

The Causation Clause: How One Phrase in MassHealth's Appendix D Closes the Orthodontic Door on Children with Autism Spectrum Disorder and Other Developmental Disabilities — A Narrative Review of Regulation, Official Unmet-Need Data, Published Appeal Decisions and National Interest

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Abstract

Background: MassHealth covers comprehensive orthodontic treatment only for members under 21 with a severe and handicapping malocclusion, operationalised through Appendix D of the Dental Manual as a Handicapping Labio-Lingual Deviation (HLD) index score of 22 or an autoqualifying condition. Below that threshold the sole remaining route is a medical-necessity narrative, three of whose five enumerated grounds require the mental, nutritional or speech condition to be "caused by the patient's malocclusion." Children with autism spectrum disorder (ASD) — identified in one in 31 eight-year-olds nationally, with co-occurring intellectual disability in 39.6% of those assessed — are the largest and fastest-growing group affected, and they reach the orthodontic question already carrying a documented burden of unmet dental need. The consequences of the causation clause for autistic members and for members with other intellectual and developmental disabilities (IDD) have not previously been examined.

Materials and Methods: Narrative review with a documentary component. The Massachusetts regulatory instruments (130 CMR 420.410 and 420.431; Appendix D, Dental Bulletin DEN-96 revised; the MassHealth Dental Program Office Reference Manual) were analysed alongside nine orthodontic decisions published by the Office of Medicaid Board of Hearings; official and nationally representative data on unmet dental care in ASD (federal National Survey of Children with Special Health Care Needs and National Survey of Children's Health analyses, the Department of Public Health disability needs assessment, Department of Developmental Services Autism Omnibus reports and Autism Commission records); MassHealth caseload and dental expenditure reports; Chapter 207 of the Acts of 2010 (ARICA); federal EPSDT guidance; and Health Resources and Services Administration shortage-area designations. Peer-reviewed evidence was retrieved from PubMed and Consensus, and the author's two prior reviews on autism and dental care in the United States and on malocclusion, oral motor function and food selectivity in ASD were integrated.

Results: Nationally, 15.1% of children with ASD had an unmet dental need, with greater odds where intellectual disability or communication and behavioural difficulties were present; autistic children remained more likely than their peers to report unmet dental needs in 2019–2020. In Massachusetts, adequate dental care was rated a big problem by 64% of disability-community respondents, second only to housing. The Department of Developmental Services found 4,500 people with ASD without intellectual disability newly eligible between November 2014 and October 2023, and autistic young adults made up more than half of the fiscal year 2024 Turning 22 class; the Commonwealth's dedicated special-care dental network lists no orthodontic service. Across the nine published appeal decisions every appeal was denied, provider and administrative HLD scores diverged by up to 13 points on the same records, no formal medical-necessity narrative was ever submitted, and in the single case involving an autistic appellant the disability entered the record only through a parent's testimony. The causation clause is structurally unsatisfiable for autistic members, because their feeding, speech and behavioural conditions are attributed to autism rather than to the occlusion, while ARICA funds the very clinicians whose attestation Appendix D demands.

Conclusion: A single phrase converts an individualised pathway into an unusable one for a population the Commonwealth already enumerates. Replacing "caused by" with an aggravation standard, adding documented ASD or IDD with attested functional oral impairment to the autoqualifier list, extending eligibility beyond 21 for these members, funding the additional chair time, and publishing prior-authorisation outcomes stratified by disability status together address a defect that is regulatory rather than fiscal.

Key Word: MassHealth; autism spectrum disorder; orthodontic coverage; unmet dental need; HLD index; developmental disability; EPSDT

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I. Introduction

Massachusetts operates one of the most generous Medicaid dental programmes in the United States. Adult benefits were restored in full after a decade of restriction, the Commonwealth spent approximately \$608.9 million on dental services across 7,436,682 claim units in fiscal year 2024, and enrolment stood at 1,866,686 members as of 31 July 2026 [1,2]. It is also a state with comparatively strong oral health capacity: 56 dental Health Professional Shortage Area designations covering 193,909 residents, 62.09% of designated need met against a national figure of 32.93%, and twenty additional practitioners required to remove the designations altogether [3].

Against that background, the Commonwealth's handling of orthodontic treatment for members with autism spectrum disorder (ASD) and other intellectual and developmental disabilities (IDD) is difficult to explain on grounds of resource scarcity. Approximately one in 31 eight-year-old children in the United States was identified with ASD in the 2022 surveillance year of the Autism and Developmental Disabilities Monitoring Network, up from one in 36 two years earlier, and 39.6% of those with available cognitive data met criteria for co-occurring intellectual disability [4]. Autistic children reach the dental chair already disadvantaged: they show higher rates of untreated caries, gingival inflammation, dental trauma and bruxism-related wear than their neurotypical peers, driven less by the condition itself than by sensory over-responsivity, communication barriers, self-injurious behaviour, clinician inexperience and insurance limitations [5], and federal survey data consistently place their unmet dental need above that of other children [6,7]. The Massachusetts Department of Developmental Services (DDS) supports more than 43,000 children and adults with intellectual and developmental disabilities including ASD [8]. Children and adolescents with special health care needs demonstrate significantly greater orthodontic treatment need than their peers, with the largest differential in those with intellectual disability [9], and individuals with IDD nonetheless do not regularly receive the orthodontic treatment they require [10].

MassHealth covers comprehensive orthodontic treatment only for members under 21 and only where the malocclusion is severe and handicapping, a determination delegated by regulation to clinical standards set out in Appendix D of the Dental Manual [11,12]. Appendix D authorises treatment on a verified autoqualifying condition

or a verified Handicapping Labio-Lingual Deviation (HLD) index score of 22 or above [13]. Below that threshold, a single route remains: a medical-necessity narrative. This article is concerned with one sentence in that route. Three of its five enumerated grounds require the diagnosed mental, nutritional or speech condition to be "caused by the patient's malocclusion" [13]. For an autistic child whose feeding difficulty, communication impairment or behavioural presentation is attributed by every treating clinician to autism, that requirement cannot be met — not because the malocclusion is clinically trivial, but because the regulation demands a direction of causation that the developmental condition reverses.

