No. 25-347

IN THE
Supreme Court of the United States

UNITED STATES OF AMERICA AND STATE OF MICHIGAN EX REL. ERIK OLSEN, M.D., WILLIAM BERK, M.D., AND SAJITH MATTHEWS, M.D.,

Petitioners,

v.

TENET HEALTHCARE CORPORATION; DETROIT MEDICAL CENTER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE AND THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS AS AMICI CURIAE IN SUPPORT OF THE PETITION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes

Regulations

Other Authorities

INTEREST OF AMICI CURIAE[1]

The American Academy of Emergency Medicine (AAEM) is a professional society of emergency physicians established to promote fair and equitable practice environments necessary to allow board-certified emergency physicians to deliver the highest quality of emergency care to every individual who seeks care in an emergency department. Through advocacy and education, AAEM champions:

- The integrity of the doctor–patient relationship, free of outside interference;
- The personal and professional well-being of emergency physicians; and
- Unencumbered access to high-quality emergency care for every individual regardless of race, ethnicity, sexual identity or orientation, religion, age, socioeconomic or immigration status, or physical or mental disability.

AAEM believes boarding is a national health emergency that negatively impacts emergency department patients, physicians, and other healthcare workers.

The American College of Emergency Physicians (ACEP) represents more than 38,000 emergency physicians, emergency medicine residents, and medical students. ACEP promotes the highest quality of

[1] Counsel for amici curiae notified counsel for all parties at least 10 days prior to the due date of amici's intention to file this brief. Amici certify that no counsel for a party authored this brief in whole or in part and no person or entity, other than amici or their counsel, has made a monetary contribution to the preparation or submission of this brief.

emergency care and is the leading advocate for emergency physicians, their patients, and the public. ACEP continually strives to improve the quality of emergency medical services through the development of evidence-based clinical policies, funding emergency medicine research, providing public education on emergency care and disaster preparedness, legislative and regulatory advocacy efforts, providing industry-leading continuing medical education in the form of educational conferences, online training, professional references and news magazines, and publishing Annals of Emergency Medicine, the specialty's leading peer-reviewed scientific journal.

INTRODUCTION

The practice of "boarding" admitted patients—that is, keeping them in emergency departments for a prolonged time while waiting for inpatient beds—is as dangerous as it is widespread. Patients come to the emergency department in urgent need of medical care, but those ill enough to be admitted often wait for hours or even days, with one in four being boarded for four hours or more. Lying on gurneys in emergency department hallways or wherever else there is space, boarded patients receive only a small fraction of the nursing and other medical care they would get in better-resourced inpatient beds. The results of this practice are roughly what one would expect: Inadequately treated and monitored patients suffer, incur lasting injuries, and sometimes even die, all while considered "inpatients" in hospitals whose very function is to care for them.

The prevalence of boarding is cause for outrage—as are profits generated by the lack of care inherent to boarding. When hospitals bill Medicare and Medicaid

for inpatient services boarded patients may not actually receive, their gains are extracted from the public fisc at the expense of boarded patients' suffering. But in five circuits, emergency physicians and others who know of these practices are nevertheless powerless—unless they somehow have visibility into hospitals' billing records—to blow the whistle and protect patients.

The best solution is to put a stop to boarding writ large. At the very least, however, whistleblowers who are aware of these practices should be able to sound the alarm.

The Court should grant the petition for a writ of certiorari.

ARGUMENT

I. The boarding crisis is a national health emergency.

Boarding represents a grave risk to patient health in the United States. Boarding compromises patient care and outcomes, yet despite its negative effects on patients, the practice is extremely common.

A. Emergency departments are ill equipped to care for inpatients.

Emergency departments are not equipped to provide the depth of care admitted inpatients need. Rather, emergency departments are equipped and intended to rapidly assess and treat patients experiencing medical emergencies. *See* Nicholas M. Mohr et al., *Boarding of Critically Ill Patients in the Emergency Department*, 48 Crit. Care Med. 1180, 1181 (2020),

https://tinyurl.com/ynmdb3u2. Emergency physicians are trained to manage the initial hours of acute illness and trauma, not ongoing care. *Id.*

