.

So it's really important in all of these lines of business for us. We can open doors and really get a powerful conversation going. It's also very important for us to be able to bring the content behind each of those businesses.

Don Casey: Your second question was about the Medtronic announcement last week. And obviously we are not going to comment on what Medtronic is doing but in a lot of ways we look at that as a validation of our strategy in that we are attacking it slightly differently. You hear us talk about the service component of that before we go into the product side, but obviously what they are doing is not a long walk from what we are doing and we are building the foundation in a slightly different way than they are.

But on the surface you look at the orthopedic business, you would say that there clearly is an opportunity to deliver the patient great care at a differential price and a couple people have tried it a couple different ways. Obviously Smith & Nephew has tried it. Medtronic is trying it in a different way. We feel that the steps we are taking will allow us to create an important growth pillar for us.

George Barrett: But directionally it is again, as Don said, it is completely unaligned with our general thinking, which is that there is an inexorable march toward some of these new kinds of payment models. That's what they have said explicitly. I'm just again quoting their commentary and I think that's our commentary as well.

What's actually very interesting, and again nobody should read through this, but if you think about the complexity of doing this, I think you're going to find companies actually sort of doing things together to accomplish some of these goals. Again, so I think that's the other thing that's going to be very intriguing and we see it now in people coming to us and saying you've got this. We've got a product that we think is valuable but we don't really have a way to bring it in a holistic way to the market and maybe you guys could handle that for us in Europe.

So that's another -- we would be very open. We know what that end game looks like that we can picture and we're going to be very open to figuring out what we do ourselves of the things we might with other players as partnerships of their products or their service so it's just an incredible time in that regard.

Sally Curley: I'm going to interrupt us here because Clay has an hour to catch a flight. So Clay, thank you very, very much. You've been very generous and very patient.

George Barrett: Usually we keep him and he just misses it.

Clay Richards: Thank you. Thank you so much.

George Barrett: Safe travels.

Sally Curley: Don and George, back to you or to the audience for any questions.

Audience Member: Evan Stover, Robert Baird. I guess I just have to be that guy and ask the obligatory question because you get it probably once every couple quarters. Is there any update in light of everything you've just told us on what Cardinal brand products, consumables and PPIs, what the goals are for percentage of revenue and gross profit in that business? It would be helpful given the background you've given us and the strategy?

Don Casey: It's interesting, what was it two years ago? It was two years ago we kind of that an objective that if you looked at the combination of our products, services including at Home, we thought that should represent over 70% of the business. We would be working toward a margin of 5.75% and we said for us a key thing is when do

we see the Cardinal branded products getting over 40% on a contribution margin basis. We still think those are very valid.

Where we are on the Cardinal branded products, we've pretty much achieved that goal now. We're not going to give you an exact number. And one of the interesting things is we are starting to win more distribution business, which may change and fluctuate how that works. But if you look at -- if you think about the aggregate margin level as we begin to bring on more of these services which are accretive and products like Cordis, we continue to think that that's a meaningful objective that we should be able to attain. On the total contribution margin from Cardinal branded we've hit the goals we've laid out and again, we are never going to give you that down to the decimal point because depending on how much national brand on the distribution side comes in if you go win a Kaiser, that may bounce that number around a little bit.

But the direction we've laid out two years ago, we are either very close to attaining or continue on focusing attaining but that's directionally what we think -- what this business should look like.

George Barrett: If I could comment on this, it's sort of an interesting question because it is always a tricky part about laying out -- and we do it internally -- margin rate goals. Because the things that we are doing, key drivers, key lead indicators for us are things like the growth of our consumables business, our Cardinal Health label business.

But then what can happen is you can pick up the business in another part of your system that has a different mix, let's say in the pharma business, we pick a big mail-order account and so the rate can get compressed. But in fact, it is a very good thing for us and for our shareholders.

So we will keep trying to set goals but we will try to let you know, look, there's some mix things happening but what we are measuring every month are those lead drivers of expansion so things like our generics program or our consumables business, those are -- our services business. Those are important growth drivers for us and as Don said, those are going well. What seems to be happening a little bit alongside is we're picking up a little bit more distribution business and that will probably -- as a rate be a little bit dilutive but I think the general direction is pretty encouraging actually.

Audience Member: Steve Valiquette, Bank of America. I guess there's probably no question that Cardinal is light-years ahead of most competitors in medical when it comes to private label and self-manufacturing. We've heard about some of the GPOs like Premier trying to build a greater presence in this area. I'm curious, competitive landscape, let's say 3-10 years down the road, is that something you worry about or are they so far behind it doesn't really matter that much?

Don Casey: It's interesting, the GPOs and there's been a just a tremendous amount of both consolidation and activity on the GPO space, I think we are obviously looking to create different revenue streams and service their customers. The conversation we will have with the Premiers is one of co-opetition -- if you will. There are places we can work together and our sourcing is at a scale that is significantly larger than theirs in a lot of categories and say can we work together in this category where we will continue making money.

And in other places they feel they may have an advantage. So more to your point, Steve, do we worry about that over time? It's safe to say that we worry about everything, first off. But I really believe the fact that we are scaled from a sourcing perspective and now particularly with Cordis and -- look, tomorrow morning we're not going to be selling every product we make here on the Cordis network outside. But it's certainly something we are planning for so that we begin to create scale beyond the acute market. The fact that I can work with Jon and go into the retail market with some of this gives you scale and that scale to me is important that you keep us with sustainable advantage three, five, 10 years out.

I do think there's going to be some consolidation though in terms of how you look at some of the competitors in the space and I'm not sure exactly how it will play out but I think there will be fewer bigger competitors as you go along the scale. Scale is absolutely essential here.

George Barrett: By the way, I think scale and experience again going back and this for us, goes all the way back to American Hospital Supply. We have been manufacturing and sourcing products for decades. So it's scale and its capability. Again this is not a criticism of anybody else. But our quality compliance regulatory organization is probably bigger than most companies who are in this space. So -- our global trade group.

This requires some expertise. So the GPOs for us are partners actually. They are customers. We are probably going to have lines of business where we bump noses but that's part of the industry -- that's sort of the world that we are in today. We have it in our retail world. We have it in almost every line of business where there's someone you are working with. They are actually a customer. But you probably have some line of business where they want to do it themselves or they source and that's okay. As long as we are at the top of the organization's strategic understanding about where each is going, we navigate it. I think that's the world that we are in.

Audience Member: When you said consolidation, are you talking about among self-manufacturers or private label brands? Are you talking GPOs and foundations? I just wanted to clarify that..

Don Casey: More in the manufacturing side.

Audience Member: I just wanted to make sure.

Don Casey: And the point and just last point, obviously, we at this point have 16 manufacturing facilities. We have been in this business for a long time. They range from Thailand down into Mexico and other places and here. It does provide a certain infrastructure advantage we believe that is sustainable over the long-term.

Sally Curley: Just as a reminder for those on the webcast, you should be able to submit a question if you'd like.

Audience Member: Nathan Rich, Goldman Sachs. Two questions on Cordis. Don, you talked a little bit about the integration process in some of the day two countries. I think you're also in the process of exiting the TSA with J&J. Can you just maybe update us on where you are, what the next steps look like over the coming months?

And then as we think about that timeline, do you still feel comfortable with the guidance for more than 20% EPS accretion for fiscal 2017 just based on where we stand now?

Don Casey: I don't think that we said 20%.

Audience Member: $0.20, sorry.

Don Casey: The question on where are we on day one and day two? A lot of that -- of those TSAs were timed for a year and during the summer we are beginning to take some of the countries off. I am not going to give you a specific litany but we believe that we will be on track if not potentially a little bit earlier on exiting those TSAs.

Mike Kaufmann: Some just go for a couple of years --. I don't want you to think like they all fall off at one time and there's no TSAs. We will still have some, pieces and parts.

Don Casey: Let's parse that out just a little bit. First the TSAs if we want to avail ourselves of the TSAs, there's no deadline. J&J seems to be very comfortable in helping us do that. It's more when do we want to get off it? There were day zero countries which occurred. The day one countries we said we would like to target to get them off within a year. Then there's day two countries like Brazil is a noteworthy day two country. You just can't switch the product registrations all that quickly.

So it's not that we are not ready to do it, it's just there are regulatory filings that take time. Over the course of the summer, we are going to look at the day one countries and we're going to be focused on moving a lot of those this summer. And we had -- in the model we had built in kind of fall, so we will see where we are in those. Again, we keep this idea there's a patient. We are not going to screw up an ability to get a patient product.

But again, tribute -- a lot of the burden falls on Mike's people in the finance organization and we are tracking about where we thought we would be tracking. But as we learned in this business, any given day there's a new set of challenges.