Three features distinguish the present analysis from the existing literature on Medicaid orthodontic policy. The first is that it places autistic members explicitly within scope and assembles the official and nationally representative data on their unmet dental care, so that the orthodontic exclusion is read against a documented baseline of deprivation rather than in isolation. The second is that Massachusetts, unusually among states, publishes the decisions of its Office of Medicaid Board of Hearings, so the operation of these criteria can be observed in individual cases rather than inferred from the rule text alone; nine such orthodontic decisions are examined here. The third is that the Commonwealth's own autism insurance statute, Chapter 207 of the Acts of 2010, mandates coverage of precisely the speech and therapeutic services whose practitioners Appendix D requires as attesting clinicians, while excluding dental and orthodontic care from the mandate. Massachusetts therefore pays for the letter and declines the treatment the letter would support. The author's prior work mapped the clinical, educational and systemic barriers autistic patients face in United States dentistry [5] and identified the intersection of malocclusion, oral motor function and food selectivity in ASD as an unexplored clinical gap [14]; this article traces the regulatory expression of that gap in a single state.

II. Materials and Methods

This is a narrative review with an embedded documentary analysis of published administrative decisions. It does not follow PRISMA methodology and makes no claim to systematic completeness.

Regulatory and administrative sources were obtained from the issuing authorities: 130 CMR 420.000 (Dental Services), in particular 420.410 on prior authorisation and 420.431 on orthodontic limitations [11]; the MassHealth Dental Program Office Reference Manual [12]; Appendix D, the authorisation form for comprehensive orthodontic treatment issued with Dental Bulletin DEN-96 as revised [13]; the MassHealth caseload snapshot and enrolment summary for July 2026 [2]; the MassHealth dental coverage report to the legislature for fiscal year 2025 [1]; Chapter 207 of the Acts of 2010 [15]; and the Department of Developmental Services [8]. Federal material comprised the Centers for Medicare & Medicaid Services EPSDT coverage guide [16]. Workforce figures were drawn from Health Resources and Services Administration shortage-area designations for the period ending 31 December 2025 [3].

Official and population-level data on unmet dental care among autistic individuals were sought from four sources: peer-reviewed analyses of the federal National Survey of Children with Special Health Care Needs and National Survey of Children's Health, both sponsored by the Health Resources and Services Administration Maternal and Child Health Bureau [6,7,17,18]; the Massachusetts Department of Public Health needs assessment of people with disabilities, funded by the Centers for Disease Control and Prevention [19]; the annual reports that DDS submits under Chapter 226 of the Acts of 2014 (the Autism Omnibus Law) and the published records of the Massachusetts Autism Commission [20,21]; and published descriptions of the Commonwealth's dedicated special-care dental network [22,23]. A Massachusetts-specific survey of families of children with special health care needs was added because it reports diagnosis-level barriers in the same state [24].

The documentary component comprises nine decisions of the Massachusetts Office of Medicaid Board of Hearings concerning prior authorisation for comprehensive orthodontic treatment, identified by searching the Commonwealth's published appeal repository and retained where the decision recorded an HLD determination [25–33]. This is a convenience sample of published decisions, not a random or exhaustive one, and the Board publishes only a subset of its decisions; the sample is used to characterise how the criteria operate in contested cases, not to estimate denial rates. For each decision the following were extracted: the HLD score assigned by the requesting provider, by the dental benefit administrator and by the MassHealth consultant; any autoqualifying condition claimed and its disposition; whether a formal medical-necessity narrative was submitted; any reference to autism, other disability, developmental condition, speech, feeding or behavioural issues; the regulations cited; and the outcome.

Bibliographic searches were run in PubMed and Consensus, combining terms for occlusal indices (HLD, Salzmann, HLD CalMod, Index of Orthodontic Treatment Need), Medicaid orthodontic policy, unmet dental need, and malocclusion or orthodontic treatment in ASD, Down syndrome, cerebral palsy and intellectual disability. Preference was given to systematic reviews, meta-analyses, nationally representative surveys and validation studies. The author's two published reviews on autism and dental care [5,14] were used as framing sources and their primary evidence was traced where it bore on the argument. All references were checked against

the indexing record for author list, journal, volume, pagination and digital object identifier; items for which a DOI could not be confirmed are flagged in the reference list.

One boundary should be stated at the outset. MassHealth does not publish prior-authorisation approval and denial rates for orthodontic services stratified by disability status, and no Massachusetts-specific estimate of unmet orthodontic need among autistic members exists. The exclusion described here is therefore characterised from the structure of the criteria, from official and survey data on unmet dental care, and from published contested cases, not measured in programme-wide outcome data; remedying that absence is one of the recommendations made in Section XI.

III. Autism Spectrum Disorder: An Enumerated Population with Documented Unmet Dental Need

The national baseline is consistent and long-standing. In the 2009–2010 National Survey of Children with Special Health Care Needs, 15.1% of 2,772 children aged 5 to 17 years with ASD had an unmet dental need; those without a medical home had more than four times the odds of unmet need (adjusted odds ratio 4.46), and children with co-occurring intellectual disability or greater communication or behavioural difficulties had higher odds than other autistic children, whereas parent-rated severity did not [6]. In the same survey, 16.3% of children with ASD, developmental disability or mental health conditions did not receive needed preventive dental care, and unmet need rose with caregivers' financial and employment burdens (adjusted multinomial odds ratios 1.38 and 1.45) [17]. Caregiver-reported dental caries in the 2016 National Survey of Children's Health was 14.7% in children with ASD against 9.5% in other children, with adjusted odds of 1.4 [18]. In the 2019 and 2020 cycles, autistic children remained more likely than nonautistic children to have unmet medical, dental and mental health needs both before and after the onset of the COVID-19 pandemic, indicating a disparity that predates and outlasts that disruption [7]. Within a specialist autism treatment network, lower intellectual functioning was the most consistent correlate of reduced access to and completion of preventive dental care [34].

These figures matter for the orthodontic argument in a specific way. The autistic children with the greatest unmet dental need — those with intellectual disability, limited communication and behaviour that complicates treatment — are the same children in whom feeding, speech and behavioural conditions will be attributed by every clinician to the developmental disorder, and therefore the children least able to satisfy a causation clause. The barriers behind the unmet need are well characterised: a scoping review grouped them into difficulty accessing appropriate care, negative past experiences, caregiver perceptions, clinician bias and gaps in clinician education, and work with immigrant families in the United States added transport, insurance coverage, competing basic needs and mistrust of the health care system [5].

