Cardinal Health, Inc. Dublin Day

December 16, 2016 10:00AM Eastern

Sally Curley: Good morning everybody. I'm Sally Curley, for those on the webcast, Senior Vice President Investor Relations. On behalf of the Investor Relations and Cardinal Health Management teams - welcome to our Dublin Day and thank you for joining us here in the room and on the webcast.

Many of you have actually participated in Dublin Day in the past so you know that this is largely a Q&A. We try to keep it as informal as possible, however we started last June with a slight change in our format and that was to take the opportunity when we do these Dublin Days twice a year to highlight some of our smaller businesses, those that you wouldn't necessarily get to hear much about but that we're very excited about. I'll go into today's highlighted business in a moment, but with me here today are Chairman and CEO George Barrett, Chief Financial Officer Mike Kaufmann, Pharma segment CEO Jon Giacomin, and Medical segment CEO Don Casey. We also have the Senior Vice President of our Retail Independent Operation, Steve Lawrence. It is his business that we've chosen to highlight today given some of the questions that we've had from our constituents, you.

Let me just say before I get started that we will be making forward-looking statements; actual results may differ materially. You can find information on risks and uncertainties in our SEC filings in the IR section of our website.

A few additional housekeeping items and a review of the agenda: I will be keeping us on track through the meeting as we're webcasting the event. We will end at 1pm Eastern. For those on the webcast we're seeing slides in the room. You should also have access to the slides on our website. For those in the room, if you do need transportation after the meeting please let one of the IR team members know.

Now, just to cover the agenda, we're going to start with George. George is going to turn it over to Jon for a few remarks to introduce the Pharma segment and to introduce Steve. Steve will cover actually our offerings in the Retail Independent area. At 11:00 Steve is going to leave us and we'll continue with any Q&A on the Pharma segment business. Then at 11:30 we'll take a short 15 minute break for lunch, but I want to note at this point we will pause the webcast and then rejoin it at 11:45 for a working lunch discussion with Don Casey and Mike Kaufmann on the Medical segment and on capital deployment. We tried to build in plenty of time for questions

today. I would encourage those of you listening to the webcast to also feel free to submit your questions as indicated on the webcast link. Hopefully we'll get to everybody's question but if not please feel free as always to reach out to the Investor Relations team if we don't get to your questions.

With that, I'll turn it over to George.

George Barrett: Thanks, Sally. Good morning everyone. Good to see you all, and good morning to those who are not here with us in Dublin, Ohio. So, incredible times and we're going to try to give you a pretty broad pass of Cardinal Health today. As Sally mentioned, obviously we have Mike and Don and Jon here who you guys know, but I'm delighted that Steve is able to join us. There's been so much discussion in the last few months about the Independent Retail space. I'm not sure there's a better expert on Retail Independents than Steve Lawrence so we're glad he's here to join us and you'll get a chance to hear from him.

Let me just share with you, because I'm really here to tee up the day; I have a good role. I want to share with you this is just about two days after the election we had—we do several times a year a strategic planning forum and it's really, it's a relatively good-sized group of about 100 people. Again, we have very small strategy teams that are working quite regularly but this is really a chance for us to bring people in from all over the globe and just to discuss sort of broad direction for the organization and where we're going, make sure we're aligned in our priorities. It's just a great opportunity for us. It was a fascinating moment to do this because it's two days after the election which all of us predicted perfectly, and I started the meeting, I said, "I want to do something. I want to put the basic trends and strategy of the organization up in front of you because we've all been obviously surprised by this outcome that we saw a couple of days ago, and tell me what we should change. What do we change based on this?"

I shared this with them and we talked about increasing global demand and demographics and we talked about payment models and transitions from fee for service to fee for value or outcomes. We talked about healthcare consumerism and how consumers are going to play a role more actively, probably in their own wellness and healthcare; shifts in how care is delivered, where it's delivered and sort of how the integration of that works. We talked about this continued bifurcation between, on the Pharmaceutical side, generics and specialty and what it takes to participate in that, and then finally government's role in this, and increasing role in healthcare. What was

interesting—we'll come to the last one I just mentioned in a second—on every one of the first we all looked at each other and said, "We're on the right side of this." Now, there will be policy as we start to hear more and more from the new Administration; we'll start to feel what that policy looks like. Are we going to see they must behave same way that we did? We'll probably see some shifting, but fundamentally the strategy that we've built, we built before the Affordable Care Act. We basically built it around saying look there are certain inescapable facts about healthcare, particularly here in the United States that we think are going to drive certain kinds of changes and we're going to build our strategy around that, and that's what we did.

I guess what came out as we were talking about this is that we're actually well positioned to continue to thrive in an environment, recognizing that we're going to have to be incredibly nimble and agile to adapt to whatever sort of policy shifts occur, and that comes back to this last piece which is government's role and how this government comes into play.

There are two aspects to this, really. One is government as payor. Clearly we have a Medicaid program. We have a Medicare program. There have been very specific commitments from the Trump camp that they want Medicare to be there; they don't want to touch it. Now, obviously in the policy side of this there'll be some shifting landscape but the government is going to continue to be active. Having said that, we certainly see a government that has a different perspective on where that control should be and how much is pushed to the states and how much is done in Washington, and I think we'll see those kinds of changes, but the federal government is still going to be a large payor in our system.

As a regulator, time will tell how this administration—we've heard a lot of commentary around common sense regulation and making sure that we get that right. We certainly would love to see that happen, but I think we're well positioned. We have an operation that can handle a highly regulated environment. We, as an organization that understands I think where activities are driven by the states and where they're driven at the federal level. So, we'll be like all of you watching carefully to see some of the policy activities. It's been very clear from the incoming Administration that they intend to repeal the Affordable Care Act to reconciliation which, as you guys know, is a budgetary process. What exactly gets repealed, it will be in some ways determined by the parliamentarian who decides what actually is budget and what's not.

But I think having said that, we've also heard very clear messaging from the Administration that they don't want to disturb the system; they don't want people who have insurance now to suddenly be without insurance, so I think there's going to be some real planning. We can talk about that later in the day. I don't want to try to give a whole perspective on that, but happy to answer questions and give my thoughts on that later.

The main point I was trying to make is that I think our basic strategy is really on the right side of where care is going, and I think that's true globally. You have here the people that are leading those activities. I'm excited about our team. I've said this to you guys before, to come up against any organization in any industry, deeply committed, really knowledgeable and able to work across boundaries which I think in a world that we're experiencing today where the lines of demarcation are really blurry, I think we did that reasonably well and we do it with a lot of enthusiasm.

It's been a really exciting last few years. We see the next few years as really exciting times for us. I think we believe that we certainly are uniquely positioned to help the system continue to be a better healthcare system.

With that, I'll turn the mic or the floor over to Jon, who I think is up next. Again, along the way, feel free to ask questions. I can come back to any of those subjects along the way, during lunch, however you want to do that. So, welcome.

Jon Giacomin: Thanks, George. What I thought I would do is just remind everybody of what my responsibilities are. I have responsibility for the pharmaceutical distribution business, the specialty solutions business, nuclear pharmacy services and then also our China business. What I thought I'd do before I introduce Steve is just give you a little bit of an overview, maybe touching a little bit on what George said relative to the environment.

Within the P segment we've been really all about trying to make sure that we're well positioned against what we believe are the key trends in healthcare going forward, and some of those key trends that we've identified that particularly impact the Pharmaceutical segment really are around specialty drugs, the growth in specialty drugs which I don't think is new news to anybody out there, and also a move towards value-based care and ensuring that as our customers navigate through all of that that we're able to support them and really provide them with

scaled solutions that are going to help them be successful, and quite honestly us be successful in that changing environment.

So that's really what we've been about, and as George said I think that sort of transcends everything going on with the election because whether or not you thought it was Hillary Clinton or whether or not it was Donald Trump, it's hard to believe that value-based care isn't going to be here to stay as we think about the sustainability of the healthcare costs in our country. Yes?

Audience Member: Sorry, Jon. Could you give us an example of how you're helping clients on the Pharma Distribution side in a value-based environment?

Jon Giacomin: I will. Can you just hold that? If I don't answer that when I—I'm going to just give you a very brief overview on that and then we're going to get into what I think are probably some very specific examples around that, if you can just hold, please.

What I thought I'd do, to that exact point, is just provide a little bit of an overview on a couple of the businesses and not go deep in all of those areas, but let me start with specialty. Our Specialty Solutions business as we re-entered the business about five or so years ago has seen, I think, some really nice and strong growth. We're seeing that today in our business and honestly, it's led by a number of different factors but let me touch on just a few of those.

On the provider side, we've actually increased sort of our exposure or our coverage relative to the categories that we touch. So, oncology obviously but we also touch now urology, nephrology, rheumatology, and that has been a result of some acquisitions that we've made in this particular area, and so we're seeing some nice benefits from that increased exposure along those lines in those categories.

Additionally I would tell you that technology is a big part of that specialty space, so whether it's practice analytics, whether it's ordering platforms, inventory management and other things that help a practice actually operate more efficiently and effectively, we've been able to leverage technology. I think as we've spoken before, we have an innovation center called Fuse which is down the street here that we've relied quite heavily on relative to consulting with our customers and really coming up with solutions that are customer-driven, and rolling those solutions then

into our existing technologies and in some cases standing up new. So, we're very pleased in terms of what's been going on on the provider side.

The manufacturing side of the business, we have a collection of different services that we offer. We've sort of strung those together as an integrated offer to manufacturers. We're seeing more and more traction relative to those offerings, in particular our hub services offering. We've seen some nice growth in that area and I think manufacturers are showing some considerable interest. So, we're really quite pleased in terms of how that's all come together and the services that we've pulled together there.

On the Pharmaceutical Distribution side of the business, obviously you're all pretty well aware of the environment that we're in and so it's a little bit of a challenging environment we find ourselves in today, but I would say this: the business is executing at a very high level. When you look top to bottom at our metrics, starting with one that's probably most important to our customers which is service level, highest it's ever been within my tenure at Cardinal Health, by far.

Audience Member: How many years?

Jon Giacomin: Fifteen years at Cardinal. We're serving customers incredibly well. I think our Customer Service organization is also pointed very nicely at customers and obviously they're facing a lot of very new and different challenges.

In addition I would tell you as customers are experiencing some of those challenges and some of those pressures, they're open to a lot more discussion around more things that we can do. You've heard us talk before and I know we're going to talk a little bit about it today relative to our Medical segment, and in particular what's going on in our acute space, but I would say those customers are more and more receptive than ever to talking about the full value that Cardinal can bring to them, not just Pharmaceutical Distribution and us delivering product and supply chain management and those sorts of things and wraparound services, but really saying, "Hey Cardinal Health, you're a big organization, a big enterprise. You should be able to deliver value across multiple points," and so as we've talked in the past I think our message is resonating there, and resonating quite well. The way we sort of positioned it and how we've gone to market is really along the lines of we have logistics or

distribution solutions which you're all well aware of; they've been the core of our business really since the beginning. We have product solutions which include all of the various products, brand, generic, home healthcare products, OTC, private label, and then of course a complete swath of products on the Medical side of the business. We have business solutions that can improve revenue, expand margins, lower costs, improve working capital, and then we have patient solutions. So I think a lot of those things now are coming together and resonating with customers as they're looking at taking on challenges across the system and really having to think differently and more holistically than they've had to do in the past.

Relative to a couple of examples, Charles, you asked about can I have an example of where you've seen us apply some of the value-based solutions. I guess I would point to probably one that seems to be gaining the most traction and that's Outcomes MTM. It turns out MTM, Medication Therapy Management, is something that's generally delivered in a retail setting and that's expanding and we'll talk a little bit more about that here in a minute, but what we've also seen though is the need for telepharmacy and people are now thinking very, very differently about the role the pharmacist plays in the delivery of care. It's no longer just show up at your retail pharmacy, someone will dispense the medications to you and go about your business. People are now thinking that telepharmacy in conjunction with pharmacy delivery, obviously in a retail setting, in addition to maybe other tools around adherence and compliance will actually make a difference. So MTM Outcomes is about delivering this medication therapy management service which includes comprehensive medication reviews and also we're looking at other aspects that can be delivered telephonically or face to face. The whole idea and the whole goal here is really to improve patient adherence and compliance. The patient obviously wellness goes higher but then the cost of delivering the care to the patient goes lower.

That's having some nice intersections with points in Don's business, particularly with NaviHealth which I think we talked about six months ago when we had Dublin Day in June. We talked a little bit about NaviHealth. So there's some nice intersections there relative to how NaviHealth is focused on value-based care, taking risk and outcomes as also focusing on that and the combination of the two and maybe some other things actually really can improve the overall care delivery and lower the costs.

George Barrett: You guys know the percentage of readmissions that are associated with medication is quite, quite high. So again, our ability to deliver value both at the retail but also with the institutional level. If there's going to be risk bearing and we can reduce the probability of an adverse event that brings that patient back, MTM is really helpful.

Audience Member: So who's paying for this service? Is it the pharmacy or the provider that's paying to you for that service? Do they get a higher reimbursement as a result from payors?

Jon Giacomin: Generally it's going to be the payor that is paying for these services, although the provider may pay as well, but predominantly it's the payor because the payor sees that an intervention into a particular disease state with a particular patient profile might have a better outcome than if they just let the patient go on and continue with care, maybe not be adherent on their medications, etc., or maybe not actually get counselling or receive counselling relative to their medications and taking them.

George Barrett: This is a place, by the way, where you may see some interesting policy discussion around, what do we actually pay for? If we are paying for things that actually reduce the probability of adverse — or improve health, I think you're going to start to see discussions on these kinds of things and I think that's important. It's important for us but for our customers as well - really, look, if you're a pharmacist you would love to be as people talk about compensated for the cognitive care that you deliver on some level and that's really where we've got to go for if we're really going to do this effectively as a system.

Audience Member: I'm sorry, just to clarify. So this is a standalone business that sells to the payor market?

Jon Giacomin: Yes, it does.

Audience Member: Does it work in conjunction with your Retail Independent arm so that …

Jon Giacomin: Yes, and so we'll talk a little bit about that. I'm going to let Steve touch on that piece. I guess transitioning then, Charles, off what you said maybe a little bit into Retail Independent, as Sally started, the reason why we asked Steve to be here today is because there's been a lot of discussion around the retail independent marketplace, etc., and we thought it would be a good idea to talk to you a little bit about our Retail Independent offering. In particular, about some of the solutions we're talking about here and Steve is going to go into a little bit more depth on that, but also I would tell you with some of these solutions - again along the lines of value-based

care and pay for performance - really about the evolving role of the pharmacist as seen as a provider that is probably underutilized in the delivery of care today doing a lot more in the way of reviewing prescriptions, making sure that the right medications are in the right vial and they get to the right patient. There's a lot more that pharmacists can deliver, so Steve is going to go into that.

I know there's probably a lot of questions around pricing and what's going on in the market, etc. We'll be able to touch on that but really wanted … Go ahead.

George Barrett: Just one thing before we go to Retail because I just want to make sure that everybody knows this. If you look at hospital pharmacy and institutional pharmacy, we're one of the largest clinical pharmacy organizations in the world, so we have—so in many cases we're actually running the hospital pharmacies. In some cases the hospital pharmacies use us, we've got a whole organization. So during the middle of the night there's an adverse event or there's some question on a clinical pharmacy matter, we've got people that are right there, online, sort of navigating that. So actually we're really, really active behind the scenes in areas that you wouldn't necessarily see.