But I would tell you we are going to meet what we said and the guidance where we are, we are still pretty comfortable with where that is. A lot of this is really going to fall where FX, FX can move that business up, down, or sideways so it will -- again I'm not going to give you a piece of the 2017 guidance. I will tell you we are pretty comfortable that Cordis is performing about where we thought it would be. There are puts and takes, but Cordis is doing what we thought it would do.

Audience Member: That makes sense. Then just a follow-up, could you kind of talk about now that you have seen the business what the stuff you need to execute on the synergy plan is and kind of how we should expect that to kind of flow through over the next several years?

Don Casey: The TMA, which is the manufacturing agreement, is I guess four -- a four-year agreement. It's a four-year agreement, so that's really the biggest gating on what you will see in terms of when those synergies roll off and on.

The second thing that again you hear us describe, catch the business, run the business, optimize the business, we are in the catching the business phase right now. To your point, day one countries coming on to us for instance the supply chain right now is probably not where it will be in a year. So right now we want to get and run those countries and then we will optimize the network.

So again the timing that we set on synergies is one we really think is about right. So the only thing that has changed in Cordis I would tell you is where FX falls and in some cases that was a bigger move than we thought. But the underlying business in some cases has been a little bit stronger than we thought. So again, FX is a challenge. I don't mean to say it's not but what we said on Cordis is about what we think Cordis is going to do.

Audience Member: You sort of alluded to Kaiser. So just curious if Kaiser was here today and we asked what were the top one or two reasons why they chose Cardinal, what would it be? Is it your portfolio of offerings, they all sound appealing but what was it specific to them?

Secondly, one of the offerings was just sort how can you help your client lower their cost structure not necessarily with absolute pricing but just some of the mechanisms that you have. So I'm just wondering, in larger strategic clients, what's the winning been on price, on absolute apples-to-apples price, versus a couple years ago? So give us a better idea of how that's trending. So is it just one or is more on the strategic partnership even if pricing isn't cheap?

Don Casey: Again I don't want to put words in Kaiser's mouth but we did the kick off meeting with them two weeks ago and they sat there and said we really want to transform healthcare. We think you are the customer to do it. So on an apples-to-apples price basis, I would say there are three options, and we're probably similar. The discussion we had with them was we can do some very innovative things around how we are going to do distribution but also the fact that we are now in 900 categories that gives them a potential cost savings opportunity around product. They are extremely interested in naviHealth. And I think they've set forth an objective internally where I don't think

Kaiser's footprint today is where Kaiser's footprint is where they think it will be in a couple of years and they wanted somebody that could grow with and provide solutions.

So it's really -- it was really a case and George has a great relationship with their CEO, Bernard Tyson. And I think George -- I would comment -- they really told us it's like everyone was competitive a price perspective but you guys differentiate yourself on your total offering.

George Barrett: Again it's really unfair for me to speak for somebody else so I won't. But I can sort of talk generically about the conversations that we are having at the C suite. At a time of change, I think progressive larger systems are thinking about where they need to be downstream. Obviously what they look like and just like we have, the same dilemma, we've got to execute today an existing business, a fee-for-service larger amount. But they are also clearing where they need to go. And I would say in many of our businesses, everybody can match price. It's generally not a differentiator. It is generally not a differentiator.

So the question you're asking, we did the same with our supply system -- who seems to be -- who is bringing us capabilities that will allow us to get to that goal and who seems to be sort of aligned with our way of thinking, like-minded about the future? Those things seem to matter if you have the basics sort of underfoot and doing it well. And we're a very, very good supply chain company. Under any measurement and it is -- by the way that is something we are obsessively measuring and our monthly meetings are all about the day-to-day and how we are doing.

But the ability to say we think we can help you navigate a new challenge that is brewing in your system or in the system, I think is an important differentiator for us. I think that's been helping some of our older -- I will call the more legacy businesses because we do those extremely well. So again, it goes back to the other thing. If you don't do them well, no one is going to grant you new business because you have interesting thoughts. But if you have interesting lines of businesses and your other businesses are really high execution businesses, you have a better shot at it. I think that is sort of what is happening.

Don Casey: Again, Garen, you had two other questions in there is how do you lower the cost structure of something like a Kaiser? How do you specifically do that? I will give you -- I'm not saying we are doing the Kaiser but as an

example of conversations that go on not only with Kaiser but other places. So a lot of them run their DME business. They are selling durable medical equipment to patients post discharge. It's not something they are good at. It's something Cardinal Health at Home is really good at.

So we can go in and sit there and say -- flip that business not only you're going to have a broader portfolio of products, you're going to have better service and it's less expensive to you with an example.

Another large customer basically sat there and said we are thinking about the supply chain wrong. We have historically looked at distribution as big pallets that come to the back of the loading dock and could you begin to talk directly to the patient bed? And we've actually badge flipped employees at that point because we believe we can offer synergies across the entire thing so across the entire supply chain.

So that's an example where literally we believe because we do this at scale and they don't we can be more efficient.

Third example is WaveMark, CIMS, Cardinal Health Inventory Management Solutions. If you look at aggregate level of inventory, number of lost products, number of dated products that they are not necessarily getting revenue or they are having a long-term conversation with the supplier, we can take that off the table. That is real money real fast for them.

Again, because you asked in the context of and where are you from a pricing perspective versus where you are three years ago? Look, I don't think any of us are expecting price increases, but the way you hold the line on price is you begin to look at shared opportunities to save money.

Audience Member: Again, the weighting in the price so if it was a third of the RFP then you're sort of implying that perhaps it's a little bit lower because of other factors that are becoming more of the conversation because of price?

George Barrett: Again I want to just be careful here. I think it's realistic to assume any incumbent doing a really good job has always got an advantage, right? I think generally that's true. We would hope that would include us as well. When we're the incumbent we're doing a really good job. What we have seen and this varies so much by system, there are some that really see themselves and they are having an internal conversation that we are not part at an

inflection point and they are looking for partners who can help them get there. They may look at their supply system and say these three or four players are exactly within a band of pricing that is not differentiated. But we think that this company has sets of tools that really actually can help us change behavior and really improve our economics and our outcomes.

We want that conversation. It doesn't always happen that way. There are many times it gets buried back down into the organization and you have somebody as Don said in the procurement department or in the pharmacy department that is making their individual call and it's at that level.

But we welcome that conversation I guess is the point. We welcome the conversation, talk about where care is going, what their strategy is all about. We try to understand our customers. So I think what we've gotten better at, we are not walking into every system assuming they are the same. We really have studied them and we know what their strategies are and what their footprint looks like and a little bit of certainly what they've said publically and we try to really stay on top of that.

So again, we don't want to be overstating this. I think incumbency is always an advantage if you are doing well but I think that we offer some value proposition that may be increasingly attractive.

Don Casey: To build on the last point, if we are shipping more Cardinal branded things through our network, obviously our cost to them is lower so it makes us more competitive.

Sally Curley: More questions before we are going to the break for lunch? Yes.

Audience Member: I don't want to talk too much about one customer but Trinity Health made some waves by deciding to centralize some of its operations in-house and I think there might be some misunderstanding as to what Cardinal's relationship is going forward with that client. Maybe just more broadly speaking, what does that type of move say about how kind of your relationships might change with some of your customers?

Don Casey: By the way, this goes to the breadth of the relationship we have with Trinity. Jon, you talk first and then I'll go second.

Jon Giacomin: I'll speak first to it. Maybe Don can address the medical product side of this and I will talk about the pharma side. We have a relationship with them. We do supply pharmaceuticals to them and at present there is no indication that there will be sort of moving to some sort of consolidated supply chain solution or 3PL type of solution for their system. So we will continue to supply pharmaceuticals to them just as we do today, delivering to every one of their locations every single day.

The pharmaceutical situation, there are very few if any health systems today managing really their supply chain around pharmaceuticals. The reason really is that it's very difficult and somewhat tricky. You get into licensing. Think about it. You are managing controlled substances. You have to have the applicable security in place. You need to have the applicable storage conditions. So whether it's frozen product, refrigerated product, product that needs to be at quote-unquote ambient temperatures, that now throws a whole other level of complexity and difficulty into doing that.

So I'm not sure I see really any sort of trend in the pharmaceutical market to suggest that they will move to 3PL models. But I will turn it to Don to talk about Med/Surg.

Don Casey: Then on our side because it really looked like it was coming at Med/Surg side. First, what are they really talking about? They are going to basically build their own warehouse and they are going to manage that and then they will use third-party logistics to push it through.

