§ 54.609 Designation of Consortium Leader.

(a) *Identifying a Consortium Leader.* Each consortium seeking support under the Healthcare Connect Fund Program must identify an entity or organization that will lead the consortium (the ''Consortium Leader'').

(b) *Consortium Leader eligibility.* The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity that is ineligible for Healthcare Connect Fund Program support. Ineligible state organizations, public sector entities, or non-profit entities may serve as Consortium Leaders or provide consulting assistance to consortia only if they do not participate as potential service providers during the competitive bidding process. An ineligible entity that serves as the Consortium Leader must pass on the full value of any discounts, funding, or other program benefits secured to the consortium members that are eligible health care providers.

(c) *Consortium Leader responsibilities.* The Consortium Leader's responsibilities include the following:

(1) *Legal and financial responsibility for supported activities.* The Consortium Leader is the legally and financially responsible entity for the activities supported by the Healthcare Connect Fund Program. By default, the Consortium Leader is the responsible entity if audits or other investigations by Administrator or the Commission reveal violations of the Act or Commission rules, with individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. Except for the responsibilities specifically described in paragraphs (c)(2) through (6) in this section, consortia may allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (*i.e.*, the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to the Administrator for approval with, or prior to, the request for services. Any such agreement must clearly identify the party(ies) responsible for repayment if the Administrator, at a later date, seeks to recover disbursements of support to the consortium due to violations of program rules.

(2) *Point of contact for the FCC and Administrator.* The Consortium Leader is responsible for designating an individual who will be the ''Project Coordinator'' and serve as the point of contact with the Commission and the Administrator for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and Administrator inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.

(3) *Typical applicant functions, including forms and certifications.* The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, pursuant to § 54.610.

(4) *Competitive bidding and cost allocation.* The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.

(5) *Invoicing.* The Consortium Leader is responsible for notifying the Administrator when supported services have commenced and for submitting invoices to the Administrator.

(6) *Recordkeeping, site visits, and audits.* The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements and for coordinating site visits and audits for all consortium members.

§ 54.610 Letters of agency (LOA).

(a) *Authorizations.* Under the Healthcare Connect Fund Program, the

Consortium Leader must obtain the following authorizations:

(1) Prior to the submission of the request for services, the Consortium Leader must obtain authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the request for services and prepare and post the request for proposal on behalf of the member.

(2) Prior to the submission of the funding request, the Consortium Leader must secure authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the funding request and manage invoicing and payments on behalf of the member.

(b) *Optional two-step process.* The Consortium Leader may secure both required authorizations from each consortium member in either a single LOA or in two separate LOAs.

(c) *Required information in a LOA.* (1) An LOA must include, at a minimum, the name of the entity filing the application (*i.e.,* lead applicant or Consortium Leader); the name of the entity authorizing the filing of the application (*i.e.,* the participating health care provider/consortium member); the physical location of the health care provider/consortium member site(s); the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the health care provider/consortium member; the signature date; and the type of services covered by the LOA.

(2) For health care providers located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate Tribal leader, such as the Tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another Tribal government representative.

§ 54.611 Health care provider contribution.

(a) *Health care provider contribution.* All health care providers receiving support under the Healthcare Connect Fund Program shall receive a 65 percent discount on the cost of eligible expenses and shall be required to contribute 35 percent of the total cost of all eligible expenses.

(b) *Limits on eligible sources of health care provider contribution.* Only funds from eligible sources may be applied toward the health care provider's required contribution.

(1) Eligible sources include the applicant or eligible health care provider participants; state grants, appropriations, or other sources of state funding; federal grants, loans, appropriations except for other federal universal service funding, or other sources of federal funding; Tribal government funding; and other grants, including private grants.

(2) Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from service providers, including contractors and consultants to such entities; and for-profit entities.

(c) *Disclosure of health care provider contribution source.* Prior to receiving support, applicants are required to identify with specificity their sources of funding for their contribution of eligible expenses.

(d) *Future revenues from excess capacity as source of health care provider contribution.* A consortium applicant that receives support for participant-owned network facilities under §54.614 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations:

(1) The consortium's selection criteria and evaluation for ''cost-effectiveness,'' pursuant to §54.622(g)(1), cannot provide a preference to bidders that offer to construct excess capacity;

(2) The applicant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network;

(3) The additional cost of constructing excess capacity facilities