Massachusetts data reproduce the national picture. A statewide survey of 1,128 families of children with special health care needs found that, although more than 90% of the children had seen a dentist in the previous year and most families were well educated and privately insured, 20% had an unmet dental need; children with autism, cerebral palsy, developmental delay and Down syndrome had more aversion to dental treatment, more complications arising from their conditions, and more difficulty finding a dentist willing to treat them [24]. In the Department of Public Health needs assessment, funded by the Centers for Disease Control and Prevention, 64% of 865 respondents from the disability community rated adequate dental care a big problem — second only to affordable housing (77%) and ahead of adequate mental health services (62%) — and 48% reported difficulty finding a clinician who accepts public insurance [19].

The population is also enumerated by the Commonwealth itself. Chapter 226 of the Acts of 2014, the Autism Omnibus Law, extended DDS adult eligibility to people with ASD who do not have an intellectual disability. DDS reported 3,325 such individuals as of 31 December 2021, 80% of them male, and noted that many had been without services since leaving school [20]. By October 2023, 4,500 people with ASD alone had been found newly eligible, of whom 2,625 were enrolled in DDS services, and a further 2,366 people with co-occurring ASD and intellectual disability had been newly identified; in the fiscal year 2024 Turning 22 class, 443 individuals with ASD alone (32%) and 308 with ASD and intellectual disability (22%) together made up more than half of the cohort leaving school-age entitlement that year [21]. Massachusetts therefore holds, in administrative form, an autism eligibility flag and an annual count of autistic young people crossing the age at which MassHealth orthodontic coverage ends.

Finally, the Commonwealth has already built dedicated dental infrastructure for this population. The Tufts Special Care Dental Clinics, formerly the Tufts Dental Facilities, originated in a 1976 court order requiring the Commonwealth to expand medical and dental access for people with special needs and now care for more than 6,500 patients with developmental disabilities [22]; operated in partnership with DDS and the Department of Public Health, the network was described by the Commissioner of Developmental Services as the only one of its kind in the country, and the services it lists are preventive, restorative, periodontal, endodontic and prosthodontic care [23]. Orthodontics is absent from that list. The Commonwealth has thus organised special-care provision for

every major dental discipline except the one whose public coverage is gated by Appendix D. The principal indicators are summarised in Table 1.

Table 1. Official and population-level indicators of unmet dental care among autistic individuals, United States and Massachusetts

Source	Population and setting	Finding
CDC ADDM Network, 2022 [4]	Children aged 8 years, 16 United States sites	ASD in 1 in 31; co-occurring intellectual disability in 39.6% of those with cognitive data
NS-CSHCN 2009–2010 [6]	2,772 children aged 5–17 with ASD, national	15.1% unmet dental need; aOR 4.46 without a medical home; higher odds with intellectual disability, communication or behavioural difficulty
NS-CSHCN 2009–2010 [17]	Children with ASD, developmental disability or mental health conditions, national	16.3% unmet preventive dental need; associated with caregiver financial and employment burden
NSCH 2016 [18]	45,155 children, 1,228 with ASD, national	Caregiver-reported caries 14.7% vs 9.5%; aOR 1.4
NSCH 2019–2020 [7]	Autistic and nonautistic children, national	Autistic children more likely to have unmet dental needs before and after the pandemic
Statewide family survey [24]	1,128 children with special health care needs, Massachusetts	20% unmet dental need; autism associated with more difficulty finding a willing dentist
MDPH needs assessment, 2013 [19]	865 disability-community respondents, Massachusetts	Adequate dental care a big problem for 64%, second only to housing
DDS Autism Omnibus reports [20,21]	People with ASD eligible for DDS, Massachusetts	4,500 newly eligible with ASD alone (2014–2023); more than half of the FY2024 Turning 22 class autistic
Tufts Special Care Dental Clinics [22,23]	State-partnered special-care network, Massachusetts	More than 6,500 patients; listed services do not include orthodontics

The point of this section is not that autistic members lack dental care in general, which is established, but that they arrive at the orthodontic gate having already absorbed the sensory, communicative, workforce and insurance barriers documented above [5]. Appendix D then adds a final barrier of a different kind — regulatory rather than clinical — at precisely the point where the clinical barriers have been overcome and a willing orthodontist has been found.

IV. The Federal Floor: EPSDT and the Individualised Medical-Necessity Standard

Under section 1905(r) of the Social Security Act, state Medicaid programmes must furnish EPSDT-eligible children with services necessary to "correct or ameliorate defects and physical and mental illnesses and conditions," whether or not those services are covered for adults in the same state [16]. Federal guidance places orthodontic services within that obligation "to the extent necessary to prevent disease, promote oral health, and restore oral structures," excluding treatment undertaken for purely cosmetic reasons [16].

Two further features of the standard bear on index-based allocation. The first is the prohibition on categorical limits: "flat, fixed, hard, or arbitrary limits (e.g., budget or monetary caps, standard deviations from the norm, or hourly maximums) are not consistent with the EPSDT requirements" [16]. States may operate soft limits that trigger individualised review, but the limit cannot be the end of the inquiry. The second is the requirement that the determination "must be made on a case-by-case basis, taking into account the child's particular needs" [16].

Massachusetts's architecture is, on its face, compliant. A numerical threshold is paired with an individualised narrative pathway, which is precisely the design federal guidance contemplates. The question this article addresses is whether the individualised pathway functions. A soft limit whose review mechanism is unusable for an identifiable population operates, for that population, as a hard one.

V. The Massachusetts Architecture: 130 CMR 420.431 and Appendix D

The regulation establishes three conditions. Coverage is limited to members under 21; the provider "must seek prior authorization for orthodontic treatment and begin initial placement and insertion of orthodontic appliances and partial banding or full banding and brackets prior to the member's 21st birthday"; and the member must have a severe and handicapping malocclusion, which "the MassHealth agency determines ... based on clinical standards for medical necessity as described in Appendix D" [11]. Comprehensive orthodontic treatment is covered once per member per lifetime, and is not covered at all for members aged 21 or older [12].

Appendix D operates in three tiers. The first is a list of seven autoqualifying conditions: cleft palate or craniofacial anomaly; deep impinging overbite with severe soft-tissue damage; anterior tooth impaction where extraction is not indicated; severe traumatic facial deviation; overjet exceeding 9 mm; reverse overjet exceeding 3.5 mm; and severe maxillary anterior crowding exceeding 8 mm [13]. The second is the HLD score, computed from overjet, overbite, mandibular protrusion, anterior open bite, ectopic eruption, anterior crowding, labio-lingual spread and posterior unilateral crossbite, with the form providing that "treatment will be authorized for cases with verified autoqualifiers or verified scores of 22 and above" [13].