The interesting issue is as we look at our partnership with Trinity, it's going to remain after they actually in fact do that because we are providing services to them that will enable them to manage the third-party logistics. So when you think about Trinity, what they are doing, there's a warehouse component. There is a movement of boxes component to third-party logistics and then there's the coordinating the billing with national brand and other people and we are providing services that will help them do that.

Is it a trend? I will go back to Dave's question about every once in a while you will see a group of people say in a pandemic situation, boy, we better have our own warehouses to make sure we have things. Ultimately it's just more cost effective to use a distribution company and we see pendulums swing back and forth.

Other than Trinity, we've actually seen more people get out of the distribution -- out of proprietary distribution coming back. But as we changed our relationship with somebody like a Trinity or some other accounts we've had, fine, if you guys want to go do that, we think it's more cost-effective to do it this way. But here's the inventory management program you need to run, which we will sell to you as a service. Here is how you manage billing and other parts of that. Here is how you actually manage your warehouse. So we can actually on a service basis create a very profitable relationship for us as well.

George Barrett: They are still a great partner. I think what happens is again you're going to find systems trying to find different approaches to being more efficient, finding new revenue streams. We have an interesting line of sight on this because we see a lot of the system. Again in full transparency, there are lots of times that companies offload ideas by us and we basically know that that's probably not the most efficient thing for them to do. But there are times that they want to do that, we will say look, how can we help? This is what you are committed to doing. We are a partner. How do we help you do that?

We have tools that will help you do that. There are times that we understand and it makes sense to us sometimes we probably think there's more effective ways to do it with various players but they sort of have a game plan. We just -- we do get to sort of see everybody and how they do it and what the scale looks like and what the capacity to do those things are and so it gives us a little bit of a unique vantage plan on it.

Jon Giacomin: I think what is also interesting is you have to step back a little bit and say what are they really trying to solve for? To George's point, there are probably a couple different approaches to solve that same problem, but the heart of it is really driving efficiency, lowering costs, and really driving standardization. Particularly in Med/Surg, where you can have multiple products in multiple categories, how do you ensure compliance and how do you ensure standardization to lower your overall acquisition costs? That is mostly at the heart of what they are trying to solve for and there are many ways to do that, many of which don't include operating a warehouse.

Sally Curley: I think we have one more question before we break for lunch from the webcast.

Webcast Member: The partnership with Henry Schein appears beneficial so far. Does it make sense to explore similar arraignments with other channel partners in the ambulatory space?

George Barrett: So let me start and then maybe turn it to Don if that's okay. As a starting point, again we think that partnership generally is something, a capability. It is in a system that going to this many moving parts will probably find companies, maybe the companies you wouldn't expect to work together working together so we are always going to be open to that. We've done some very successful -- obviously Red Oak and our partnership with CVS is probably the largest example.

And on sharing arrangements, I would just say in its early stages truthfully. Again, it takes a while to sort of line up specifications and all those things, so it's relatively early. But we broadly are open to that, so what else would you --?

Don Casey: I wanted to add, look if we can do a capital efficient partnership that gives us a capability in another channel, we will absolutely look at that. Ultimately as we begin to build this product portfolio, we are going to want to push it into a bunch of different channels and I don't think we have to own all the assets to do that effectively.

Sally Curley: With that, I'm going to suggest that we pause the webcast. We will return at about 12:00 noon. For those in the room I invite you to join us for lunch. We are going to -- as a reminder, lunch is just around the corner. And we have a working lunch, so if you can grab your lunch, come back to your seat, we will try to get the webcast going again at noon. Thanks, everyone.

(BREAK)

Sally Curley: Okay, so welcome back. Hopefully everybody can hear me, welcome back to the webcast and welcome back to the meeting.

The last hour here we are going to kick off actually with the Pharmaceutical segment, but also if you have any questions on capital deployment, please feel free to ask our CFO, Mike Coffman.

Jon, I'm going to hand it over to you maybe for a few introductory comments.

Jon Giacomin: I will make a few introductory comments but I think George wanted to say something.

George Barrett: Sure, just a couple of quick things. Welcome back, for those dialing in. Hopefully we won't be chewing too loudly in your ear for those of us who are eating.

As you guys have heard us talk about before, our Pharmaceutical segment has been performing very well. Jon and his team deserve a tremendous credit for that.

High priorities for us have been broadening that customer base, really achieving scale and value creation from those generics programs, particularly some of the value coming from our ability to source globally with Red Oak, our joint venture with CVS Health. Growing our specialty business, and that really is in two directions and Joe is going to talk about that. Again, this is largely -- you cannot ignore the evolution of the pharmaceutical sciences and what's happening between -- sort of this collision between data science and biology and the opportunity that is creating.

We have felt, as you know, for many years that that's a place in which we need to be strong, well-positioned, and creating value. And I think we've made some great progress there. So those are high-priority areas for us.

And with that I will turn it to Jon and Joe is going to join us as well.

Jon Giacomin: Great. Thanks, everybody. Good to be with you.

Before I jump in with some opening remarks, let me introduce again Joe DePinto. He is our President of our Specialty Solutions business. Joe has been with us about a little bit over a year now and couldn't be happier with

Joe being a part of the team and the contributions he is making to not only the Specialty business but our overall business.

A couple of opening remarks and then we will turn it to all of you for some questions. To pick up a little bit on what George said, I think across the segment we are executing really well in the markets that we are serving, but also against our strategic priorities. And as we think about the pharmaceutical distribution business for a moment, it goes without saying that in order to play you have to be really good at the basics of that business, the basic blocking and tackling, and executing day in and day out against the supply chain and customer requirements and demands there. And I think we are performing exceedingly well on that front.

The environment is such, though, that right now -- a little bit dovetailing off of what we talked about this morning -- that customers are faced with some tremendous challenges. Whether it's value-based care or whether it's performance and being paid for outcomes, all of our customers are challenged in that regard as healthcare goes through this transformation. I think as a result our customers, now more than ever, are thinking about new and different ways to partner and we are seeing more and more opportunities relative to driving deeper and deeper relationships with our customers relative to solutions.

And while this morning we spent a lot of time talking about acute, and rightfully so, it's not just in acute. It's also in retail, and retail from the very large to the retail independent customers. It's also in places like alternate care, particularly in long-term care where customers are coming to us.

The solutions that we are talking about, to pick up a little bit where Don left off, is mostly in the pharmacy solutions area within acute and also within retail. So let me spend a minute on pharmacy solutions and acute.

You may or may not know this but we have a business that employs in excess of a thousand clinical pharmacists and those pharmacists do everything from managing an in-patient pharmacy to also providing telephonic pharmacy services so we are on the phone with patients. We are providing consulting. We are doing medication therapy management and, in the case of outcomes MTM, we are even facilitating that to include a relationship with roughly 50,000 retail pharmacies who are delivering face-to-face interactions with patients.

So clinical pharmacy is a critical piece of what we do. Again, it's everything from inpatient to telephonic to even managing retail outpatient pharmacies. And that is applicable not just to acute and not just to retail, but now we are seeing some applicability even in long-term care.

When you switch over to the retail space, obviously their challenges and problems are a little bit different, but all of it is about performance now. All of it is about moving to star ratings as CMS has described star ratings. These star ratings become increasingly important because, if you can't perform, you run the risk of being cut out of networks. And I think, as many of you know today, probably within your own health insurance, limited networks are sort of the thing that is in, in an effort to reduced cost as a result of higher access, higher utilization.

And so the way retail pharmacies perform is critically important to how they can participate in networks going forward. We have been doing a lot of work in that regard and much of it has really been about data, analytics, generic dispense rates, and giving them insights into how they are performing relative to the attributes that determine their star ratings.

And while this is something that CMS has put out now for Medicare, it wouldn't be so much of a stretch to think that it's going to be important in commercial as well. It has really been about providing the solutions that are necessary for our customers to meet the challenges of today as they work through the transition.

George mentioned also generics. Generics is obviously very key to our business and strategic to our business and, of course, we are very pleased with the relationship that we have with CVS and the Red Oak sourcing joint venture. It's creating a lot of value, I think, for both organizations and as importantly, for us, it's creating value for our customers and obviously our shareholders. We are pleased with the progress that we have made and believe that that is going to be something that's going to be critically important as we move now into the future. So very good position there.

Specialty is an area where we are seeing some very nice growth. As we expect to finish the year here, we will probably be revenue in excess of $8 billion, double-digit growth year over year, and I think positioned well, both on the provider side as well as the biopharma services side.

On the provider side, we have been adding scale with new relationships, new partnerships with customers, and also on the biopharma side, we've been working and very focused on adding to our capabilities there. Everything from regulatory science capabilities and helping manufacturers with their filings up to and through a patient or hub services where we are focused on patients assistance programs, everything from prior authorization to 24/7 hotlines and assistance programs that we offer patients. So very pleased with the progress that we are making in our Specialty business.