Patients boarded in the emergency department are also unlikely to receive the full nursing care that admitted inpatients require. Appropriate nurse-staffing levels are critical to proper patient care. Katie Boston-Leary et al., *Patient Safety Amid Nursing Workforce Challenges*, PSNet (Apr. 24, 2024), https://tinyurl.com/ywbvd642; Sarah N. Musy et al., *The Association Between Nurse Staffing and Inpatient Mortality*, 120 Int'l J. Nursing Stud. 1, 8 (2021), https://tinyurl.com/2fwajyth. Higher nursing ratios are positively correlated with better patient outcomes, Daleen Aragon Penoyer, *Nurse Staffing and Patient Outcomes in Critical Care*, 38 Critical Care Medicine 1521, 1527 (2010), https://tinyurl.com/mtew7tre, and lower nursing ratios with increased patient mortality, Jack Needleman et al., *Nurse Staffing and Inpatient Hospital Mortality*, 364 New England J. Med. 1037, 1043 (2011), https://tinyurl.com/55mwakn2. But while inpatient and intensive-care unit (ICU) services include defined nurse-to-patient ratios, emergency departments usually do not. For example, most U.S. adult ICUs maintain a nurse-to-patient staffing ratio of one nurse to every two patients. Hayley B. Gershengorn et al., *ICU Staffing in the United States*, 166 CHEST 743, 752 (Oct. 2024); *see* Victoria Rich, *Nursing Staffing Ratios*, PSNet (Aug. 1, 2009), https://tinyurl.com/3bhdz4we ("The standard rule of thumb is to have a nurse–patient ratio of … 1:2 in ICUs."). That ratio is the "minimum nurse-patient ratio" an ICU may maintain in order to qualify as an "intensive care type unit" for purposes of Medicare

cost reporting/reimbursement. *See* 42 C.F.R. § 413.53(d)(5).

But unlike with ICUs, Medicare does not require a specific nursing ratio for emergency departments. What it does require is that emergency department staff provide care to all patients who arrive—regardless of staffing levels. *See* 42 U.S.C. § 13955dd(a)-(b). In the emergency department, volume and acuity of arriving patients is unpredictable. It is not unusual for an emergency department to experience a large influx of patients in a short period of time, *see* Reham Mostafa & Khaled El-Atawi, *Strategies to Measure and Improve Emergency Department Performance*, 16 Cureus e52879, at 2 (2024), https://tinyurl.com/aaebwzju, and those patients often have urgent or critical needs. As a result, nurses are stretched thin, leaving each patient with a smaller share of essential nursing care.

B. Boarding harms patients.

Given the mismatch between emergency department resources and inpatient needs, it should come as no surprise that housing admitted patients in the emergency department is associated with negative outcomes. The damage done by boarding is well established by scientific studies and academic literature, and its real-world effects are devastating.

Boarding leads to reduced quality of care for critically ill patients. When boarded, such patients experience an increase in medication-related adverse events, as well as delays in medication initiation, antibiotic and fluid administration, and disease-specific, protocol-based care. Mohr et al., *supra*, at 1183.

Boarding of the critically ill is also associated with poor clinical outcomes. Critically ill patients who are first boarded tend to be in the ICU longer and on mechanical ventilation longer—and they are more likely to die. *Id.* at 1182-83. For every eighty-two admitted patients whose transfer to an inpatient bed is "delayed beyond six to eight hours" from their arrival at the emergency department, "there is one extra death." Simon Jones et al., *Association between Delays to Patient Admission from the Emergency Department and All-Cause 30-Day Mortality*, 39 Emerg. Med. J. 168, 168 (2022), https://tinyurl.com/4kvbjjhp. Longer boarding times are also associated with longer hospital stays, worsening organ disfunction, and "a fourfold increase in the probability of poor neurologic recovery" for patients presenting with stroke. Mohr et al., *supra*, at 1183.

Boarding harms even patients who are not boarded. It increases the length of stay of *all* emergency department patients—including those who are admitted without being boarded, Leslie A. Laam, *Quantifying the Impact of Patient Boarding on Emergency Department Length of Stay*, 2 J. Am. Coll. Emerg. Phys. Open e12401, at 8 (2021), https://tinyurl.com/JACEP1, and those who are discharged rather than admitted, Benjamin A. White et al., *Boarding Inpatients in the Emergency Department Increases Discharged Patient Length of Stay*, 44 J. Emerg. Med. 230, 232 (2013), https://tinyurl.com/bdehm8pe. And it can delay care for new emergency department arrivals. Jones et al., *supra*, at 172.

