

GOLDEN THREAD

A GOLDEN THREAD WHITE PAPER

Access to Pediatric Cancer Care

State Licensure Barriers and the Case for Federal Reform

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Executive Summary

The practice of medicine in the United States is regulated at the state level, requiring physicians to obtain a separate license in each state where they treat patients. While this framework has served public safety objectives for over a century, it creates significant barriers for patients—particularly children with cancer—who require subspecialized care that may only be available from physicians in other states.

Pediatric cancer is a rare disease, with approximately 15,000 new cases diagnosed annually in children and adolescents less than 20 years of age. Treatment requires highly specialized multidisciplinary teams concentrated in a limited number of academic medical centers and children's hospitals, often located far from patients' homes. Many families must travel great distances to access the subspecialized care their children need. Increasingly, telemedicine offers a critical bridge, but patients' access remains restricted to physicians that are licensed in their state.

Congress and the states have recognized the need for cross-state medical practice in other contexts. Federal law permits Department of Veterans Affairs physicians to treat patients across state lines regardless of where they hold licensure. The Sports Medicine Licensure Clarity Act of 2018 protects team physicians who travel with athletic teams to other states. During the COVID-19 pandemic, virtually every state temporarily waived licensure requirements to ensure continuity of care in the setting of travel restrictions during the global pandemic. The Interstate Medical Licensure Compact has streamlined but not eliminated the multi-state licensing process for physicians in 44 member jurisdictions (42 states, Washington, DC, and Guam). Most recently, the Accelerating Kids' Access to Care Act, signed into law in February 2026 facilitates Medicaid and Children's Health Insurance Program (CHIP) provider enrollment across state lines for pediatric specialists. This Act offers a meaningful but limited step that helps facilitate medical billing but leaves the core licensure barrier unresolved.

This white paper argues that children with cancer deserve the same access to physicians that veterans, athletes, and pandemic-era patients have received. A recent Supreme Court decision, *Chiles v. Salazar*, adds a constitutional dimension to this debate, raising questions about whether state restrictions on physician speech in telemedicine visits can withstand First Amendment scrutiny. This white paper examines the current licensure landscape, existing exceptions and precedents, the unique challenges facing pediatric oncology patients, and the policy case for federal legislation enabling physicians who treat children with cancer to practice across state lines.

I. Background: Pediatric Cancer and the Need for Subspecialized Care

The Rarity of Childhood Cancer

Cancer in children and adolescents is rare. Approximately 15,000 individuals under the age of 20 are diagnosed with cancer each year in the United States, and about 9,680 of those are

children under age 15.¹ Under the U.S. Rare Diseases Act of 2002, which defines a rare disease as one affecting fewer than 200,000 people, all forms of pediatric cancer qualify as rare diseases.² While five-year survival rates have improved dramatically from 58% in the mid-1970s to approximately 85% today, this progress is a direct result of the highly specialized, multidisciplinary care that pediatric oncology demands.³ Additionally, there remain numerous pediatric cancers which are considered ultra-rare (affecting fewer than 7,000 people in America).^{4*} These cancers often lack standard of care therapies requiring even more subspecialized and expert pediatric oncology care.

Geographic Barriers to Access

A 2023 study examining geographic access to pediatric cancer care found that while 83.3% of children lived within 60 minutes of a pediatric oncologist, significant populations faced much longer travel times. Median travel times were longest for American Indian or Alaska Native children (46 minutes), residents of rural areas (95 minutes), and communities with high deprivation levels.⁵ This is also an issue for military families who are commonly stationed in rural areas where subspecialty care does not exist.⁶ For families whose children are diagnosed with ultra-rare or complex cancers requiring very specialized expertise available at only a handful of centers nationwide, the geographic barriers are even more substantial.

These families often face an impossible choice: uproot their lives to relocate near a treatment center, endure exhausting and expensive long-distance travel for regular appointments, or forgo the most specialized care available.