With that --

George Barrett: Before we do that I'd just like to remind everybody, we blew past generics. Don't worry, I promise we will come back to it because I know there are going to be no questions.

Jon Giacomin: There aren't going to be any questions on generics? Okay, good.

George Barrett: So we will make sure -- so you guys know, we will talk about Specialty for a while and we will come back.

Jon Giacomin: So with that, I will open it up to you for any questions you may have. You're right. No questions, George.

Audience Member: Stephen Hagan, Deutsche Bank. Just wondering on the Specialty side how much variance is there in terms of the margins that you've got on specialty drugs. Is there kind of significant difference in some specialty drugs in terms of how profitable they are and what drives them differently?

Jon Giacomin: Well, I guess I would say, and Joe and even Mike could chime in on this one, while you obviously have brand specialty drugs, there are also generics within the specialty space. Although some of those are somewhat limited in terms of oncolytics.

But relative to brand and specialty drugs, I would say a lot of that is ultimately dependent on the particular drug, line extensions, and other things that go into determining just how difficult it is to handle those products. Because, as you know, many of those products require special handling. They sit within the specialty distribution channel for a reason and that is most of them are high dollar cost, require special handling, usually come with some sort of temperature requirement associated with them. And so a lot of that actually influences as we think about specialty drugs and the margins that we might earn on them.

Anything else?

Mike Kaufmann: I guess the only thing I would add just to give maybe a little bit more color, if you broke it down you'd have some normal solid oral generics that would be going through Red Oak, just like the rest of our generics in the rest of the distribution business. Those are going to be your highest margin, both in terms of rate and dollars.

Then you're going to have your injectable generics, which are again like pharma distribution: higher margins, but not as high a margin typically as solid orals. And then you have your branded products, which, as Jon said, are going to have various margin rates, depending on a lot of times the storage conditions and the market pricing on those drugs. And so those are kind of the mix.

The other kind of unique thing a little bit about specialty is the branded drug mix in specialty tends to be a little bit more heavily weighted on the non-contingent piece of fee-for-service, so there is less contingent fees in specialty type products just due to the limited type of products in there and the cost of those drugs. And they tend to have lower price increases as a percentage. And so over the years we have negotiated more fee-for-service mix in there, so it's a little bit higher fee-for-service mix, the non-contingent fee per service deals, then contingent in specialty versus normal pharma.

George Barrett: Just for clarification, I think it's worth doing this -- and probably most of you know this, but if you don't, I want to make sure.

Everybody sort of defines specialty differently it seems. For us, I think we've got -- you guys tell me if this is as simple as possible, if it runs to our traditional pharmaceutical distribution network and our logistics center, then it's in PD in pharmaceutical distribution. If it's running through our specialty logistics system, it's specialty.

For example, hepatitis C, which is easily described as a specialty drug, the Sovaldi and other drugs for hep C, actually for us are not in specialty. Those are in pharmaceutical distribution. They run through our traditional channels and our traditional network.

So that might be helpful so when we are talking we have common language.

Jon Giacomin: That's right.

Audience Member: So I have to ask a generic question; it has two parts for it. First of all, in generic price dynamics, obviously generic price inflation and then deflation have taken a toll.

And your two competitors have quantified the impact for them on a going-forward basis. Obviously you're not giving guidance today, but when we think about fiscal year 2017 -- you are almost done with 2016 -- should we think about generic inflation headwinds as greater, lesser, or about the same as what you saw in 2016? So that's the pricing question.

The second question is you keep going back to kind of the point that generics will continue to be a very important contributor of profit for the segment going forward. And you are not alone in it. We are hearing McKesson and ABC saying the same thing.

Can you maybe help us quantify that opportunity? The market is at 85% generic conversion, the industry same, but this really doesn't correlate to where we are. So maybe give us some kind of data points that will help us tie these two.

George Barrett: Let me start, if I could, and then we've got a bunch of knowledgeable folks here, probably more knowledgeable than I.

So even with our competitor's breakout, just for what it's worth, it's not -- it's usually a group of things. Again, we have to be careful so I said generic pricing and renewals. I would just caution everybody to be careful that it's rarely a specific line that's just pure price. Again, that's not a criticism or a compliment; it's again fact, because I think people have misunderstood some of what that is.

Second for us, generics continue to be very important. Let me just broadly; we are not rolling back the clock on the pressure to reduce healthcare costs and pharmaceuticals, and generics are the most obvious answer.

The demand continues to grow. So no matter what we do -- and benefit design can cause temporary blips -- but we have a gigantic wave of now late 60s, early 70s, entering 80s; these are essentially the super users in the system. So the demand is going to increase.

Our market position is extremely good. Red Oak, I think is the most capable and largest scale purchasing entity, in our view, in the world. And our customer base, or let's call it the broad customer base, is also thinking about what's the most efficient way to source generics.

We tend to think of that as those who buy directly and those who buy through a distribution partner. But we forget, while that's true, and even that is shifting, there are also many that do both. They buy some through direct sources and they buy some from a distribution partner.

The more capable, the more attractive our program is in generics, the more we can actually even influence that mix. And so if someone is buying 50/50 and we can get them to 55/45 in our direction, it's a very good thing for us. So I do think that people sort of forget that there's a large part of the system.

Quantifying all of this is externally difficult, Ricky. It really is. Even if I were absolutely sure it was the right thing to do, it's so hard to quantify what that exact opportunity looks like. And, again, it depends on so many moving parts, but we continue to see it as really a growth engine for us.

Again, with a qualifier -- and I think is this on the call and it's really important -- that the 2016 over 2015 benefit of a full year of Red Oak versus a partial year is hard to reproduce. You can't reproduce that step function so easily, and so again we have to be realistic about that.

But I just wanted to make sure that I frame that out and then we've got -- Jon and Mike can really, I think, put more meat on the bones here.

Jon Giacomin: Let me start, Mike, and you can chime in. But I would say over the last 18 months or so we've been suggesting that generic inflation was moderating. I know you've heard that before.

When we get into 2016, I think Q2 of 2016 was probably a little steeper than we expected and then Q3 was maybe even a little bit more steeper than that and even slightly deflationary. I think an important thing to keep in mind is that definitionally we probably, when you look across the industry, competitors, etc., we probably measure that differently. We have 4,000 items within our generics portfolio today.

When we think about measuring this, we don't include items that have been launched in the last year. We do a weighted average of that with some items going up, some items going down, and when you look at all of that, puts and takes around that determining whether or not there was net inflation or deflation.

That said, I still think, to George's point, generics are an incredibly important piece for us and continue, even in a deflationary environment, to offer growth. And a lot of it gets to what George said. We have huge demographic shifts coming. You've got the 10,000 people per day that are turning age 65, going into Medicare.

The demand for these products is going to be high. You do have new launches coming in, albeit maybe a little bit less year over year and we have great opportunities with our customers today, existing customers who today are buying direct to take those generics then through the distributor model. We always have the opportunity to drive new business as well.

Then I think the anchor of our generics program is really Red Oak sourcing and the position that it gives to us. So we continue to feel very, very good about our generics programs and our ability to drive value in the market.

Mike Kaufmann: The only thing I would add is back in our Q3 call, when I gave a little color in my prepared remarks and then in the Q&A. In the generic area two things were headwinds is what we said back then would be in generic: pricing we would expect to be headwind in 2017 versus 2016, as well as generic launches, back at the end of Q3. Again, we are continuing to look at that and we will give you more color when we come out.

Our insight at that time said that those two would be headwinds. Then Red Oak would still be a tailwind for us in the generic area and that what we were seeing was in that mid-single-digit area of deflation, what we were seeing in late Q3. And that that would be something that, again, we would take a look at, but might anticipate going forward.

But, again, we will put all those headwinds and tailwinds together when we come out with guidance and give you some color. But back in my Q3 remarks, that's what I talked about on those.

George Barrett: Again, just to drill down a little bit more on that, on the inflation/deflation, because again this is -- you've probably heard it enough so that it’s sticking but it's not always intuitive. We describe inflation, which is an aggregate, basically a blended number, of almost 4,000 SKUs, each its own market. The vast majority of those --

call it, just to pick a number, 3,500 of those -- are in a relatively predictable state of slow price decline. That's the normal pattern and it has been for decades.

Just they are older, they are mature, more entrants; many with low entry barriers some of these products and they just deflate. Then you have several hundred products, and that can be 200 products, it could be 350 products, that have actually been moving the needle. Where we've seen -- and the reason a year ago, or more than a year ago, we said we expected to see a moderating price dynamic is it was historically a relatively larger number of products going up and the rates of that increase were a little higher. And so we are getting this net inflation.

