



1925-2025
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October 8, 2025

Senator Evan Vickers
Representative Cory Maloy
Business and Labor Interim Committee
Utah State Legislature
350 North State
Salt Lake City, UT 84114

RE: Opposition to the Recommendation to Downgrade State Regulation of Audiologists and Speech-Language Pathologists From Licensure to Mandatory Certification

Dear Senator Vickers and Representative Maloy,

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to express our deep concerns regarding the Office of Professional Licensure Review's (OPLR) recommendation to move audiologists and speech-language pathologists (SLPs) from state licensure to mandatory certification. This proposed regulatory downgrade fundamentally misunderstands the critical nature of these professions and poses an unacceptable risk to consumer safety and access to essential care in Utah.

ASHA is the national professional, scientific, and credentialing association for 241,000 members, certificate holders, and affiliates who are audiologists; SLPs; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Over 2,000 ASHA members reside in Utah and serve its residents daily.¹

Health Care Risk in Audiology and Speech-Language Pathology

Audiologists and SLPs are doctoral and master's level health care providers, respectively, whose work addresses complex, life-altering conditions. Their roles carry a significant risk of harm that current licensure is designed to mitigate. OPLR's argument for moving to a less restrictive model based on "relatively low harm" is short-sighted because it focuses only on actual harm rather than the vast, daily risk of harm inherent in their clinical scopes of practice.

Audiologists specialize in preventing and assessing hearing and balance disorders, as well as providing audiologic treatment, including hearing aids. While most audiology procedures are safe, harm can occur. The potential for patient injury often relates to invasive procedures or errors in diagnosis and treatment that compromise the delicate auditory and vestibular systems. For complex cases, intraoperative monitoring (IOM) errors, such as an incorrect interpretation or delayed communication of critical nerve signal changes to the surgeon, can result in irreversible neural injury to the facial, cochlear, or vestibular nerves. Furthermore, mapping errors during the programming of cochlear or auditory brainstem implants (ABI) can cause intense discomfort, muscle twitching, or neural damage, with ABIs carrying even more serious neurological ramifications.

Additional examples of potential harm include:

- During cerumen or foreign body removal, physical trauma from a tool or ignoring existing ear conditions (like a perforation) can cause lacerations or bleeding.
- The process of taking an earmold impression for a custom device carries a risk of physical trauma to the ear canal or eardrum, especially if the material is inserted too deep or into a surgically altered ear, potentially leading to surgical complications if the material enters the middle ear space.
- Hearing aid fitting errors, specifically over-amplification, can cause further permanent hearing damage due to excessive sound exposure.

Additionally, many states are modernizing the scope of audiology to include imaging and bloodwork cultures, which could represent a future risk.

SLPs identify, assess, and treat speech, language, cognitive and swallowing disorders. SLPs regularly perform procedures and clinical activities that, if carried out by unqualified individuals, can result in significant harm to patients. These high-risk activities span several areas of clinical practice. For example, in dysphagia management, SLPs assess and treat swallowing disorders that can lead to aspiration pneumonia, malnutrition, or airway obstruction if mismanaged. In tracheoesophageal puncture (TEP) management, SLPs provide care for individuals with total laryngectomy, including prosthesis changes and troubleshooting, where errors can result in aspiration of the device or airway compromise. Similarly, in tracheostomy and ventilator management, SLPs participate in speaking valve placement, secretion management, and weaning protocols—procedures that directly affect airway patency and respiratory status.

Additional areas of high clinical risk include:

- Instrumental swallowing assessments (e.g., videofluoroscopic swallow studies, FEES), which require accurate interpretation to guide life-sustaining nutrition and airway protection decisions.
- Cognitive-communication and language evaluations following acquired brain injury or stroke, which inform decisions about supervision, safety, and discharge planning.
- Augmentative and alternative communication (AAC) device programming for medically complex individuals, where errors can limit a patient's ability to express medical needs.
- Voice restoration and upper airway interventions, including working with head and neck cancer populations and post-surgical patients.
- Aspiration and aerodigestive disorders in the ICU/NICU may lead to increased morbidity and mortality.
- Delirium prevention and management, an acute medical condition linked to increased mortality, may lead to longer hospital stays, and decreased likelihood of discharge to home.

Because these services directly affect patients' ability to breathe, eat safely, communicate critical needs, and make medical decisions, they carry a clear potential for harm if performed incompetently.

OPLR looked at state disciplinary actions, ASHA's ethics complaints, and the U.S. Department of Labor's consequence of error ratings to determine that these professions cause "low harm." However, these data points are an incomplete measure of consumer harm. The low volume of formal disciplinary actions should not be interpreted as evidence of low risk. Rather, this statistic reflects the inherent difficulty consumers experience when attempting to file complaints, coupled with the reporting of harm across multiple, non-disciplinary systems, including:

- Hospital adverse event reporting systems (e.g., incident reports and readmissions for complications).

- Malpractice insurer datasets and closed claim reviews, which provide insight into litigation-level events.
- Internal facility Quality Assurance (QA) and risk management logs (within nursing homes, hospitals, and schools), which often manage incidents internally.

