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Disproportionate Impact: Supreme Court Narrows Disproportionate Share Hospital Reimbursement to Supplemental Security Income Cash Recipients

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The U.S. Supreme Court has issued a significant ruling affecting hospitals that serve low-income Medicare beneficiaries, narrowing the interpretation of the Disproportionate Share Hospital ("DSH") payment formula. In Advocate Christ Medical Center v. Kennedy, the Court determined that only Medicare patients who were eligible to receive a cash Supplemental Security Income ("SSI") payment during the month of their hospitalization may be included in the calculation for additional DSH reimbursement. This decision represents a setback for more than 200 hospitals that had advocated for a broader, more inclusive definition of SSI entitlement, potentially reducing the financial support available for treating Medicare's poorest patients.

The DSH Program and the Medicare Fraction at Issue

Medicare, the government-funded health insurance program for elderly and disabled Americans, reimburses hospitals for inpatient services at standardized rates based on diagnosis-related groups. Since this fixed-rate system does not account for the higher treatment costs of low-income patients—who often face greater health challenges and social service needs—Congress established the DSH adjustment to support hospitals serving these populations. The DSH adjustment increases reimbursement to incentivize providers to maintain access for underserved patients.

The DSH adjustment is calculated using two fractions:

- **Medicare fraction** – the percentage of a hospital's Medicare patients who are also entitled to SSI, a proxy for low-income Medicare beneficiaries.
- **Medicaid fraction** – the proportion of total patient days attributable to individuals not entitled to Medicare, but eligible for Medicaid.

This system ensures hospitals receive additional financial support for treating economically disadvantaged patients.

The dispute revolved around the calculation of the Medicare fraction—specifically, the definition of "entitled to [SSI] benefits" under 42 U.S.C. §1395ww(d)(5)(F)(vi)(I).

More than 200 hospitals argued that all patients enrolled in SSI at the time of hospitalization should be counted, even if they did not receive an SSI payment during the month of their hospitalization. They maintained that SSI entitlement continues unless an individual remains ineligible for 12 consecutive months and emphasized that SSI benefits extend beyond cash payments to include services like continued Medicaid coverage. In contrast, the United States Department of Health and Human Services ("HHS")—the federal agency tasked with calculating and administering the DSH adjustment—asserted that only patients who received an SSI cash payment during their hospitalization month qualified under the statute. HHS emphasized that SSI is a monthly, cash-based benefit, meaning entitlement applies only when an individual is eligible for and *receives* payment in a given month.

In a 7–2 decision, the Supreme Court sided with HHS. The majority reasoned that SSI benefits consist of monthly *cash* payments provided to low-income individuals who meet certain financial and categorical eligibility criteria and did not include non-cash benefits such as ongoing Medicaid eligibility or access to vocational services. The Court reasoned that the SSI program is structured to assess eligibility for those cash payments on a month-by-month basis, based on an individual's income and resources during each specific month. Accordingly, the Court determined a person may be eligible for a payment in one month and ineligible in the next, even if they remain otherwise enrolled in the SSI program.

Building out from this understanding, the Court concluded that a Medicare patient is "entitled to SSI benefits" within the meaning of the Medicare fraction only if they receive an SSI cash payment during the month of their hospitalization. In reaching this conclusion, the majority rejected the argument that general enrollment in the SSI program suffices to establish entitlement. Rather, the Court reasoned that the phrase "entitled to benefits" in this context tracks the monthly cash-payment eligibility that defines the structure of the SSI program, thereby requiring that the Medicare beneficiary actually receive their SSI cash payment during the month of their hospitalization. Because Congress specifically tied the Medicare fraction numerator to this entitlement, the Court held that hospitals may count only those Medicare patients whose monthly income and resource levels made them eligible for an SSI cash benefit during the month of hospitalization.

The Court rejected the hospitals' broader reading and dismissed the dissent's arguments, which characterized the SSI benefit as a long-term, insurance-style entitlement. The majority also rebuffed the notion that non-cash services (such as Medicaid continuation) could be counted as SSI benefits under the Medicare statute. Finally, the Court held that the 12-month reapplication provision cited by the hospitals did not mean patients remained "entitled" to benefits during months of ineligibility—it merely required reenrollment after a year without payments.

What's Next? Reimbursement Impacts for Safety-Net Hospitals

The Court's decision reinforces a narrow, text-based approach to statutory interpretation in the Medicare context, and limits hospitals' ability to count patients enrolled in—but not actively receiving—SSI as low-income for DSH reimbursement purposes. While the ruling clarifies how the Medicare fraction must be calculated, it also lowers reimbursement for safety-net hospitals serving economically vulnerable populations. Meanwhile, recent litigation in other courts has already begun to reshape related aspects of the DSH formula, signaling that judicial scrutiny of HHS's interpretation of reimbursement provisions is far from settled. Providers should thus assess how this decision may affect their DSH payments and monitor whether Congress or CMS pursue additional legislative or regulatory changes in response.

Proskauer's Health Care Group is closely monitoring developments in this area. For more insights into this and related regulatory trends, subscribe to the Health Care Law Brief.

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