We said that just -- we didn't -- it wasn't like we had a perfect crystal ball. We just said that seems a little bit a historical anomaly and it's likely to sort of return to a different pattern. We were a little early on that call. In Q1 actually it didn't -- we expected it to happen a little earlier. It didn't and, as Jon said, as we got into Q2 and Q3 we began to see that happen.

This is -- for those of you have been around for a long time, this is sort of -- we have seen these patterns before. I don't know if I can call it cyclical, because it's not classically cyclical, but there are sort of these waves to it. And so we did take some time in Q3 and I know for some it didn't make you happy, but I think we felt it was important to describe the conditions of the market as we saw them. And basically those are the conditions that we saw.

And relatively fewer launches. We thought that was important to highlight as we were trying to describe it. It's so hard to model. Those of you who know me know that I've been on the other side of this. Even sitting in that seat it's hard to model generics.

But, again, a key point is that it is really in a relatively small part of that back end where you see the movement that tends to cause the aggregate number to be inflationary or deflationary. I think a lot of the difference in language that you may hear from our peer group -- we all operate in the same environment. It just has probably to do with the way we measure it and the way we capture the numbers, but by and large, I assume we all …

Jon Giacomin: Probably a little bit to do with mix. Based on customer mix drives really sort of your generic, underlying generics.

George Barrett: Right, and a few tactics as it relates to how you purchase, right? So we can come back to that if you want.

Audience Member: Just one follow-up on Mike's comments. You are talking in your fiscal third quarter about mid-single digits, right? Is that what you've seen to date in the June quarter in terms of pricing behavior?

Mike Kaufmann: I can't update the fourth quarter at this point in time, but that's what we mentioned back then as what we were seeing in the third quarter and what we said we probably expected when we said guidance for the full year and for fourth quarter. But I don't want to update that assumption at this point in time.

Audience Member: Manoj Garg, Healthco. I have a few on Red Oak.

One, can you overview a little of how it mechanistically works? The reason I'm asking, I was a little surprised to see CVS's purchases through McKesson up significantly for the most recent fiscal year.

Two, what kind of margin improvement have you seen with the joint venture versus standalone? And then lastly, George, what kind of impact on pricing, if any, are you expecting from your old shop, Teva, tying up with the Allergan generics?

George Barrett: Let me start with the second. This is just trying to -- this is like Jedi. Start with the second, but then go to Mike and then maybe I will try to -- I can't speak for Teva, but I'll just give observations about this sort of environment.

But we won't -- the second is easy because we are not comfortable giving, here is what we used to buy and here is what we buy at. So that differential with the improvement from Red Oak is not something that I would disclose, so that part I can answer for you. Maybe Mike will talk a little bit at the mechanics, which I think are useful. Or Jon, one of you guys.

Then what I will do is I will come back and maybe give some observations about the manufacturer or -- any of us can. We're all living in that world.

Jon Giacomin: I guess relative to Red Oak and the mechanics, if you recall it's a 50/50 JV and each organization -- think of it as mostly a contracting organization, so they are out working with manufacturers and contracting the combined volume of both CVS and Cardinal Health.

Relative to the supply chains, though, each organization maintains its own supply chain. We have our own inventory management and operations folks who deal day in and day out with the manufacturer, managing and replenishing our inventories throughout our supply chain. And so does CVS. So CVS continues to do all of that.

I am not quite certain what you could be referencing relative to McKesson's purchases or CVS's purchases through McKesson, but I would just venture to guess that it might be related to some of the acquisitions that CVS Health has completed relative to Omnicare, relative to Target. That would be driving a lot of that. But I think, as we have heard CVS Health say publicly, any and all generics that would be applicable would be contracted through Red Oak sourcing. So all of that has essentially moved over.

Mike Kaufmann: The way it would've worked before is, for instance, on Omnicare, McKesson would have sourced the generics and the brand for them. When it moved to CVS, McKesson kept the branded product, but the generics are being sourced by -- CVS's own warehouses cut the POs, but Red Oak does 100% of the negotiating.

So if Red Oak had 10,000 total units between Cardinal and CVS prior to Omnicare and that added another 1,000 units, now they're just negotiating for 11,000 units. So they negotiate the price, the terms and conditions, and then they just communicate that to the two buying departments.

When I say buying, it's really just cutting the POs, as Jon described. There's no negotiating of price or terms and conditions. That's all 100% done by Red Oak. They just communicate, hey, Cardinal, we have switched from Mylan to Teva. You're now going to pay $10 a bottle, start cutting your POs to Teva, and we start cutting POs to Teva at that point in time.

So they work very independently in the sense there is a Board -- I serve on the Board -- and there's three from each company as it's a 50/50 JV, but they work independently to negotiate price and terms and conditions.

George Barrett: Going back to your question, as a percentage of -- as a growth, remember the revenue phenomenon associated with the branded distribution is going to be more noteworthy.

Does that answer your question? Good. Oh, I didn't get to the last part; I'm sorry. Let me try on consolidation. This is for all of us really, I think. So I won't speak about Teva specifically. Consolidation is not a new phenomenon in the generic industry. We have lived it for a long time.

It's very interesting; you see consolidation and you see continued new entrants. It's a very interesting industry structure. If you look at it, you have a relatively small number of players with a pretty good-sized aggregate share and then a really large flow of new entrants always excited about trying to enter this huge US market.

So the consolidation is something with which we are familiar, but I'd say it sort of cuts both ways. There are going to be opportunities where a company -- they have a commanding position on a given product and essentially in that negotiation they may have a little bit more power at that moment on that product.

But there are -- also, when you get bigger, you need market share movements that move the needle for you. And our ability, through Red Oak sourcing, to commit substantial volume is attractive to a large player, so that big-to-big phenomenon can be valuable.

Our goal in our relationship with Red Oak as it relates to manufacturers is to create value for both sides. And so that opportunity exists because we can move between our business and CVS business significant market share and that's valuable to a company that's getting larger.

Audience Member: One last follow-up. You mentioned 10% of the product, actually about 10% of the product actually move the needle on the generic side. Do they have any level of commonality in terms of they tend to be of a particular formulation type or is there any commonality amongst those?

George Barrett: Yes, that's really a hard one to answer. Again, there are two answers and then the third one is hard to answer, but there are two patterns you might see.

One would be products that are reasonably newly launched and where the flow of new entrants is gradual. Fair enough? There's probably a third bucket. Second would be a product that has extremely high entry barriers,

something in the technology that makes it very difficult: an inhaler, something that -- a very complex, sustained-release drug that has formulation complexity or raw material complexity.

And the last might be a product that is just sort of at its late stage. It has been mature for a really long time and it's gone through this long decline. People have exited this system and the product is starting to come back up because there are fewer market entrants there.

Audience Member: So I think the genesis of what when we ask these generic questions everyone's trying to get to you on a multiyear basis is, George, what would need to happen? I'm not asking on a 2017 basis, but let's fast-forward three or five years from now. What would need to happen if we sat in the same room and we were having a conversation for it to be that your generic profitability were not higher in that period or was only moderately higher in that period than where it was today?

Because I think what we are trying to all figure out is the messaging around this inflation/deflation is very confusing and so how to extrapolate that to a financial model in the context of a business of your size. Very difficult, but I think all of us understand generics are clearly a key part of the business. So if we think about the key variables, other than inflation, how do we sort of mix that all together to think about what else would need to happen outside of just inflation for that to be so?

Or if inflation returned to kind of its historical moderate deflationary period and we had the aging population and you gain share, is the picture really that different than what would've assumed maybe three years ago versus this odd period where we had sort of extra normal profits for some time during inflation?

George Barrett: It's a really good question. I think we will sort of tag team this if that's okay, Mike and Jon? So let's start with the pricing phenomenon. You touched on something important.

This is a familiar pricing environment that we described. Actually, the period of I don't know how long it lasted, 24 months or whatever, was a little bit more abnormal but we've seen this. If I got back over my 30 years of doing this, we have seen these fluctuations.

So what are some of the moving parts? The key fundamental here is the process or the difference between our acquisition cost and our selling price. It's critical for us, over a sustained period of time, to continue to improve

efficiency, reduce our acquisition cost, and then compete at the market, however that market exists. That's where again the Red Oak sourcing venture does create real value for us, because it puts us in a position to manage acquisition cost very effectively. So that is a very large driver.