The third tier is the medical-necessity narrative. A provider may establish necessity below 22 points by documenting one of five conditions. Two are unqualified but undefined: "a severe deviation affecting the patient's mouth and/or underlying dentofacial structures" and "a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent." Three are qualified by an explicit causal requirement: "a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion"; "a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion"; and "a diagnosed speech or language pathology caused by the patient's malocclusion" [13]. Each of the three additionally requires documentation from an appropriately qualified licensed clinician other than the requesting orthodontist, on that clinician's letterhead, with diagnosis, treatment dates and a recommendation for orthodontic evaluation [13].

The word "verified" in the authorisation sentence is not decorative. As Section VI shows, the verification step is where most contested cases are decided, and it is applied to autoqualifying conditions with considerable stringency.

VI. Evidence from Published Board of Hearings Decisions

Massachusetts publishes decisions of the Office of Medicaid Board of Hearings, which permits direct observation of how these criteria operate. Nine published orthodontic decisions were examined [25–33]; their principal features are set out in Table 2.

Four findings emerge. The first is that every one of the nine appeals was denied. This is unsurprising in a sample of contested denials and is not offered as a denial rate, but it establishes that the appeal stage does not in practice function as a corrective for the scoring stage.

The second is the degree of scoring disagreement. Provider-assigned scores ranged from 12 to 24 and administrative scores from 11 to 19. In one decision the requesting provider scored 24, the dental benefit administrator scored 11 and the MassHealth consultant scored 19 on the same set of records — a 13-point spread on a 22-point threshold [30]. In another the provider scored 21 against a consultant score of 17 [32]; in a third the administrator scored 12 against a consultant score of 13, with the requesting orthodontist declining to score the case at all [33]. Where scores agreed, they agreed at values well below threshold (19 and 19; 16 and 16; 15 and 15; 14 and 14) [25,27,28,31]. This pattern is consistent with published evidence that agreement between managed care organisation coverage decisions and HLD scores computed from digital models or visual inspection is weak [35].

The third finding is the most consequential for the present argument: in none of the nine decisions was a formal medical-necessity narrative submitted. In three the record affirmatively states that the provider "checked 'no' when asked if he was submitting a medical necessity narrative" [25,27,28]; in a fourth the orthodontist "indicated that she would not be submitting a medical necessity narrative" [33]. Where functional complaints did reach the record, they arrived informally and were accordingly given no regulatory weight: a mother's letter describing chewing pain with harder foods [26], testimony about occasional tooth pain and a developed lisp for which no speech-therapy evaluation was documented [30], and a mother's testimony that the orthodontist believed treatment was needed and the condition would worsen [29,31]. The pathway that federal guidance requires to individualise the determination was, in this sample, never used.

The fourth finding concerns the single decision in which a developmental disability appears. The appellant was autistic; his mother reported that he may not report discomfort and frequently chews on objects; the provider claimed an impinging overbite as an autoqualifier and scored 21, against a consultant score of 17 [32]. The autoqualifier failed verification because, although an overbite was confirmed, no evidence of contact into the opposing soft tissue was established. No medical-necessity narrative was submitted. The autism entered the record solely through parental testimony and played no part in the determination, because no part of the criteria provides a place for it to play one. The features the mother described are not idiosyncratic: altered pain reporting, oral sensory seeking and parafunctional chewing belong to the sensory and behavioural profile of ASD, and bruxism and self-injurious orofacial behaviour are reported at elevated rates in this population and can be difficult to distinguish from one another clinically [5]. They have direct implications for occlusal loading, attrition, soft-tissue injury and the reliability of symptom-based assessment; none of it is scoreable under Appendix D, and none of it satisfies a causation clause.

These decisions are contested cases and cannot be generalised to the programme as a whole. What they do establish is that the narrative pathway is not merely difficult for autistic members in theory. In the published record of contested orthodontic appeals in Massachusetts, it is not used at all.

Table 2. Published Massachusetts Office of Medicaid Board of Hearings decisions on comprehensive orthodontic treatment (n = 9)

Appeal	HLD score: provider / administrator / MassHealth consultant	Autoqualifier claimed and disposition	Medical-necessity narrative	Autism or other disability noted	Outcome
2204165 [25]	19 / — / 19	None claimed	Not submitted; provider "checked 'no'"	None	Denied
2206197 [26]	13 / — / 12	Impaction claimed; not verified	Not submitted; parent letter on chewing pain only	None	Denied
2206364 [27]	16 / — / 16	None claimed	Not submitted; provider "checked 'no'"	None	Denied
2209052 [28]	14 / — / 14	None claimed	Not submitted; provider "checked 'no'"	None	Denied
2303657 [29]	12 / — / —	None verified	Not submitted	None	Denied
2306669 [30]	24 / 11 / 19	Impaction claimed; molar not erupted, not verified	Not submitted; lisp mentioned in testimony, no evaluation documented	None	Denied
2306992 [31]	15 / — / 15	None; consultant noted possible future impaction	Not submitted; parent testimony only	None	Denied
2404274 [32]	21 / — / 17	Impinging overbite claimed; no soft-tissue contact verified	Not submitted	Autistic; parent reported he may not report discomfort and chews on objects	Denied
2409906 [33]	not calculated / 12 / 13	Impinging overbite claimed; not verified	Explicitly declined by the orthodontist	None	Denied

VII. The Causation Clause and the Structure of Autism-Related Need

Consider a fourteen-year-old MassHealth member with ASD, oral-motor dysfunction, marked food selectivity and a posterior crossbite with a 5 mm overjet, scoring perhaps 14 points on the HLD index. Three narrative routes are nominally available.

The nutritional route requires a diagnosed nutritional deficiency or substantiated inability to eat or chew "caused by the patient's malocclusion," attested by a clinician other than the orthodontist [13]. The treating dietitian or paediatrician will attribute the restricted diet to autism, in which food selectivity affects an estimated half to nearly nine in ten children and is driven by oral sensory sensitivity to taste, smell and texture and by oral motor difficulty [14] — and will be clinically correct to do so. The speech route requires a diagnosed speech or language pathology caused by the malocclusion; the speech-language pathologist will attribute the impairment to the developmental disorder. The behavioural route requires a diagnosed mental, emotional or behavioural condition caused by the malocclusion; no clinician will certify that autism was caused by a crossbite.