Licensure vs. Certification

The recommendation to move audiology and SLP to mandatory certification ignores the essential purpose of state licensure: the protection of consumers. A state license is a mandatory credential granted by a governmental authority that provides scope protection and is required to engage in the practice of a profession. Crucially, it establishes the legal authority to practice and ensures continuous oversight while maintaining strong public protection.

In contrast, a mandatory state certification, as proposed by OPLR, is a less restrictive form of regulation, often lacking the full enforcement and scope-of-practice protection that a license provides. While OPLR claims it will maintain current entry requirements and disciplinary oversight, removing the term "licensure" weakens the state's direct legal authority to regulate the scope of services offered, which is the primary mechanism for public protection.

OPLR's Flawed Comparison to Colorado

In stakeholder calls, OPLR relied heavily on Colorado's decision to "certify" SLPs as justification for this recommendation. However, this comparison is materially inaccurate and misleading.

In Colorado, the certification model is de facto licensure. The terms "certification" and "licensure" are used interchangeably by the Department of Regulatory Agencies (DORA). The credential is not a "one-and-done" step; it is a required state authorization to practice that maintains full regulatory oversight, including professional misconduct investigation, disciplinary action, and clear delineation of the legal scope of practice.

Colorado goes further than OPLR's proposal by requiring mandatory renewal and continuing education. Furthermore, Colorado requires practitioners to maintain a Healthcare Professions Profile, ensuring the public has up-to-date information on any disciplinary history.

Rather, OPLR's recommendation, which suggests a path to "certification" with no renewal process (a "one and done" credential) and allowing 500 hours of practice per year as a path to "continued professional competency," is drastically different from the Colorado model. Maintaining 500 hours of practice without any requirement for continuing professional development or demonstrated competence does nothing to ensure a practitioner is up-to-date on evidence-based practice and current technologies, such as advancements in complex swallowing rehabilitation or cochlear implant programming. This particular OPLR option is wholly inadequate for protecting the public.

Risk to Health Care Reimbursement and Access to Care

A move away from state licensure could directly compromise a practitioner's ability to obtain reimbursement for services, which would ultimately decrease access to care for Utah consumers, especially in rural areas.

OPLR indicated that they are relying on the Centers for Medicare & Medicaid Services (CMS) definition of a qualified professional for Medicare reimbursement. However, Utah Medicaid

specifically articulates in its provider manual that a “Qualified Health Professional is an individual who is qualified by education, training, licensure, and, regulation who performs a professional medical service within their scope of practice and is enrolled with Medicaid as a provider.”² The provider manual is incorporated by reference in the regulations surrounding SLP participation in Medicaid.³ Utah Medicaid, a state and federal program, recognizes the importance of licensure as part of proving qualification for serving some of the most vulnerable Utah residents.

Additionally, OPLR neglects to recognize that private payers/commercial insurance companies, which cover a significant portion of the Utah population, are not obligated to follow CMS definitions. Private payers often use state licensure as the primary gatekeeping credential for network inclusion and reimbursement eligibility. Downgrading the state's regulatory mechanism creates an immediate bureaucratic and legal ambiguity that private insurers will use to deny coverage for services, forcing patients to pay out-of-pocket or forgo essential treatment entirely.

ASHA strongly encourages further rigorous research and due diligence into the adverse effects this recommendation will have on reimbursement networks and the resulting decline in consumer access to medically necessary care.

Consumer and Practitioner Confusion

The proposed change from the well-understood term "licensure" to "mandatory certification" will create widespread confusion among consumers, practitioners, and other health care professionals.

In general health care regulation, certification is often understood to be voluntary or a specialty credential beyond the minimum standard set by licensure. Adopting the ambiguous term "mandatory certification" will blur regulatory lines, potentially leading to: (1) consumers struggling to determine the legitimacy of a provider; (2) other states potentially refusing to grant licensure by endorsement to Utah-certified professionals, creating barriers to professional mobility; and (3) an erosion of the professions' standing within the broader health care community.

We urge OPLR to reconsider this recommendation and maintain the current system of state licensure for audiologists and SLPs to ensure the highest standard of public protection and continued access to critical health care services for all Utah residents.

Thank you for your consideration of ASHA's position. If you or your staff have any questions, please contact Susan Adams, ASHA's director of state legislative and regulatory affairs, at sadams@asha.org.

Sincerely,



A. B. Mayfield-Clarke, PhD, CCC-SLP
2025 ASHA President

¹ American Speech-Language-Hearing Association. (2025). *Utah* [Quick Facts].

<https://www.asha.org/siteassets/advocacy/state-flyers/utah-state-flyer.pdf>

² Utah Department of Health and Human Services. (September 2025). *Utah Medicaid Provider Manual*.

<https://medicaid->

[documents.dhhs.utah.gov/Documents%2Fmanuals%2Fpdfs%2FMedicaid+Provider+Manuals%2FAI+Providers+General+Information+Section+I%2FAIProvidersGeneralInfo_Section_1.pdf](https://medicaid-documents.dhhs.utah.gov/Documents%2Fmanuals%2Fpdfs%2FMedicaid+Provider+Manuals%2FAI+Providers+General+Information+Section+I%2FAIProvidersGeneralInfo_Section_1.pdf)

³ Utah Admin. Code R414-54-1 (2023)