We described some of the drivers which have to do with demographics, public health. I think benefit design is a little less a phenomenon in pharma than it is in the medical world because Med Part D is pretty well-established and the system is relatively stable. So whereas in the medical world we've seen a lot of fluctuations designed with -- sort of associated with benefit design, I think there's less of it actually in the pharma world. I don't know if you guys agree.

So other issues that we watch for are competitive dynamics around any given product, and this is the hard part. Every product is its own competitive market, so we could have a market that is relatively below the radar for you but that actually move the needle for us because the competitive dynamics of that market are such.

You have the behavior of customers. How are they sourcing products? How are they sourcing products? Are they continuing to believe that it's an effective way to buy directly or actually do they realize they are subscaled now and that it's more effective to buy through a partner?

The flow of new products out of FDA is another factor to watch for.

Audience Member: Is that good or bad?

George Barrett: It's sort of cuts both ways.

Mike Kaufmann: If you can improve your costing better than your competitors can and you maintain some sell price in the marketplace, more competitors can drive higher margin rates. If you get so many and the market price comes down, then maybe you go the other way. So it absolutely cuts both ways.

Jon Giacomin: I think, Ross, you said it's confusing and I think it's because there's a lot of variables, whether it's consolidation going on with manufacturers, whether it's API shortages, whether it's a regulatory environment where there's more scrutiny on manufacturers. They have to raise the bar in their manufacturing operations; some

do, some don't. Some come back to the market; some exit the market. There's a host of different variables and levers that go on within this which make it very challenging to project well into the future.

But it's a very dynamic market, I guess I would say.

Mike Kaufmann: I guess the only thing maybe just to finish this off is I really think about three big drivers of the whole generic bucket. You've got launches from a year-over-year standpoint, launches your net inflation or deflation and your penetration/market share driven by existing and new customers.

To your question over any three- or five-year period I think, as George has said well, launches tends to be wavy and probably over any longer period of time you're going to have years where it's better than the prior year and years where it's worse than the prior year. And each year we are probably going to be a factor that we're going to have to tell you what our opinion is on that year and whether it's better than the prior year or not, but I don't see that it's ever going to be consistently going up or going down. I think it will be wavy.

I think inflation and deflation will tend to be wavy. I think most years it's probably going to be more net deflation than inflation, as we've talked about, but again there are going to be years where we can see that go up. It's a little less -- not a little; it's a lot less predictable than launches where we can give you more probably accurate type of thoughts when we get towards providing guidance each year.

Then the last is that penetration and share of wallet where you are able to penetrate existing customers and win new ones. For us, I think because we sit in a really good position, both from a costing and our ability to service customers effectively, I think that is something that I hope to see as a steady increase for us in both cases with new customers. So it's hard to actually tell you in any -- over a long period exactly what it's going to do, but I think those are the three factors that we will try to give you insights to each year on how we think it's going to drive our numbers.

George Barrett: Again, I think partly what we did in Q3 is just provide some short-term insight as to what we were seeing, which was inflation/deflation, providing some insight there, a little bit of thought on the flow of new products into the market, and actually the approval rate coming out of FDA. For us, those were noteworthy, short-term characteristics. I wouldn't describe those as tailwinds, those are more challenging.

But again, over the longer cycle we have some things going for us here, but that's what we've been trying to describe, Ross. We -- in generics, you model as best you can until you do some risk adjustment, as we do, and then hope you've got your hands around the moving parts. It's always the most challenging part of our business to model, in many ways.

Audience Member: Now that the three big purchasing entities, there's been some time and the models have kind of I guess defined themselves pretty clearly, does your view on global purchasing scale versus North American purchasing scale -- has that changed? Where do we sit versus history?

George Barrett: I'm going to try on this one -- and I'll try to do without poking anyone. I'll just give you -- just is observational.

It's not -- we started down this path with a view that the aggregation of demand was a beneficial thing; scale was valuable and that's something that could create value for our shareholders. Our ideal way of doing that was in a collaboration with CVS, if we could have picked any way of doing that, and that's we have been able to achieve.

There are opportunities on a global basis, but they present challenges. And so, for us, again for us, it has not been the highest priority and the reason it presents challenges is that you have multiple different models throughout, let's call it -- let's start with Europe.

Europe is not a single model, so in some cases it actually looks somewhat similar to the US model, in which case opportunity for synergy is probably the greatest. In some cases, the manufacturer negotiates directly with either a national insurer or a semi-state-managed insurer through a tender and the distribution partner is not moving market share. It is the logistics manager. And then you have all these in between different versions of that.

In some cases it still looks like a branded generic model where you actually have to go out and sell. You have salespeople actually out pushing the product. The US has a very efficient system partly driven by that J code, by that AB rating system.

So for us, as we look at Europe -- again that's not to say this will be our view forever, but as we look at the opportunity to create value from generics globally that the complexity was very high, the synergy was a little bit

more limited. It existed, but more limited, because what we want to be able to say to the manufacturer -- this is really, really important and again Jon lives it and drives and Mike is on the Board of it.

We wanted to say to the manufacturer, when we commit to you 1,000 pieces, we will move 1,000 pieces. And by the way, you are going to negotiate with one player. There is going to be one set of terms and conditions. We're going to be completely transparent, there's not going to be all these other fees. You're not going to be negotiating in multiple markets. You're going to negotiate with one player, one set of conditions.

And we thought -- again, from my perspective, having sat in the other seat -- that that would be valuable. Maybe that answers it.

Again, that is not a state of permanence. That is what I would describe today and in the short term and there's nothing driving a very different perspective today than I had on this six months ago or 12 months ago. I don't know if you guys want to add anything to that at all.

Mike Kaufmann: I would totally agree. The only other thing I would add is you also see different formulations outside the US. Their packaging is different, the formulations can be slightly different, so the same players don't necessarily compete globally.

And I think that's why we also had a focus of a set of -- feeling like we had to align with only the players who could bring you global. We also believe there's a lot of small and midsized players that are very effective in the US with great quality, great ability to supply. They may have limited SKUs that we can also work with in order to keep that competitive environment going for us in the US in order to keep our costs as low as possible.

Because that's our everyday focus at Red Oak is just get the lowest cost and then we will figure out as a business how to price effectively as high as we possibly can, take into account all the things that our customers need from us and reimbursement and all that. But just go cost really, really -- get a great cost.

Audience Member: George, can you --? I think you've been very complementary about Red Oak and moving things as quickly as possible and talking about the immense talent that you've acquired and created there.

As we look forward, is it more about finding additional ways to lever that platform, or is it you've gone through the heavy lifting and now you can slim it down and get more leverage out of it? What are kind of the --? How does it progress from here?

George Barrett: Let me try -- I don't think slimming it down is really -- it's not a very fat organization. I mean Red Oak is incredibly -- I'm going to say incredibly talented and it's a pretty lean organization.

I think we still see great opportunity in the generic space and that is the priority for Red Oak for sure. We also, though, now know that we've got a model that I think the two partners believe in, and so we will continue to explore ways -- without again providing any other color, we will explore ways to take advantage of that model and that construct and that capability.

But I don't think this is one of those plays where we say, look, we got it up to here; now we can slim down. It's not big enough to even -- in terms of headcount that's not the goal at all. In fact, I'd be happy -- the capabilities creates so much value I think for both of us that that's more the priority.

Jon Giacomin: Not to mention I think the generic market -- one thing we were just talking about -- is quite dynamic. So thinking that we've reached some point in time and it's going to be static from here out, I would find hard to believe.

George Barrett: I want to make sure we leave some time. Because we have a hard stop at 1, I want to make sure that we get some time with Joe, but let's take a few more here and then we'll --.

Jon Giacomin: Maybe if we have a specialty question.

Audience Member: I don't have that. I do have a slightly different question on generics, really more towards the margins on generics. Just to frame it for a second, obviously we had this big generic inflation cycle over the past couple of years on generics. Now we're seemingly heading back to deflation.

I think no matter where we are on the industry on the generic pricing cycles, I think we are all in the investment community sort of trained to think that the gross margins that distributors make on generics will stay pretty steady through these cycles.

So I guess the question is really should we generally assume that your generic gross margins will still hold pretty steady, let's say, over the next three years, whatever the cycle is going to be? Or is there any directional comment you can make that your gross margin on generics may still expand from here or compress? I just want to get some color around the margins on generics as we ebb and flow through these cycles.

Mike Kaufmann: Gross margins, if you're talking about gross margin percentage, I would think yes, you can probably continue to maintain or expand that. And then depending again -- the dollars I think are going to be impacted by the amount of launches, your penetration, Red Oak's ability to expand those margins and so you have those other components.

But even if you think about it in a deflating environment, if you are able to keep your dollars the same, theoretically your margin rates have gone up. If your dollars are the same on a lower cost situation, you can have higher margin rates. So I do think from a rate standpoint.