Jon Giacomin: Yes. Effectively we're running 200 hospital pharmacies today. Those are Cardinal employees. We employ roughly 1,000 clinical pharmacists and so ideally we're very well positioned as you think about transitions of care and discharging out of a hospital to really make sure that the appropriate handoffs occur but also that the patient has the right medications as they leave the hospital, know how to take those medications and then the handoffs occur from there.

So with that, I'm going to turn it to Steve, and just to give you just a little bit of background on Steve Lawrence, I think you've spent your entire career in and around 30 some-odd years in and around pharmacy and retail pharmacy, but for the last 13 to 14, we as an organization I think have been very fortunate to have Steve lead our Retail independent sales organization and also at time handling the marketing as well. So, he is that resident expert as we talked about. He's been in and around this space for a considerable amount of time and I think you're going to enjoy hearing from him about our solutions and how they're resonating with this particular customer class. So, Steve, I'll turn it over to you.

Steve Lawrence: Okay. Thank you, Jon. Good morning everybody. Talked a lot about our Retail Independent class of trade. This is really a very important market for us at Cardinal for a lot of reasons but the biggest reason is that they look to us for products and services. We're not just selling pharmaceuticals and out front items to our retail independents. They look to us to provide a lot of services. We're their back office. If you look at the chains in retail, they have a whole back office that takes the administrative burden off the pharmacist to try to allow them to do pharmacy work. That's why our retail independents rely on us and that's the foundation that we've built our whole strategy in the retail independent market around, is we build, either we build or partner with people to provide services to all these customers to allow the pharmacist to get out from behind the counter and spend more time with the patient because that's really where you get the value-based care and that's where the pharmacist really wants to work is touching the patient and not doing administrative stuff. So we do all kinds of things, and I'll go through those as we go through a few slides here.

We'll start with a very important part of our retail strategy is our annual customer meeting. It's really not a meeting for Cardinal; it's really a meeting for our customers and we get quotes and I get letters constantly from our customers that come to our trade show that basically say they get a lot of value from this because it gets them out of their pharmacy. You've got to remember these are small independent business people. When they're in the pharmacy, they are swamped with everything that's going on, trying to take care of the patients and run the business. This gives them two or three or four days a years where they get out of the pharmacy and they're surrounded by 4,000 or 5,000 of their peers and they share all kinds of ideas about how are they making their pharmacy profitable, what are they running into, what roadblocks and how are they getting around them? The biggest thing that they come out of this is they then diversify their pharmacies. So they don't sit back and just fill prescriptions. Your retail independent pharmacies constantly diversify their business. They'll get into things, some get very big into front of store, others get into things like servicing a local nursing home; they get into HME/DME; some get into specialty. There's all kinds of places that they get into. Many of ours recently have partnered with hospitals to take care of their discharges to make sure the readmission rates are as low as possible. So, a lot of those ideas come from them getting out of their pharmacy and coming to our show.

This show has grown into the industry's largest. You can see there we had almost 9,000 people attend this year. We had roughly 5,800 pharmacies represented at this trade show, and again, they get to sit at dinner with many of their peers across the country and they get to share ideas and that's the biggest thing they take away from. We provide them with a lot of education. There's a lot of continuing education there so they can get their full year's CE at the show. Then we also provide them with some great industry speakers, so they get to talk to these people one-on-one; they also get to see our executives. Jon spends a lot of time in this community anyways but this gets them a chance to see everybody on our executive team and George is good enough to be there. He actually played guitar on stage one year and entertained our troops, so they got a lot out of that. But it gets them the time to talk to George and let George talk about the vision that Cardinal has for healthcare in general because they don't hear that a lot. I mean they're in the local community; they really want to know what Cardinal has to say about the direction of healthcare and then they'll understand how we then are taking that direction that we believe healthcare is going, create our services to help them move their business in the right trajection.

From this, I'll move a little bit into our services.

Jon Giacomin: Just one more thing before you go there. What's interesting is we ask for feedback constantly. We do a lot of surveying of our customers about what they need from this type of setting because they're sacrificing a lot, right? You're an individual business owner/operator and you're going out of town someplace for a week. Usually it's difficult to find a substitute so you have to go where there's value. We've been highly sensitive to ensure that they are getting value out of it, so we've done a lot of surveying. If you look at the make up of our show, probably three, four or five years ago, a lot of it was us bringing experts in to talk to them about certain things, and what we've got back from the surveying and just to underscore a little bit of what Steve said is they want to hear from their peers. So a lot the people now on stage are really our customers talking to our customers and their peers and colleagues about best practices that they're seeing. So whether it's in Washington state where provider status has been given for roughly 30 different types of drugs, or it's something else, they're sharing all of that with—and I think what we're seeing is as we sort of adapted our show to make sure that we're in line with where customers see value, our attendance numbers continue to grow, which is really important, obviously, for us to ensure that we continue to deliver value. Sorry, go ahead.

Steve Lawrence: No, that's a great segue. The other thing that comes out of that trade show is a lot of best practices. We collect best practices from around the country. We actually create a magazine and we put those best practice people up on stage and let them tell their story. These can be simple things, like we had one person create a vitamin club for kids where it gave away free vitamins, children's vitamins to kids. Grew his business dramatically. All of a sudden moms started bringing their children in. All of a sudden the whole family's prescriptions went to that pharmacy. It can be little things like that to complete game changers, so best practice is big piece of this.

On our services, we basically take our services into three categories. The first one we'll talk about here is what we call our Retail Advantage. We help our stores maximize their front of store. Retail independent pharmacists went to school and became pharmacists and they love taking care of patients; generally speaking they're not the best business people. Their front of store sometimes depict that. So, we'll go into pharmacies where they've got holes on their shelves; they're just not really focused on it. We bring in retail experts to help them manage that front of store. Our goal is always to expand the growth of their front of store and many of our customers we've coached into actually hiring front end managers on their staff. When they do that we've seen double and triple sales growth in front of store and so that's the real critical component that we provide. Obviously we provide all the products to complete their front of store package from all the OTC's to diabetic supplies to HME/DME products, but the real value that we bring to them is we bring that retail expertise to their store to help teach them how to be a retailer because they know how to be a pharmacist but a lot of times they'll forget about the companion product. Most prescription medications deplete some element in your body and there's all kinds of vitamins that should be taken when you take almost every drug out there. Most pharmacists forget about that, so we provide them the service and the training and the tools to make sure that that is something they talk to about with the patient so that they can maximize the basket when the patient walks out of the store.

So, this is a really important part for us. We have people all around the country that spend their entire day going into our pharmacies, working with their front of stores and what we've tried to do recently over the last two years is not go in and stock their shelves because that doesn't benefit anybody; we're just stocking their shelves and their shelves are going to look really bad when we leave and we come back next month. It's to teach them how to take care of their front of store and run it and maximize their sales in their front of store, and when they do that, like I said, we've seen tremendous growth in the front of store which obviously helps everything in the business.

Our next group of services is around really the back office, the business part of our pharmacy. This is an area where we really spend a lot of time. If you look at the back office of retail pharmacy today, it is very, very complex. With the reimbursement world the way it is, with DIR fees and everything, it is very hard to actually balance your books and understand what you got paid for a claim and understand did you get paid appropriately or did you misbill something, and if you did misbill something how can you rebill that? We spend a lot of time and effort and have a lot of services that run the gamut of the back office for the pharmacy to allow them to not focus on that. We'll look at their data, we'll help them do those things. We'll help them correct billing errors. We'll help them reconcile all their claims and make sure that they're getting the appropriate amount of money, and we'll take all that work off of their shoulders so that, again, we want them out in front of the pharmacy counter talking to patients, taking care of patients, ultimately getting better outcomes.

So this whole group of services runs the gamut and you can see on the slide from inventory management to obviously our managed care. In the managed care area we do a lot around the whole star ratings, which you've probably heard about the star ratings. We have seen a tremendous growth in our network of improvement in star ratings. Some 75% of our customers are over 5-star rated which is the highest rating they can be, which ultimately drives better outcomes for the patients because they're really rated on adherence, compliance and a few key measures based on the disease state of the patient.

George Barrett: I just want to add on this ownership issue just as a side note where we've tried to be really creative and our organization has and our customers have. A high percentage of graduates of pharmacy schools are women. Sixty some-odd percent now, roughly? The percentage of pharmacy owners that are women, very small. So again, we've worked with this group using in a way this meeting as a platform to help women think about how they might turn that professional training into a career as an owner. It's a really exciting opportunity and it in a sense touches so many points that are important to us. I just wanted to share that with you guys.

Steve Lawrence: Yes, we create a whole what we call Women In Pharmacy initiative, and so we have a Facebook page called Women In Pharmacy. We basically set up a peer-to-peer network for women that are in pharmacy so they can reach out to some of their peers to learn. Again, these are independent business people that struggle with things like payroll and HR issues and all kinds of stuff and so we through this network we've created and the

Facebook pages, they can get on there and share things and learn things and basically ultimately be better business people.

Audience Member: How do you get paid for all this?

Steve Lawrence: Well, most of our services have a fee, but one of the things we've learned and I've learned through my career is if you give stuff away for free it has no value and they won't use the service. So these services have a fee. They're market based. They have to provide more value than what the fee is but that's how we get paid for it.

Audience Member: So is this segment of the market more profitable as a result of that for you?

Steve Lawrence: On the services side - we do a lot of services on the hospital side.

Audience Member: In the overall Independent, the Independent side for sure.

Sally Curley: I think with the retail independents – are you profitable?

Steve Lawrence: Yes, I would say so.

Audience Member: Just to clarify, is this business, is this an overlay onto their back office operation or is this like a total outsourcing service?

Steve Lawrence: It's a bit of both.

Audience Member: Do you have like a centralized back office?

Steve Lawrence: It's a bit of both and why I say that is because one of the ways that I think we differentiate ourselves from our competitors is that we really go deep and understand our customers, and we à la carte our services where the customers need. If they need a complete back office outsourced service, we'll do that. If they just need inventory management then we'll do that. So a lot of customers—every retail independent is a different customer and so if you try to take a box to them and say here's what you need, it's not going to work.

Audience Member: Do you see trends moving in one direction? Do you see a trend moving towards total outsourcing?

Steve Lawrence: Not really. Again, they have niches where they understand what they're good at it. We have a lot of customers that are very good at marketing so we don't really need to help them with their marketing. We have some that do great inventory control because some of their pharmacy systems have a good piece of inventory management, some don't. It really is an à la carte and I don't see a trend going either way. I do see a trend of them looking for us for programs for the future and that's where we try to focus is where's pharmacy going over the next five years? Where do we need to start building offers so that we can be your back office of the future? The back office changes.

George Barrett: Again, I'm playing the other side for a second here but I just think it's useful and I've had this conversation with a couple of you before. If you had asked many of us 15 years ago how many of these independent, we'll call them community or independent pharmacies, would exist today, we would have probably picked a much smaller—today the number is, what? About …

Steve Lawrence: About 22,000 or 23,000.

George Barrett: Twenty-three. If you had asked me 15 years ago there's no way I would have come up with that number, so I guess the question, Steve, that might be useful just what do you think we would have all gotten wrong? What's happened?

Steve Lawrence: I think the issue is they're very resilient business people. If you just take it down to the base of everything, they've got kids they've got to put through college. They've got families they've got to feed and they're going to go out and find a way to make money. Whether it be filling a prescription or servicing long-term care or doing immunizations which they didn't do 15 years ago, travel vaccines, they're going to service the population. You also got to look where a lot of these people are. They're in very urban areas or very rural areas. Those are a lot of underserved areas, so in a lot of cases they're also the doctors. I mean a lot of these rural areas the pharmacists are the doctors.

George Barrett: Point of care for everybody.

Steve Lawrence: They're going to the home at midnight to take care of the kid that's got a 102 degree temperature. That's what happens and they get paid for that. They basically own the town. They're the—you look at many of these small towns, they're the mayor, they're everything.

George Barrett: Literally.

Steve Lawrence: I think that's what you miss is they're resilient.

George Barrett: And fair to say that the other thing is that the work that we do and others do, again-

Steve Lawrence: Absolutely.

George Barrett: Have essentially…

Jon Giacomin: Freed them up to do that.

George Barrett: Freed them.

Steve Lawrence: They couldn't, they wouldn't be able to do that without us being the back office, but our back office always has to continue to change also because pharmacy is changing.

Sally Curley: Steve, I think Craig and Steve have questions.

Audience Member: So you describe these services as being à la carte. Is that irrespective of whether they're distribution customers and how much of a distribution customer, or are these services really tied to distribution?

Steve Lawrence: Most of these services are for our distribution customers because we've got sales people going in there and we get to know them very, very well. There are some services like Outcomes MTM that it doesn't matter.

Jon Giacomin: It becomes really hard to support these if you don't have a distribution business underlying it because of exactly what he said. We've got support teams and other things around the customer that will help in either standing these things up, the ongoing running and maintaining of them so it just becomes a little challenging.

I guess one other final point, an exclamation point to put on it, when we were talking about the pharmacist as being the mayor, actually, the relationships they have with their patients/customers is phenomenal and just a very quick story. I'll take you right back to RBC. Steve said we have motivational speakers come in every now and again. Two years ago we had Colin Powell come in and Colin Powell was surprisingly, not surprisingly lives in McLean, Virginia, and we asked him to speak to a group of retail independent pharmacists and honestly he had no idea who he was speaking to. He had to figure out well who is this customer? I don't know who this is. He went to his own hometown in McLean, Virginia and he looked around and said is there one there, and he found the one there. It was in an old building built back in I think the early 1800s. So he was really surprised and shocked because he had—around that there's a Walmart, there's a CVS, there's a Walgreen's, there are a number of different chains including grocery stores, etc. and so he walked in and he spent some time with the owner and the staff. As he was talking to them and asking them about their business he was seeing their patients come in and engage. What he quickly surmised was that their relationships are very tight because as they were walking up to give prescriptions or walking up to ask the pharmacist a question, etc., the pharmacist was very quickly to engage on, "How's your family? Where's Jimmy going? Did the dog—what happened with the dog?" They have made some incredibly personal connections that I think have really helped their business, and so those connections have stood the test of time which has allowed those customers then to keep those customers and even grow their business.

That's a really important aspect I think and a really important differentiator which I believe has kept retail independents around.

George Barrett: And what's really interesting is there's a role for all of these. If you look at what we're experiencing now, which is really challenges with primary care, you're going to see pharmacy, whether—again, changes to pharmacy as well. You're going to see pharmacies play a more active role: nursing and nurse practitioners, so I think these guys play a role in the system and our job is to have enough knowledge and intimacy to know as Steve said, the difference between what that pharmacy needs and that pharmacy needs, and they can be wildly different.

Sally Curley: Let's go to Steve and then Dan.

George Barrett: I don't want to—make sure we talk a little bit on pricing because I know Dan said that …

Sally Curley: Yes.

Audience Member: Maybe I'll get into the numbers then, Steve. A couple of questions. The Red Oak opportunity is obviously important for most of these independents because they can channel that business through one point of contact but given some of the disruptions in the market recently, have you had meaningful re-pricings of your generic basket in those kind of prime vendor traditional clients in the independent awning?

Steve Lawrence: I would say that our pricings—there's a market out there and the market kind of sets the pricing, and we have to price to market and we have to keep our customers to market. They have children to put through college and kids to feed so if we aren't priced at market, they're going to look elsewhere.

There is a little bit of a differentiation when you get deep with them with the services but you can't profitize that customer over and above or else they'll start looking.

Audience Member: Fair to characterize it as it waxes and wanes but you're constantly keeping those clients competitive?