Unlike many adult cancers, pediatric cancers are biologically distinct and require treatment protocols developed specifically for children. The Children's Oncology Group (COG), a National Cancer Institute (NCI)-supported clinical trials network, coordinates care and research across more than 200 institutions. However, these specialized centers are concentrated in urban areas, and two states (Montana and Wyoming) lack any COG-affiliated institutions.

Access becomes even more limited for children who need early-phase clinical trials, typically the only treatment option for patients whose cancer has relapsed or is refractory to standard therapies. While COG institutions are numerous, the subset that participates in early-phase trials is far smaller. The COG Pediatric Early Phase-Clinical Trial Network (PEP-CTN), which conducts phase I/II studies of new therapies, operates at only a fraction of COG's member sites. Beyond COG, disease-specific consortia further concentrate this expertise at a handful of institutions nationwide. The Pediatric Brain Tumor Consortium (PBTC), previously funded by the NCI, conducted early-phase trials for children with brain tumors at 15 member sites. The Pediatric Neuro-Oncology Consortium (PNOC), New Approaches to Neuroblastoma Therapy (NANT) consortium, Therapeutic Advances in Childhood Leukemia & Lymphoma (TACL) consortium, and Collaborative Network for Neuro-oncology Clinical Trials (CONNECT) consortium each operate at a similarly small number of highly specialized centers. These groups collectively provide therapy options to some of the highest risk pediatric cancers, but access often remains limited to patients who reside in the locoregional footprint of a consortia site.

For a child with a relapsed brain tumor in rural Mississippi or a child with high-risk neuroblastoma in Montana, access to therapeutic trials can require long-distance travel to one of a very small number of institutions across the country. The geographic concentration of early-phase trial expertise means that cross-state medical practice is not a convenience but a medical necessity for children with cancer.

Telemedicine has emerged as a critical tool to bridge this gap by enabling follow-up consultations, treatment monitoring, and expert second opinions without requiring families to travel. But the promise of telemedicine for children with pediatric cancer is constrained by one persistent barrier: state medical licensure requirements that prevent their physician from legally providing care across state lines.

II. The History and Structure of Physician State Licensure

Constitutional Authority and the Modern Framework

States have long held the authority to license physicians and regulate medical practice within their borders, a principle upheld by the Supreme Court as far back as 1889.⁷

Physicians must hold a valid license in each state where they practice medicine. Because the practice of medicine is generally defined as occurring where the patient is located at the time of the encounter, not where the physician is located, this requirement applies equally to in-person visits and telemedicine visits. A pediatric oncologist in Philadelphia who conducts a video follow-up with a patient who has returned home to West Virginia is, under the law, practicing medicine in West Virginia and must hold a West Virginia medical license.

While the basic standards for medical licensure are broadly uniform (graduation from an accredited medical school, completion of residency training, passage of the United States Medical Licensing Examination), states impose their own additional requirements for acquiring and maintaining licenses. These varied and often burdensome requirements, in addition to the associated costs, deter physicians from obtaining licenses in multiple states, particularly when the patient population they would serve across state lines is small, as is the case with pediatric oncology.

An Emerging Constitutional Dimension

The constitutional framework governing state regulation of physician speech may be relevant to the telehealth licensure debate in light of a recent Supreme Court decision. In *Chiles v. Salazar*, the Supreme Court ruled 8-1 that a Colorado law prohibiting licensed therapists from engaging in talk-based conversion therapy with minors regulated speech, and that lower courts had erred by applying only rational-basis review rather than the heightened scrutiny the First Amendment requires. The Court rejected the argument that the law was insulated from First Amendment challenge because it regulated professional conduct rather than speech, holding that when the practical effect of a law is to control what a licensed professional may say to a patient, it constitutes a speech restriction subject to meaningful First Amendment scrutiny.⁸

The reasoning in *Chiles* has potential implications for state telehealth licensure requirements. A telemedicine visit between a physician and a patient in another state consists substantially of speech. The physician asks questions, explains diagnoses, discusses treatment options, and advises on next steps. When a state licensure requirement prohibits that consultation from occurring, its practical effect is to restrict what a licensed physician may communicate to a patient across state lines. Under the analytical framework articulated in *Chiles*, such a restriction may be more constitutionally vulnerable than courts have historically assumed.