But all those other factors are each year I think is going to be a different answer that we are going to have to give you color to. And obviously, we will do that in a month or two when we come out with some guidance for next year.

George Barrett: This is more just a reminder to everybody. We do -- we source incredibly efficiently. We've got really talented analytics teams that price, but we are also very conscious of our customers and where they are.

And so I've said this to you before: we can capture value and our customers can suddenly get caught in a squeeze where reimbursement is not following the market quickly. We need to be there for them, so we are going to always be a company that has an eye on where our customers are. I think it's just really important just as a reminder all the time that they have to be able to compete and thrive in their environment and we will make sure that we are sensitive to it. Just as a qualifier.

Audience Member: I have a different question, but it's probably equally ambiguous. Just on the political front, given the election cycle, we've got on one party sort of a wildcard; on the other party sort of tough talk on government Medicare pricing, negotiating pricing, which could be the beginning of some overflow into the commercial segment.

Could you help us just think through what the scenarios could look like and how you envision it in your business and how you guys discuss it as you guys talk through it in your meetings?

George Barrett: Look, there's no question that -- particularly drug pricing, healthcare costs but drug pricing have been just this huge subject and it's -- on the short term I don't see it will get less noisy. This is part of the political narrative.

Let's talk generics. I think generics have had -- there's been a little bit of attention on the rate. Again, this is not as an apologist for anybody; I'm not trying -- but the reality on a lot of the big increase percentages on generic drugs, if the product was at $0.06 and it has gone to $0.14 but the brand is at $0.96. I just don't believe that on generics we are going to see a systemic change.

Yes, the regulators are talking about some of the deals and what is competitive and what's not, and you will see some changes there. But generally speaking, if you'll look at the total cost of generics versus the percentage of scripts, it's still a huge value-add into the system in terms of a system trying to contain costs.

Branded side is a little bit more complex. Here's what I'd say. Obviously, some of the really expensive drugs have gotten a lot of attention. Ironically, the rate of increase on those drugs tends to be smaller as a percent. It's just the dollars are big. So when we look at the inflation of the more expensive drug, the tens of thousands or up, those rates of inflation have actually been more moderate than on some of the smaller drugs.

It's hard to say how this plays out in the long term. I think there's no question that companies have to be thoughtful about this in this environment. We have seen, and Mike again qualify -- inflation rates and I there's what we said there in the Q3 call in the branded side that is high single digits to low double digits. It's probably been in the lower band of that. I would say some companies are probably using more caution right now.

But again, primarily when we look at our branded basket, the way we measure branded, these are not typically the products that are $50,000. They are products that are $2,400 a year, so that area will probably -- I think is going to behave fairly typically.

So I think, in the big sense, it's hard to predict what the outcome is. The noise around this stuff will be very high. I think it will stay that way through the election cycle. The public is pretty worked up about it, understandably, and it will stay as a relevant subject.

But addressing it is a complicated story, as you guys know. How do you value the drug that seems incredibly expensive and yet cures Hep C? How do you value that and over what period of time?

So we just -- we have tried to stay very close to that discussion. I think from our standpoint, as a company, what we do in service for pharmaceutical companies -- we measure every company with whom we do business. We measure every SKU, every cube, every storage requirement, every logistics pattern to the market, and we know what it would take to do that in the absence of us. And we price below that. That is basically what we say we are the most efficient way for you to get this product into a patient's hands.

And so for us no matter how that model tweaks a little bit, that's going to be our value proposition, which is we can do this more efficiently than any other way to do that. So I think it is still going to be a noisy subject.

It's hard to know what that comes out of in policy standpoint, because right now again we are in the middle of all this rhetoric making this -- even the question of Medicare negotiating directly, you talk to economists on both sides of the aisle and they will say that probably doesn't have any impact. Because essentially you still have a company in a certain position of exclusivity, essentially, negotiating with somebody.

It's hard to know how that plays out. We just sort of stick to our approach to how do we create value. If there is some shifting around to the business model, which over some period time we could see, we will capture the value that we think we deserve for doing this really important work. And that's the way we will approach it.

I don't think it gives you a very good answer, but I expect it to still be a very highly-polarizing subject and plenty of discussion and rhetoric around it.

Mike Kaufmann: The only thing I would add to that is -- I agree with George on the generics. It's hard for me to imagine price controls of some type on generics. When it's a deflating item how can you not allow someone who has deflated so much to not adjust their pricing based on the market demands?

On brand, don't forget the fact is over 80% of our fees are non-contingent to inflation. So even if it did go into some significant price control that significantly reduced the ability of brand companies to raise price, over 80% of our fees are non-contingent to that inflation anyway and so it would have little impact on us on at least 80% of our margins on that. Just keep that in mind too as you are going through it.

Jon Giacomin: And I think many of these generics are already sourced through -- you've got many entities that are already doing these Part D plans and managed care already and they are some of the biggest sourcers of generics now. So to George's earlier point, I'm not sure there's going to be a lot more value relative to some of that.

Sally Curley: I'm just going to keep us on time. We've got about five minutes left, so get your questions in.

Audience Member: Evan Stover, Baird. I think one of the things -- I'm going to ask on traditional brand for a change and not on generics here. I think one of the things that a lot of investors love about inflation in that space is you're paid on list price. It's very stable over time; it's been remarkably stable.

But is Cardinal or any other distributor really going to be able to capture gross profit dollars to the same extent when you see widening gross to net spreads? I guess is the question. Is that model really going to be sustainable long term, or are your brand manufacturers going to come back to you with different margin profiles on those drugs over time? Because realistically net pricing in the industry is low to mid-single digits.

George Barrett: It's an interesting question. This goes back to the comment I made earlier. The mechanism by which we get paid today is primarily almost like a miniature royalty on the selling price, but essentially it's a certain amount of basis points or dollars.

However we are going to create that value, however that model occurs, we are still going to fight for that value with our branded partners in order to do that for them more efficiently than they can do that themselves. Whether we get paid off our list or -- so is it possible that over time we will see changes to the model?

Possible. The question for us is how do we capture value for doing the work that we are doing? You can capture off the gross margin rate. You can capture off the revenue line. We can do that on a pure fee basis, but one way or the other we are doing what we do incredibly efficiently relative to an alternative and will want to be compensated for that.

So regardless -- does that make sense? I think that is sort of where we take some comfort that we are not living high off the hog on some artificial dynamic. And if that's what happens, as you know, when there's inflation we have to often sort of net back.

So I think the basics of what we do on the pharmaceutical distribution I think are pretty robust and the way we create value is pretty straightforward. It's the mechanism of payment models that could over time could start to see some --.

Jon Giacomin: I think it's about getting compensated really for the value we provide versus the manufacturers' margin rates and taking some portion of that. So to George's point, we provide all those supply chain services from their point of distribution all the way through the provider and the last-mile services and a number of things that go and wraparound that. So it's not specific to that, but it's more about the value creation and delivering our services.

George Barrett: Somebody ask Joe a question.

Audience Member: I'll maybe try it. Question just around the long-term market formation of biosimilars in the US and then just how you see your opportunity evolving over the next decade to capitalize on that.

Joe DePinto: Great question. We are very early in the biosimilar era. And it's interesting; as you look at the biosimilars, if you've seen one biosimilar, you've seen one biosimilar. They will act differently depending on how many will enter into a market and what market they will enter.

So it will be something -- and we believe that many of them will need some of those services that we were talking about to support them and that's a key component. We are positioned well on the specialty side there with our hub services that we provide through our acquisition of Sonexus and the technology that goes along with it, especially with prior authorizations and making sure that we are doing all the reimbursement work as these manufacturers launch in this space.

And at this point in time still watching closely what the government is doing around reimbursement as well. Understanding the interchangeability, or lack of interchangeability, as it exists at this point in time and what those differences in reimbursement codes will be from the initial product that is launched that is a branded product in the market that will have a specific J code versus products that a biosimilar will have that same J code.

So there's a lot of differences; it's still evolving. It's an exciting time in this space and one that, as Cardinal Health -- on the specialty side, because of our vast distribution systems, both on the hospital side as well as the clinic

side, we think we're well-positioned. But more importantly, on the services side we can bring significant value to those manufacturers.

George Barrett: We really do think each product is going to be its own market, therapeutic area. What are the services required? What does that patient population look like? What are their special needs? How big are they? Is there substitution? Those will dictate the way a product flows into the system and actually where in our business.

For example, if it was AB rated and likely going to some retail setting, it's very likely to come through our Red Oak sourcing. If it's not, it's likely to be in our Specialty group.