Steve Lawrence: There's ups and downs but you're constantly keeping—you're keeping to market and real time.

Audience Member: Steve, there's no big board where somebody's looking at, "Hey, here's the price of omeprazole," but there is a market out there and people know pricing.

Steve Lawrence: And it's regional too.

Audience Member: Maybe two others that are kind of germane to that whole discussion about these guys finding profit centers. You guys have a specialty presence which you characterize, Jon, as kind of emerging. How many of your independents rely on you for specialty in particular and how many of these independents have kind of put that stake in the ground and said, "I want to be a guy who's servicing MS patients or cancer patients." Is that an important part of your business?

Jon Giacomin: It is. There's a—specialty as you all know is a complex area and if you're a retail independent you're either in it or you're out of it.

Audience Member: Right.

Jon Giacomin: So they rely on us for some products. A rough number would be that we have about 200 pharmacies in our retail independent space that do specialty, and I'm not just talking about the one hep C prescription here or there. They're doing it in a big way, probably 10 million a year plus, and we have some of our independents that do upwards of $100 million in specialty, so they become true large specialty pharmacies. Again, it's a whole separate business they create. They create a specialty pharmacy, they have retail pharmacies, they have long-term care pharmacies and they become a diversified kind of healthcare provider.

Audience Member: So that segment specifically we've seen some disruption, suffice it to say, around access and around various network fees that have reared their head with the independents. How is that impacting your customers in the last six months?

Steve Lawrence: If you look at the specialty market, there's a pie that's retail independents. That pie has never changed from a percentage over the last six or seven years.

Audience Member: Ten percent? Twenty?

Steve Lawrence: It's between 10 and 20. It's somewhere 15, 16% of the market. It has been for many, many years. I don't see that changing. Again, they are resilient. We have a couple that get access to products that we can't get access to. Again, they build that physician/patient relationship that goes beyond the other issues and the pharmacist physician patient will override the PBM, the manufacturer or whatever and will get that product to that pharmacy, if you build that relationship tight enough. We've seen people do it constantly.

So, they get access to those products even though they're not a pharmacy, so you see these limited distributed products that go out to six pharmacies; there's really probably more like 30 pharmacies that get it but six are huge volume, the others are small independents that might have four or five of these scripts in a year but they get it and they get access to it because the doctor demanded it. So, that's where we really see them.

Jon Giacomin: Steve, talk a little bit about how they've got to that point. I mean some of these people have selling organizations and other things that are attached to their pharmacy now.

Steve Lawrence: Again, like I said, they're either in it or they're out of it. If they are in it they have people that—they have marketing people that sell right to the physicians, that live out in the field, that are selling to the physicians, they're recruiting the patients. They have clinical pharmacists on staff that take care of the patients. They have nurses on staff. They do 24 hour call centers because they have to. To cover the drug protocols of these specialty drugs, they have to have these nurses on staff and the clinical pharmacists, and like I said, they create a whole separate business. They become a closed-door specialty pharmacy. They have to basically mail these products that cover—like our largest one covers about 14 states. He's mailing to 14 states and he's covering all these patients. So it's a whole different business than a retail independent pharmacy, so they either get in it or they stay out of it.

George Barrett: We probably have groups that are completely focused on long-term care, right?

Steve Lawrence: Absolutely.

George Barrett: Like they totally specialize. It's really interesting how this—there are these subsets inside the system.

Audience Member: It's just that one seems to be a point of some pressure right now in terms of, frankly, reimbursement and profits. Your clients sound like they're well embedded in specialty, perhaps less affected by some of these access fees and some other things that seem to have been thrown about here in recent quarters.

Steve Lawrence: I think they go under the radar a lot of times and sometimes when, in specialty, being under the radar is a good thing in our customers, especially from a reimbursement rate perspective.

George Barrett: And they're deep with their customers.

Steve Lawrence: Very deep.

Audience Member: Just 340B, how many of your guys participate in 340B?

Steve Lawrence: You know, I don't have the exact number. It's a lot. I mean most—I wouldn't say most but it's probably 30% of our customers do some form of 340B. It just depends on their geography to 340B facilities, if they're close, if they're in the network, that kind of stuff. Again, a lot of our rural stores - they treat it a little bit different. Most of our 340B retail independents are in the urban areas.

Jon Giacomin: That's another example of how they're trying to redefine themselves, go to us or the covered entity and say I could be a contract pharmacy for you and some of them have had some pretty good success in doing it.

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

Audience Member: Thank you.

Audience Member: How differentiated are these services versus your competitors?

Steve Lawrence: Some services that we provide our customers are - everybody has to provide this service, so if you look at a PSAO, we all have to have a PSAO.

Sally Curley: Explain what that is, just to make sure everybody knows.

Steve Lawrence: A Pharmacy Service Administrative Organization, which we basically contract on their behalf with managed care organizations, the PBMs. That way the PBMs don't have to go out and have contracts with 23,000 pharmacies. They can contract with us for 5,500 stores. Some of those are me-too that you have to have, some are differentiated. Like our inventory management is differentiated. A lot of our other—some of our marketing programs—a marketing program by definition is differentiated because it's customized to the pharmacy. So a lot of those—it's a mixed bag. We have a few that you just have to have, they're stalwarts that everybody has to have, but we constantly try to figure out how to create new programs that will differentiate us and I think the biggest part is what I said before, is it's how you go to the customer is how we differentiate ourselves. We don't say you have to have these 10 programs. If you only need two of them then that's what you provide because, again, we're charging a fee for them, so if they're paying us and they're not getting the value for it, they're going to quit paying for it.

Audience Member: So are you gaining share, losing share or steady?

Steve Lawrence: We've been slowly gaining share for the last probably, what, Jon? Six, seven, eight years. It's been-

Jon Giacomin: We've had a couple of key acquisitions along the way.

George Barrett: That's true. That helps.

Jon Giacomin: That helped out tremendously … in a couple of markets where we didn't have a whole lot of exposure, so that's been quite good and the Kinray acquisition...

Steve Lawrence: But if you partner with the right customers, they're growing and so you organically grow share—our customers, our organic growth in this space is really good, it's higher than market. It shows that we are partnering with the right customers that are growing.

George Barrett: Again, I'm going to say this and it ties in a little bit to Steve's question about pricing. Again, these are not dramatic step function movements of share other than through the acquisition. This is sort of just slow growth.

Slow growth, in my view - and Steve, you can tell me if I'm overstating it - is a customer believing that you have an intimacy with their business, their community that will allow them to compete effectively and with their pharmacy and grow their pharmacy. It's not about price. Everybody can match price. Price never moves share. It may for a minute on a product but it never really moves share. Share moves because that pharmacy says I am basically entrusting—they are entrusting a huge amount of what they do to us and so they have to really believe that you get their business and I think that it's all about intimacy.

Audience Member: But George, I mean if you listen to some of the commentary from last quarter, right, it was kind of suggested that you had some participants offering some pretty aggressive pricing and there was the impression that that could actually move some share. Are you saying that…?

George Barrett: We actually said the opposite.

Mike Kaufmann: There was a situation that, as you guys know, that's been out there that someone did lower price in the market and that created some of this market pricing discussion that some of our competitors including ourself have talked about and impacting our earnings, but it's really important to know no share moved.

George Barrett: That's the challenge.

Mike Kaufmann: So it's not-

George Barrett: We can't—by the way, we can't speak to whether or not someone else had a group that shifted. I mean that may have happened but I would say generally speaking much of the activity doesn't really move share if it's in pricing. If it's pricing alone-

Audience Member: But did everyone have to kind of reset to … Did that really kind of reset what the market was and so the market all had to change?

Steve Lawrence: A little but I think loyalty is what moves share in this market and George made an interesting comment there about the community. The biggest thing that I saw as the sales leader when we moved share in the market was when we got our sales people to become more like our customers and get involved with their communities through things like GenerationRx and some of the things that we've done to help the communities; all of a sudden we actually got—we did a lot of work with colleges doing scholarships, we did a lot of work with GenerationRx. All of a sudden we've got customers saying, "You believe in pharmacy at the community level? Then we want to do business with you."

George Barrett: I don't want to dog Charles' observation about pricing. We did experience—I would say during that period there was sort of a reset and the answer is because we need to keep our customers competitive. We can't be in a position where they think we're out of market. So I do think that when you have that kind of flurry I think it does… Again, as Mike said, it doesn't really create value because the share doesn't really move.

Sally Curley: May I ask that we cover the last slide and then Kevin I know has a question and then we can take any other questions, including we've had at least one come through on the web about Red Oak and the sourcing and opportunities so maybe afterwards…Steve, if you can stay to answer those that would great.

Steve Lawrence: Yes, sure thing. Our last slide really is kind of the—it talks a little bit about the future. We spend a lot of time in this saying where is pharmacy going? I personally believe and I think we all believe that community pharmacy, retail pharmacy is going more clinical and so we are building in a lot of services. If you look at, you know, immunizations, travel vaccines, collaborative practice agreements with physicians, those didn't exist before. Jon brought up Washington state. One of our customers was one of the leading pharmacists in Washington state. He now has the ability to diagnose and prescribe minor ailments, has her own clinic in her pharmacy, has

completely changed her pharmacy to basically become a healthcare destination. Now, this is a retail independent pharmacy that now has a collaborative practice agreement with physicians and can diagnose and prescribe. So instead of going to urgent care, the people in her community go to her pharmacy. That's the vision that we have for community pharmacy.

There's things that we've created like diabetes specialized care center, and diabetes is a huge problem. We have education for our customers. We sell them products to sell to diabetics. They become diabetes educators. It transforms their pharmacy from just a place to get your prescription to basically become a healthcare destination and that's what we see our independents, our better ones doing, and I see that going forward. I mean one of the biggest issues I think we have in healthcare is access, yet you have 50-some thousand community pharmacies out there that could be access points for healthcare. So if you take that person in Washington and you said, "We're all consumers of healthcare." When your child gets sick or whatever, if you could go to the local pharmacy and get them diagnosed and prescribed and be out of there in 10 minutes at a much lower cost to the system, it makes total sense. So, we're pushing real hard for provider status, all those kind of things in this whole wellness advantage part of our portfolio of offers.

George Barrett: Again, this is to offer proper balance. You guys all know how important the major chain pharmacies are in the system, so there's—obviously and critical to us—but there is a role here for community pharmacy and they're shaping their own role in a way and it's sort of, it's almost like first responders.

Audience Member: Just a financial question on your business. In the last six or eight years you've added tons of services, you're gaining a little bit of share, partly through acquisitions. In absolute dollars, has retail pharmacy, is it growing in the top line? Is it growing faster on the profit line? I don't need to know the exact but just trend line, what's happened if you were just to P&L that business?

Steve Lawrence: The top line is growing, not just with us but in the market.

Audience Member: So the market is actually growing.

Mike Kaufmann: Compared to some of the other businesses it's growing a little slower as you would look at IMS data by various components-

George Barrett: And scripts.

Mike Kaufmann: We're outgrowing the market there. Again, a lot of that growth, remember is just generic introductions and it takes a brand at $100 down to $10 so that doesn't mean—so from a unit standpoint it's clearly growing as a business and it continues to expand its profitability for us.

Audience Member: So margins keep expanding. I mean is that the trend you expect to see? Are margins—with all these services, is there a way to keep-

Mike Kaufmann: Well obviously we've had, because of this pricing event that we've talked about we've had some margin erosion which is what translated through to what you earlier heard from one of our competitors last quarter and then us with our follow-up is that we did see some margin erosion in that standpoint due to the competitiveness on the generic pricing, but over the long term this has been a margin-growing and a margin dollar-growing business.

Sally Curley: I have three questions from the web, if that's okay. So first is—and they're all on Retail Independent. The first is where there are still large and small pharmacies that we hear can buy generics directly for materially lower cost from what they can buy from Cardinal Health or Red Oak. How can that be true?

Steve Lawrence: Retail Independents have a lot of options when it comes to generics. I don't know many of them can buy direct from the manufacturer but there are smaller organizations, telesales organizations, a lot of the buying groups in the retail independent space have warehouses that we constantly compete against. So to say that they can buy them at dramatically lower prices, again, that's a market. Those prices that they can get from other places come into the market and we adjust to them.

George Barrett: But I would say as a broad answer that's not going to happen. There may be individual product, individual telemarketed in from one company but I would say if you look at the overall it just—that's not a realistic.

Audience Member: You bought a telemarketing firm here a couple of years ago, so how has that changed your interaction with your independents?

Steve Lawrence: It's actually helped us. I mean it's helped us get our share of wallet with our independents from a generic perspective. The way that most wholesalers go to market with generics is a contract with a large number of customers all pay the same price for a product. In today's market in generics, that doesn't work. You need to be more fluid than that, and so it's allowed us to be more fluid. It's allowed us to stay at market. It's allowed us to offer the right pricing at the right time and the right place for the right customers because generic pricing is regional. It's a very complex market and that telemarketing arm has allowed us to go where the market needs to go.

George Barrett: It is a really complex market.

Mike Kaufmann: Yes, I was going to say that one thing, and Steve kind of alluded at it is that telemarketing arm, because they are talking to thousands of independents on a daily, sometimes hourly basis, I believe we have the best market intel of what's actually going on in the marketplace, so besides our feet on the street listening to customers every day and bringing that competitive intel back, we have telemarketers that are all of a sudden they're selling something at $50 a bottle; they seem to be able to get all what they need and then all of a sudden they can't sell a bottle at it and they realize the market has dropped to $40, that information is coming back in a very quick basis to us and then we can determine do we have a pricing problem? Do we have a costing problem? What do we need to do?

Audience Member: Is it a one-off?

Mike Kaufmann: Is it a one-off? Is it somebody just trying to do something and so we shouldn't respond, or do we need to lower price? We use all of that to help us in our market intelligence.

Sally Curley: We've got a three-part question. Here we go.

George Barrett: That sounds like three parts.

Mike Kaufmann: With a sub-part.

Sally Curley: With a sub-part, exactly. How many total independent stores do we serve?

Steve Lawrence: We serve around 10,000.

Sally Curley: What percentage of your independent customers use you exclusively for distribution? Then what are the barriers to switching distributors?

Steve Lawrence: Of the 10,000, it's hard to have an exact number of what percent use us primarily for distribution but it's somewhere around 4,000.

Sally Curley: Then barriers to switching?

Steve Lawrence: It varies depending on the distributor. If a distributor is like us—you know, if you look at our longevity of our customer base, it's 10-plus years because we go deep with these programs. That's why we wanted to talk about these. It's very difficult to take one of our customers and move it because we're embedded in their business. If we run into competitors where the customers are not—the competition isn't embedded into that customer, those are easy for us to move over to our business. So it really depends on how good the provider is that's providing services to them because they need these services. They can't do them themselves and so the deeper that we get into the customers the harder it is to move.

George Barrett: This is true for our competitors. If our competitors do really good job of embedding themselves deeply into a pharmacy then they're smart.

Jon Giacomin: The more value you demonstrate, one quick sort of side note here, back to RBC again. What's funny is those that go to RBC tend to be more loyal customers. We end up selling them more solutions; they're willing to take on more solutions. They take on more of the programs, etc. and the reason is, is because they see value. So if we can get them to RBC where we can actually highlight many of these solutions, they are more inclined to buy and when they buy we're delivering more value and it becomes more difficult to switch. So, I think it's all about value delivery.