The clinical reality in these patients is interactive rather than unidirectional. Malocclusion and food selectivity in ASD converge on the same structure and share a plausible mechanism in oral motor function: difficulties in mastication, deglutition and oral motor proficiency have been associated both with the development of malocclusion and, independently, with food selectivity, and a systematic review of malocclusion in ASD explicitly recommended that dietary and feeding history be treated as a confounder [14]. A malocclusion in such a child therefore compounds nutritional risk beyond what either factor produces alone, and the orthodontic contribution to that interaction is not captured by attributing the whole to one cause or the other. The same structure appears in the behavioural domain: sleep-related and awake bruxism, attrition and self-injurious orofacial behaviour interact with occlusal relationships in autistic patients without having been caused by them [5]. Comparable mechanisms operate across the wider IDD spectrum: open bite and lip incompetence bear on bolus control, drooling and airway in cerebral palsy; transverse deficiency and hypodontia interact with caregiver-dependent hygiene and periodontal susceptibility in Down syndrome. In every instance the malocclusion aggravates a functional deficit that it did not originate. The clause admits only the case in which it originated the deficit outright, which is the rarer case and the one least likely to arise in autism.

The two unqualified routes do not rescue the position. "A severe deviation affecting the patient's mouth and/or underlying dentofacial structures" and "a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent" are undefined, carry no attestation framework, and — on the evidence of the nine published decisions, in which hearing officers consistently required objective verification before departing from the score [25–33] — offer a provider no predictable basis on which to build a submission. A pathway that providers cannot predict is a pathway providers do not use, which is precisely what Section VI observed.

Table 3. The three tiers of MassHealth Appendix D and their accessibility to members with autism spectrum disorder and other intellectual and developmental disabilities

Tier	Content	Accessibility in ASD and IDD
Tier 1 — Autoqualifiers	Cleft palate or craniofacial anomaly; deep impinging overbite with severe soft-tissue damage; anterior impaction where extraction not indicated; severe traumatic facial deviation; overjet >9 mm; reverse overjet >3.5 mm; maxillary anterior crowding >8 mm [13]	Available only where the anatomical criterion is independently met; craniofacial syndromes qualify, ASD and non-syndromic IDD do not. Verification applied stringently in published decisions, including the only autistic appellant [30,32,33]
Tier 2 — HLD score ≥ 22	Overjet, overbite, mandibular protrusion, anterior open bite, ectopic eruption, anterior crowding, labio-lingual spread, posterior unilateral crossbite [13]	No disability-related variable exists in the instrument; oral motor dysfunction, food selectivity, bruxism and self-injury are unscored [5,14]
Tier 3a — Narrative, unqualified routes	"A severe deviation affecting the patient's mouth and/or underlying dentofacial structures"; "a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent" [13]	Undefined, no attestation framework, no predictable evidentiary standard; not invoked in any of the nine published decisions [25–33]
Tier 3b — Narrative, causally qualified routes	Diagnosed mental, emotional or behavioural condition; diagnosed nutritional deficiency or inability to eat or chew; diagnosed speech or language pathology — each "caused by the patient's malocclusion" and attested by an independent licensed clinician [13]	Structurally unsatisfiable: the attesting clinician attributes the condition to autism or the underlying disability, which is clinically correct and regulatorily disqualifying

VIII. What the HLD Index Cannot Measure

The HLD index was published in 1960 as an epidemiological screening device for public health orthodontic programmes, explicitly designed so that its cut-off could be "adjusted to correspond to budget changes without abandoning objectivity of measurements" [36]. Its variables were selected for measurement reliability, not for correspondence to functional impairment, and its validity as an allocation instrument remains poorly supported on its own terms.

Two findings are directly relevant. Against a reference standard composed of a panel of thirteen orthodontists scoring 153 study casts, the California-modified HLD at a 26-point cut-off demonstrated a sensitivity of 25.9% and a specificity of 96.8%, with classification and regression tree modelling identifying 18.5 as the optimal cut-off, at which sensitivity rose to 92.9% [37]. Massachusetts's threshold of 22 sits between the modelled optimum and the cut-off for which that low sensitivity was demonstrated, and the Commonwealth has published no validation of its own figure. Separately, in a study of 100 participants aged 11 to 14 assessing the Salzmann, HLD and HLD(CalMod) indices against the condition-specific Oral Impacts on Daily Performances measure, no meaningful association was found between any of the three indices and oral health-related quality of life, and none predicted quality-of-life impact in regression modelling; the authors concluded that their findings "challenge the validity of current systems for the allocation of Medicaid-funded orthodontic treatment" [38]. Where a state has replaced other criteria with the HLD index, the measurable consequence has been a significant fall in approval rates [39].

For autistic members the deficiency is structural rather than statistical. Every HLD variable — overjet, overbite, mandibular protrusion, open bite, ectopic eruption, anterior crowding, labio-lingual spread, posterior unilateral crossbite — measures where teeth are. None measures what the patient can do, tolerate or report. A 5 mm overjet in a neurotypical adolescent and a 5 mm overjet in an autistic adolescent with oral sensory hypersensitivity, a restricted diet, parafunctional chewing and limited ability to report pain score identically and are not the same clinical problem; the same is true of a hypotonic adolescent with incompetent lips, chronic drooling and a caregiver-dependent hygiene regimen.

The clinical literature supports the underlying need without overstating it. Children and adolescents with special health care needs show significantly greater orthodontic treatment need on both components of the Index of Orthodontic Treatment Need and on the Dental Aesthetic Index, with intellectual disability showing the largest differential [9]. Among children referred for orthodontic treatment, both malocclusion complexity measured by the Discrepancy Index and treatment need measured by the IOTN were significantly higher in those with ASD, independent of age and sex [40], a finding that the author's earlier review placed alongside the separate literature

on food selectivity and oral motor function as two converging but previously unconnected bodies of evidence [14]. Individuals with cerebral palsy have higher odds of Class II malocclusion (OR 2.56, 95% CI 1.49–4.38) and open bite (OR 4.27, 95% CI 1.95–9.37) [41]; individuals with Down syndrome show consistently higher prevalence of Class III malocclusion, concave profile and anterior crossbite across age groups, with maxillary transverse discrepancy and posterior crossbite predominating in adolescence and adulthood [42], and hypodontia as the most frequent orthodontic indication in treated series [43]. A meta-analysis of unselected malocclusion prevalence in ASD, by contrast, found substantial heterogeneity and concluded that an increased risk could not be stated [44]; the argument advanced here does not require that claim. It requires only that the malocclusion, where present, is functionally consequential and that the patient is treatable. Both are established: thirty-seven children with ASD treated with aligner therapy showed median ICON scores falling from 74 to 14 and median PAR scores from 36 to 8, with outcomes rated excellent to substantial in 89.2% of cases and comorbidities, present in 62%, not significantly affecting treatment duration [45]; behaviour-management protocols with pharmacological sedation where indicated bring treatment within reach for behaviour-challenged patients [10]; and sensory-adapted dental environments, applied behaviour analysis-based desensitisation, graduated sedation and augmentative and alternative communication tools such as picture exchange systems have each been shown to reduce distress and the reliance on general anaesthesia in autistic patients [5].

