May 2026 Caseload Estimating Conference

Executive Office of Health and Human Services Follow-up Questions to April 27, 2026 Testimony

1. **Provide status update on Medicaid claiming for BHDDH's RIPTA contract (question from BHDDH testimony).**

   Background

   The BHDDH RIPTA contract was discussed between Medicaid and BHDDH in 2022, however, Medicaid did not provide full approval of the inclusion and indicated that additional review of the contract would be required. Medicaid asked for documentation and data to show that the transportation provided was related to a Medicaid-eligible service. At that time, the materials provided did not support that.

   In September 2025, EOHHS' cost allocation vendor reached out to Medicaid regarding the BHDDH quarterly cost allocation plan (CAP) and included a request to include the RIPTA contract in the CAP. Medicaid notified BHDDH in October 2025 that additional information was required to consider amending the ISA and CAP to ensure that any Medicaid administrative claiming is appropriate and complies with federal regulations. Without data and information demonstrating that the RIPTA contract meets the federal requirements, Medicaid could not authorize administrative claiming. In October 2025, Medicaid again requested information on the waiver services individuals are being transported to and from, and how this is tracked.

   In December 2025, Medicaid and BHDDH met to discuss new processes for ISA amendments. During this meeting, BHDDH requested an update on the status of its request for administrative match for the RIPTA contract. Medicaid reiterated that the agency had not received the information previously requested from BHDDH to evaluate eligibility for administrative match. The Medicaid Director also sent a communication to the BHDDH Director about the issue and requested additional information.

   In February 2026, Medicaid received answers to outstanding questions, however the responses were insufficient to evaluate allowability for claiming. In March 2026, Medicaid requested a standard operating procedure from BHDDH on how they administer and oversee the RIPTA contract to ensure compliance with federal requirements. The responses received in April 2026 were again insufficient and Medicaid requested further detail. Once Medicaid receives sufficient information on how the RIPTA contract benefits are administered to members, Medicaid will bring the questions to CMS to determine whether claiming is allowable.

   Medicaid Concerns

   When the inclusion of the RIPTA contract resurfaced in 2025, Medicaid had several concerns with including it in the CAP. The main concern is allowing administrative claiming for transportation services given this is a Medicaid service rather than an administrative function. The only authority Medicaid has for transportation is non-emergency medical transportation (NEMT) via the broker (MTM). The services included in the RIPTA contract are not part of NEMT but separate transportation. Historically, RIPTA was unwilling to become a Medicaid transportation provider, which meant they could not be reimbursed for Medicaid services via NEMT.

   The services provided by RIPTA must meet the following requirements to claim federal admin match:

   1. Under CFR 431.53, transportation to medical services must be provided through NEMT, not administrative match. Therefore, we need destination data from BHDDH to verify RIPTA is not providing services that fall under the NEMT benefit.
   2. The state Medicaid agency must attest that transportation is provided solely to access a Medicaid waiver service. This requires trip destination data showing that each trip aligns with the passenger's individualized service plan (ISP). The waiver service must not include transportation in

its rate, and if providers have the capacity to provide transportation, those costs should be incorporated into their rate.

3. The service provided by the public transit authority must be billed at actual cost.

BHDDH has not provided sufficient evidence that these requirements are met by the RIPTA contract.

Next Steps

Medicaid is awaiting additional information from BHDDH in the form of a standard operating procedure. This was originally requested on 3/12/26 and while information was provided by BHDDH on 4/9/26, the information was not responsive to the request. Medicaid asked again for additional detail. Once Medicaid receives sufficient detail based on our requests, Medicaid will ask CMS for a decision on whether administrative claiming is allowable for the RIPTA contract.

2. Make corrections to tables and incorrect references.

Version 3 of testimony reflects the following updates

- Fixes FY 2024 reference to FY 2025 on page 6
- Fixes incorrect references on pages 13 and 15
- Replaces the enacted label in Table II-1 and Table II-1 –with revised
- Replaces Figure II-2 on page 11 to correct the Aged, Blind, and Disabled labels

3. Provide more information on barriers to accessing pharmacy rebate data rebate information.

Supplemental rebate data are considered proprietary information. Our rebate vendor, Prime (a subcontractor of Gainwell), has indicated that a prior determination concluded that the state is unable to adequately protect this information and there is a clause in our agreement that supports this determination. As a result, access to the supplemental rebate data is currently restricted to view-only presentations during meetings between the state and Prime and Gainwell. During these meetings, Prime presents data to the Pharmacy Director, which is used to the extent possible for decision making. However, the state was successful in acquiring data for its actuary Milliman in support of the SFY 2026 enacted budget initiative. This is being used to develop a report for the state that will present options for changing the Rhode Island Medicaid pharmacy benefit delivery system to promote efficiencies. As referenced in testimony, this report is expected to be complete in June.

