ISSUE BRIEF

AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT (ASLP-IC)

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

History of the ASLP Interstate Compact

Several years ago, the Council of State Governments (CSG), was asked to develop a model compact for allied health professionals, in this case, audiologists and speech-language pathologists. CSG is an organization dedicated to working with state officials to shape public policy and includes a policy program dedicated to developing interstate compacts. CSG received funding from ASHA and the National Council of State Boards of Examiners (NCSB) to draft their compact. Two years ago, the AAO-HNS was invited to share our comments on the proposed draft of the ASLP-IC. Unfortunately, the Academy's stated comments and concerns on the draft were ignored. The flawed compact was subsequently introduced in 12 state legislatures beginning in January 2020.

ADVOCACY: Unable to have our concerns heard, the AAO-HNS worked with the AMA to craft amendatory language that would clarify and improve the compact. Wherever possible, the Academy works with state otolaryngology societies and state medical societies to urge state legislators to add the AAO/AMA amendments to the bill.

What Is the ASLP Interstate Compact?

The proposed ASLP-IC is distinctly different than most of the other health professional licensure compacts. It is a "privilege to practice" compact which gives legal authority for the practice of audiology/speech pathology in a remote state without an additional license. This is achieved by simply applying to notify another member state in the compact that the individual will be practicing there. This model is very different than the Medical Licensure Compact that creates a voluntary expedited license.

What are the Major Issues with the ASLP Interstate Compact?

Briefly, there are 7 major issues with the compact:

1. **The proposed compact creates a Commission with the power to override state laws.** The states participating in the compact will have the ability to adjust scope of practice to mirror the requirements of the least restrictive states. This would allow members of the compact to bypass those states with stronger standards of practice in place designed to "protect the public" and maintain patient safety. Therefore, under the section entitled: "Establishment of the Audiology and Speech-Language Pathology Compact Commission," a new subsection should be added: *D. The Commission shall have no authority to change or modify the laws of the member states which define the practice of audiology and speech-language pathology in the respective states.*

2. **A lack of transparency by the Commission.** There are **no requirements in the compact for minutes of the Commission to be made available to the public.** Therefore, a sentence should be added to the language addressing the meetings of the Commission and the Executive Committee meetings: *All minutes and documents of meetings other than closed meetings shall be made available to members of the public.*

3. **Weak definition of telehealth and practice statement.** Ensure that the application of telecommunication meets the **appropriate standard of care** by amending the definition of telehealth to include the additional wording: "Telehealth means the application of telecommunication, *audio-visual or other technologies that meets the applicable standard of care* to deliver..." In alignment with this, it should be specified that compact licensees providing telehealth services must follow the telehealth laws and regulations of the client's locale. **Many states already have telehealth standards in place for the protection of the patient. These existing state provisions should be recognized** by adding an additional paragraph under the section entitled "Compact Privilege to Practice Telehealth": *A licensee providing audiology or speech-language pathology telehealth services in a remote state under the compact privilege shall function within the laws and regulations of the state where the patient/client is located.*

4. **Inadequate oversight of the Commission.** Of concern, in the section entitled "Oversight, Dispute Resolution and Enforcement", the section on **"Oversight" is conspicuously missing** and not addressed at all. Written information is needed on how oversight will be conducted.

For questions or concerns, please contact **stateleg@entnet.org**

5. **Physician members are excluded.** By statute, physicians are appointed members of the audiology/speech pathology licensing boards in **25** states. Despite this requirement, in the section entitled the "Establishment of the Audiology and Speech-Language Pathology Compact Commission" that describes eligible delegates to the Commission, the physician members are excluded. This means the composition of the Commission will not mirror the required board representation in nearly half the states. This omission sacrifices valuable collaboration and oversight in place to protect the public.

6. **Universal Licensure.** Unlike the medical licensure compact where a physician must be already licensed to practice in a state, this compact creates and dictates uniform licensure for two very different professions. This is detailed in the section entitled "State Participation in the Compact." Some of the organizations that helped craft the compact language have had universal licensure as a goal for many years. The rationale has been that it would increase accessibility to and reimbursement from third party payer sources. This is an unusual and inappropriate vehicle to use to establish such licensure.

7. **Active Duty Military.** The compact calls for active duty military (most of whom are already exempted in state occupational licensure laws) or their spouse to retain their home state designation. This is an unnecessary provision in the compact despite being used to garner support for the compact; most states have already addressed this issue. According to the Department of Defense, 39 states have already enacted laws that allow for endorsement of a current license from another state; 42 states have passed temporary licensure laws, 31 states now have laws for expedited applications procedures and 24 states have laws that utilize all three methods on behalf of military spouses. In addition, the National Defense Authorization Act allows up to $1,000 for re-licensure and costs related to relocations.

How is the Compact Financed/How Will it Impact the States?

The Compact Commission will levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of operations. The amount will be formulated by the Commission and will be binding upon all member states. At the present time, **the amount that will be imposed upon each state's budget is unknown**. Fiscal concerns have been noted in multiple states, particularly as **the compact would commit state agencies to unknown amounts that cannot be budgeted**. This is also onerous on a state that wishes to withdraw from the compact. In addition to a legislative repeal of the statute, the state's withdrawal is not effective until **6 months after the enactment of the repeal**. The state would likely still have to continue to pay their membership fee for half a year even after they have withdrawn from the compact.

Some state legislative analysts have also noted that the processing of the new "privilege to practice" applications will yield little time savings and a likely **increase in the overall regulatory burden**.

How Many States Must Join the Compact to Become Effective?

This interstate contract must be agreed to and passed by **10** state legislatures to become effective.