IX. The ARICA Paradox: Massachusetts Funds the Letter but Not the Treatment

Chapter 207 of the Acts of 2010, An Act Relative to Insurance Coverage for Autism, requires insurers to cover the diagnosis and treatment of autism spectrum disorders, defining treatment as "care prescribed, provided or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care" [15]. Habilitative care expressly includes applied behaviour analysis supervised by board certified behaviour analysts, and therapeutic care includes speech, occupational and physical therapy and social work services [15]. The statute makes no mention of dental or orthodontic services.

The juxtaposition with Appendix D is exact. Appendix D will accept a narrative establishing a diagnosed speech or language pathology, attested by an appropriately qualified licensed clinician other than the orthodontist [13]. ARICA is the mechanism by which many Massachusetts children with autism obtain access to precisely that clinician [15]. The Commonwealth has therefore built a statutory framework that funds the speech-language pathologist, the occupational therapist and the behaviour analyst — the same multidisciplinary team whose involvement the author's earlier work identified as necessary to monitor diet and oral function during orthodontic treatment in ASD [14] — and a separate regulatory framework that will consider their attestation only if they certify that the condition they treat was caused by the patient's malocclusion, which, for autism spectrum disorder, none of them can do.

This is not an argument that ARICA should have covered orthodontics; it is a mandate on commercial insurers, not on MassHealth, and orthodontic coverage for MassHealth members is governed by 130 CMR 420.431 [11]. It is an argument that the Commonwealth has already accepted, in statute, that autism spectrum disorder generates medically necessary care across habilitative, therapeutic and behavioural domains, and that the domains it named in 2010 are the same domains Appendix D names as grounds for orthodontic medical necessity. Only the direction of causation differs. Aligning the two would be an act of internal consistency rather than an expansion of principle.

Two closer precedents exist within the Commonwealth's own administration. During periods in which adult members had restricted dental benefits, adults enrolled through DDS retained comprehensive dental coverage [1], so disability status has already been operationalised as a basis for departing from a general dental coverage rule, using an eligibility flag held for a population of more than 43,000 [8]. And since the Autism Omnibus Law, that flag extends to autistic people without intellectual disability, whose numbers DDS reports to the legislature every year [20,21]. The mechanism exists and is already autism-specific; it has simply never been applied to orthodontics.

X. Access Beyond Authorisation: Workforce and the Age-21 Cliff

Authorisation is not treatment. Massachusetts approaches this problem from a comparatively strong workforce position — 62.09% of designated dental practitioner need met, against 32.93% nationally, with twenty practitioners required to eliminate its shortage designations [3] — which makes the remaining access barriers more clearly attributable to participation, training and willingness than to raw supply. Massachusetts families of autistic children nevertheless report particular difficulty finding a dentist willing to treat them [24].

Three constraints operate. The first is Medicaid specialty participation. A cross-sectional analysis of specialist listings on the federal InsureKidsNow directory found that children enrolled in Medicaid have very limited or no access to orthodontic and dentofacial orthopaedic specialists, oral and maxillofacial surgeons or

endodontists in half of United States jurisdictions [46]. Survey data indicate that only 23.5% of responding general and paediatric dentists provided orthodontic services to children enrolled in Medicaid, citing low reimbursement, billing difficulty and patient non-compliance [47]. The second is training. Until the Commission on Dental Accreditation revised its standards in 2019, United States dental schools were not uniformly required to teach the care of patients with developmental disabilities, and before that change only 64% of United States and Canadian programmes offered a dedicated special-needs course, leaving much of the practising workforce — including orthodontists trained before that date — without structured preparation for autistic patients [5]. The third is a distinct reluctance to treat patients with disabilities. In a national survey of specialist orthodontists in Switzerland — a setting without the American reimbursement differential, and therefore a cleaner test of the non-financial component — 84% reported treating patients with special needs but most saw only one or two such new patients annually; chairside time was increased by an average of 50% and treatment duration by 25%; treatment goals were compromised in roughly half of these patients; and among those not treating such patients, 79% stated they would not be interested in doing so, as did 56% of those already providing such treatment when asked about increasing their intake [48]. The reasons given were the absence of additional strategies, lack of referrals, cooperation problems and time constraints.

The regulation's temporal condition compounds all three. Massachusetts requires not merely authorisation but physical appliance placement before the twenty-first birthday [11]. For the general member population this is a conventional boundary aligned with the EPSDT age limit. For autistic members it interacts with a set of disability-specific delays: median age at earliest known autism diagnosis in the 2022 ADDM surveillance was 47 months and ranged to 69.5 months across sites [4], and diagnosis is typically the gateway to specialist dental referral; behavioural readiness for appliances may be reached years after dental development would suggest, and desensitisation and graded exposure take time [5]; fixed appliances may further narrow an already restricted dietary repertoire, so that orthodontic planning must be coordinated with nutrition and speech-language support [14]; treatment requiring sedation or general anaesthesia depends on constrained hospital scheduling; and families navigating the participation barriers above may spend a year or more locating a willing provider. Each delay is individually reasonable. Cumulatively they consume the window, and they do so for the population least able to absorb the loss, since at 21 the member transitions into an adult benefit under which orthodontic treatment does not exist at all [12]. The scale is not hypothetical: in fiscal year 2024 more than half of the DDS Turning 22 class was autistic [21], and DDS has reported that many of these young adults had been without services since leaving school [20].

A member who becomes behaviourally ready at 22 has not become clinically ineligible. Skeletal maturity constrains orthopaedic objectives but not the large majority of alignment, crossbite correction, space management and occlusal-stability goals relevant to this population, and aligner therapy — effective and well tolerated in ASD [45], with material behaviour and biomechanical limits now reasonably characterised [49], and avoiding the dietary restrictions imposed by fixed appliances [14] — is not age-dependent in any respect that matters here.

XI. A Reform Framework for MassHealth

Five levers follow from the barriers identified, set out in order of administrative cost and mapped to barriers in Table 4.