The Pharmacy Director and legal staff are continuing to work to obtain direct access to our pharmacy data to better inform internal decision making. While there are still barriers as discussed, Medicaid is in a better position today for pharmacy-related decision making compared to last year at this time.

4. Provide nursing home March adjusted numbers and estimates for April through June.

March data was not available at the time the estimate was being prepared; only data through February. For FY 2026, we assume a monthly average of $3,610,803 for Hospice and $35,377,281 for Nursing Facilities. based on actual expenses between October and December. For FY 2027, we assume a monthly average of $3,802,768 for Hospice and $37,258,078 for Nursing Facilities. Please note that additional Nursing Home claims fall under Managed Care FFS and Expansion FFS are not separately forecast as part of reprojection. The following tables show expenses on both a cash and incurred basis.

Cash Basis:

			2024	2025	2026								
					Q1	Q2			Q3				
					202507	202508	202509	202510	202511	202512	202601	202602	202603
Paid	Nursing and Hospice Care	Hospice	$25,601,193	$32,437,065	$3,106,109	$2,920,779	$3,297,967	$3,198,282	$3,622,226	$3,176,509	$3,330,349	$3,668,821	$3,358,207
		Nursing Home	$320,324,210	$367,659,030	$31,444,007	$31,753,730	$33,779,076	$31,895,443	$33,291,782	$34,197,270	$36,172,003	$34,748,333	$29,430,960
	Nursing and Hospice Care Total		**$345,925,403**	**$400,096,096**	**$34,550,116**	**$34,674,509**	**$37,077,043**	**$35,093,725**	**$36,914,008**	**$37,373,779**	**$39,502,352**	**$38,417,154**	**$32,789,167**

Incurred Basis:

			2024	2025	2026								
					Q1			Q2			Q3		
					202507	202508	202509	202510	202511	202512	202601	202602	
Incurred	**Nursing and Hospice Care**	Hospice	$25,695,831	$32,539,130	$3,101,363	$3,098,704	$2,873,310	$3,314,405	$3,131,948	$3,231,985	$3,135,567	$2,536,168	
		Nursing Home	$320,958,789	$372,513,900	$32,122,386	$32,095,571	$30,557,385	$33,707,376	$32,084,001	$32,418,243	$31,174,871	$23,820,026	
	Nursing and Hospice Care Total		**$346,654,620**	**$405,053,031**	**$35,223,749**	**$35,194,274**	**$33,430,694**	**$37,021,781**	**$35,215,949**	**$35,650,227**	**$34,310,437**	**$26,356,194**	
Incurred @100%	**Nursing and Hospice Care**	Hospice	$25,697,011	$32,764,401	$3,192,256	$3,228,533	$3,040,692	$3,578,715	$3,490,380	$3,763,313	$3,881,775	$3,918,300	
		Nursing Home	$320,965,898	$373,785,254	$32,673,283	$32,912,142	$31,692,307	$35,539,349	$34,591,058	$36,001,435	$36,058,228	$29,325,975	
	Nursing and Hospice Care Total		**$346,662,909**	**$406,549,655**	**$35,865,539**	**$36,140,675**	**$34,732,998**	**$39,118,065**	**$38,081,438**	**$39,764,748**	**$39,940,003**	**$33,244,275**	

5. Provide the hospital IBNR amount.

Medicaid estimates its budget on an incurred basis by applying an IBNR factor to account for outstanding claims activity that the agency anticipates will eventually by paid by the state. In applying IBNR, the most recent months become unreliable (as there is not enough activity from which to apply the IBNR factors). For purposes of its revised May 2026 estimate, Medicaid based it estimates on activity incurred through December 31, 2026, estimating a monthly expenditure level that it then multiplied by six to get the anticipated expenditures for the second half of the fiscal year. This allows for a minimum of 90 days of runout and application of IBNR factors based on the 24 months of historical claims processing for services incurred between April 2023 and March 2025. For the second half of SFY 2026, we are estimating $2.8 million IP and $0.7 million OP.