Audience Member: You talked about mix of customers earlier, so in a timeframe where we're seeing some generic deflation, can you maybe expand a bit more on what you mean by mix? Like where would you see potentially either more or less, I guess, favorable impact from it, a deflationary environment? Is this like size of customers, like retail chains, or independents?

Jon Giacomin: I think what I was referring to, Dave, was really around when you look at customers and sort of what they buy -- let's assume everybody buys branded generics predominantly with some OTC products.

If you think about those customers, some have the ability to, say, take generics direct. They will go contract those and they will source those directly. In many cases, we might find ourselves in a backup role. In other instances, customers are buying everything from us.

And so what I was referring to is, generally speaking, what might change -- I think I was making that comment relative to inflation, deflation, and how you might think about that -- is the mix of those customers and what percentage of those things that they are buying from us? You might be more heavily weighted in products where, say, a mail-order customer is buying generics from you and they are buying more chronic type of generics from you. That would influence how you would calculate or impact your calculation around inflation/deflation. That's what I was referring to.

Audience Member: Given that ABC's largest customer is Walgreens, do you think there's a more unfavorable impact to ABC in a deflationary environment than it would be to Cardinal?

Jon Giacomin: That's really hard to say. Probably not one we're going to answer, so thanks.

Sally Curley: We're going to take two more questions and then we're going to turn over to George to wrap up and end it.

Audience Member: George, you said that you measure all the deliverables to manufacturers, so you really know kind of what you need to be paid or what you think is fair. Very different deliverables on specialty side versus solid orals, so can you talk a little bit about what are those deliverables that you're providing to manufacturers on specialty drugs? And what is that revenue model? How are you being paid for it and how is that revenue model evolving?

Joe DePinto: The revenue model to the manufacturers on the services side is very different, obviously, than the distribution side, and those deliverables are shaping up nicely as we continue to build scale on our services or upstream manufacturer services side of our business.

When you think about what we have been able to amass here at Cardinal on the specialty side, we like to think of ourselves as being able to provide end-to-end services for the biopharmaceutical companies as they look at optimizing their brands. Everything, as I think George or John stated earlier, about regulatory science consulting as they prepare to bring their products to market with the regulatory authorities, providing the writing and preparation for their files, as well as consulting, all the way through some of the work we do in reimbursement assistance programs, hub services, adherence and compliance programs.

So we continue to add those services at a very different margin level than you would in the typical provider distribution. It's a combination of you have to be in the space for that specific specialty from a distribution side to be relevant upstream with the manufacturer. So they want to make sure that you are active there and we are very active across many different specialties.

That gives us the opportunity to go to those manufacturers who play in those specialties with our host of services and be able to provide them that end-to-end consultative services, as well as deliverables, that will vary anywhere from prior authorization help in our e-hub and our technology play with our patient-centric hub at Sonexus, all the way through to some of the stuff we do on our 3PL, where we do order to cash and some of the technology work we do with them on their billing. So we've been able to provide that support to large biopharm and small biotechs.

George Barrett: Again, the model on most of that is a fee for that service. It's payment for the actual substantive work that we are doing there.

Mike Kaufmann: We still get the same -- we still get the base fees, like we do in PD, for the pick, pack, and ship and forecasting and all that. So that same next-best alternative modeling that George talked about that we do in PD, we do the same thing in specialty and have those for the base. So you have that. Then you have on top of it all the services that Joe talked about, too.

Final question over here?

Audience Member: Thanks, I guess, for making me final. Kristen Stewart, Deutsche Bank.

Just wondering from a capital allocation and M&A perspective, how do you guys think about just deploying capital? And I guess from the medical side, it seems like you're making a shift there obviously to higher-margin business. How do you think about, from a medical device industry which has clearly been really consolidating, competing against them longer term since they are building a lot of scale and really focusing more on the service line perspective?

You've obviously made a lot of great acquisitions looking more on the solution side and really being more dedicated on making hospitals become more focused on efficient management. But really how do you plan on differentiating against a lot of these medical device companies with really a lot of strength in service lines? And I have one other follow-up.

George Barrett: So let me start with the very basics. I think our general view of having some kind of balance to our capital deployment is important. We really do believe that having a dividend that's noteworthy is an important feature for us.

We invest heavily in technologies that improve our efficiency internally. A lot of our IT investments really are about our ability to work across the enterprise the most efficient way, capturing data on every -- not every customer, but now really doing patient-related data as it relates to things like naviHealth. So we will continue to invest in infrastructure.

I've talked about repurchase as a tool in the arsenal. Acquisitions are really about driving our strategy and so people have asked us it seems like you're doing more in M than in P. Actually the reality is we are going to take it where the opportunity is to drive value, given what we do and what our core strengths are. You find me another Kinray tomorrow, we are all in. It's about finding the right opportunity in the right moment.

As it relates to the medical side and the med device, there is going to be plenty of opportunity. I think we have, as Don defined it, been a pretty early and thoughtful mover about what that's going to look like and it's not all about the device. It's about the episode of care.

We will actually be able to compete effectively and partner effectively with companies out there today. I think we are already differentiating ourselves in some ways. I think we are building tools that are going to be extremely valuable, either for us alone or us in partnership with folks, and so I think we're actually well-positioned on this side of it.

Again, I think we're going to find in medical devices, where there's limited clinical differentiation, the key differentiation is going to be in this ability to help a provider, or whoever's paying for it, manage an episode of care at high quality, low cost, and safely. So I think that's at the heart of it.

We will continue to be thoughtful about capital deployment. There are times where we won't deploy capital and we can create a partnership, CVS Health and Red Oak was a great example. So we will try to be disciplined stewards of your capital.

Mike Kaufmann: I was just going to say to your question on the medical, competing in medical, I think Don described it well earlier around we already are an incredibly large medical device or Med/Surg distribution company. Where I think we will be able to compete very effectively in that space against all the other consolidation is the fact that we are already so broad.

Don mentioned the 360 program. We can out-bundle anybody today, in our opinion, with what we have because we don't have to bundle just one piece. We can bundle, as we said, post-acute, pharma, services, products, so I think we have a multitude of ways to compete very effectively in that space. And it's why I think you will continue to see us deploy capital strategically and culturally and the price is right in the med space.

George Barrett: Again, I think around acquisition it will always be not just is the opportunity attractive intellectually, meaning you can identify a growth dynamic, but A) are we an advantaged donor? And can we execute?

It has to pass those three hurdles, other than the obvious financial hurdles, for us to say we are going to go there. But where we can do, we will and we won't be shy about that.

Audience Member: Is the strategy to continue to have your own products and continue to distribute alongside that?

George Barrett: We will have our own products and we are very likely to be working with other partners, as Don described in Europe on a drug-eluting stent, to fill out the bag in cardiovascular.

So why don't I just wrap us up, if I could, just with this? It's an incredible time in healthcare; you guys know that. We are in a system going through a lot of changes. We will see pressures to do more coordination, more integration, more action out of the acute-care centers.

The hospitals are actually going to be for sick people and many more -- much more of the care will be treated in a post-acute setting and, in many cases, at home. We will see more consumerism. We will see focus on data and evidence-based medicine more and more.

And I think we're going to see more breakthrough drugs, I really do. You know what the pipelines look like and I think they are going to be surprising to all of us. And we even see that in our own research being done here in the community.

We're going to see more partnerships. I think we are probably going to see companies that have made moves in the last couple of years that as they grow value, as their portfolio has gone forward saying, I don't know, maybe everything that I acquired doesn't completely fit. And we will see some more shifting around landscape.

For us, we will continue to focus on making sure we are the best in class and largest in generics. Very important for us. Our specialty business will continue to try to leverage capability, grow that ability to serve both the downstream and upstream, especially at a time where there's more innovation happening in pharmaceuticals than we've seen in many years.

We will continue to follow the continuum of care outside of that acute-care settings and all the way to the home. Manage -- helping to manage post-acute. Providing services to hospitals and health systems that are navigating these very tricky dynamics.

Leveraging our international footprint. We didn't talk about that much today but we are beginning, as Don said, to stand up businesses around the world, particularly on the product side. And I wouldn't mind selling every consumable we have in every market, so we will look at that opportunity.

In general, a really highly-motivated organization here at Cardinal Health that internalizes our work in a very deep sense. Everybody here knows why we are here. It's not just about creating value for shareholders. That's a critical dynamic for us, but we know that we are here to serve patients who're at the end of everything we do.

So I think we have a really deep connection to the work that we do and why we do it and a very disciplined approach to serving you guys and being the stewards of your support.

Thank you all for being here. We appreciated the great questions and look forward to talking with you going forward. Thanks, everybody.