National Oral Health Policy Center

A Technical Issue Brief

EPSDT Periodicity Schedules and their Relation to Pediatric Oral Health Standards in Head Start and Early Head Start

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EXECUTIVE SUMMARY

Oral health and dental services are important concerns for Head Start and Early Head Start (HS/EHS) programs. From an epidemiological perspective, dental caries (tooth decay) remains the most common chronic disease of childhood, with the highest rates observed in economically disadvantaged and racial and ethnic minority children – conditions that characterize children enrolled in HS/EHS.

Medicaid plays an important role in reducing financial barriers and facilitating access to health care services – including dental services – for low-income children. Accordingly, a close relationship exists between HS/EHS and Medicaid, particularly Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. In January 1998, the promulgation of new HS/EHS Program Performance Standards strengthened the linkage between HS/EHS and EPSDT benefits. Hence, beginning in 1998, state EPSDT periodicity schedules became key supporting elements of the new HS/EHS performance standards.

Despite the requirement for a distinct periodicity schedule for EPSDT well-child dental services and the availability of model periodicity schedules from entities such as the American Academy of Pediatric Dentistry (AAPD)[1] and Bright Futures,[2] few state Medicaid agencies have published or made available separate periodicity schedules for dental services. This omission has contributed to confusion on the part of many local HS/EHS programs in their efforts to assure that enrolled infants and children are obtaining necessary dental services.

Guidelines developed by recognized dental organizations involved in the delivery of dental services (e.g., the American Academy of Pediatric Dentistry) recommend that children have periodic dental examinations, preventive services and necessary oral health follow-up services starting at one year of age and, thereafter, at intervals based on risk assessments. These recommendations are supported by current policies developed by the American Academy of Pediatrics for children at high risk for dental disease such as children enrolled in HS/EHS.

It is recommended, therefore, that HS/EHS officials: take steps to provide information that explains and clarifies program standards for pediatric dental services to key national, state and local organizations and HS/EHS programs; work to devise and implement strategies to assure that state and local entities whose members provide dental services for children are aware of relevant policies; and support efforts among national, state and local organizations for implementing recommended guidelines for pediatric dental care services for HS/EHS children.

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[1] Clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Clinical Guidelines, American Academy of Pediatric Dentistry. Reference Manual 2004-5:81-3. Available at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.

[2] Green M, Palfry JS, eds. Bright Futures: Guidelines for heath supervision of infants, children, and adolescents. Second Edition. Arlington, VA: National Center for Education in Maternal and Child Health. 2000:xiv+337. Available at: http://brightfutures.aap.org/web/aboutBrightFutures.asp.

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❖ Oral Health and Dental Services Are Important Concerns for EHS/HS Programs

Oral health and dental services are important concerns for Head Start and Early Head Start (HS/EHS) programs. From an epidemiological perspective, dental caries (tooth decay) remains the most common chronic disease of childhood, with the highest rates observed in economically disadvantaged and racial and ethnic minority children. Left untreated, it leads to tooth destruction (cavities), spread of infection, pain and diminished quality of life. Nearly 30% of 2- to 5-year-old U.S. children living in poverty exhibit untreated tooth decay; and nearly 80% of decayed teeth in children living below 100% of the federal poverty level (FPL) go untreated.[3] Low-income preschoolers – i.e., those between 100% and 200% of the FPL – are 3 to 5 times more likely to have untreated decayed teeth than their more affluent counterparts. Head Start agency officials have duly noted data from state-wide epidemiological surveys of Head Start children and the broad significance of this issue, and have responded by designating oral health as a priority area within Head Start.

❖ Role of Medicaid and Its Relationship to Head Start

Medicaid plays an important role in reducing financial barriers and facilitating access to health care services – including dental services – for low-income children. Accordingly, a close relationship exists between HS/EHS and Medicaid, particularly Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. EPSDT is defined in section 1905(r) of the Social Security Act (the Act) and includes periodic screening, vision, dental, and hearing services and other necessary health services. Schedules specifying the content and periodicity of these services are to be established by each state after consultation with recognized medical organizations involved in child health care in the case of screening, vision and hearing services and dental organizations in the case of dental services.[4] Despite long-standing difficulties that continue to hinder children's access to Medicaid dental services in many states, HS/EHS programs rely heavily on the provisions of the EPSDT dental benefit for guidance in determining appropriate levels and periodicity of dental services for children enrolled in HS/EHS.