			2024	2025	2026								
					Q1			Q2			Q3		
					202507	202508	202509	202510	202511	202512	202601	202602	202603
Incurred	**Hospitals**	Inpatient Facility	$34,903,028	$32,634,525	$2,645,787	$1,818,673	$2,025,902	$1,714,803	$2,573,488	$1,738,456	$1,255,725	$745,790	$25,896
		Outpatient Facility	$7,162,907	$8,166,703	$688,764	$643,952	$816,299	$698,141	$610,628	$705,249	$519,771	$373,491	$129,064
	Hospitals Total		**$42,065,935**	**$40,801,228**	**$3,334,550**	**$2,462,626**	**$2,842,201**	**$2,412,944**	**$3,184,115**	**$2,443,705**	**$1,775,496**	**$1,119,282**	**$154,959**
Incurred @100%	**Hospitals**	Inpatient Facility	$34,984,099	$34,140,330	$3,019,912	$2,117,808	$2,455,986	$2,184,628	$3,591,694	$2,610,332	$2,188,479	$2,031,650	$654,253
		Outpatient Facility	$7,162,937	$8,215,992	$709,653	$669,883	$857,161	$745,137	$668,706	$806,283	$691,191	$677,510	$851,710
	Hospitals Total		**$42,147,035**	**$42,356,322**	**$3,729,566**	**$2,787,691**	**$3,313,146**	**$2,929,764**	**$4,260,400**	**$3,416,615**	**$2,879,670**	**$2,709,160**	**$1,505,963**

The following table shows the IBNR factor applied to claims through December 2026 to account for any missing claims activity for inpatient and outpatient activity under the Hospitals – Regular product line.

Lag (in months)	Inpatient	Outpatient
-	3.96%	21.84%
1	35.87%	73.69%
2	54.51%	84.77%
3	64.60%	90.15%
4	70.57%	93.39%
5	76.50%	95.18%
6	81.21%	96.19%
7	84.63%	96.81%
8	86.82%	97.52%
9	89.88%	98.15%
10	91.43%	98.69%
11	92.79%	98.96%
12	94.28%	99.32%
13	95.05%	99.50%
14	95.38%	99.66%
15	95.82%	99.75%
16	96.31%	99.83%
17	96.98%	99.83%
18	97.26%	99.86%
19	97.98%	99.97%
20	98.28%	99.99%
21	98.28%	99.99%
22	98.38%	100.00%
23	100.00%	100.00%

6. **Correct Recoveries: $21.M FY26 and $24.5M FY27**

Version 3 of testimony includes updates to the other services section on pages 50 and 51, to correct the recoveries line to account for the November adopted estimate. Specifically, the updated recoveries amount under November CEC in Table XIII-2 was updated from $20.0 million for FY 2026 and $22.0 million for FY 2027 to 21.2 million and 24.4 million, respectively.

7. **Balance Model: What are the current PA guidelines required in both FFS and managed care and how does that compare to the PA requirements in the model**

Our current FFS PA guidelines are as follows:

1. Weight loss: follow FDA indication, BMI of 27+ with comorbidity and 30+ without. We also require a minimum of 4 pounds of weight loss for continuation of treatment. We do request evidence of obesity with ICD-10 code on the PA form. The PA form can be accessed here. It is important to note that we collect additional clinical data to allow for future internal evaluation and analysis of these treatments.
2. Diabetes: follow FDA indication. Must have a history of either metformin or TZD therapy in the past 90 days.

MCO PA guidelines:

1. Neighborhood Health Plan of Rhode Island: Neighborhood's current criteria for anti-obesity GLP1 products requires the following to be met, which is more restrictive than the label:

a. Weight loss/obesity: Member is involved in a comprehensive weight management program that includes a Behavioral Health Counseling component, a Dietary/Nutritional education/counseling component, and reinforcement of and advocacy for an exercise regimen. BMI greater than or equal to 30 without additional risk factors, or 27 with additional risk factors.

b. OSA: Member has documentation of current, active participation in a comprehensive weight management program. Documentation the member has moderate to severe OSA evidenced by an apnea hypopnea index [AHI] of ≥15 measured on polysomnography (PSG). Documentation the member has been receiving treatment for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP)] for at least one month and has documented evidence of residual sleepiness despite compliance.

c. MASH: The member's moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) at baseline has been confirmed by ONE of the following within the past 6 months: non-invasive liver disease assessment (e.g., ultrasound-based elastography, magnetic resonance elastography [MRE]) OR historical liver biopsy. The requested drug is being used with a reduced-calorie diet AND increased physical activity.

d. Diabetes: Member has a documented diagnosis of type 2 diabetes confirmed by accepted lab testing methodologies. Member has tried and failed tolerated dose of metformin (2gm/day) for 3 months. Neighborhood has preferred therapeutic products. No criteria for prediabetes.

e. Type 2 Diabetes with cardiovascular disease/cardiovascular risk factors/CKD: Member has a documented diagnosis of type 2 diabetes confirmed by accepted lab testing methodologies. Neighborhood states what symptomatic PAD is. Neighborhood allows for prior history of revascularization (CABG, PCI, or angioplasty), which we don't see for EOHHS.