The cited academic literature firmly establishes that boarding is harmful to patients writ large—and behind each statistic are individual people who have

suffered needlessly because of boarding. Firsthand accounts from emergency physicians tell the stories of many, including: an elderly woman who slumped over in the emergency department waiting room with complete renal failure and was then boarded for an entire day before being transferred to the ICU, *Emergency Department Boarding Stories—It's a Tragedy*, ACEP, https://tinyurl.com/3996zxum (last visited Oct. 20, 2025); an immobile patient boarded in a hallway and hooked up to a portable urine-suction machine with no privacy, *Emergency Department Boarding Stories—Without Privacy*, ACEP, https://tinyurl.com/444sanxh (last visited Oct. 20, 2025); and an eighty-one-year-old woman with a broken hip who, "because of how boarded" the emergency department was, had to wait for six hours before being seen, "inches from an intoxicated man who was vomiting on himself and other patient screaming obscenities," without pain medication or the ability to use the bathroom, *Emergency Department Boarding Stories—MacGyver Solutions*, ACEP, https://tinyurl.com/mr4b92cf (last visited Oct. 20, 2025). These, and the stories related in the petition (at 8-9), convey but an infinitesimal fraction of the damage done by boarding.

C. Boarding exacerbates emergency department staff burnout.

Emergency department staff are also negatively affected by boarding. In addition to expressing concerns about boarding's effect on patient safety and care, emergency physicians report that boarding contributes to burnout and to a "high prevalence of verbal and physical abuse" by patients. Vicki Norton et al.,

Workforce Impact of Emergency Department Boarding, 3 Health Aff. Scholar qxaf134, at 2 (July 2025), https://tinyurl.com/f3fxarcj.

Physicians' firsthand accounts are filled with stories that illustrate boarding's toll. One physician reported that "[i]t's embarrassing to have such limited resources to offer patients who arrive in distress. I am aware of at least two cases where someone has died due to delays in being seen. Multiple providers have left our department due to the stress of an untenable work environment." *Emergency Department Boarding Stories—Everything with Nothing*, ACEP, https://tinyurl.com/yrtwuu7v (last visited Oct. 22, 2025). According to another, "[w]e have been operating under crisis standards of care for years, and our patients are suffering. Our staff is suffering with the moral injury imposed upon us by this horrendous medical system in which we operate. Our patients and providers need help!" *Emergency Department Boarding Stories—Moral Injury*, ACEP, https://tinyurl.com/6mpvph6v (last visited Oct. 22, 2025).

D. Boarding is widespread.

Despite boarding's well-documented ill effects, the practice is common. The Joint Commission—the largest U.S. accreditor of hospitals and other healthcare organizations, *see Accreditation*, The Joint Commission, https://www.jointcommission.org/en-us/accreditation (last visited Oct. 17, 2025)—has long recognized that boarding patients for over four hours constitutes a safety risk. The Joint Commission, *Patient Flow through the Emergency Department*, R3 Report, Dec. 19, 2012, at 1-2, https://tinyurl.com/ysf6vjhp. Yet boarding for more than four hours "has become increasingly widespread." Alexander T. Janke et al.,

Hospital 'Boarding' of Patients in the Emergency Department Increasingly Common, 44 Health Affs. 739, 742 (2025). Between June and September 2024, around twenty-five percent of admitted patients were boarded in U.S. emergency departments for more than four hours. *Id.* at 739; *see also id.* at 742 (even "[b]oarding in excess of twenty-four hours, which was rare before the pandemic, is now more common"). Physicians report dozens of patients being boarded in their emergency departments simultaneously, sometimes for days at a time. *See, e.g.*, *Emergency Department Boarding Stories—It's a Tragedy, supra* ("For over a year now we have been boarding 60–80 patients daily in our 80–90 bed ED."); *Emergency Department Boarding Stories—A National Issue,* ACEP, https://tinyurl.com/2c6ezxn4 (last visited Oct. 20, 2025) (reporting a continuous "holding of ten to 30 patients in our emergency department for seven to 72 hours"); *Emergency Department Boarding Stories—Leave without Being Seen*, ACEP, https://tinyurl.com/4j9haus6 (last visited Oct. 20, 2025) ("We have had 20+ boarders in an ED with 40 beds on many days over the last few months.").