The analogy is not perfect. States retain broad authority to regulate the medical profession on quality-of-care and public safety grounds. However, *Chiles* at minimum calls into question the assumption that professional conduct regulations with a significant speech component are insulated from First Amendment scrutiny. For children with cancer who depend on access to distant subspecialists, this constitutional uncertainty is an additional reason for Congress to address the licensure barrier directly through legislation, rather than leaving the question to be resolved through years of litigation.

III. Existing Exceptions and Precedents for Cross-State Medical Practice

The principle that physicians must be licensed in every state where they treat patients is not absolute. Federal law, interstate agreements, and state-level policies have carved out important exceptions in contexts where rigid adherence to single-state licensure would harm patient welfare or impede the delivery of care. These precedents demonstrate both the legal feasibility and the policy wisdom of allowing cross-state practice under defined circumstances.

The Department of Veterans Affairs: Federal Preemption

The most far-reaching existing exception to state licensure requirements is found within the Department of Veterans Affairs (VA) healthcare system. Under a November 2020 interim final rule, the VA confirmed its longstanding policy that VA health care professionals may practice their profession consistent with the scope and requirements of their VA employment, regardless of the state in which the patient is located and notwithstanding any conflicting state licensure requirements.⁹

This rule, part of the VA's "Anywhere to Anywhere" telehealth initiative, exercises federal preemption under the Supremacy Clause of the Constitution to override state licensing restrictions and state-specific telehealth laws. It allows VA physicians, nurses, and other health care providers to administer care to veterans using telehealth, regardless of where in the United States the provider or veteran is located.¹⁰

The rationale is compelling: veterans, particularly those in rural areas, should not be denied access to their physicians simply because they live in a different state from where their provider is licensed. As of January 2020, approximately 14% of the VA's 182,100 licensed healthcare professionals did not hold a license in the state of their main VA medical facility—yet they were

providing care to veterans across the country. During the COVID-19 pandemic, the VA deployed more than 3,000 health care professionals to 47 states under this authority.⁹

VA providers are still required to maintain a state license as a condition of employment, ensuring baseline competency standards. The exception applies to where they may practice, not whether they are licensed at all. This model demonstrates that federal preemption can coexist with meaningful quality oversight.

The Sports Medicine Licensure Clarity Act: Protecting Traveling Team Physicians

In 2018, Congress enacted the Sports Medicine Licensure Clarity Act, a federal law that protects sports medicine professionals who travel across state lines with athletic teams.¹¹ Prior to this legislation, a survey of state medical licensing boards found that 36 states (67%) did not have a clear legal pathway for team physicians to practice medicine when accompanying their team to another state and 27 states (50%) did not allow it at all.

The Act addresses the problem by ensuring that a covered sports medicine professional's medical malpractice insurance remains in effect when providing care in a state other than their state of licensure, provided they are treating an athlete, athletic team, or team staff member pursuant to an agreement with the team. The law effectively removes the practical barrier to cross-state medical practice for team physicians by clarifying the legal and insurance framework, even though it does not directly grant a license in the destination state.

The policy rationale is straightforward: athletes should be able to receive consistent care from the physicians who know them best, regardless of which state their team happens to be playing in. The same logic applies with even greater force to children with cancer, whose medical histories are complex, whose treatment protocols are highly individualized, and whose continuity of care is medically critical.

