 <p>JOHNS HOPKINS MEDICINE JOHNS HOPKINS ALL CHILDREN'S HOSPITAL</p>	Johns Hopkins All Children's Hospital, Inc.	<i>Policy Number</i>	RC003
	Revenue Cycle General	<i>Effective Date</i>	07/01/2019
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This document applies to the following Participating Organizations:

Johns Hopkins All Children's Health System
 Johns Hopkins All Children's Home Care
 Johns Hopkins All Children's Hospital
 Pediatric Physician Services, Inc. (FL)
 West Coast Neonatology, Inc.

Keywords: AGB, FAP, Financial Assistance, Financial Assistance Application, Medical Hardship

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I. SCOPE


This policy further applies to all locations operating under the license of the participating organizations. All entities are further referred to as “Provider Healthcare System” and includes all hospital facilities and regional outpatient centers. A listing of all providers, in addition to the Hospital itself, delivering emergency or other medically necessary care at the Hospital that specifies which providers are covered by this policy and which are not covered, is updated quarterly on our website www.hopkinsallchildrens.org/financialassistance.

II. PURPOSE

The purpose of the Financial Assistance Policy ("FAP") is to comply with Section 501(r) of the Internal Revenue Code of 1986, as amended (the “Code”) and the Treasury Regulations issued thereunder.

III. POLICY STATEMENT

- A. **Commitment to Provide Financial Assistance:** Provider Healthcare System is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. A Provider Healthcare System Financial Counselor, designated business office representative, or committee with authority to offer financial assistance will review each individual case and make a determination of financial assistance that may be offered in accordance with this policy
- B. **Commitment to Provide Emergency Medical Care:** Provider Healthcare System provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this


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policy. Provider Healthcare System will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all Provider Healthcare System patients in a non-discriminatory manner, pursuant to Provider Healthcare System EMTALA policy.


- C. Accordingly, this written policy:
1. Includes eligibility criteria for financial assistance – from partial to fully discounted care;
 2. Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy;
 3. Describes the method by which patients may apply for financial assistance;
 4. Describes how the hospital will widely publicize the policy within the community served by the hospital; and
 5. Describes the limited amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the hospital for commercially insured patients
- D. Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Provider Healthcare System procedures for obtaining financial assistance or other forms of payment or external financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

IV. DEFINITIONS

Family Income	Patient's and/or financially responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, and natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.

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Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. The patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property may be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non-qualified deferred compensation plans.
Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by Provider Healthcare System. Medical Debt does not include those hospital bills for which the patient chose to be registered as Elective Self-Pay (opting out of insurance coverage, insurance billing or services deemed elective).
Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Elective Procedure	An elective procedure is defined as medical treatment that is not necessary to protect the health status of a patient and will not adversely impact the patient's condition if omitted, in accordance with accepted standards of medical practice. For the purposes of this policy, elective procedures include but is not limited to procedures for the convenience of the patient or cosmetic in nature.



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Medical Financial Hardship Assistance	Defined as Medical Debt for medically necessary treatment incurred by a family over a twelve (12) month period that exceeds 50% of that family's household income.
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V. PROCEDURE

A. Eligibility for Financial Assistance:

1. Eligibility for financial assistance will be considered for those individuals who:
 - a. Are uninsured, underinsured, ineligible for any government health care benefit program, and/or have excessive Medical Debt and who are unable to pay for their care, based upon determination of financial need in accordance with this Policy; and
 - b. A citizen of or permanent legal resident, residing for a minimum of one (1) year, in the United States of America and a resident of the state of Florida for the past six (6) months; and
 - c. Have cooperated fully with the Medical Assistance team or its designated agent in the application for Medical Assistance including the completion of the Provider Healthcare System Financial Assistance Application; and
 - d. Applied and been denied for Florida Medicaid, Florida Medicaid Managed Care or Federal Medicare benefits; and
 - e. Ineligible for other resources (i.e. endowment funds, external foundation support, etc.) or have exhausted all insurance benefits.
2. A preliminary screening using household size and income as defined by Federal Poverty Guidelines will be accepted for a probable determination of financial assistance eligibility.
3. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social status, sexual orientation or religious affiliation. All determinations of eligibility for financial assistance shall be solely at the Provider Healthcare System's discretion.
4. Provider Healthcare System shall determine whether or not patients are eligible to receive financial assistance for deductibles, co- insurance, or co-payment responsibilities.
5. Deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient are not eligible for financial assistance.
6. Presumptive Financial Assistance Eligibility:
 - a. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, Provider Healthcare System reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Furthermore a list of life circumstances that may qualify a patient for Presumptive Eligibility is:
 - i. Active Medical Assistance pharmacy coverage