II. The current legal framework enables practices that perpetuate boarding.

A. Hospitals already have a profit motive to board patients.

Hospitals have a financial incentive to admit patients as inpatients while keeping them in the emergency department. "Hospitals make more money if patients are admitted." David H. Howard, *The Hospital Inpatient-Outpatient Payment Differential*, 6 JAMA Health Forum e253293, at 1 (2025), https://tinyurl.com/y7eehw73. With respect to patients on

Medicare, "payments for inpatient care are about $3000 higher than those for the equivalent treatment delivered on an outpatient basis." *Id.* But billable inpatient status is not tied to a particular level of care or to the patient's physical location in the hospital. The Centers for Medicare and Medicaid Services (CMS) defines an "inpatient" as "a person who has been *admitted* to a hospital for bed occupancy purposes," even if "it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight." Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., *Medicare Benefit Policy Manual, ch. 1* § 10 (rev. 10892, Aug. 6, 2021), https://tinyurl.com/47s9jk7f (emphasis added).

Appropriately staffing inpatient beds—while critical to patient care, *see supra* pp. 4-5—is expensive. *See, e.g.*, *The Cost of Caring*, Am. Hosp. Ass'n (Apr. 2025), https://tinyurl.com/3je7cxbj. Boarding enables hospitals to categorize and bill patients as inpatients without necessarily providing the expected, baseline level of inpatient care (including appropriate nursing coverage).

B. Practices like those at issue here enhance the profit motive to board patients.

Present CMS rules do not prohibit boarding. The practice of labeling and billing boarded patients as inpatients/ICU patients is unethical, not least because it constitutes a misrepresentation of the level of care patients are actually receiving—but it is not by itself unlawful. *See supra* pp. 9-10. It is AAEM's and ACEP's fervent belief, grounded in our members' medical experience, that this must change.

When profit motives outweigh the emphasis on providing quality patient care, patients are put in jeopardy. For example, the acquisition of hospitals by private-equity firms is correlated with increased patient death rates, Jake Miller, *Deaths Rose in Emergency Rooms After Hospitals Were Acquired by Private Equity Firms*, Harv. Med. Sch. (Sept. 22, 2025), https://tinyurl.com/y7j9th53, and with higher incidence of hospital-acquired adverse events like falls and central-line-associated bloodstream infections, Sneha Kannan et al., *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2371 (2023), https://tinyurl.com/39dcm3sn. When private operators acquire hospitals, they often save costs by cutting staff. *See* Miller, *supra*; James R. Webster, *Private Equity and the Ravaging of United States Health Care*, 122 Mo. Med. 7, 8 (2025), https://tinyurl.com/mr3nvhxa; Mark Duggan et al., *The Impact of Privatization*, NBER Working Paper No. 30824, at 3 (Sept. 2024), https://tinyurl.com/4aer9fmr. Workforce reduction reduces the nursing ratios that are so crucial to proper patient care, *supra* pp. 4-5, and exacerbates boarding, *see* Norton et al., *supra*, at 1.

When patients are labeled as inpatients but remain housed in the emergency department, hospitals are able to bill for inpatient services like higher-level nursing care, meals, and medication that may not actually be provided. *See* Pet.App.55a-57a, 60a-74a. Although CMS and its Recovery Audit Contractors audit inpatient claims, those reviews are retrospective and limited in scope, and they typically target medical-necessity documentation rather than the actual provision of inpatient-level care. Hospitals may there-

fore bill for inpatient services during prolonged emergency department boarding, knowing that patients are receiving care inconsistent with what is reimbursed. The resulting gains are extracted at the high price of patient safety and wellbeing.

III. Emergency physicians in five federal circuits cannot currently blow the whistle.

Emergency physicians frequently witness boarding. *See, e.g.*, *supra* pp. 6-8. They are well aware of the needless suffering it engenders, *see, e.g.*, *id.*, and of how badly it affects patient care and outcomes, *see supra* pp. 5-7. They may also know that their hospitals' billing protocols include submissions of claims for inpatient care for boarded patients. But because emergency physicians generally lack visibility into hospitals' billing records, such physicians are powerless, in five federal circuits, to protect patients by blowing the whistle on the practice.

That is unacceptable. Boarding itself is a harmful practice that the law does not recognize as fraudulent, but the law *does* prohibit billing for inpatient services that are not provided. Emergency physicians who are privy to conditions that cause patients harm should not be required to look the other way—regardless of the circuit in which they work. The Court should grant the writ and empower emergency physicians to protect their patients against the opportunistic billing practices boarding facilitates.

CONCLUSION

The Court should grant the petition for a writ of certiorari.

Respectfully submitted.

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