Practice Areas

- Appellate & Supreme Court
- Health Care & Life Sciences

Industry Sectors

- Insurance

Education

- Georgetown University Law Center, J.D., 1975
- Rutgers University, A.B., 1972

Bar Admissions

- District of Columbia
- Pennsylvania

Court Admissions

- U.S. Court of Appeals for the District of Columbia Circuit
- U.S. Court of Appeals for the Sixth Circuit
- U.S. Court of Appeals for the Tenth Circuit
- U.S. Court of Appeals for the Third Circuit
- U.S. District Court -- District of Columbia
- U.S. District Court -- Eastern District of Pennsylvania
- U.S. Supreme Court

Affiliations

- American Bar Association
- American Health Lawyers Association
- Pennsylvania Bar Association

Awards & Honors

- 2017 and 2019 Health Law Lawyer of the Year in Philadelphia by Best Lawyers in America
- Best Lawyers in America 2005-2025
- Chambers & Partners USA 2014-2024
- Pennsylvania Super Lawyers 2004-2022
- Business Today, Top 10 Visionary Health Care Lawyers Shaping Pennsylvania's Legal Landscape in 2023

Mark H. Gallant

Of Counsel

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Mark concentrates his practice in client counseling and litigation involving federal and state regulation of health care providers and third-party payers. Prior to entering private practice in Philadelphia in 1988, Mark served as the deputy chief counsel to the Centers for Medicare & Medicaid Services in Washington, D.C., where he managed all litigation under the Medicare and Medicaid programs for the federal government nationally. Prior to that, Mark served for more than 10 years with the Civil Division of the U.S. Justice Department and U.S. Attorney's Office in D.C.

Perennially listed in *The Best Lawyers in America* and selected as a Pennsylvania "Super Lawyer" by his peers, Mark is a recipient of Martindale-Hubbell's highest rating. He has written and lectured widely for the American Health Lawyers Association, Pennsylvania Bar Association, and other organizations on Medicare and Medicaid reimbursement, state/federal regulations under the Medicaid program, Medicaid managed care and compliance with health care fraud and abuse laws, and serves as a co-chair of AHLA's annual Medicare and Medicaid Reimbursement Institute. He also is the author of the Medicaid Reimbursement section of the American Health Lawyers Association (Clark, Boardman, Callaghan) *Health Law Practice Guide* and speaks regularly at AHLA and Pennsylvania Bar Institute programs on governmental and third-party payer health care reimbursement and fraud issues. He also serves as a planning committee member and co-chair for AHLA's Annual Medicare and Medicaid Reimbursement Institute in Baltimore.

Mark has served as counsel of record in litigation and other matters for health care systems, hospitals, pharmacy chains, durable medical equipment manufacturers and suppliers, long-term care providers, and for national and state trade associations. Mark's representative matters for health care industry clients have included:

• Litigation resulting in the invalidation of CMS reaudit rule that prevented teaching hospitals from adding misclassified teaching costs to their base-year Average Per Resident Amounts.

• Defense of False Claim Act investigations and *qui tam* suits, including settlement of a Medicare "outlier" fraud case with no corporate integrity agreement.

• Rulemaking comments on behalf of national trade association contesting CMS' proposal to eliminate Medicaid funding for graduate medical education costs.

• Formulation and legal audits of provider taxes and intergovernmental transfers (IGTs) on behalf of hospital, trade association, and governmental clients.

• Suits and high stakes arbitrations against private third-party payers and Medicaid managed care plans (involving down-codes, disallowances, breach of contract claims, and out-of-network reimbursements).

• Negotiations and restructuring of third-party payer contracts.

• Successful suits against various states challenging reductions to Medicaid reimbursement, including budget-driven Medicaid cuts and rate discrimination against out-of-state providers.

• Litigation resulting in the Third Circuit *University Medical Center* rule (prohibiting Medicare

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recoupments against health care providers operating in bankruptcy reorganization).