George Barrett: But this is a case where—I used to joke that the definition of strategy, Butch Cassidy which is the competitor is looking and somebody looks at it and says, "Who are those? How do they do that?" To me that's one. The other is the customer that says, "I really depend on you." Not like, "I'm stuck with you." Stickiness is a word in some ways I sort of hate because it really is, I depend on you. You know you've got the right strategy when people say, "Who are those guys?" and when your customers say, "I really depend on you."

Sally Curley: So, I have one more on Retail Independents then I'm going to switch the topic here, this one I can handle. Can you provide any color on top line? A rough percentage of top line or margin profile for the Retail Independent versus other customers other than to say that they are our most profitable customer for all of the reasons?

For Jon and Mike, talking about Red Oak. Generic sourcing penetration for your retail pharmacy customers, how much more room do you have to increase?

Jon Giacomin: I don't know that we would get into the specifics in and around that but what I would say is not every customer is buying 100% of their generic needs from us and so all of that represents opportunity. Steve's team, as we talked a little bit about in conjunction with I think really putting together a compelling financial offer in addition to a lot of the solutions is how we're going after that. So I think we have very good intelligence around our customers. We know what they're buying, we know what their needs are, and we know, to Steve's point, we're getting deeper and deeper into their business and able to understand what solutions they have and the whole idea is to create more value and along with solutions also pull through the generics.

George Barrett: Is it reasonable to say—obviously it's a lot more mature than it was, but is it reasonable to say generally on this set of customers, that they're lower penetration than you're going to see in the major chains, right? So there's more…

Jon Giacomin: They're pretty well penetrated.

George Barrett: … that the chains would have a higher …

Mike Kaufmann: I would say it depends because you know with the chains, a lot of the chains that we have will commit to 100% because they can drive compliance to their stores, if the corporate office says you're buying 100% then...

George Barrett: I was talking total penetration.

Mike Kaufmann: Oh, total penetration of-

George Barrett: Generics, yes.

Mike Kaufmann: Oh, generics. Yes, but then I guess chains would be slightly higher but all the work that Steve and the team are doing around our star ratings is we help provide them with reports because that's one of the things you can't allow to happen. Our independents need to look like they're as effective as chains if they want to stay in the networks, which is important, and so our team looks at generic dispensing rates to help those customers and say, "Your dispensing rate is lower than it should be; that's a key driver of star ratings," and we help provide them with the data. "Here's the scripts you missed. Here's where you can do better," so they can drive that penetration. I think we are helping our customers and what helps lower overall healthcare costs.

Sally Curley: We have a couple of more but let's-

Audience Member: Can I follow up? Yes. On the star ratings, right, my understanding is that it's only in the last couple of years that DIR fees have been attached now to star ratings and some of the compliance metrics and I think that has caused some of the uncertainty around what you're going to be faced with in DIR. Can you talk about on the Pharmacy side or can you kind of maybe elaborate on how you guys look at the DIRs in general and how much does it really impact your customers?

Steve Lawrence: It is over the last couple of years the DIRs have come into play in the PBM space. Most of them are tied to their star ratings or a rating that the PBM has of their own—a lot of them are generic dispensing rates because they want to push generic dispensing rates up as high as possible. I think the NCPA Digest says that retail independents are at like 82% and they were trying to push them over 80. So a lot of the DIR fees you don't get hit with them, but they do affect our customers, absolutely. The biggest challenge is how do you reconcile? I mean how do you actually understand what you got paid for that prescription because the DIR fee comes out, it could be 30, 45 days later, so sometimes it could be up to three or four months later actually when they look at the quarter. Some of these are based on quarter results, and so it does affect them, but like Mike said, our job is to constantly understand what the ratings are and so when I talked about our PSAO we're negotiating the contracts with the PBMs so we understand what the DIR fees are based on, and then we actually provide services to our customers to maximize their ability to match it so they don't get hit with DIR fees.

Hopefully, again, when you look at the stickiness of customers and how hard it is to change, our customers are getting less DIR fees pulled from them than others because they're more compliant to whatever the actual PBM's

calculation is. They're not all just star ratings but they vary, and then we build that into our services to look at their data and say, "Here's an opportunity, here's an opportunity and if you make these changes you'll maximize and lower your DIR fees."

Jon Giacomin: It definitely has an impact though because of the uncertainty and there's the amplitude of it.

Audience Member: Is it—it seems like it's become more pronounced in the specialty pharmacy and specialty has really no generics. Do you find that for your customers that have a specialty pharmacy it's being applied across their entire business or it's really applied just to the business where..

Steve Lawrence: The challenge with DIR fees and specialty is they're a percent of the price of prescription. So in a specialty script that's much higher priced, the dollars are bigger, and so that's really what hurts them.

Mike Kaufmann: That's often too why they separate the pharmacy, the specialty pharmacy from the regular pharmacy and all that.

Audience Member: That 30%, have your clients come back to you, Steve, saying, "Boy, we're getting hammered. We need to find some ways to meet these metrics and/or either move away from specialty or find some other profit center," because just broadly speaking I guess our expectation is independent pharmacies have been doing pretty well for a period of time and that may be shifting, that the profit profile of these guys may be a little tighter than it was say, 9, 12 months ago. Is that fair?

Steve Lawrence: Yes, so if you look at, again, the NCPA Digest, if you look at their latest book, the gross profit of retail independent pharmacies actually has ticked up a little bit above—and this is calendar year 2015. It's actually ticked up a little bit above 2014, which is interesting. So, with specialty, the DIR fees are there, but again, there's not a DIR fee on every prescription. It also depends on the mix of your patients, how much are government paid and how much are private pay. The independents have a different mix than your typical large specialty pharmacies so the DIR fees don't hit them quite as much. So, it's more complicated. I wouldn't just say that the overall market.

Audience Member: Are your customers are facing a huge headwind there that…

Steve Lawrence: No, we're not seeing it.

George Barrett: Yes, I think it's a really interesting distinction between those who are like singly focused on specialty pharmacy and so it's more a direct frontal hit. This is a part, a subset of a mix of things that they do.

Steve Lawrence: If you look over the history of reimbursement rates and you look at retail independents, you know, if specialty comes under a little bit of attack, they'll grow their long-term care business or they'll grow their retail business. When that moves, long-term care reimbursements will move, then they'll grow another part of their business, and that's why they want to diversify. If you're just a retail pharmacy sitting on the corner competing with Walgreens or CVS, you're challenged and we know that. So our best customers have long-term care, they have a specialty, they have an HME/DME business that's not really part of their retail independent but they own it all and so they diversified and that way as healthcare reimbursements change, their portfolios will diversify to handle that.

Audience Member: We haven't even asked about DME. I'd be very interested in those 10,000 customers. What kind of pull-through have you gotten from Don's business with the home health opportunity in the last two years?

Steve Lawrence: So there's a lot of crossover between his business and our business when you come to front of store, especially in the HME/DME space. We have a lot of customers that, again, they're retail independent pharmacy but they own an HME/DME distributor. Don's business services a lot of those customers, a good majority of them. So there's a lot of crossover.

George Barrett: Like at RBC we have a booth right?

Jon Giacomin: We have a booth there.

Audience Member: Independents, but of those 10,000, have 500 added DME in the last two years? A couple hundred?

Steve Lawrence: If I had to say it would probably be more—it would probably be closer to your 500 than it would be the 100.

Mike Kaufmann: Steve, this wouldn't be them like changing a store and putting in walkers and chairs and all this.

Steve Lawrence: The advantage the retail independents have again is their geography. So one of the problems with HME/DME is competitive bidding and a lot of them in their geographies the competitive bidding isn't there. So if you look at these rural areas they are growing in HME/DME because there isn't a provider anywhere near.

Audience Member: But just to be clear, not a lot of—I think the storefront DME business is contracting still, is that fair?

Steve Lawrence: Yes.

Audience Member: From Bill's Drug to home.

Sally Curley: This is their independent medical business.

Jon Giacomin: Actually Bill's doesn't even do it. It comes from us on behalf of Bill's.

Sally Curley: Chris?

Audience Member: You mentioned buying groups. Can you just talk a little bit about the role there and what kind of customers are using them and how and just kind of what that looks like and whether it's changed significantly in the last few years?

Steve Lawrence: Yes, buying groups have been in the retail independent space for as long as I can remember. Our mix is probably 50/50 buying group and non-buying group. There's not a particular profile of person that's in a buying group or out of a buying group. I would say that the more diversified a customer gets and the larger they get, the more they tend to go out of a buying group. A buying group is going to benefit a small store because of the size. Most of them want everybody to get a similar price and so a really small store is going to benefit from it. So you do—if you had to have any kind of a profile you would say you're smaller stores tend to be in buying groups. That's not always the case but it probably is the majority. But as we see customers get more sophisticated, they tend to go out of buying groups, but they've been around for a long time. We have great relationships with them. We probably have more buying group relationships than about anybody but, you know, we know them and they've been around for a long time. They're like half our business and so it's real important to us.

Audience Member: GDR fees, have they changed from like a flat dollar amount?

Steve Lawrence: There's a mix. It depends on the PBM. Some are percentages, some are flat dollars. Purely on the contract.

Audience Member: Can there be benefits to your independent customers if their GDR is higher than say an overall average of PDP plan?

Steve Lawrence: They're not just generic dispensing rates; it's other categories. Like on the 5-star rating, if they're 5-star they benefit from it. They don't get the DIR fees, they get a lower DIR fee than if they're not a 5-star rating.

George Barrett: I assume that's very specialized to the contract, right?

Steve Lawrence: Absolutely.

George Barrett: Each of these contracts are very distinct.

Audience Member: Then you own the PSAO, right?

Steve Lawrence: Correct. The way we do it though is we have a board of our customers, so that no Cardinal employee is a member of, that we basically negotiate a contract as good as we think we can get it and we present it to that board and that board says thumbs up or thumbs down. Our customers actually say they want it or they don't want it. So we'll negotiate as much as we can; if they turn it down we'll go back to the PBM and say, "They turned it down. Is there anything else we can do?" and we'll keep negotiating if possible. So we don't actually say yes or no, it's our customers.

Audience Member: Do you think more PBMs in the future will get how their calculating DIR fees?

Steve Lawrence: You know, PBMs like anything else are under pressure to grow and we constantly see that they're going to—they get more aggressive to our lower reimbursement rates. So George has said it, across all of healthcare there's always pressure on reimbursement rates.

George Barrett: I think you need to put DIR fees, it's just a component of reimbursement.

Steve Lawrence: A component of reimbursement.

George Barrett: So you could do away with them tomorrow but if reimbursement, it's just another tool for managing reimbursement.

Audience Member: Maybe a more general reimbursement question. There's this kind of assumption several years ago that independents benefited within retail networks because the PBMs wanted to have these extra access, so they were beating up on the big guys and there's a halo effect around sort of the retail independents. Has that dynamic changed? As they've kind of had more pressure, is that—are they kind of coming down harder on the independents now?

Steve Lawrence: The benefit that retail independents bring a network is the rural stores, in a lot of cases. So if you're building a network you need some retail independents and so that's really the benefit they bring. Outside of that they're just like anybody else. It's tough. I mean they have narrow networks that they get shut out of. They have narrow networks that they get into, but the big benefit that they bring overall, if you look at the entire market, retail independents are needed in a network because of rural stores. So, some will partner with ours, some will partner with others.

George Barrett: But they have probably debated whether they got a halo, right?

Steve Lawrence: They would say there's no halo. Because I mean they lose to mail order, they lose to narrow networks, they lose—it's tough for them and it's like—but it's not any different than, it's the same for the chains. It's a retail—this is really a retail pharmacy phenomenon. I wouldn't say retail independents benefit or don't benefit other than the rural areas.

George Barrett: Or underserved.

Steve Lawrence: Or underserved.

George Barrett: I mean I think there's some very unique needs in terms of network design when you think about making sure you've got coverage and I think a lot of these guys offer that full balance.

Sally Curley: There's actually a question from the web that's a little bit of a follow-up to that so I want to go to it. What is the demographic profile EG age of customers of our retail independents, the retail pharmacy customers? Then secondly, a clarification: did you say that our customers are located in urban locations in addition to rural?

Steve Lawrence: Yes, so if you look at the demographics of the customers in our retail independents, or not just ours but all retail independents, it is an older population, it's also a sicker population. A lot of it is because they need more attention and more attention to care. The retail independent will come out from behind the counter and they'll take care of them, and they'll do other things that are necessary. Some of it is just where they're located also.

I did say that retail independents, if you look at them, you're not going to find them in Dublin, Ohio. You're going to find them in Downtown Columbus or you're going to find them out in Delaware, Ohio, out in the rural areas. So they are in the urban areas. You look at New York City, it's full of—any of your large populations, L.A., Miami, New York City, Chicago, they're full of retail independents in the urban areas because some of that is underserved. There are truly pharmacy deserts in some of these urban areas and so you do see them there and you do see them in the rural areas. That's pretty much where they're located.

Jon Giacomin: And does line up by ethnicity. Ethnicity in New York City is very big, and Hispanic.

Steve Lawrence: We've seen more move in retail independent ethnic pharmacies over the last probably five years than I've ever seen.

Mike Kaufmann: They can speak the language. They carry up front merchandise and the cultural need

Steve Lawrence: We have some Korean pharmacies that actually don't speak English so we have Korean sales people that go into those stores and they service that population, and you see the same thing with some other ethnic populations.

Sally Curley: I just want to give a time check for everyone. We've got about 10 minutes. Steve has been kind enough to keep going, if you're able to keep going for another 10 minutes?

Steve Lawrence: Sure.

Sally Curley: We'll just keep you on to the break. There are two questions that have come through on the webcast. For those that asked them on the webcast, I just want to let you know, we'll actually pick that up after the break, so I want to keep going on the Retail Independent side while we've got Steve here still.

Audience Member: A policy question, kind of back to George's introductory commentary. The new Secretary of Health and Human Services has perhaps a different perspective, presuming he's in fact approved, and has a legacy of kind of focus on certain issues, one of which I think in concert with Rep. Carter down in Georgia, is the independent pharmacy. They've been very adamant about full disclosure, about provider status. I mean as a practical matter, are these issues that you're hearing from your customers now where the national independents are lobbying around some of the changes coming, or is that just sort of pie in the sky, we'll see if it happens?

Steve Lawrence: Our independents are lobbying around a lot of those. Provider status is a huge one. Any provider actually has been a huge benefit to retail independents and a lot in the specialty area. A lot of our retail independents have pulled a provider card in some of the states and been able to get access to some of these products. So, they have a very large lobbying arm with NCPA and I would say even APHA lobbies a lot for the retail independents around provider status, but the associations, they lobby hard. I mean DIR fees, it's your constant things that you'd read about in the press. Whether the incoming administration will be more favorable or not, I go back to George and Jon's comment is it's really about outcomes and what we focus with our retail independents is how do you get better outcomes? That's why some of the sicker people sometimes go to the retail independents because they'll focus on diabetics and some of these people and they'll get better outcomes and they'll prove it.

George Barrett: I will add this political aspect to it. Community pharmacy punches above its weight in Washington. They'll probably punch even higher above its weight, but this is not just healthcare. It's not just a discussion about healthcare; it's a discussion about small business.

Audience Member: If you think about drug pricing in general, right, how much does sort of the actions, I think just part of looking at generic price collusion, this idea of collusion in drug pricing. How do you think that affects you? Then secondly, if the Administration, depending on the comments of President-elect Trump is talking about wants to do

something like drug pricing, outside of rewriting legislation to let CMS negotiate, what other—what would happen like if they changed let's say the protected classes, or eliminated some of them?