COVID-19 Emergency Waivers: A Natural Experiment

The COVID-19 pandemic produced what amounted to a natural experiment in cross-state medical practice. During the public health emergency, all 50 states and Washington, D.C. used emergency authority to waive at least some aspects of their licensure requirements, enabling physicians to provide telehealth services across state lines without holding a license in the patient's state.¹²

At the federal level, the Fourth Amendment to the Public Readiness and Preparedness (PREP) Act Declaration provided additional exemptions during the pandemic for providers delivering care for COVID-related needs under covered countermeasures using telehealth across state lines.¹³ The result was an unprecedented expansion of access to care, particularly for patients in rural and underserved areas.

As these waivers expired, the reinstitution of pre-pandemic licensure regulations disrupted established care relationships. Research has documented that this disproportionately impacted patients who live near state borders, geographically mobile patients such as college students, and patients with rare diseases who require care from out-of-state specialists.¹⁴

Children with cancer, whose diseases are by definition rare and who are often treated at institutions far from home, fall directly within this affected population.

The pandemic experience demonstrated two important things: first, that cross-state medical practice can be implemented safely and effectively when circumstances demand it; and second, that the expiration of temporary flexibilities causes real harm to vulnerable patients.

Other Existing Exceptions

Beyond these major precedents, a number of state-specific additional exceptions to strict single-state licensure already exist in various forms:

- **Consultation exceptions:** Some states permit out-of-state physicians to provide one-time or limited consultations at the request of an in-state physician, without requiring full licensure in the consulting state.
- **Border state agreements:** Some states allow physicians from neighboring states to provide telehealth services across their shared border.
- **Temporary practice permits:** Some states issue temporary or limited licenses for physicians accompanying patients who are traveling or who have recently relocated.
- **Military and federal physicians:** Beyond the VA, physicians employed by other federal agencies, including the Department of Defense and the Indian Health Service, practice under federal authority that supersedes state licensure requirements in defined contexts.

The Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC), which became operational in 2017, represents the most significant state-level effort to streamline cross-state physician licensure. Currently encompassing 44 member jurisdictions (42 states, the District of Columbia, and Guam), the Compact creates an expedited pathway for eligible physicians to obtain licenses in multiple member states through a single application.¹⁵

The Compact works by designating a physician's "state of principal licensure" to issue a letter of qualification, which is transmitted to other member states to facilitate expedited license issuance. Approximately 80% of U.S. physicians meet the eligibility criteria. However, the IMLC is not a license itself—physicians must still obtain and pay for separate state licenses, comply with each state's continuing education requirements, and submit to each state's jurisdiction and disciplinary authority.

The process to obtain medical licensure in states that do not participate in the IMLC is even more onerous. Application processing typically takes two to four months, with some states requiring six months or more for physicians with lengthy practice histories or international medical graduates. The preparation of paperwork itself is challenging as each state requires its own application forms, letters of reference, verification of training credentials, malpractice history disclosures, and often notarized documents. A pediatric oncologist seeking to provide

telemedicine visits to children in ten states could spend thousands of dollars and many months navigating ten different bureaucratic processes.

The financial burden of maintaining licenses in multiple states is substantial. Initial application fees alone range from approximately \$75 to over \$1,400 per state, with an average of roughly \$500 when application and license fees are combined. Many states also require criminal background checks (\$10–\$50), fingerprinting (\$15–\$50), and Federal Credentials Verification Service (FCVS) processing (\$395). Renewal fees add further ongoing costs. California, for example, charges \$1,206 for biennial renewal, and renewal cycles vary by state, typically occurring every one to three years, meaning physicians must track different deadlines and continuing education requirements for each state license they hold.

While the Compact is a meaningful step forward, it does not eliminate these burdens. It streamlines the initial application, but physicians must still pay for and maintain each individual state license, satisfy each state's distinct renewal and continuing education requirements, and absorb the cumulative cost and administrative overhead. Some member states impose additional requirements beyond the Compact process and not all states have joined or will join the Compact. For a pediatric oncologist who may need to provide telemedicine follow-up or second opinions to patients in many different states, the Compact does not solve the fundamental problem.