• Part A reimbursement hearings before the Provider Reimbursement Review Board, including a PRRB decision striking CMS' requirement for filing duplicate claims forms with Part A intermediaries as a condition of receiving medical education supplements for Medicare managed care enrollees.

Mark earned his undergraduate degree from Rutgers University-New Brunswick in 1972 and his law degree from Georgetown University Law Center in 1975.

Experience

Won summary judgment, affirmed by the U.S. Court of Appeals for the Third Circuit, on behalf of an employee health plan operated by a health system in an ERISA case involving the recovery of a substantial overpayment to an out-of-network health care provider by the plan on behalf of a plan beneficiary. The opinion clarifies ambiguities in recent Supreme Court cases governing recoveries by ERISA plans based on equitable liens by agreement. The circuit court found that our client's claims were equitable rather than legal, thus permitted by ERISA, and awarded the plan an equitable lien by agreement based on a provision of the plan requiring the return of overpayments made in error. The plaintiff was ordered to repay our client the substantial overpayments. Additionally, we won summary judgment on the provider's ERISA claims against our client, through which the provider sought $1.2 million in reimbursement based on its full-billed charges.

Represented New Jersey Hospital Association in *New Jersey Hospital Ass'n v. Waldman, 73 F.3d 509* (3d Cir. 1995). Challenge by New Jersey hospitals to reduction of DRG rates and adequacy of disproportionate share payments.

Represented Children's Seashore House in *Children's Seashore House v. Waldman, 197 F. 654* (3d Cir. 1999), affirming constitutional claim to require state to pay Medicaid disproportionate share adjustments to out-of-state providers.

Provided guidance to hospital client regarding inter-relationship of state and federal patient safety laws.

Assisted a local hospital obtain training reimbursement rates from Medicare after an eight year fight from the initial administrative appeal challenging the government's interpretation of its re-audit rules to a federal case in the Third Circuit. The court ordered the government to recalculate its reimbursements without reliance on its discriminatory re-audit rule.

Prohibited Medicare program from recouping pre-petition overpayments from hospitals that have filed for bankruptcy in In re: *Universal Medical Center, 973 F.2d 1065* (3d Cir. 1992).

Defended a multi-state provider of behavioral health services against a False Claims Act suit brought by the federal and state governments, and advised the client with respect to its obligations under a resulting Corporate Integrity Agreement.

Represented the American Hospital Association and Association of American Medical Colleges as friends of the court in In re: *Cardiac Device Litigation* (Second Circuit U.S. Court of Appeal) involving Medicare billings for services including investigational devices.

Represented physician group practices before the New Jersey Board of Medical Examiners in connection with compliance with the New Jersey anti-referral law, commonly referred to as the "Codey Law."

Represented a national pharmacy chain in various regulatory counseling on manufacturer rebate programs, patient refill compliance programs, federal fraud and abuse compliance, and issues related

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to an affiliated PBM.

Represented a national pharmacy chain in regulatory advice and defense of claims by state PACE programs involving application of mandatory discounts.

Served as counsel to a national long term care pharmacy specialty provider in connection with Pennsylvania Medicaid rate setting and compliance issues.

Represented national nursing home chain in Medicare Part A appeals involving "related party" (institutional pharmacy) reimbursements.

Served as compliance counsel for several long term care organizations.

Represented a major hospital center in an arbitrated dispute with a Medicaid Managed Care Organization (MCO). Over the hospital's objection, the MCO sought to justify failures to pay for hospital services on medical necessity grounds, even though the MCO had denied the relevant claims solely for lack of authorization. After the arbitrator ruled in the hospital's favor on this issue and a variety of others, the matter settled on favorable terms for our client.

Represented an air ambulance company in a dispute with a Medicaid managed care organization (MCO) that refused to pay more for out-of-network transportation services than the federal default rate applicable to emergency hospital services. We brought suit alleging that the default rate did not apply, that the MCO had breached an implied-in-fact contract with the company and the terms under which it participated as a Medicaid plan, and that the MCO had been unjustly enriched. After the court denied most of a motion to dismiss by defendant, the matter settled on favorable terms for our client.

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