❖ HS/EHS Performance Standards for Oral Health and Dental Services

Prior to 1998, HS performance standards contained multiple items applying directly to oral health and dental services.[5] HS programs were required to obtain or arrange for basic dental care services which included a dental exam by a dentist, dental prophylaxis, instruction in self care

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[3] Vargas CM, Crall JJ, Schneider DA. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988-1994. J Am Dent Assoc 1998;129:1229-1238.

[4] Center for Medicare and Medicaid Services (DHHS). A Guide to Children's Dental Care in Medicaid. Baltimore, MD: U.S. Department of Health and Human Services, October, 2004.

[5] Edelstein BL. Access to dental care for Head Start enrollees. J Public Health Dent 2000;60:221-9.

oral hygiene procedures and application of topical fluoride in communities that lacked adequate fluoride levels in the public water supply, services for relief of pain or infection, restoration of decayed primary and permanent teeth, pulp therapy for primary and permanent teeth, and extraction of non-restorable teeth. Programs also were required to have a plan of action for dental emergencies. These standards did not address frequency of visits, age of referral for dental services or the role of the program's health advisory committee.

In January 1998, the promulgation of new HS/EHS Program Performance Standards strengthened the linkage between HS/EHS and EPSDT benefits. Whereas previously the HS/EHS performance standards did not reference the state Medicaid agency's EPSDT schedule of well child care – commonly known as the state's 'EPSDT periodicity schedule(s)' – the new performance standards required that, within 90 days of the child's entrance into HS/EHS, the program:

> "(ii) Obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventive and primary health care which includes medical, dental and mental health. Such a schedule *must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program* (italics added) of the Medicaid agency of the State in which they [the HS/EHS programs] operate." (See Exhibit A)

Accordingly, beginning in 1998, state EPSDT periodicity schedules became key supporting elements of the new HS/EHS performance standards. Although the new program performance standards allow "additional recommendations from the local Health Services Advisory Committee" to be included in establishing the schedule of age-appropriate health care, the determination of whether HS/EHS children are receiving adequate diagnostic testing, examinations, treatment and follow-up are tied closely to the schedule of services specified in states' EPSDT periodicity schedules.

❖ Linkage to EPSDT Underscores the Need for Suitable Dental Periodicity Schedules

Linking the new HS/EHS performance standards to EPSDT periodicity schedules, although seemingly straightforward, has created unforeseen complications for HS/EHS programs. National and local HS/EHS administrators have discovered that state EPSDT periodicity schedules (for general health screening and for dental services) often are not readily available, lack detail or comprehensiveness, are at variance with contemporary oral health and dental care policies and practices, or lack the support of health professionals involved in providing services to young children. These problems have contributed to confusion on the part of many local HS/EHS programs in their efforts to assure that enrolled infants and children are obtaining necessary dental services.

➢ Requirements for EPSDT Dental Services and State EPSDT Dental Periodicity Schedules

While inclusion of dental 'assessment' or 'screening' as part of the primary care provider's general health screen is optional for state Medicaid agencies, the provision of dental *services* is mandatory (Section 1905(r)(3)(B) of the Social Security Act). As defined by the federal

Omnibus Budget Reconciliation Act of 1989 (OBRA 89), dental services "shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health." This definition of dental services incorporates all levels of dental care including diagnostic and preventive services (i.e., well-child services), therapeutic (treatment) services, emergency services and orthodontic services when medically necessary to correct handicapping malocclusions.[6]

The *State Medicaid Manual* requires that "distinct periodicity schedules must be established" for dental services and for each of the other EPSDT services (i.e., periodic general health screening, vision, and hearing services). Dental services, as noted in Section 1905(r)(3)(A) of the Act, must be provided:

> "(i) at intervals which meet reasonable standards of dental practice, as determined by the State *after consultation with recognized dental organizations involved in child health care* (Italics added), and
>
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition;"

With respect to (ii) above, the CMS *Guide to Children's Dental Care in Medicaid* states that "The determination of medical necessity should be based on accepted standards of dental and oral health practice, and relevant policies developed by recognized dental organizations involved in children's oral health care. The CMS *Guide* further notes that "Each state's dental periodicity schedule should include recommended intervals for routine dental services (e.g., periodic examinations and preventive services). States may also simply adopt a nationally recognized dental periodicity standard without substantial formal consultation." Both the *State Medicaid Manual* and the CMS *Guide to Children's Dental Care in Medicaid* state that the periodicity schedule for other EPSDT services (e.g., general health screening services) may not govern the schedule for dental services.