George Barrett: I'm going to suggest if we could—I will not avoid that question. I just want to make sure while we have Steve, because I want to make sure we come back to that—if there's any more that's specific to the retail independents, and then I'll make sure that I—because this is sort of a broader subject that touches us.

Sally Curley: Go ahead, Andrew.

George Barrett: I'll come back to you.

Audience Member: For your most embedded customers, are those people coming to you through a GPO or not? Is the top of the funnel for people like that, the purchasing organization, your PSAO or some other thing that leads them to Cardinal? The guy that you're describing, are they like sort of model customers that are...

Steve Lawrence: There's a mix. Our most embedded customers, some are in GPOs, some are not. It's really—now, if you're talking about customer acquisitions?

Audience Member: Yes.

Steve Lawrence: It's typically we're acquiring them in a direct manner because if they were in the GPO we would already be embedded with them and when they come to us with that many services, typically they're going past the GPO services and we're basically bringing them in in a direct manner. But our currently heavily embedded customers, it's a mix. Some are in GPOs and some—we don't really try to steer them. If they feel like they can get benefit from GPO they should do that. We're still going to provide the services that we need to provide to them, embed ourself deeply into them. That way sometimes through the GPO we've got the relationship with the customer, we're still in good standing.

Audience Member: That's actually my sort of follow-on question to that. Do you see any changes in the stability of the GPO organizations whereas for whatever reasons, either yours that are under contract or others are gaining or losing meaningful numbers of members?

Steve Lawrence: There is some consolidation going on in the GPO space, so some of the smaller GPOs have consolidated with some of the larger. We've seen that over the last two or three years, but I wouldn't say that there's any meaningful shift between the GPOs. In our case we have longstanding, long-term relationships and contracts with those GPOs so I think we're in a good space right now with our GPO partners, but I haven't seen huge shifts from one GPO to another, but I have seen consolidation. We didn't see that before.

Audience Member: But no numbers?

Jon Giacomin: Membership is not dropping off.

Steve Lawrence: Nothing different than the normal. I mean members move so if that happens, but I haven't seen any dramatic shifts lately.

Audience Member: Okay, thank you.

George Barrett: Sal, would you like us to … it's about 11:30. So the question is do you want us to grab food and then I'll come back and touch on Charles' question or do you want us to do that now? Tell me what's better for you.

Sally Curley: Why don't we—can we do three quick questions and then break. Then we'll break for the webcast and then come back? Maybe if you want to start with Charles' question and then jump on the other two.

George Barrett: I'll do my best, yes. Let me start and then Mike—we've got a bunch of people close to it in various ways. It's hard for us to comment on. We've seen basically exactly what you've seen, the public announcement. In terms of the implications and effect of that. Here's what we had said.

We started to see and we have been very public about that, generic pricing reverting more back to typical patterns for quite some time. I don't know how many quarters but for a while now. So I don't really see this changing. I mean I don't see—again, forgetting about whether or not this affects any individual company or an executive, that's a completely separate question I wouldn't comment on. But in terms of the pattern of what's going on in a general way, the system prices, I would not expect to see this. We've already seen some more reversion back to typical pattern.

Frankly, you will always see some price increases, right? It's just—and I think it's necessary, having sat on the other side. You have to do this at times but I think we'll see more typical patterns. That's what we've been seeing and we've commented on that.

As it relates to the broader question about—this is a hard one to answer—on pharma pricing and the policy tools and the discussion and the rhetoric. I'll do the best I can.

Obviously it's been a subject that's gotten tremendous attention. The policy options are tricky, as you know, and some of the policy solutions would be really I don't think very good for America, honestly. I mean in price controls, we know what the impact of price controls can be generally: distortions and hoarding and shortages and I think that there's a lot of economic data that that's a troubling outcome.

Reimportation has its own really complex problems if you thought about that as a tool. We have the most secure, stable supply chain in the world, the United States. There's almost no counterfeiting, unless you're sort of messing around through the Internet. So I don't think from what we've heard there's a lot of draw to that as a solution. Having said that, I think pharma companies have done some—as you know, some have been very public about some commitments. I do think we'll see some, I'm going to call voluntary moderation. We're already seeing that and we've commented on that. So I think it's possible that it's not so much a clear policy solution. It is the market behaving like a market. Competition, various kinds of pressures that influence the way people price.

I would also say given if we're committed to curing disease, we're probably going to continue to see some price increases because I think they're necessary, but I think we've seen moderation, we've commented on that, and I think that's largely been self-regulated, and some companies that have been very explicit about that, and that wouldn't surprise me if that's a pattern.

I don't know if that's helpful. It's just really hard to comment on this because we're really early stages in terms of this Administrations executing on some of the commentary, but I wouldn't be surprised to see again.

Audience Member: There were these state AGs, I think there were 20 of them in this lawsuit that came up this week. They sued on behalf of their state Medicaid programs, presumably. Are there other parties that would be

potentially including independent drug stores, wholesalers? Pile on, follow on who are participants in some claim for damages?

George Barrett: Yes, I mean we've seen that before. That's a good question. We've got one of our legal people here but that's a good question. I don't know the answer but it's not unusual when there is an activity that there's the periphery starts to watch and see, see how they can participate in that. So, it's certainly possible.

Sally Curley: A further website questions and then we're going to go ahead and to break. Do you expect further pricing headwinds on renewals? We talked about the market resetting and so I think this question, I'm going to talk about customer contract.

Mike Kaufmann: You know, as Steve mentioned early on, generics are priced at market on daily basis and so we raise and lower prices and they are not necessarily a fixed contract. The rebates we may have with a customer are fixed but the invoice prices change on a daily basis. So I don't see that what we're seeing in the increased competitiveness that we saw over the last couple of quarters, and again, what we translated into a takedown for our earning guidance for the year and the impact of it really affecting the rest of our renewals because again we've already had to keep all of our customers competitive and so I don't see that having a big effect against other renewals. Those we still continue to believe that the repricings that we see on a yearly basis are always a headwind, have always been a headwind. We don't see those being any different than we've seen historically.

Sally Curley: The second question is CVS has recently highlighted 40 million script losses to Walgreens. Are those 40 million losses also losses for you?

Mike Kaufmann: A couple of things to think about on those losses. I don't think they all went to Walgreens, which I think is important. Some of those losses have gone to other customers of ours. That's one piece of it. Also, it was 40 million scripts was what they talked about. A large portion of those scripts are going to be generics. As you know, generics are 85% of the scripts anyways out there, so a large portion of those are going to be generics of which we don't sell CVS all of their generics. We buy all of them through Red Oak, or we—Red Oak has the purchasing power of all of the generics of CVS and Cardinal, but CVS still buys their generics direct into their warehouses as we do, a portion of them, so all the scripts related to those, again, have no impact on us as far as

downstream volume. Now, the impact on Red Oak would be so miniscule, so if you net that against all the wins and increases in Red Oak with Target, OmniCare, our wins, etc. over the last couple of years, Red Oak is much bigger than it was when we formed.

To summarize in few ways, the script loss to Red Oak won't de-lever Red Oak; it will be small. The scripts lost, a lot of them will not affect Cardinal or will move to Cardinal customers, and bottom line, they were all contemplated when we set guidance the last time. We already kind of generally knew about those wins and losses and they were already contemplated in our numbers.

Sally Curley:So, we're just about 11:35. We are going to pause the webcast. We're going to—for those in the room, lunch is served right outside. We'll come back in about 10 minutes, so 11:45, and do a working lunch. Steve, thank you very much for being here today, and George, Mike, Jon, Don and the rest of the IR team will be here and we can pick up where we left off.

Mike Kaufmann:Yes, and let's make sure that we keep the questions off for 10 minutes because we want to go back—we don't want to be public and non-public, so let's keep it, have some lunch and then we'll come back.

Sally Curley: Excellent. So, thank you. For the webcast, we'll join you at about 11:45am Eastern.

(BREAK)

Sally Curley: I think we're live back on the webcast. For those on the webcast, welcome. Bear with us if you hear us unwrapping the sandwiches, etc., on the live webcast, but I think what we'll try do is—Jon Giacomin is certainly still here, but what I'd like to try to do is actually hand it over Don to just make a few comments, update folks on the Medical segment progress, Cordis, NaviHealth, some of other businesses there, and then we can go straight into Q&A on Medical. Certainly, if there's anything on the Pharmaceutical side that we haven't covered, we can always come back to it with Jon—and then, Mike, I think maybe you wanted to make a couple of comments beyond just capital deployment and different thoughts there. So, Don?

Don Casey: Good, Sally. Thank you for feeding people here, so I'm anticipating that prevents any serious questions as we go through. On the Medical side, we've been pretty consistent about talking about a journey that we've gone on and it really reflects changes in the acute care space, and all after what Jon said, I feel like today, by focusing on our customer needs, both at the enterprise level, Cardinal is more relevant when you start talking about the Pharmaceutical side, as well as the Medical side, and then as you get into the Medical side of the business, we really feel that we've been changing how we look at serving the customer, so that we've gone well beyond a classic straight-forward distribution company.

If you just step back, so much of what we've talked about today with Steve Lawrence is a lot about scale, how do we bring scaled solutions to our customers, and that's what we're doing in the acute space, almost if the journey and the parallels—because the fortunate thing at Cardinal, we get to touch the healthcare business in so many different places, and not too many people are linking independent pharmacies and hospitals, but if you think about Dublin Lutheran, which is literally right down the road, you can almost see it from here, that used to be a hospital, and then hospitals begat multiple hospitals, so it became changed, and then, okay, what are we going to do, we might need to buy our physicians, get into urgent care, and begin to move beyond just the four walls of a hospital, and then you saw fee-for-value. So, you really saw just a very dynamic market in the acute care space over the last 10 years, and really accelerated over the last five, where they have a different set of problems, and what we've been doing on the Medical side is really trying to focus aggressively on what are these customers' needs. We kind of box it up into like three or four kind of major opportunities to grow.

The first is sit there and say, “Okay, what are their pain points?” A lot of them are saying, product. We would like to put as much pressure on getting and availing ourselves of the best product pricing, whether that’s on commodity-oriented items or physician-preference items. As such, we’ve had to grow strategies designed to meet that, the first being very strong expansion of our commodity play. We, today, believe we are at parity with the market, if not better, in terms of offering a broad range of what you would call medical commodities. If you actually look at the technical definition, there’s about a thousand categories that would show up as a GHX definition of what goes into distribution. We’re in over 90% of those categories, where either we source or make that today, which puts us in a very competitive position.

The second is physician preference and we’ve talked about—if you look at certain categories, where you have a high physician preference category, where there may not be that much clinical differentiation anymore, that you see IP kind of moving away, intellectual property, and you see it, increasingly, the material management side of the institution involved in making that decision, we think that there’s an opportunity in several categories. We’ve identified three over time, and I’ll talk in depth about one and we can answer questions about it, but if you look interventional cardiology, as an example, we had purchased AccessClosure and we have purchased Cordis, with the idea that we believe looking at that space, you know, drug-eluting stents, kind of south of that—what I mean by “south,” less technical—we believe there’s a combination of services, products and, basically, analytics that go along with that, that would allow us to compete differently than how the market has competed in the past. We bought these assets and we’ve gone—I think people have seen deals, like Biosensors, where we’ve now created kind of a different R&D model, which is we’re not going to spend huge on the R, as George always goes “the big R”—I can’t quite do an R, I can do an O. But, we’re really focused on availing ourselves of partners who have invested in technology in the spaces that are relevant to us and take advantage of what is now a very compelling and complete global sales force. So, whether it’s Tryton, whether it’s Mared, whether it’s others, you see Kaneka and others—not Mared, Merrill—where we’ve been able to basically build out our interventional cardiology bag and be very competitive on a global basis. So, let’s think about products, both high and low.

Then, the second area, you say, how do we serve the continuum of care, because it's no longer about just how do you serve a patient and hospital, and that's where our Cardinal Health at Home business came. We've now owned that business for a little over three years and we're more excited about that business today than we were when we acquired it. It's really given us a broad look at how not only do we service the hospital by helping them follow the patients out—you know, Steve here needs a hip or a knee and he goes home and is going to need a slew of medical products, we believe we can service that, and our Edgepark and Independence business offers us two different ways of getting that done. That business continues to show growth on both the top line and bottom line, and we are excited about the prospects as we move forward, because we believe the home is going to be a very important place.

The last kind of big swath is, as our customers really kind of wrestle around with how do they participate in fee-for-value, a lot of this is going to be looking at bundles. So, whether that's a payor looking at patients being discharged through a Medicare Advantage program or whether that's a hospital serving as a convener and looking at a bundle, they're really beginning to look at the continuum of what that bundle and where the costs are, and in a lot of cases those costs are in post-acute care. Our Navi product, NaviHealth, which is a company we've owned for probably about 15 months, is really a scaled benefit here for them, because we can help them manage that post-acute risk. So, basically, what Navi does—and Clay was here six months ago and talked about it—it'll sit there and say, "We'll take a patient. We'll profile that against all the discharges we have and we'll have the algorithm," and then say, "This person should go to a SNP, this person should go to an ERF, this person should go to LTAC. Dave gets to home. Andrew, you get to go to augmented home." We basically do that. We've made two acquisitions to really boost the capabilities in there. We bought a company, Curaspan, which is a work flow management tool that gives additional capabilities to Navi, and we bought a company, RightCare, which really soups up our health risk assessment when combined with Navi.

The interesting topic, as we get through, we believe that we are really competing at the acute level very effectively, because we're offering a much broader range of products that we've ever launched, that made available. We can follow the patient across the care continuum, whether that's serving at home, something I highlighted, but we think we're very effective going into surgery centers and other alternate sites of care, and then we believe we can help them take risks.

So, that, in kind of a nutshell, is where we are and what we're doing. We feel that, that offer has been validated in the marketplace when you see a win like a Kaiser, but we've had other people that we've brought in to—it's not let's get into exactly what accounts we're winning or losing, but we feel that we've won more business this year than we've had in the past by a long shot, and we're excited about where we are. We're excited about competing. We're excited to be able to put forward results that we're pretty proud of, and George is always nice to acknowledge he's got a good team here. We've put together a pretty terrific team on the Medical side, as well.

George Barrett: So, just maybe a little bit of additional color. If you remember back to our last New York Analyst Day, Don sort of laid out the evolution of the components of these business, right, and you could sort of layer in the traditional, let's say, historical legacy Medical Surgical commodity business, that was primarily branded Medical Surgical, and then whatever, and a little surgical kitting. So, if you look at that model and what sort of emerged from out of that Allegiance American Supply tradition, that's primarily what that business looked like, and as Don said, over time, that business—the profit flow in that business has shrunk, but through other components, products, services, post-acute, PPI, etc., that we're going to be growing out. What's been interesting, I would say, for us, too, over the last six/nine months, is that that business that we're saying has come down—and it's certainly very competitive—we're actually seeing sort of a little bit of a resurgence in that business, growth in that business, in addition to seeing these other components which are high-priority avenues of growth for us in our Medical segment, and that's been sort of interesting. I think, as we've studied it, I think what it's really been about is our customers are becoming much more complex with greater needs, and they're looking for solutions, and the more that that discussion becomes a big solution, "How can we help you, not just on a line of business?" "How can we help you compete in this world?" it seems to be benefiting the overall portfolio.