The Accelerating Kids' Access to Care Act: A Recent Legislative Milestone

In a significant recent development directly relevant to this white paper's subject matter, Congress enacted the Accelerating Kids' Access to Care Act (AKACA) as part of the Consolidated Appropriations Act of 2026, signed into law on February 3, 2026. In doing so, Congress formally acknowledged a reality that advocates for children with cancer have long documented: children with complex medical conditions routinely must travel across state lines to access the specialized care they need. The very premise of AKACA is that federal law must facilitate out-of-state care for children. The Act confirmed congressional recognition that cross-state access to pediatric specialists is an established and necessary feature of how children with serious illnesses receive care in the United States. The legislation addresses a specific but critical barrier by allowing and making more efficient interstate physician enrollment into the burdensome Medicaid and Children's Health Insurance Program (CHIP) programs, which commonly delay or prevent out-of-state specialists from treating children covered under these programs.

Prior to AKACA, when a child on Medicaid needed care from an out-of-state specialist, a common case for children with cancer seeking treatment at leading pediatric oncology centers, the treating physician was required to undergo the full Medicaid provider screening and enrollment in the child's home state. This was required even when the physician was enrolled in good standing in their own state's Medicaid program. This duplicative screening delayed care by weeks or months, a particularly serious problem for children with rapidly progressing cancers where care cannot wait.

AKACA creates a streamlined national pathway for out-of-state providers to enroll in multiple state Medicaid programs, provided they meet certain qualifications: they must not have been excluded or terminated from any federal health care program or state Medicaid program, and they must have been enrolled in Medicare or a state Medicaid program based on a determination that they pose a limited risk of fraud, waste, or abuse.

The bipartisan legislation drew broad support from children's health advocacy organizations, all of which cited the particular importance of the legislation for children battling cancer and other rare diseases.

AKACA represents an important step forward, but it is a partial solution. Its passage constitutes a bipartisan, bicameral acknowledgment that children regularly cross state lines to receive medical care. Such care can include second opinions, assessment for clinical trial eligibility, or to establish ongoing treatment from a specialist unavailable in their home state. If Congress has already accepted the premise that children must travel across state lines for subspecialized care, the logical next step is to give them access to that same care while alleviating the burden of travel. For a family whose child is fighting cancer, every trip across state lines means time away from home, work, school, and psychosocial support systems. These added hardships become overwhelming when added to the already impossible experience of having a child with cancer. The better solution for patients, families, physicians, and the health system, is to allow children to receive care from the specialists they need without having to leave home.

IV. The Case for Federal Legislation for Pediatric Oncology

Why Existing Solutions Are Insufficient

While the IMLC, state-level consultation exceptions, and other existing mechanisms provide partial relief, they are insufficient to meet the needs of children with cancer and their families. The IMLC streamlines but does not eliminate the burden of multi-state licensure. Consultation exceptions are typically limited to one-time interactions and do not support the ongoing care relationships that cancer treatment requires. Temporary practice permits are inconsistent across states and rarely designed with pediatric subspecialists in mind. The recently enacted AKACA addresses Medicaid and CHIP enrollment delays for out-of-state providers, but it does not resolve the underlying state medical licensure requirement and applies only to publicly insured children.

The fundamental problem remains: a pediatric oncologist at a leading children's hospital who provides initial treatment to a child from another state cannot legally continue to manage that child's care via telemedicine once the child returns home, unless the physician holds a license in the child's home state. Equally problematic, a family seeking a critical second opinion from a renowned specialist only available at an out-of-state institution faces the same barrier, the specialist cannot even evaluate the child's case via telemedicine without first obtaining a license in the family's state. For rare and complex pediatric cancers, where only a handful of experts may exist nationwide, the inability to access these physicians for consultations and second opinions can have life-or-death consequences.