➢ Locating EPSDT Dental Services Periodicity Schedule Information

Despite the requirement for a distinct periodicity schedule for EPSDT well-child dental services and the availability of model periodicity schedules from entities such as the American Academy of Pediatric Dentistry (AAPD)[7] and Bright Futures,[8] few state Medicaid agencies have published or made available separate periodicity schedules for dental well-child or therapeutic services. To be sure, most states – especially states with traditional fee-for-service dental Medicaid programs – distribute manuals for participating dental providers (which may be available on the Internet). Obtaining dental provider manuals in states where services are delivered through managed care

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[6] Additional information complementing, supplementing and expanding upon oral health policy information contained in CMS' *State Medicaid Manual* may be found in the CMS *Guide to Children's Dental Care in Medicaid*. Ibid.

[7] Clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Clinical Guidelines, American Academy of Pediatric Dentistry. Reference Manual 2004-5:81-3. Available at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.

[8] Green M, Palfry JS, eds. Bright Futures: Guidelines for heath supervision of infants, children, and adolescents. Second Edition. Arlington, VA: National Center for Education in Maternal and Child Health. 2000:xiv+337. Available at: http://brightfutures.aap.org/web/aboutBrightFutures.asp.

entities may be more difficult or impossible. Dental provider manuals are developed primarily for the purpose of establishing rules for reimbursement of dental services, and may be separate and distinct from EPSDT provider manuals. Dental provider manuals may include 'limits' placed on payment for specific dental diagnostic, preventive and therapeutic services based on the child's age; type of tooth; tooth number or surface; monthly, yearly or other time interval limits; therapeutic materials that may/may not be used; or prior authorization requirements, etc.).

HS/EHS programs could obtain and review state dental Medicaid provider manuals in an effort to compile '*de facto* periodicity schedules' that may assist in understanding what Medicaid dental services are available to eligible HS/EHS children in the state. Compilation by HS/EHS programs of such a "schedule," however, generally will require knowledge of dental nomenclature and procedures, be time-consuming to develop, and quickly become incomplete or outdated if not updated through regular review of newly published Medicaid bulletins. More importantly, efforts to create such '*de facto* schedules' may appear to absolve the state of its responsibility to develop a separate EPSDT dental periodicity schedule.

In March 2005, the National Health Law Program (NHeLP) completed a survey conducted through web-based research and telephone conversations with state Medicaid agency personnel for the stated purpose of determining "the dental examination schedules being used in all 50 states."[9] NHeLP concluded that the results of their survey "show that the vast majority of states require dental examinations every six months." A review of data compiled for the NHeLP survey from state Medicaid sources suggests that the information essentially represents sets of state-specific 'limits' placed on reimbursement for specific dental diagnostic, preventive and therapeutic services, not professionally derived guidelines for periodic diagnostic and preventive (i.e., well-child) services developed by recognized dental organizations involved in providing dental services for children, as required by EPSDT regulations. Notably absent are entries for each state designating the recommended age when children should begin obtaining dental services.

➢ Policies Developed by Prominent Organizations Involved in Providing Pediatric Dental Services

Professional guidelines developed by recognized dental organizations such as the American Academy of Pediatric Dentistry (AAPD) for addressing pediatric oral health needs as well as Medicaid statutes and regulations emphasize early and periodic dental services. Such services include early and periodic examinations to assess risks and evidence of pathologic changes or developmental abnormalities, develop diagnoses, and determine treatment needs and follow-up care necessary for conditions requiring treatment. These recurring periodic oral assessments ("dental checkups") generally are coupled with routine preventive services (self-care instructions, fluoride applications, dental sealants, etc.) and increasingly seek to incorporate assessments of risk factors that elevate the likelihood of destructive changes if these risks are allowed to persist. This pattern of periodic assessments, preventive services and necessary follow-up care also generally applies for adults, who collectively are more susceptible to the development of periodontal diseases, oral-pharyngeal cancers and other soft tissue problems.