Don Casey: Just to build on that, it's a virtual cycle. It's like you get scale on some of these solutions, you win more distribution, you win more distribution, and then you have a very tight relationship that you can bring product and services in. The other thing I would just add, George, to that is they're not talking about—when you go into an acute care setting, they're not talking to Medical anymore, they want to talk to Cardinal, which is another opportunity. Jon and I spend a ton of time now together, because so many of our customers who sit there might have started as a P customer that's now an M customer or an M customer that's now a P customer. Two-and-a-half years ago, we executed an enterprise selling approach in the acute care space that represents both M&P,

because we have to look across the enterprise to provide solutions. So, when you talk about medication therapy management, and that might be a pharmacy, well, you—one of the things that we talk about is like NaviHealth can go in and sit there and say, "Dave may be home, as he has been discharged, but he tends to be poly-pharmaceutical, where there might be eight or nine prescriptions, which is actually a risk profile to bring him back on a readmission and actually managing the pharmaceuticals in addition to the other care becomes really important," and that's an example of where we think we have a pretty compelling offering.

Audience Member: What percentage of your customers are you going in at the enterprise level?

Don Casey: If you were to look at our top hundred, Charles—again, we serve literally thousands of customers. If you kind of look at the top hundred, it's probably more than half we have a relationship on what we would refer to as both sides of the house. It is our intent, though, in 100% of our accounts to go in at the …

Jon Giacomin: It's the enterprise.

Don Casey: We always pitch, and then, being the ever-practical people we are, if they want to do Pharmaceutical first, that's great, and then it's up to us to build off that relationship. It's been very interesting. Jon, you've got—I'm coming up on five years, so I've got five years of experience, but cumulatively here, we probably have—I hate to say it—close to 60 years, but we're probably doing more enterprise pitching today. Not everybody wants to buy it as an enterprise, but the point being is if you're a hospital CEO today, you're in a whole different bailiwick than you were five years ago. They actually want to hear the plethora of things that we can bring to them and "Can you integrate it?" because sometimes their system isn't integrated.

George Barrett: There are going to be moments, and we're finding this, where even someone who's sort of only a customer and a very small line of products with us wants to talk about the direction of where things are going. Those are conversations we'd rather have. That's a good place for us to be. Because, if we're listening carefully, and we try to, and I think we're pretty intimate again here, as we're trying to understand where our customers are gone, we usually have some ideas, probably can create value that they haven't necessarily thought about. So, once we get into those conversations, I think we have a lot of tools that are intriguing to these kinds of customers.

Sally Curley: Will you touch on—there's a question from the web that I want to give you, but will you also touch on—because we've gotten a lot of questions about the Affordable Care Act, repeal and replace or repeal and delay, volume, utilization, just you're in the thick of it, what are you seeing out there—and, George, maybe you can …

George Barrett: Yes.

Don Casey: Yes, sure. I'm going to echo what George said. I mean, literally, our strategy for the last five—close to five years has been we bring scaled solutions to the acute care space to allow then to deliver better patient care at better prices—at better value, not better prices, better value. Whether the Affordable Care Act is in place or not, there's not too many hospitals that are not looking to provide, you know, a more comprehensive set of care at better prices. So, we believe we're fully aligned with them.

Now, look, are the hospitals asking questions about how they're going to be reimbursed and what are some specific angles about the Affordable Care Act? Absolutely. But on a strategic level, on a strategic level, we don't see the emphasis in the acute care space moving off to "Oh, great, the Affordable Care Act doesn't exist anymore. We want to make sure that we take what we pay for products up 15%." That's just not going to happen.

George Barrett: Yes, I think the direction—I was just at a meeting this week, which was sort of a cross-sector meeting, and to a person, the answer on the question of pay-for-value, directionally, I don't think you can put the horse back in the barn on that. Whether or not some of the impetus coming—for example, could CMS or CMMI be different in terms of less mandatory things, for example. So, we could see some like subtle policy changes, but directionally, Don hit it. I think this is going to happen both in the commercial sector and from the public sector. It'll be implemented in different ways, there's no question, but I think the general direction. But, having said that, we will still live in a combo world of fee-for service, and if you can't do both, you have to be able to live in both worlds and I think we'll be in that.

Audience Member: Just specific to, say, NaviHealth, which has been a huge driver for you in recent quarters, with all the noise around revoke and the demonstration projects, hip and knees, I think most people assume will continue, but

now they've thrown out CABG and some other procedures. Any signal from those customers that they're backing off implementation of some of the NaviHealth products or some of the services?

Don Casey: Well, if you actually pull back, Steve, again, I think it's going to take a while for people to get fully educated as to what Navi is. Navi's got two components. It's got a BPCI bundled component which will be aimed directly at the hospitals. Are a couple of people scratching their heads and saying, "What does this mean?" Yes, but by the way they're saying, "What does it mean?" but BPCI, as part of the Affordable Care Act, isn't going to be up for renewal for another 18 months, so they're basically looking at that and saying, "Is this an opportunity for us to do it?"

There's also a large MA component, Medicare Advantage component to the business, which, again, depending on which way the payment reforms go, if you start seeing more people sign up into, say, the Medicare Advantage arena, we believe that we are very, very well positioned to take advantage of that.

To build on George's last point, the commercial payors have been doing bundling for a while. So, if it's not a CMMI-led bundling payment, you know, whether it's a comprehensive joint replacement, whether it's CABG or other stuff, you're still seeing the commercial payors look for the bundling, so it lets them compete on a more competitive basis.

The other thing that we have done on the Navi side, with the acquisitions of Curaspan and RightCare, we've also built into this a work flow management tool that not only facilitates the efficiency of the bundles, but it also creates a different way for Navi to engage in the hospitals. Basically, the Curaspan tool is an opportunity to—think of it as a work flow management augmentation, where, Steve, I guess we were discharging you from the hospital—if you were being discharged from Hospital A, B or C, it automates the process of "Mr. Slaughter is going to be coming out to this hospital, from this hospital to this SNF," and it actually automates that process. So, that's now a service that Navi begins to bring into the process. You can either do that as an augment, where you're going to use the algorithms and just do as a work flow management. So, we believe that Navi's position in the marketplace, in terms of not only managing post-acute discharge spending, but actually managing the process, we've really built a pretty compelling engine.

George Barrett: I'd like to just add to this, because you mentioned it's had a big impact on us. Economically, it's been a relatively small impact on our business, but I think the impact in terms of positioning has been bigger. I think Don's exactly right, I think Med Advantage will be on.

Sally Curley: Don, just to drill down a little bit further on that, there's a question—two questions, actually, from the web with bundling. So, with bundling gaining steam, how have the different areas of post-discharge care changed, ERF, home, SNF; and then the second piece of that is what percentage of patients do you recommend for home healthcare and has that dynamic changed?

Don Casey: Well, first, I think we're in the very early innings of how we're actually going to see a much more analytically driven post-acute discharge process. So, I'd say it's early innings. I don't think the tide has really shifted to the point where you're going say there's been a huge difference. If you were going to look at that as a pie and say SNFs represented 18% of the business—this is totally hypothetically numbers—it now all of a sudden represents 15%. Post-acute discharge across the entire continuum of care is a multi-billion-billion-dollar business and I think it's going to take a little while before we see changes.

However, what we do see is that there has been a tendency where we've been able to analytically focus on a particular market or particular set of surgeries and post-acute discharge, that there tends to be kind of a knee-jerk reflex on the part of some of the physicians to sit there and say, "Let's push this person …" If this doctor has had great experiences with ERFs or this one with LTACs, they tend to follow that almost as habit, as opposed to a more careful assessment, as to based on this patient's history and based on a cost benefit, where they would go. Look, I think I would speak for almost every patient that's ever been discharged. They want to be discharged all the way to the home. They would rather be discharged there. So, what Navi does is actually built on millions of discharges analytically say, "The chances for this person to get the best outcome in terms of length of stay and quality of outcome, they should be looking at this level of discharge." What we tend to see is you tend to see people discharged to the right place. Over time, we expect that to begin to impact the macro numbers, and over time, I think the most cost-efficient place, in most cases, to serve these patients is going to be at the home. It just becomes a question as to, clinically, what is the most appropriate place to put these people.

George Barrett: We have been able to demonstrate through our data—again, this is that sort of big data virtuous cycle, which is the more clinical data you have, the more effectively your predictive modeling is working. But, we're able to demonstrate reduced readmissions, reduced costs and higher functionality for the patient. So, I think we're building—I always say this. I have to qualify it by saying it's still a relatively small business, but the capability is enormously important, and we hope to exploit that capability.

Audience Member: How good is the—I understand that you're saying with NaviHealth you understand what is the best care setting for that patient go get into. How good is the data right now within a channel of care setting; within, let's say, "This patient should go to a skilled nursing?" How good is the data to understand which of the skilled nursing providers is actually going to give you the best outcome or the best value for the costs? Because, some might be just keeping them the full length of stay or …

Don Casey: Yes, it's really relative. It almost depends geographically, over time, how much data we have there. On a national basis, we can certainly say, "This is the place to go." We're not at the position today where we go in with our customers and say, "We would recommend this SNF versus that SNF," but the data—to George's point, the big data we have certainly is letting us begin to do that, and we'll have to evaluate when and if that service becomes appropriate.

Mike Kaufmann: When you say we have a huge head start on anybody else with the amount of data, we keep getting bigger every single day, which is kind of an advantage for us.

Don Casey: Absolutely, Mike. It's a network effect, though. I mean, the more data you get the better your data is, the more data you get the better your data is.

Audience Member: With all that big data, and based on average patient population, is there an optimal mix that you would say were sent to SNFs versus ERFs, LTAC, home health?

Don Casey: No, it's—we can roll the whole thing up and we can say there may be overutilization at some end of the spectrum in a specific condition of care, but, by and large, this is an individual thing. You would be individually profiled. You might be an 80-year-old woman who was on—she's diabetic, hypertensive and on eight prescriptions, and might not have a—from a social setting, she might be—if she was discharged home, there

might not be anybody there to receive her or might not be there to be able to get the ride back into the doctor, so that would all be factored into the algorithm that said, “She may be best served going to a SNF.”

George Barrett: It’s an interesting question though, and it’s not really what we’re doing right now, but it is—what we’re now doing is to say, for an individual, based on people with like characteristics it’s the optimal side of care. But, it’s an interesting question that you’re asking. If you get enough data, might start telling you, as an example, we are sending too many people to SNFs or the long-term cares or too many people home. We’re probably not—that’s not the way we’re using the data right now. I suppose at some point we may have enough to actually start to see some patterns that have policy implications. But I think today we’re really focused on like characteristics clinically and not individuals. But, it’s a really interesting question.

Audience Member: Has Kaiser expressed any interest in that product, given their fairly sophisticated ACO?

Don Casey: We have a relationship with Kaiser.

Audience Member: So, banned in Northern and Southern California?

George Barrett: Probably no. But totally respectable.

Audience Member: As a kind of market where service providers look to thought leaders, are there opportunities for you to leverage that? I hear what you’re saying, George, it may not be a huge revenue contributor but are there places where you’ve got centers of excellence that have had successes with that software and this combined entity, I guess, with these two tuck-ins, that you can actually do referrals and you can put people in contact with each other for the purposes of kind of spreading that word?

Don Casey: Well, first, we do have a thought leadership program around that that we’ve been publishing. Clay Richards and others, have been relatively public in terms of what we think we can do. The interesting dynamic, and this—I think Jon said this really well. Our challenge with Navi is every single one of our hospital relationships wants to talk to Navi. I mean, there’s not enough humans in Navi to get to almost meet the demand. I think George said it really well. It’s not necessarily that we expect every one of our hospital partners to move into a BPCI bundle where we may be a convener, but they want to talk about it, they want to understand. Some of those conversations lead directly to a financial relationship. Some, it’s an advisory relationship that’s important to our

overall strategic relationship. But, it certainly has been important to us, as we begin to try and having more global conversation about what we can do to help you navigate an increasingly complex healthcare world.

Sally Curley: Don, there's a question from the Internet, from the web … Can you quantify the savings that NaviHealth has been able to save for customers?

Don Casey: It really ranges by what the relationship is with the customer and how much risk, but it's significant. We've kind of stayed away, Sally, from ever specifically quantifying that, but we have an extremely high renewal rate of people that we've been doing business with Navi over time, and our partners have saved a significant amount of money, to the point where—I can almost inversely tell you, like, we might have had one person not sign up across all the hospitals or the MA relationships. We've had an extremely high rate of renewal.

George Barrett: Again, this is population-specific, but generally speaking, our ability to both reduce costs and reduce readmissions.

Don Casey: Yes, and like I said, I mean, it's really—a lot of this is going to stay driven.

Sally Curley: So, just raising it to the level—and keeping with the webcast question—raising it to the level of the Medical segment, there's two financial questions. The first is what percentage of cost of goods in Medical is now Cardinal Health brands? The second is are you comfortable that the Med segment EBIT margin can improve over time? Why hasn't it improved more given the layering on of Cordis' high-teens EBIT margins?

Mike Kaufmann: I can help on the first one. We don't actually do it as a percentage of cost of goods, but as a percentage of segment gross profit, our sales would be in the mid-20s, and as a percentage of our earnings in that section, it's going to be in the high 30s. Our goal is to be around 45% is what we have stated publicly, and we're well on our way there to be able to achieve that.

Don Casey: Then, the margin expansion question, specifically in 2013, we laid out a 5.75 goal as an aspirational target, which we continue to keep as an aspirational target. The interesting dynamic that Sally actually mentioned, as we have brought things like Cordis on and the expansion of products, we've actually winning more distribution, which tends to be a little bit dilutive to the margin expansion. So, when you bring on a customer the size of Cordis …excuse me, Kaiser—some hard C that lives in California—when you bring on somebody like a Kaiser—and

we've won other business that's significant, that does put some downward pressure on the aggregate margin of the business if you rate, but again, once you bring these people on, we expect to be able to begin to monetize that relationship by bringing the product and service bundles. So, we continue to believe that this business will be margin accretive. We will be focusing on margin-accretive activity for a long time.

Audience Member: That 5.75, is it still realistic now with the different business mix?

Don Casey: Yes, we had said we wanted to get there kind of—the run rate going out this year, next year, probably not going to hit it this year, next year, given—again, we've won a considerable amount of business, but, yes, we do think it's realistic over time.

George Barrett: I think there are things that contribute to it. It's always so mix-sensitive. I think, generally speaking, you would—I think you'd find that the things that we're doing to grow margin rate, we're still doing. We've had this slightly unexpected uptick in lower margin parts of the distribution business, but when Don brings …

Mike Kaufmann: It's good, uptick.

George Barrett: Yes, I know, actually, and by the way—this is such an important point to make and I probably should have said it upfront. We treasure our distribution businesses. I mean, what we have now is balance. But, those distribution businesses, as Don often likes to say, and Jon says, they're the pipes into the system. So, we're getting more efficient at that every day. We're really good at this. Our service rates are extremely high across our business. It creates touch points and relevance to those customers; they need us every day. So, we think those are really important businesses. They are, by definition, lower margin rate businesses, and so when they grow they're going to distort the picture. But, when Don adds a new product in to that Cordis bag, again, just that kind of thing that expands margin. So, we're sort of always doing things that are directed at expanding those margins, but on a mix basis, will be affected, just the way—it's more dramatic in Pharma when you pick up an Optum, for example, but it still can happen in Med.

Don Casey: Yes, the exact same thing in Pharma; they did pick up Optum as we picked up Kaiser, big business.