1. Amend the causation clause. The three qualified narrative routes in Appendix D should read, in place of "caused by the patient's malocclusion," a formulation such as "caused or materially aggravated by the patient's malocclusion, or whose clinical management is materially impaired by it" [13]. This is one phrase in one form. It preserves independent clinician attestation, preserves the exclusion of cosmetic treatment, and removes the single element that makes the pathway unusable for autism and other developmental disabilities. Of the five levers it is the cheapest and, on the evidence of Section VI, the most consequential.

2. Add documented ASD or IDD with attested functional oral impairment to the autoqualifier list. Appendix D already bypasses scoring for seven enumerated conditions [13]. A category for members with documented ASD or another intellectual or developmental disability together with an attested functional oral impairment — impaired mastication or bolus control, oral motor dysfunction with clinically significant food selectivity, caregiver-dependent hygiene with crowding, lip incompetence with drooling, bruxism-related attrition, or self-injurious occlusal loading [5,14] — requires no new instrument, no new adjudication logic and no change to the HLD form. It uses the mechanism the Commonwealth already operates, applied to a population DDS already enumerates, including autistic members without intellectual disability under the Autism Omnibus Law [8,20].

3. Publish and validate the threshold, or adjust it for disability. Massachusetts has not published a validation of its 22-point cut-off. The closest available evidence, from the California modification, places the modelled optimum at 18.5 and demonstrates 25.9% sensitivity at 26 [37], while no index in this family has shown a meaningful relationship to oral health-related quality of life [38]. At minimum, a lower qualifying score where documented ASD or IDD is present would approximate categorical eligibility while retaining a numerical gate. The scoring divergence documented in Section VI — including a 13-point spread across three assessors on one

set of records [30] — additionally argues for a published calibration protocol and a defined reconciliation procedure when assessors disagree.

4. Extend eligibility beyond 21 for members with documented ASD or IDD. Eligibility for comprehensive orthodontic treatment should run to 26 for these members, on the precedent MassHealth has already established by preserving comprehensive adult dental coverage for members enrolled through DDS [1,8]. The incremental cost is bounded by the size of an already-enumerated population — DDS reports the autistic share of each Turning 22 class to the legislature [21] — and offset by the downstream cost of untreated functional malocclusion in a group with lifelong MassHealth enrolment.

5. Fund the additional burden, and publish stratified outcomes. Documented increases of approximately 50% in chairside time and 25% in treatment duration [48] should be met by a defined reimbursement add-on for behavioural support, extended and sensory-adapted appointments and caregiver coordination — the Medicaid reimbursement adequacy for behaviourally adapted visits that the author's earlier review identified as a necessary complement to clinical interventions [5] — paired with support for accredited fellowship training in craniofacial and special-care orthodontics [10], explicit coverage of aligner-based protocols [45,49], structured dietary monitoring with nutrition and speech-language input during treatment [14], and the addition of orthodontic capacity to the state-partnered special-care network [23]. Separately, MassHealth should report orthodontic prior-authorisation requests, approvals, denials and appeal outcomes stratified by documented disability status, with autism reported separately. This costs almost nothing, would make the size of the problem visible for the first time, and would permit the effect of the preceding four levers to be evaluated.

Table 4. Reform levers mapped to identified barriers, MassHealth

Barrier identified	Proposed lever	Administrative vehicle
Causation clause closes the narrative pathway (§VII); pathway never invoked in nine published decisions (§VI)	1. Replace "caused by the patient's malocclusion" with "caused or materially aggravated by ... or whose clinical management is materially impaired by it"	Amendment to Appendix D of the Dental Manual [13]
HLD instrument cannot register autism-related functional need — oral motor dysfunction, food selectivity, bruxism, self-injury (§§VII, VIII)	2. Add documented ASD or IDD with attested functional oral impairment to the autoqualifier list	Addition to the Appendix D autoqualifier list [13], using the DDS eligibility flag, including Autism Omnibus eligibility [8,20]
Unpublished, unvalidated 22-point threshold; up to 13-point inter-assessor spread (§§VI, VIII)	3. Publish a validation, adopt a disability-adjusted lower threshold, and define a calibration and reconciliation protocol	Appendix D revision informed by CART-derived cut-off evidence [37] and inter-rater data [35]
Age-21 placement deadline interacts with autism-related delay; autistic majority in the Turning 22 class (§§III, X)	4. Extend eligibility to age 26 for members with documented ASD or IDD	Amendment to 130 CMR 420.431 [11]; precedent in the MassHealth DDS adult dental carve-in [1]
Workforce untrained, unwilling and unfunded for ~50% additional chair time; no orthodontics in the special-care network; no visibility of denial patterns (§§III, X, XIII)	5. Special-care chair-time differential, fellowship pipeline, aligner coverage, dietary monitoring, special-care orthodontic capacity, and mandatory stratified reporting	Fee schedule add-on codes; workforce funding [5,10,45,48,49]; agency reporting to the legislature [1]

XII. National Interest and Significance

The findings are specific to Massachusetts but the significance is not confined to it.

First, the mechanism generalises. The HLD index and its variants are used by Medicaid programmes across the country, and a fifty-state comparison found both wide variation in qualifiers and a decade-long tightening of them, with expenditures and reimbursement rates falling and barriers to Medicaid-funded orthodontic treatment increasing [50]. The pairing of a numerical gate with a causally-qualified narrative escape is a common design. Wherever it appears, it will exclude autistic children for the same reason.

Second, the unmet need is national and documented by federal surveys. Across successive federal surveys of children's health, autistic children have carried higher unmet dental need and higher caregiver-reported caries than their peers, with the deficit concentrated in those with intellectual disability and communication difficulty [6,7,17,18], and the barriers behind it — sensory, communicative, educational and financial — are common to every state [5]. A regulatory barrier at the orthodontic stage compounds a disparity that federal data already record.

Third, Massachusetts is the strong case. If the exclusion were a function of scarcity, it should be absent in a state meeting 62.09% of its designated dental need against a national 32.93% [3], spending over \$600 million annually on Medicaid dental care [1], operating a fully restored adult dental benefit, running a state-partnered special-care dental network since 1976 [22], and maintaining both a statutory autism treatment mandate since 2010 [15] and an autism-specific DDS eligibility pathway since 2014 [20]. That it is present there indicates the cause is regulatory design rather than resource constraint — which is encouraging, because regulatory design is cheaper to change.