[9] Results of the NHELP survey can be found at www.healthlaw.org.

▪ Age of First Dental Visit

AAPD policies recommend that children be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. The AAPD recommendation is embraced by the Bright Futures consortium of 28 child health organizations and is consistent with the policies of the dental and public health groups including the American Dental Association, American Dental Hygienists Association, American Association of Public Health Dentistry and the American Public Health Association.

Until recently, there was a discrepancy between the policies of the above organizations and the American Academy of Pediatrics (AAP) regarding the recommended age of first dental visit for HS/EHS children. However, in May of 2003, the AAP published a new policy statement on oral health risk assessment timing and establishment of a dental home.[10] The AAP policy states that:

> "To prevent caries in children, high-risk individuals must be identified at an early age (preferably high-risk mothers during prenatal care), and aggressive strategies should be adopted, including anticipatory guidance, behavior modifications (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk."

Because HS/EHS children are children in families of low socioeconomic status – and may also fall within one or more of the other risk groups specified in the AAP policy (e.g., children with special health care needs, mothers with high caries rates) – the new AAP policy statement may be understood as recommending that HS/EHS children be referred to a dental home by age one.

▪ Periodicity of Services

Detailed recommendations regarding the periodicity of professional dental services for children can be found in the AAPD 's clinical guideline on *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children* (which can be found in the AAPD's Reference Manual on the Internet at www.aapd.org). The AAPD guideline contains a schedule and accompanying text outlining the recommended content and periodicity of developmental assessments, clinical examinations, diagnostic tests (including radiographic assessments), counseling, preventive services and periodic re-evaluations.[11] These recommendations generally call for procedures to be repeated at six-month intervals or as indicated by individual patient's needs or risk for disease.

❖ Summary of Periodicity Considerations for HS/EHS Oral Health Services

1. Epidemiologic surveys have shown that children enrolled in HS/EHS kids are at elevated risk for dental caries (tooth decay) and exhibit substantial levels of untreated caries.

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[10] Policy statement: Oral health risk assessment timing and the establishment of a dental home. Section on Pediatric Dentistry, American Academy of Pediatrics. PEDIATRICS Vol. 111 No. 5 May 2003, pp. 1113-1116. Available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113

[11] The AAPD periodicity schedule also contains recommendations for various treatment services; however the indications for such services generally are based on 'medical necessity' (as determined by qualified dental professionals), not on the basis of time intervals.

2. Beginning in 1998, Head Start and Early Head Start standards have linked the recommended periodicity of preventive and primary care health services – including dental services – to state EPSDT requirements and periodicity schedules.

3. Medicaid policies stipulate that state EPSDT periodicity schedules for dental services are to be developed by each state in consultation with recognized dental organizations involved in pediatric dental care; states also may adopt a nationally recognized dental periodicity standard. However, at present, this is not common practice.

4. Guidelines developed by recognized dental organizations involved in the delivery of dental services (e.g., the American Academy of Pediatric Dentistry) recommend that children have periodic dental examinations, preventive services and follow-up necessary oral health services starting at one year of age and, thereafter, at intervals based on risk assessments.

❖ Strategic Recommendations

1. Leadership of the Head Start Bureau of the Administration on Children, Youth and Families should meet with leadership of the Centers for Medicare and Medicaid Services (CMS) to develop a national strategy aimed at influencing state Medicaid agencies to update or, where necessary, develop new EPSDT dental services periodicity schedules based on recommendations of recognized dental organizations involved in providing dental services for children. These schedules should specifically include periodicity recommendations for children in age groups that encompass HS/EHS children.

2. Head Start Bureau officials should work with HS/EHS state program officials to develop and implement strategies for collaborating with state Medicaid officials to facilitate updating and, where necessary, development of EPSDT periodicity schedules for dental services for children in HS/EHS age groups. Head Start officials should encourage state Medicaid agencies to consult with recognized dental organizations involved in providing dental services for children in the updating/development of dental periodicity schedules.

3. Head Start Bureau officials should continue to collaborate with HRSA Maternal and Child Health Bureau officials to develop and disseminate information that assists state and local HS/EHS programs in understanding program requirements concerning pediatric oral health services and facilitates implementation of recommended pediatric oral health care practices.