Audience Member: Don, when you look at interventional cardiology now and then you think about what percentage of the kit you're able to deliver, and you hear from the larger device manufacturers, you know, they're bundling their

products, as well, how often do you run into a situation where a provider, you know, they have to break open two different kits and then you could have issues like wastage? Earlier more so than …

Don Casey: You know, that's actually changed a little bit, Charles. Where we actually see that business going is they're beginning to ask for more custom kitting, so it's less that "Hey look, I'm going to have an XYZ bundle come in and an ABC bundle come, I'm going to take the best of both." We actually have a large custom procedure kitting business that, again, we're starting to see good pickup on the Cordis side, where, "Hey look, we want a base bundle," if you will. "We want to basically have everything we need to do the opening, the closures, and then if we want to use somebody's drug-eluting stent or we want to have somebody's X, Y or Z," they actually pull that separately and do it off more of a base kit. But, yes, if they were purchasing two different bundles that had overlap, that's wastage.

One of the things that I'll tell you that did, probably inordinately excited about, which—it's just because we're optimistic about a lot of stuff—this CIMS program, Cardinal Health Inventory Management System, which is our RFID program that we've begun to put forward—and it's actually made the most progress in the U.S. right now in the interventional cardiology lab. The amount of product that is either wasted, Charles, to your exact point, we think is between 5% and 10%. The amount of product that is expired might be between zero and 5%. That's just a tremendous cost that this RFID program effectively eliminates. Then, if you begin to look at the cost associated with managing consignment inventory, and other things, you begin to see the value of something like this inventory management program. We've had excellent pickup, particularly in some of the larger academic medical centers that are beginning to recognize that the way that they've been managing inventory is not sustainable. You can't get 42 FedEx boxes going up in what they refer to as the Pro Shop every day and having to order the inventory management program - there is a challenge.

Audience Member: Is it the idea that the device manufacturers, in order to protect some of their product portfolio, might try to bundle it together themselves? If a provider wants custom kitting, do they go to the—they go to you and say, "We want this base kit," and then they have negotiate separately with the kit manufacturers specifically what they need?

Don Casey: I think you might benefit from thinking about the bundle as more financial than physical.

Audience Member: Okay.

Don Casey: Sure, they'll look to protect the landscape by saying, "Hey, we can represent 60/70% of the procedure if you use our guidewires, our catheters, our closure devices, our drug-eluting stent." What we've seen, there's some accounts that have purchased that way, they're looking to see what the bundle is, but the accounts have gotten pretty sophisticated, because, over time, you might have seen some of the device manufacturers loss lead in one area to protect another area. The level of sophistication the accounts have today, have really sat there and said, "Well, if somebody is going to offer me this price on this, you know, the drug-eluting stent, but the accessories are going to be this price, maybe I should bid that separately." So, it really depends on how the account approaches the procurement angle of that, but they've gotten very sharp.

Audience Member: I guess the follow-up is what percent of accounts you say clients are that sophisticated now, to be able to say, "Hey, we're going to look at each of the pieces, because we really need to drive value here?

Don Casey: I think it would be easier to say not, you know. I'd say, you know, in excess of 70% are sophisticated enough to really think through that.

George Barrett: Again, I think the customers, largely, are sophisticated. Now, they may conclude that, whether it's a bundle from a particular device manufacturer or from Cardinal Health, which is product and services, it's an economic model they're looking at. Ultimately, they still have to ask the fundamental question, "Are the products and the services valuable?" If I had to say what's one of the directions that we'll continue to see, which is that data is going to matter, right? I mean, what is clinically valuable and cost-effective? That probably was less in everybody's eye, in a way, 10 years ago. I think that's a healthy thing for us, as consumers. So, we'll continue to see bundling as a financial tool, but with sophisticated buyers.

Audience Member: You touched on the bundling and hips and knees and the like. You guys are a little bit ahead of that kind of opportunity. What's the next opportunity that might be—part of the med-tech industry that might be commoditized, in your idea, for lack of – using your words, not mine.

Don Casey: I think there's a lot of categories that you could take a hard look at. Categories that we like and we're participating in—like, negative pressure wound, we made a small acquisition and we're making some incremental

progress there. It's not showing up yet, because it's small. Some of the bets we're making back. But look, the big three and four categories, these are not areas that we are committing to go and participate in, but if you look ex-US at places like the UK that have begun to look at things like a drug-eluting stent, and they've kind of said a drug-eluting stent is – them and Germany, they've kind of said the same thing. They're beginning to see ortho, they're beginning to see areas like cardiac rhythm management where they see some interchangeability. You might see interventional radiology ex-US. In the U.S., those categories haven't necessarily—you haven't seen the same move yet there.

George Barrett: Yes, I mean, I think I'd add to this, you know, the word "commoditized" is always tricky, because it has other implications that—I would say this, there are—again, the data is going to be important. So, I think there are going to be categories where the clinical differentiation just is not clear. I think, where sophisticated systems are looking at that, or government payors around the world, then you'll see the dynamic around competition a little bit different, versus where they're going to say, "Look, this really is clinically different than that and it has value to the patient," and the decision-making will be done strictly by clinicians, versus something where the clinicians have collectively said, "There's not a lot of difference," and then it's possible the decision-making may move to a different manner and maybe in a different place than it has been. So, we have to just stay close to that.

Don Casey: You almost need to look at it as a continuum in terms of—and we look at it as almost a tipping point as to—and the evolution toward that tipping point. In the beginning, there was complete physician preference, and there's still going to be categories where it's going to be all about 100% physician preference. Over time, you know—and orthopedics is a very good example where they talk about it. You've seen kind of a merger, where the physician is given a part of the decision and the material manager is showing up and saying, "Hey, do we need this many trauma people, this many spine people, this many orthopedic people?" and then you see some stuff where—like, traditionally, where we are, you know, where a shoe cover is not necessarily going to be a physician preference item, so that's what falls into distribution, where the material managers can make 100% of the decision. You could almost draw a heat map in terms of where those categories are in their mind. There are some categories, I think, particularly about really new innovation that are going to be almost completely physician preference driven.

George Barrett: I think if you drew a chart of …

Audience Member: You won't compete in any of those?

George Barrett: No.

Audience Member:Even internationally, with the footprint you have with Cordis?

Don Casey: I think what you're seeing, Steve, internationally is that the Cordis footprint we have will allow somebody who has developed a new technology to take advantage of our commercial engine, but it's not something—we're not going go invest in the R&D to go do that.

Audience Member: A tuck-in?

Don Casey: Yes, but …

George Barrett: That's actually a really important distinction. We may be the commercializing and sell in these areas where physicians are very active. The likelihood that we're going to be doing heavy R on that is very low. That's not really going to be our model. But, one way to think about this, if you drew it out, is that the line is going to change over time, and that's actually what happened in the drug world, and that's even with an AB rating system. There was still for many years, and some of you know this, resistance, right, and then over time it just became understood. Now, it's trickier because there's not an AB rating system. It means that it'll happen more gradually than the way it did in generic drugs, where it just popped.

Audience Member: You guys have a really meaningful commercial distribution presence in cardiology by virtue of the Cordis transaction. Should we think of that as, "Okay, we're going to take three years or five years, we're going to move through the TSAs, we're going to get this where we want it, and then we'll think about …" pick another therapeutic category. I'm not going to pick one, but we talked about orthopedics here a minute ago. Or should we think about you as actively thinking, "Geez, there may be another platform play and another disease state that would be a good use of capital, to put that to work."?

Don Casey: I think, Steve, we believe in a broad position preference strategy. We've made the progress in interventional cardiology. I think, if you want to look at that over the next three to five—again, I'm just echoing what George says. We're not going to spend a ton on R&D, but we're active. We just did Tryton, as an example, which is a bifurcated stent. That's a great example for us, which is a little bit more sophisticated than what we do. It actually gives us a reason to go in and talk to the doctor, it was something new, but then present the entire value. So, I think that the Biosensors, as an ex-US platform, is another good example of that, and we will continue to look to refresh and expand that bag, but we think there are other categories. Again, there's a number of physician-preference items that we think we could bring our product, analytics and service to. We're going to do that based on bandwidth, based on opportunity, and based on opportunities to do with partners.

Mike Kaufmann: The other thing I would just say to add to that is, if part of your question is have we absorbed Cordis enough that we could do something else, and that the timing is—the answer to that is yes. I think Don and his team have done an excellent job across the corporate entity, and everybody working together, to get that where we wanted it to be. So, we have both the balance sheet firepower and the internal capabilities, that if the right asset came along that was the right culture, right fit, right price, we could do it. So, we're constantly looking for those types of things to expand our capabilities.

George Barrett: Yes, and it's a great add, which is that we look at them as broadly parallel, as activities, but six months ago, we would not have tried to do it. We really needed to execute on Cordis. It's a heavy lift. There's a lot of global things that we needed to do. So, we're always conscious of that, as well as both the strategy element, Steve, and we need to execute on this, and to do something where you can't execute, it's just not going to be where we are. We'll try to make sure we're disciplined about it.

Sally Curley: About half-a-dozen from the web, if I can jump in here. One, Don, very specifically, how big of a headwind is the medical device tax and what might be the benefit if it is repealed? Just as a reminder, we've had a one-year free tax year.

Mike Kaufmann: Well, the medical device tax repeal is really already baked into all of the numbers and guidance we've given for the year, so at this point in time our expectation is that it's probably—I mean, at least the way we're

looking at it is it's probably permanently repealed. Now, that may change and then that would adjust our thought processes going forward, but at this time that is kind of already in our numbers.

Sally Curley: Yes, and the last—this is from the web—the last historical, you know, commentary that we made, when it actually was in place, it was somewhere between 5 million and 15 million a year pretty small. Now, that was a different footprint a couple of years ago.

Mike Kaufmann: Yes, correct.

Sally Curley: The question is probably more suited for Mike and for George, although, any of you please chime in. Corporate tax reforms, impact on us? Thoughts?

George Barrett: Well, just as a starting point, you guys know what our corporate tax rate is, right? We've been in the 36 range. So, certainly, we would look to see a reduced corporate tax, and we'd probably love to see our territorial tax, if we could have our way. Mike, what do you want to add to it?

Mike Kaufmann: I'd say the only thing I would say, again, it's way too early to tell because there's a lot of different proposals out there, but the vast majority of those proposals, you know, have corporate tax rates between 15% and 25%. Obviously, as currently a 36%, roughly, payer, that's going to be a net gain to us, compared to maybe some of our competitors who are already maybe a little bit lower for different reasons in their mix. The only offset, I would say, that could be that is out there is the importation taxes. Because, we do manufacture our gloves, our drapes and gowns, and some of our kits outside of the country, in Mexico, Thailand, Dominican Republic, etc., there could be some offset, depending on that portion of the tax regulations that if that were to go into place could offset some of the gains there. The other piece that somewhat people talk about a little bit as LIFO. Again, I think there's a lot of people that would be affected, particularly small businesses that would be highly impacted by LIFO, but if they did, it doesn't really affect our rate, it's just a catch-up from a cash flow standpoint, which is something, again, that we can handle. So, again, I'd say net, probably net net, probably a win for us, but a little too early to tell.

George Barrett: I just should add, the import thing is getting an enormous pushback.

Mike Kaufmann: Yes.

Audience Member: Does it change how you think about capital planning long term? If we had—let's just say we had a 15% corporate income tax codified in law in two years, do you think about, not to turn this into a Carrier discussion, but is there a change in how you do that type of planning?

Mike Kaufmann: I think it would be unrealistic to say there wouldn't be, right? I mean, with that type of a tax rate differential, you would look at some of your tax planning and capital deployment ideas a little bit differently, but with that would be exactly and how we would look at it and what it would mean, it's just so hard to tell right now, but I think you would have to take it into account.

George Barrett: Yes, and then I'd say, generally speaking, we've been—our deployment, our manufacturing strategy, has really been driven on strategic value, you know, literally how we best position and compete. We'll watch all these tax proposals to see whether or not any of them suggest that we should be doing anything differently. Certainly, as it relates to capital deployment, if suddenly we get this significant change, we would want to look at it. But, you know, we've tried to make sure that we keep our eye on the ball here, which is how do we most effectively create value for shareholders. So, it's driven really all over it.

Sally Curley: Here's another one for you. Mike, you might want to chime in. So, what percentage of your overall revenues is self-manufacturing products versus sourcing; and then how does commodities impact that?

Mike Kaufmann: Commodity costs.

Sally Curley:Commodity costs, yes, exactly.

Don Casey:Yes, yes. Commodities have actually been kind of quiet for the last, you know, 18 months, 24 months, we haven't seen big movements commodity-wise. Then, on the self-manufactured percentage side, we typically don't talk about that, and it also flexes a heck of a lot, because one of the things—and, Steve, it almost goes to your question—is we're always making a decision about whether you source or manufacture, and that will literally move depending on where we see the efficiencies in the system. So, we tend to look at that as not a target that we have mind that we want to be this much self-manufacturing. It's more we're trying to look at our aggregate cost of product to make available to a customer, and we'll make a buy decision based on that.

George Barrett: It is nice to have the capability to make in a lot of categories, and particularly when we can bolt things on, but it gives us the optionality. There are times where it's more efficient for us to actually source.

Sally Curley: A couple of questions now more for Jon, in general, so back to Pharma a little bit. One is IMS data indicates that total script, total adjusted script growth was 1.9%. In your view, what do you expect from overall script growth in 2017?

Jon Giacomin: I think that's an interesting question. It strikes me as there's a lot of moving pieces and parts now, given the fact that you're staring at ACA, repeal, replace, what's the impact? I think that's unclear at the moment, so I'm not sure what that ultimately means. The other aspect of it though is the demographics and the continued people getting older, 10,000 a day turning age 65, and presumably they're consuming more healthcare, more prescriptions, and they're living longer, so it's hard to say. I guess, you know, all things being equal, maybe it stays about the same, but I think the ACA and the repeal and replace, and what pieces and parts of that go away, I think are going to be interesting to see the overall dynamic.

George Barrett: Yes, I mean, for us—I'd like to comment on a couple things, on the ACA volume and then I'm going to comment more on the prescription. We said, and we have said consistently, that we were not really able—we were never able to discern an increase in volume to us from the ACA, which actually makes a lot of sense, because many of the at-risk patients that had no coverage were coming through the system through the ER, and they were touching us in some point. So, the absence of that, also, for us, we couldn't even measure it, and I'm not sure it's discernible or meaningful, and I don't think those people are coming off the system in the short term, and we know that.

I think the question about scripts is really interesting and I would just offer the following. It is, logically, sort of improbable that we're not going to see—and we're not seeing—increased demand. Our population is aging in an unprecedented way. We know for certain that that aging population consumes more healthcare and needs more healthcare. So, it's been interesting to watch the prescription data and the utilization, really choppy. Prescription is a little smoother, but that's partly because—I think IMS has been doing this for such a long time, actually, as a platform for doing this. Medical data has been unbelievably hard to get and it's been unbelievably choppy. My observation again, this is not based absolutely on perfect data, is that all the increment benefit design is distorting

those data, but you cannot—if you look over, let's say a five-year period, it is almost incomprehensible that we're not going to see increased demand, and you can call that your knees, hips, prescriptions, products for cardiovascular disease, diabetes, etc., etc. That is just pure demographics at work.

So, I think what we've been seeing, and it's probably been true for, I'm going to say, a couple of years, it's just choppiness as the system experiments with benefit design and consumers start to behave differently. So, it will depend on what happens to benefit design. For example, if part of the replace bill—this is complete speculation—had something that limited out-of-pocket expense you'd suddenly see this differently, right? You'd see the more normalized pattern. So, I think we just have to be aware that there are some policy issues—and that's not just from the government, it's from commercial payors—that are probably have been distorting or causing some choppiness.