2. Tufts Health Plan: Documentation of the following:

a. The Member is 12 through 17 years of age with a BMI in the 95 percentile or greater standardized for age and sex and the request is for Osymia **OR**

b. The Member is 12 through 17 years of age with a body weight above 60 kilograms and an initial BMi corresponding to 30 kg/m or greater for adults by international cut-offs (I.e., Cole Criteria) **OR**

c. The Member meets all of the following:

i. The member has a body mass index (BMI) ≥ 30 kg/m?
ii. -OR- The member has a BMI ≥ 27 kg/m and has at least one of the following high-risk factors:
    a. Coronary heart disease
    b. Atherosclerotic disease
    c. Type 2 diabetes
    d. Sleep apnea
    e. Hypertension
    f. Hyperlipidemia
iii. -AND- Member was not able to meet weight loss target despite lifestyle modifications, including dietary changes and participating in a structured exercise program for at least 2 months
iv. -AND- Member has had a trial and failure of therapy with or contraindication to over-the-counter Alli

3. United Health Care: Policies cover BALANCE eligible, FDA approved indications but they include utilization management requirements that exceed CMS Balance standards.

A. Diabetes: One of the following:

(a) Submission of medical records confirming diagnosis of type 2 diabetes as evidence by one of the following laboratory values (A1C greater than or equal to 6.5%, Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test, random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis)

- OR - (b) For patients requiring ongoing treatment for type 2 diabetes (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus.

-AND-

One of the following:

(a) Suboptimal response (i.e., suboptimal glycemic control) to one product, or a combination thereof, from any of the following drugs/classes: metformin, metformin combinations, DPP-4 inhibitors, DPP-4 inhibitor combinations, SGLT2 inhibitors, SGLT2 inhibitor combinations, sulfonylureas for 90 days in the past 365 days, as confirmed by claims history or submission of medical records

-OR- (b) History of contraindication or intolerance to one product from any of the following drugs/classes: metformin, metformin combinations, DPP-4 inhibitors, DPP-4 inhibitor combinations, SGLT2 inhibitors, SGLT2 inhibitor combinations, or sulfonylureas (please specify contraindication or intolerance)

Reauthorization requires documentation of positive clinical response to therapy (improved A1C).

B. Weight loss:

Wegovy: Based on all of the following:

(1) Treatment is being requested to reduce the risk of major adverse cardiovascular events

-AND- (2) Patient is 45 years of age or older

-AND- (3) Submission of medical records documenting all the following:

(a) BMI ≥ 27 kg/m2

-AND- (b) Established cardiovascular disease as evidenced by one of the following:

i. Prior myocardial infarction (MI)

ii. Prior ischemic or hemorrhagic stroke

iii. Symptomatic peripheral arterial disease (PAD) evidenced by one of the following: · Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest) · Peripheral arterial revascularization procedure · Amputation due to atherosclerotic disease

-AND- (4) Used in combination with a reduced calorie diet and increased physical activity

-AND- (5) One of the following:

(a) For patients with history of MI, one of the following:

(a) For patients with history of MI, one of the following:

i. Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records): · cholesterol lowering medication (e.g., statin, PCSK9i) · beta blocker (i.e., carvedilol, metoprolol, or bisoprolol) · angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI) · antiplatelet (e.g., aspirin, clopidogrel)

-**OR-** ii. Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication): · cholesterol lowering medication (e.g., statin, PCSK9i) · beta blocker (i.e., carvedilol, metoprolol, or bisoprolol) · angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI) · antiplatelet (e.g., aspirin, clopidogrel)

(b) For patients with a history of ischemic or hemorrhagic stroke, one of the following:

i. Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records): · cholesterol lowering medication (e.g., statin, PCSK9i) · angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI) · antiplatelet (e.g., aspirin, clopidogrel)

-OR- ii. Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication):

- cholesterol lowering medication (e.g., statin, PCSK9i)

- angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

- antiplatelet (e.g., aspirin, clopidogrel)

(c) For patients with a history of symptomatic PAD, one of the following:

i. Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

- cholesterol lowering medication (e.g., statin, PCSK9i)

- angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

- antiplatelet (e.g., aspirin, clopidogrel)

-OR- ii.Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication):

- cholesterol lowering medication (e.g., statin, PCSK9i)

- angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

- antiplatelet (e.g., aspirin, clopidogrel)

-AND- (6) Patient does not have either of the following:

(a) Diagnosis of diabetes or HgA1c > 6.5%

(b) New York Heart Association class IV heart failure

Reauthorization approved based on use in combination with a reduced calorie diet and increased physical activity and patient does not have either diagnosis of diabetes or HbA1c ≥ 6.5% or New York Heart Association class IV heart failure.