4. National Head Start program officials should meet with the leadership of the American Academy of Pediatric Dentistry, the American Dental Association and other appropriate organizations to devise a strategy to assure that state and local organizations whose members provide dental services for children are aware of current national policies regarding age of initial dental visit and subsequent periodic services. Efforts also should be directed toward building support among national, state and local organizations for implementing recommended pediatric dental care guidelines for HS/EHS children.

Exhibit A

[Code of Federal Regulations]
[Title 45, Volume 4]
[Revised as of October 1, 2004]
From the U.S. Government Printing Office via GPO Access
[CITE: 45CFR1304.20]
[Page 121-124]

TITLE 45--PUBLIC WELFARE

CHAPTER XIII--OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 1304_PROGRAM PERFORMANCE STANDARDS FOR THE OPERATION OF HEAD START PROGRAMS BY GRANTEE AND DELEGATE AGENCIES--Table of Contents

Subpart B_Early Childhood Development and Health Services

Sec. 1304.20 Child health and developmental services.

(a) Determining child health status. (1) In collaboration with the parents and as quickly as possible, but no later than 90 calendar days (with the exception noted in paragraph (a)(2) of this section) from the child's entry into the program (for the purposes of 45 CFR 1304.20(a)(1), 45 CFR 1304.20(a)(2), and 45 CFR 1304.20(b)(1), ``entry'' means the first day that Early Head Start or Head Start services are provided to the child), grantee and delegate agencies must:

(i) Make a determination as to whether or not each child has an ongoing source of continuous, accessible health care. If a child does not have a source of ongoing health care, grantee and delegate agencies must assist the parents in accessing a source of care;

(ii) Obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventive and primary health care which includes medical, dental and mental health. Such a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate, and the latest immunization recommendations issued by the Centers for Disease Control and Prevention, as well as any additional recommendations from the local Health Services Advisory Committee that are based on prevalent community health problems:

(A) For children who are not up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must assist parents in making the necessary arrangements to bring the child up-to-date;

(B) For children who are up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must ensure that they continue to follow the recommended schedule of well child care; and

(C) Grantee and delegate agencies must establish procedures to track the provision of health care services.

(iii) Obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified professional for each child with an observable, known or suspected health or developmental problem; and

(iv) Develop and implement a follow-up plan for any condition identified in 45 CFR 1304.20(a)(1)(ii) and (iii) so that any needed treatment has begun.

(3) Dental follow-up and treatment must include:

(i) Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and

(ii) Other necessary preventive measures and further dental treatment as recommended by the dental professional.

[Code of Federal Regulations]
[Title 45, Volume 4]
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[Page 120-121]

TITLE 45--PUBLIC WELFARE

CHAPTER XIII--OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 1304_PROGRAM PERFORMANCE STANDARDS FOR THE OPERATION OF HEAD START PROGRAMS BY GRANTEE AND DELEGATE AGENCIES--Table of Contents

Subpart A_General

Sec. 1304.3 Definitions.

(11) Health means medical, dental, and mental well-being

Exhibit B

OBRA 89 Provisions

regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6403. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES DEFINED.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(r) The term 'early and periodic screening, diagnostic, and treatment services' means the following items and services:

"(1) Screening services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

"(B) which shall at a minimum include—

"(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

"(ii) a comprehensive unclothed physical exam,

"(iii) appropriate immunizations according to age and health history,

"(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

"(v) health education (including anticipatory guidance).

"(2) Vision services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

"(3) Dental services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

"(4) Hearing services—

"(A) which are provided—

"(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

"(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

"(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

"(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services.".

(b) REPORT ON PROVISION OF EPSDT.—Section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)) is amended—

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the semicolon at the end of subparagraph (C) and inserting ", and", and

(3) by adding at the end the following new subparagraph:

"(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

"(i) the number of children provided child health screening services,

"(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

"(iii) the number of children receiving dental services, and

"(iv) the State's results in attaining the participation goals set for the State under section 1905(r);".

(c) ANNUAL PARTICIPATION GOALS.—Section 1905(r) of such Act, as added by subsection (a), is amended by adding at the end the following: "The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.".

(d) CONFORMING AMENDMENTS.—(1) Section 1902(a)(43)(A) of such Act (42 U.S.C. 1396a(a)(43)(A)) is amended by striking "and treatment services as described in section 1905(a)(4)(B)" and inserting " nd treatment services as described in section 1905(r)".