Audience Member: Maybe a corollary question off of the potential for an ACA repeal. If there's a slow bleed in those lives, or 11 million or so non-Medicaid lives, and your hospital customers as a result see a meaningful uptick in uncompensated care, do you have something baked into your numbers to reflect that, maybe, on the med-surg side in particular?

George Barrett: We don't, we don't. I would have a hard time believing, given the mix of our business, that this would be material, and we wouldn't even know—honestly, we just wouldn't even know how to model it. So, I think the assumption is there's nothing built into it. That would be probably one of the things that you'd watch for, which is our hospitals feeling suddenly an increase in uncompensated care.

I think, just for clarity, as I'm spending time on the Hill the last few weeks, there is a very clear message from a lot of stakeholders saying, "Okay, repeal it is what you need to do, but recognize that if you don't acknowledge the following five things, you're going to have some distortions that are hurtful," and I think that that is understood.

Don Casey: Just to build on that point, Steve, if you actually go back pre-ACA—we got the ACA and there was supposed to be a surge in med-surg demand, if you will, associated with that because also some hospitals are …

Audience Member: But the hospital balance sheets were, arguably, much healthier under that scenario than they may be going forward. Is that a fair statement?

Don Casey: It is a fair statement, but it hasn't necessarily affected the amount of demand. So, what their financial statement looks like is different, but the actual amount of care they're delivering is not. So, are you seeing slight, in some cases, hospitals look a little healthier because they're being compensated for that? Absolutely. But, the absolute amount of demand is going to be reflected on population than it is on anything.

George Barrett: That word that you just expressed is being communicated.

Audience Member: What about generic deflation? What are you seeing now in terms of that trend since the last time we've spoken?

George Barrett: So, again, we can't give an update from our last quarter, but again, I think we gave some numbers at that point which …

Sally Curley: We gave our guidance.

Mike Kaufmann: Well, we talked about—remember at the beginning of the year, we talked about the total bucket of generic deflation being in the mid-single-digits, net deflation. Remember that that bucket includes several things. It includes the actual inflation and deflation you get from the manufacturer, the actual price increases and decreases you get from the manufacturer. It also includes our selling price inflation and deflation to our customers, and so that is all netted into that net, that number. So, back at the Q1 earnings, we said that that number was mid-single-digits down, was our projection, and we changed it to be mid-single to high-single down, which is really the difference between the two, not because of the manufacturer portion of the up and down increases—that, we seem to have predicted so far pretty well. It's been more this competitive sell price issue that we talked about very early in the conversation and have spent a lot of time on, that's really what drove it from mid-singles to mid to high.

Sally Curley: I have two questions from the web. One, I don't think we're going to be able to answer, but I'm going to ask it anyway just to get it out there. Can you estimate what percentage of generic c-cell CDS? We've seen street estimates of 10% to 15%. Is that the right ballpark? We can't really …

Mike Kaufmann: We can't speak—yes, disclose that specific.

Sally Curley: Customer contracts, so … Here's a broader level, or higher level, broader question. Can you discuss the evolution of value-based care from a private market approach, such as new programs like UNH's expanded joint bundling program, and how Cardinal Health thinks about attacking some of these free market based opportunities?

George Barrett: Don, do you want to start?

Don Casey: Yes, I'll go first. You know, it's interesting. With all the conversation about the ACA—and CJR is the best example of where there was a government sponsored bundle. We had seen in the commercial market a move toward bundling in a lot of cases where you would see people appeal to a large employer and saying, "We're going to look at these three or four areas, and disease state management," or something, but there were bundles around that. We had seen that. I mean, again, I've been doing this for a long time and we started seeing that 10 years ago. Actually, unfortunately, if any of you guys are old enough to remember the original managed care organizations, like US Healthcare, I mean, they were actually doing bundles all the way back then, back in the HMO days. But specifically, how we've looked at this across the board, whether it was a government or whether it was a private payor, is almost the same, which is, "Look, if you assume there's going to be a bundle and there's going to be a product component, a labor component and a post-acute discharge component to it, we believe that we want to assemble the assets, whether it's a product or service, so that we can offer best-in-class pieces, that we could be really relevant in the bundle," and that's what we've been doing for the last five years.

Again, the conversations we're having increasingly with commercial payors, a lot of whom we know because of our Cardinal Health at Home business, among other things, we're very relevant to them in those conversations. I would say, Sally,that we've seen a lot more of those in the last two or three and we expect that to continue.

George Barrett: I'd a little—just a little historical context to this. BMMI, a lot of what they're doing in their early days was taking what they were seeing and experimentation in the commercial market, and looking at that and trying to weave sort of a best-in-class best practices around what they had already seen started to emerge in the commercial market. So, I think Don's exactly right, which is we've seen this along both dimensions of the payor

world, on the commercial side and on the government side. Again, whether or not the policy implications push it a little differently, or don't push it, we're still directionally, I think, moving there.

Sally Curley: We're going to take the last question, just to keep us on time here, the last question from the web. Again, if you have any questions that we haven't gotten to, please feel free to reach out to the IR team and we'd be happy to help you out. So, that question is—CMS cancelled the Part B demo this morning. What are the implications for Cardinal Health? Then, George, when you're done, I'd love for Jon to just maybe touch on specialty and nuclear for a little bit, and then, Mike, I don't know if you want to make any comments about capital deployment, and then we'll wrap it up.

George Barrett: Yes, let me touch base on—touch the Part B demo and then I'll turn it to Jon. So, again, this is one of those—you know, CMMI has done some really interesting work, and I'd be very honest, I actually think there's an important place for that kind of experimentation in the system. Part B demo, as you know, got a lot of pushback in the oncology world in particular, so I think this is sort of the right call. The one thing I would say, to their credit, is that there have been incidences where there has been experimentation and some pushback and they've listened. So, I think that for many of our customers in the oncology world is good news.

Directly, for us, it's probably—again, I don't think it's a material issue, but I think sort of broadly speaking, and I don't mind saying it, I think CMMI has done some interesting pilot work and I think this probably is the right call, based on industry response, and I think it's good and healthy that they responded to the industry that said this had some by-products that are not good. So, I'm a believer that there's some reasons, not just Part B, but, you know, just using a part of CMMI to experiment a little bit.

Audience Member: What about bringing drugs into episodes of care? My understanding is that most—when they're talking about bundling, drugs are separate, right, so there's no—and people argue that you can't really do value-based pricing on drugs by itself, but if you put the drugs into the episode of care …

George Barrett: I wouldn't be—so here's the thing. It is probably harder, but it depends on the disease area or the episode of care. So, for example, if it's an elderly patient experiencing some of the early signs of Alzheimer's, you have so many comorbidities, it's just extremely hard to define outcomes. In other cases, there may be—you

know, if it's connected into a hip procedure. So, there may be places where this is more easily done, but we're not going to be able to say there's an across-the-board way to do this. I think it's going to depend on the episode of care and whether or not you can isolate the outcome in combination with the whole procedure, but I think we'll see experimentation here in pricing models.

Don Casey: I think that's right. You almost want to distinguish whether it's an acute condition versus a chronic disease management, which is what George was saying, just to chop it. The 90-day care around a hip or knee is pretty measurable and you could look at that, versus the comorbidities George is describing. For somebody who may need a hip or knee, it would require a lot of pharmaceutical treatment over a longer period of time.

George Barrett: Or some of the complex behavioral issues, really, really hard.

Audience Member:Even in a chronic management program down the road, you don't think there's a way you could - like diabetes care or …

George Barrett: I wouldn't reject it out of hand. I'm just saying it's just—I think the early work will be in areas that are more easily walled, where you can say, "I can get a boundary around this."

Audience Member: Yes.

George Barrett: I think we'll see experimentation everywhere, but it's just going to be much harder in places that are big chronic care diseases with likely comorbidity.

Jon Giacomin: I'll mention a couple specialties. So, just to pick up a little bit on what I said in the sort of opening comments, our specialty business has seen some nice growth. In fact, I think we communicated earlier this year that we expect to see double-digit revenue and earnings growth out of that business. I think we're on track relative to that. We have absolutely expanded into some of the ologies, oncology and then the other ones that I mentioned, so it's our list of ologies, and I think that's gone off exceedingly well, as has the RainTree acquisition that we did earlier in the year. That's added, actually, some nice scale in oncology for us, both on the contracting side, as well as additional services, and we're really pleased with that acquisition, how it's performed and how it's integrated,. So, feeling really good on the provider side and feeling like we've got a lot of momentum, and as I said, there's probably not a week that goes by where we don't have customers visiting our Fuse Innovation

Center and talking to us about different ideas relative to existing technologies we have and enhancements we might do, as well as even thinking about new things that we might even bring to market that would have more applicability across an entire ology. So, we're really excited about the progress in the provider space and think good things are coming there.

Audience Member: What ologies aren't you in?

Jon Giacomin: There's more ologies we're probably not in. We're in oncology, urology, nephrology, rheumatology. I would say those are the main...

Audience Member: What enables you to be in an ology and not be in an ology? Is it just the definition of the ology, or is there actually new things that you need to bring on board to …

Mike Kaufmann: Servicing those kinds of doctors. Each one of those has some unique needs, and so we provide services to them and sales reps that have the relationships to …

Audience Member: Direct interface with them.

Jon Giacomin: It's really just finding the right doctors and finding the right reps who can visit the doctors and be able to service them the right way.

Audience Member: That's right.

Jon Giacomin: What's interesting is, when we acquired Metro Medical, they brought, actually, a lot of that with them, and so they had established relationships. As Mike pointed out, the sales team was calling on them. They had some pretty good scale within those particular practices. They knew the needs of those practices, and they had solutions, suites and services around that, that we honestly looked to scale up even as they've come over. So we've taken advantage of the presence that they've had there, and even grown it since.

George Barrett: And you also need some clinical chops.

Jon Giacomin: So, again, this isn't like pure supply chain management. If you're going to interface with a rheumatology office or an oncologist, you have to speak the language. It's not as simple as saying, "We can move a cold chain

product that requires special handling from here to there," and suddenly we're in the business. It's not really the way it works. You have to be fluent. There's different work flows and different practices, and they look for practice analytics to be slightly tweaked for the different aspects and uniqueness of their practices.

As I said earlier, on the biopharma side, I think the thing we can talk about is certainly our hub services, we've seen continued interest on that, and, honestly, some continued growth. We feel good about what we've done there. We're sort of offering a standard type of offering and then some services à la carte, and even will customize, obviously, if you're willing to pay for the value that customization brings. So, that business has continued to grow. As you probably know, it's down in Dallas and is doing really a nice job. So, manufacturer interest, I would say couldn't be higher right now.

Audience Member: Hub services – is that based on clear…

Jon Giacomin: Patient programs 24/7 lines of...That's with Sonexus. Yes, Sonexus acquisition.

Audience Member: So, are you finding that more manufacturers are saying, "Hey, let's just go through you guys for the hub services versus building our own hub."?

Jon Giacomin: Yes, I think so, that's exactly right, and so …

Audience Member: Because that seems like that kind of vulcanization actually slows down access, right, or it slows down that first build for patients …

Jon Giacomin: You mean if it's all done separately?

Audience Member: Yes, like, if a doctor has to go to different hubs, because he's got three drugs for a patient …

George Barrett: Again, I think doing things at scale, generally speaking, matters.

Jon Giacomin: Our 3PL business, just to offer one more highlight, probably had one of the best years it's ever had in the last few years. We've actually moved into a new facility down there. We've added—it's quite a large facility, and added quite a number of customers over the last year. On the bio, we see some great momentum on the provider side and we're seeing some very good momentum on the manufacturer side, as well.

Mike Kaufmann: I'll wrap up my piece before turning it over to George to close us. You know, we've talked a lot individually about M&P, which we should, but I also think that there's also a lot of corporate departments that service both M&P, and so we leverage scale where we can in areas like IT and customer service and finance and legal and QRA, and so a big piece of Cardinal is taking these corporate departments and then managing and servicing the businesses, but also a part is—you look to our second half and you think about the various initiatives. You've heard what's going on in the segments. There's also a lot of focus from the corporate to teams to be able to pay attention to our expenses, make sure we're managing all of our expenses right, and providing that, and you've heard us talk a little bit about that, that we're going to be very focused to make sure we're spending the right things in order to deliver upon the financial commitments there. So, I just want to mention that quickly.

I think, also, as you think about Cardinal and you think about the moving parts—before, it was kind of this negative piece about Medical and all this great flavor, feelings around P, and now P is having a little bit of a struggle and now we've got M going in the right direction, with a lot of really good activity there. What I like is the breadth of our business. I think what really truly differentiates us from our competitors in this space is we're not wholly dependent on one individual piece of the business. In fact, when you take our significant cash flow and you then have the ability to leverage it across not only M&P, but within M&P, several different very large-scale businesses, to either acquire or invest in organic types of growth opportunities, I think that's what differentiates us to be able to continue to grow going forward.

Specifically, as it relates to the cash flow and our capital deployment, nothing's really changed there. We're going to continue to focus first on capital expenditures; as we mentioned in our Q1 earnings release, you know, the $400 million to $450 million range this year. We also are committed to our differentiated dividend, to stay in the 30% to 35% payout area for our dividend. As far as then the remaining cash, we're going to split it between M&A and stock repo. I'd love to do M&A, but it's got to be—you know, we've got to be very, very focused and on top of making sure it's, first of all, a strategic fit, cultural fit, and then at the right price, and so when we find businesses that meet all three of those, we would be more than happy to deploy capital against those opportunities. You're going to see us take smaller bets in areas like NaviHealth that might be one degree from some of the cores, and then bigger bets in businesses like Cordis that are more in the core, and our products and services businesses.

But, I will commit to you, we're not going to hoard cash, either. So, we're not going to let large amounts of cash build up on our balance sheet, particularly when we think our stock is undervalued, although we always think our stock is undervalued, that we're going to take opportunities to do targeted stock buybacks, but we're always going to try to balance doing those with keeping some powder dry to take advantage of opportunities. I'll turn it over to George to wrap things up.

George Barrett: Well, look, I don't want to keep you guys. I know many of you have flights and you're getting ready for the holiday season. So, first, thank you for being here. For those calling in, thank you for calling in. We do wish everybody a chance to have a good holiday season, restful and recharged for what's going to be an interesting year. I'll just finish by saying a couple of things.

I think of this sort of in four components. In terms of positioning, we've been really focused on where we think healthcare is going here in the U.S. and globally and how we position to be a solution provider at scale, and we continue to focus there.

Second is discipline. Mike talked to you about discipline in terms of capital deployment. If you watch our operations internally and you try to figure out how a company this big can grow this much and manage their inventory that well, that's just pure discipline. It's expertise, it's knowledge, and it's folks that really have their eye on the ball and they don't get distracted.

Third is balance. I'd love for all of our lines of business to be cruising at every moment. It's just not the nature of life. It's nice to have some balance in the portfolio, increasingly.

Probably, finally, is the ability to bring integrated solutions. We have to organize in some way and we have to report in some way, but the reality is we are operating as an integrated company and when we go to our customers that's the way they are increasingly seeing us, and that's valuable. That's the place we want to be.

So, an exciting time, we're going to—like everybody else, there are bumps and bruises, but we've got a really good team. We're very optimistic about where we are and where we're positioned, and we look forward to the New Year. For us, it's the second half of the year fiscally but look forward with excitement to what's happening in

front of us. I think you should expect Cardinal will be a player. We'll always have a seat at the table in terms of where care is going because that's a big part of our mission.

So, we appreciate you taking the time to join us and wish everybody a happy holiday. Thanks.

Sally Curley: Thanks, everyone. That concludes the webcast and we wish you all a happy holiday.