Zepbound for weight loss: will be approved based on all of the following criteria:

(1) Treatment is being requested for appetite suppression or weight loss

-AND- (2) Patient is 18 years of age or older

-AND- (3) Submission of medical records confirming that Zepbound will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using Zepbound

-AND- (4) One of the following:

(a) Body Mass Index (BMI) ≥ 30 kg/m2, or for pediatric patients a BMI > 95th percentile, as documented by submission of medical records

-OR- (b) Both of the following:

i. BMI ≥ 27 kg/m2, as documented by submission of medical records

-AND- ii. Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

-AND- (5) Zepbound must be prescribed by, or in consultation with, a weight loss clinic, or a dietician/nutritionist

Zepbound for OSA: approved based on all the following criteria:

(1) Treatment is being requested for obstructive sleep apnea (OSA)

-AND- (2) Patient is 18 years of age or older

–AND- (3) Submission of medical records confirming all of the following:

(a) Moderate-to-severe obstructive sleep apnea evidenced by both of the following: i. Sleep study ii. One of the following: · Apnea Hypopnea Index (AHI) ≥ 15 · Respiratory Disturbance Index (RDI) ≥ 15 · Respiratory Event Index (REI) ≥ 15

-AND- (b) BMI ≥ 30 kg/m2 in the past 6 months

-AND- (c) At least one previous unsuccessful dietary effort to lose weight

-AND- (d) One of the following: i. Both of the following: · Patient is currently on positive airway pressure (PAP) therapy for at least 3 consecutive months · Patient is adherent to PAP therapy, defined as ≥ 4 hours of use per night for ≥ 70 percent of nights ii. Patient is not a candidate for, or is intolerant to, PAP therapy (e.g., upper airway anatomic abnormalities, etc.)

-AND- (4) Used in combination with a reduced calorie diet and increased physical activity

-AND- (5) Provider attests to both of the following:

(a) Patient counseled on appropriate positional therapy

(b) Patient counseled on avoidance of alcohol and/or sedatives before bedtime

-AND- (6) Patient does not have a diagnosis of diabetes or HgA1c > 6.5%

-AND- (7) Prescriber attests the patient does not have either of the following: (a) Planned surgery for sleep apnea or obesity (b) A diagnosis of predominant central or mixed sleep apnea (i.e. percent of mixed or central apneas/hypopneas ≥ 50% of all respiratory events)

-AND- (8) Prescribed by or in consultation with, a sleep specialist

The balance model standardized access policy is below. Please note, states may choose to adopt Coverage Criteria that are less restrictive at their discretion, provided the criteria remain within the FDA approved label.

a. Must be without step therapy that is more burdensome than the applicable Model Drug's label (and no such step therapy or utilization management may include step therapy related to lifestyle or similar requirements); and with any prior authorization criteria being no more burdensome than those set forth below, provided that the model drugs are prescribed solely for indications approved by FDA.

    i. Provider must attest that the patient:

        1. Has type 2 diabetes or noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)

        2. Has obstructive sleep apnea (OSA) or is currently on and will continue lifestyle modification (as clinically appropriate) and one or more of the following:

            a. Patient is at least 18 years of age and has a Body Mass Index (BMI) $\underline{\geq}$ 35 at the time of initiation of therapy.

            b. Patient is at least 18 years of age and has a Body Mass Index (BMI) > 30 at the time of initiation of therapy with a diagnosis of one or more of the following:

i. heart failure with preserved ejection fraction

ii. uncontrolled hypertension (defined as systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90mm Hg, despite concurrent treatment with two antihypertensive medications)

iii. chronic kidney disease stage 3a or above

iv. moderate or severe obstructive sleep apnea (defined as apnea–hypopnea index >15 without central or mixed sleep apnea)

v. noncirrhotic MASH with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) F2/F3 stage will be confirmed using one guideline-supported test, including: Fib-4, Ultrasound, ELF, Fibroscan, MRE/MRI, or Fibrosure

c. Patient is at least 18 years of age and has a Body Mass Index (BMI) > 27 at the time of initiation of therapy with a diagnosis of one or more of the following:

i. Pre-diabetes (as defined by American Diabetes Association guidelines)

ii. Previous myocardial infarction

iii. Previous stroke

iv. Symptomatic peripheral artery disease