Fourth, there is a compliance dimension. Federal guidance prohibits flat, fixed or arbitrary limits and requires case-by-case determination of medical necessity [16]. A numerical threshold whose family of instruments shows 25.9% sensitivity against a professional reference standard [37] and no relationship to quality of life [38], paired with an individualised pathway that in nine published contested decisions was never once invoked [25–33], raises a question about whether the federal individualisation requirement is satisfied in substance as well as in form. States have an interest in resolving that question on their own terms rather than through litigation, as California's experience with index-driven litigation illustrates [37].

Fifth, the affected population is enumerated, growing and publicly insured for life. Autism identification among eight-year-olds reached 32.2 per 1,000 in 2022, with 39.6% of those assessed showing co-occurring intellectual disability, and early identification is accelerating [4]. More than 43,000 individuals are served by DDS [8], autistic people now make up more than half of each year's Turning 22 class [21], and all of this sits within a MassHealth enrolment of 1,866,686 [2]. The consequences of untreated functional malocclusion — compromised nutrition in children whose diets are already restricted, periodontal deterioration under caregiver-dependent hygiene, temporomandibular dysfunction and tooth wear in a population with elevated bruxism, and the restorative and surgical costs that follow — are borne by the same payer that declined the orthodontic treatment.

XIII. Discussion and Limitations

The central finding is that MassHealth's orthodontic criteria contain an individualised pathway that, for autistic members and members with other intellectual and developmental disabilities, cannot be used, and that in the published record of contested orthodontic appeals it was not used by anyone. The defect is traceable to a single causal qualifier applied to three of five narrative grounds, and it falls on a population that official and survey data already show to be underserved in dental care generally [6,7,19,24]. The finding is reinforced by the Commonwealth's own conduct elsewhere: it has legislated coverage of autism-related speech and therapeutic care [15], extended DDS eligibility to autistic adults without intellectual disability [20], preserved comprehensive adult dental benefits for DDS members [1], and built a special-care dental network that offers every major discipline except orthodontics [23], all of which presuppose exactly the reasoning Appendix D declines to accept.

Several limitations qualify the analysis. The nine Board of Hearings decisions are a convenience sample of published contested cases, not a random or exhaustive sample; the Board publishes only a subset of its decisions, appellants who prevail at earlier stages never reach it, and decisions are redacted, which limits demographic and clinical detail. The sample therefore characterises the operation of the criteria in contested cases and supports no inference about programme-wide approval or denial rates. Only one of the nine records autism, so the autism-specific observations rest on a single case read alongside the structure of the rule and the population data rather than on a case series. The unmet-need estimates are caregiver-reported, refer to dental care in general rather than to orthodontics, are national rather than MassHealth-specific, and in part derive from the 2009–2010 survey cycle [6,17]; the Massachusetts family survey over-represented well-educated, privately insured families [24], and the Department of Public Health assessment used a voluntary online sample [19], so both are more likely to understate than overstate need among MassHealth members. The DDS enrolment figures for 2023 are taken from the published minutes of the Autism Commission rather than from a formal statistical report [21]. The programme-wide claim cannot be verified because MassHealth does not publish prior-authorisation outcomes stratified by disability status; this is itself a finding, and lever five addresses it. The most directly damaging validity evidence concerns the California modification of the HLD index rather than the Massachusetts instrument [37], and the approval-rate and inter-assessor agreement data are drawn from Illinois [35,39]. The malocclusion-prevalence literature in ASD is heterogeneous and does not establish elevated unselected prevalence [44], a point the argument is constructed not to require. Treatment-effectiveness evidence rests on small non-United States samples [43,45,48], and compliance-related attrition is real [43]. Two of the sources integrated here are the author's own reviews [5,14]; they were used to frame the clinical context, and the primary evidence they summarise was traced where it bore on the argument. The reform framework has not been costed.

Four lines of further work follow. The first is empirical: a retrospective analysis of MassHealth orthodontic prior-authorisation records linked to the DDS and autism eligibility flags the Commonwealth already holds would convert the structural inference offered here into a measured denial differential, and would indicate whether the non-use of the narrative pathway observed in contested cases holds programme-wide. The second is methodological: a short, scoreable functional supplement to the HLD instrument — covering mastication, bolus control, oral motor proficiency, food selectivity, lip competence, hygiene dependency and parafunction, and drawing on instruments already validated in the feeding literature [14] — would give the programme a defensible alternative to categorical eligibility and would also address the inter-assessor divergence documented in Section VI. The third is clinical: prospective follow-up of autistic MassHealth members receiving orthodontic treatment, monitoring dietary intake and nutritional status with a multidisciplinary team, would test whether treatment narrows or widens an already restricted diet, as the author's earlier research agenda proposed [14]. The fourth is

economic: modelling the lifetime MassHealth cost of untreated functional malocclusion in the autistic and wider IDD population against the cost of treating it would test whether the present arrangement is even efficient.

XIV. Conclusion

MassHealth requires 22 points on an instrument published in 1960 to let public programmes adjust their orthodontic cut-off to the budget, and the Commonwealth has never published a validation of that number. Below it, the regulation offers an individualised pathway that federal guidance requires and that Massachusetts, to its credit, built in some detail — five enumerated grounds, independent clinician attestation, a documented diagnosis. Three of those grounds are then qualified by four words that an autistic child can never satisfy, because the feeding, speech and behavioural conditions the pathway contemplates are, in that child, attributed to autism rather than to the occlusion.

The children affected are not an abstraction. Federal surveys have recorded their unmet dental need for more than a decade; the Commonwealth's own needs assessment ranks dental care among the top problems of its disability community; DDS counts them as they turn 22; and the state's special-care dental network treats them for everything except malocclusion. In nine published Board of Hearings decisions, provider and administrative scores diverged by as much as thirteen points on the same records, every appeal was denied, and not one formal medical-necessity narrative was submitted. In the single decision involving an autistic appellant, the disability was audible only in a parent's testimony and inaudible in the determination, because the criteria give it nowhere to be heard.

None of the remedies is novel or expensive. Four words in Appendix D would reopen a pathway that already exists. Adding documented autism or developmental disability with attested functional impairment to a list of autoqualifiers uses a mechanism already in daily use. Extending eligibility past 21 applies a precedent MassHealth has already set in adult dental coverage to a population DDS already enumerates. A chair-time differential prices a burden that is already measured. Stratified reporting would cost almost nothing. What is at stake is not orthodontic aesthetics but mastication, nutrition in children whose diets are already narrow, speech, periodontal maintenance under caregiver-dependent hygiene, and the avoidance of a lifetime of restorative and surgical consequence in members who will remain publicly insured throughout it. Massachusetts has the resources, the eligibility infrastructure and the statutory precedent to fix this. It has a regulation that does not let it.

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