The Precedent Is Clear

The federal government has repeatedly demonstrated its willingness and authority to create exceptions to state licensure requirements when patient welfare demands it. The VA exception is grounded in federal preemption. The Sports Medicine Licensure Clarity Act reflects congressional recognition that continuity of care should follow patients across state lines. The COVID-19 waivers showed that cross-state practice can be implemented rapidly and safely when the political will and critical health requirements exist.

If Congress determined that a professional football player's access to a team physician is important enough to warrant federal legislation and that a veteran's access to a VA provider is important enough to warrant federal preemption of state law, a vulnerable child battling cancer deserves the same protection.

Key Principles for Legislation

Federal legislation enabling cross-state practice for physicians treating children with cancer should be guided by several core principles:

1. **Defined clinical scenarios:** The legislation should specify the clinical circumstances under which a physician may practice across state lines to care for a child with cancer. These should include: (a) providing a second opinion or initial diagnostic consultation at the request of a patient's family or referring physician; (b) evaluating a child for eligibility for a clinical trial; (c) continuing treatment management for a child who has received or is receiving care at the physician's institution; and (d) providing follow-up care, including telemedicine visits, to monitor a child's response to treatment or manage complications. Each of these scenarios reflects a real and recurring need in pediatric oncology where state licensure barriers currently prevent or delay access to care.
2. **Maintained quality standards:** Physicians should be required to hold a valid, unrestricted license in at least one state, consistent with the VA model. The goal is to remove geographic barriers while preserving competency safeguards.
3. **Coverage of both in-person and telehealth encounters:** The legislation should permit both telemedicine visits and in-person follow-up care when a physician travels to a patient's state, similar to the protections afforded to sports medicine professionals.
4. **Malpractice and liability clarity:** Following the model of the Sports Medicine Licensure Clarity Act, the legislation should clarify that malpractice insurance coverage remains in effect for cross-state practice and should address which state's laws govern the physician-patient relationship.
5. **Disciplinary accountability:** The physician's home state licensing board should retain primary disciplinary authority, with mechanisms for cooperation with the patient's state if complaints arise, mirroring the framework established by the Interstate Medical Licensure Compact.

V. Conclusion

The state-by-state medical licensure system was designed to protect patients. But when that system prevents children with cancer from accessing the subspecialized physicians who are best equipped to save their lives, it is failing in its most fundamental purpose.

Pediatric cancer is rare. The physicians who treat it are few and geographically concentrated. The children who develop these diseases and their families are already bearing extraordinary burdens. Adding the barrier of state licensure, requiring their oncologist to obtain a separate license simply to conduct a telemedicine follow-up or adjust a treatment protocol remotely, serves no meaningful patient safety purpose that cannot be addressed through the quality safeguards already demonstrated by the VA model, the IMLC, and as seen during times of global health crises. The Supreme Court's recent decision in *Chiles v. Salazar*⁸ further suggests that state restrictions on professional speech in a clinical context may face heightened First Amendment scrutiny.

Congress has acted before to protect cross-state medical practice when the need was clear for veterans, for athletes, and during a pandemic. The need is equally clear for the approximately 15,000 children diagnosed with cancer each year. Federal legislation allowing physicians who care for children with cancer to practice across state lines would ensure that no child is denied access to the best possible care because of an arbitrary geographic boundary.

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** The “ultra-rare” threshold is widely used in the rare disease advocacy and clinical literature but is not formally codified in U.S. federal statute.*

About Golden Thread

Golden Thread is a physician-led nonprofit with a clear mission: to remove the barriers that stand between a child with cancer and the care that could save their life. We leverage a diverse cross-sector network — spanning government, healthcare, philanthropy, education, and corporate partners — to tackle specific challenges, connect resources, and remove the financial, structural, and systemic barriers that slow progress in pediatric cancer.

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