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- ii. Qualified Medicare Beneficiary (QMB) coverage/ Specified Low Income Medicare Beneficiary (SLMB) coverage
 - iii. Primary Adult Care Program (PAC) coverage
 - iv. Homelessness
 - v. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs. For example, patients qualifying for Emergency Medical Assistance coverage, receiving services outside of the ER.
 - vi. Public Health System Emergency Petition patients
 - vii. Participation in Women, Infants and Children Programs (WIC)
 - viii. Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility
 - ix. Eligibility for participation in other state or local assistance programs such as:
 - Medically Needy (Share of Cost Medicaid)
 - Children's Medical Services
 - x. Patient is deceased with no known estate
7. Medical Financial Hardship Assistance:
- a. Medical Financial Hardship Assistance is available for patients whom:
 - i. Medical Debt incurred over a twelve (12) month period exceeds 50% of the Family Income creating Medical Financial Hardship; and
 - ii. Meet income standards for this level of assistance; and
 - iii. Exhausted all insurance coverage options/benefits; and
 - iv. Patient and/or guarantor do not own liquid assets in excess of \$10,000 which would be available to satisfy the Provider Healthcare System bills; and
 - v. Patient is not eligible for Medical Assistance or other forms of assistance through Provider Healthcare System or affiliates.
 - b. Factors for consideration for Medical Hardship:
 - i. Medical Debt incurred over the twelve (12) calendar months preceding the date of the Financial Assistance Application.
 - ii. Liquid Assets (leaving a residual of \$10,000)
 - iii. Family Income for the twelve (12) calendar months preceding the date of the Financial Assistance Application.
 - iv. Supporting Documentation
 - v. The Financial Assistance Committee or equivalent reserves the right to make exceptions according to individual circumstances.
 - c. Medical Hardship Approval Grid:
 - i. Medical Bills Exceeding 50% of family income = 70% of Financial Assistance
 - ii. Medical Bills Exceeding 60% of family income = 80% of Financial Assistance
 - iii. Medical Bills Exceeding 70% of family income = 90% of Financial Assistance
 - iv. Medical Bills Exceeding 80% of family income = 100% of Financial Assistance
 - d. If patient is approved for a discount based upon financial hardship it is recommended that the patient make a good-faith payment at the beginning of the financial assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set above, Provider Healthcare System shall make a payment plan available to the family/patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated director, a payment schedule may be extended.



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B. Services Eligible Under This Policy:


1. For purposes of this policy, "financial assistance" refers to healthcare services provided by Provider Healthcare System at a discounted patient responsibility rate or without patient responsibility to qualifying patients. If qualifying under this policy, the following healthcare services are eligible for financial assistance:
 - a. Emergency medical services provided in an emergency room setting;
 - b. Medically necessary services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
 - c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting;
 - d. Medically necessary services, evaluated on a case-by-case basis at Provider Healthcare System's discretion.
2. The following healthcare services are ineligible for financial assistance:
 - a. Non-essential or elective services such as cosmetic surgery, cosmetic dentistry, and convenience items;
 - b. Private room accommodations that are not medically necessary;
 - c. Services provided to patients registered as Elective Self Pay patients;
 - d. Certain elective services, designated by each clinical department, for which no Financial Assistance will be given.
 - e. Services not covered by Medicare, Medicaid or other third-party payers when these services can be covered by another performing facility or provider as required by a patients insurance.
3. The admitting physician and/or the physician advisor appointed by Provider Healthcare System will be consulted when questions arise as to whether a service is "elective" or "medically necessary."

C. Methods by Which Patients May Apply for Financial Assistance Care:

1. The patient/family is required to:
 - a. Apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. In cases where the patient has active Medical Assistance pharmacy coverage, Medically Needy or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient/family may be awarded full Medical Assistance benefits.
 - b. Provide the following documentation:
 - i. A completed Financial Assistance Application (Appendix A).
 - ii. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations)
 - iii. A copy of paystubs for the last six (6) weeks (if employed), award letters for unemployment, workers compensation, public assistance, alimony, retirement, notarized letter of income, and/or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - iv. A Medical Assistance Notice of Determination, if applicable.
 - v. Proof of U.S. citizenship or lawful permanent residence status.
 - vi. Proof of Florida Residency.
 - vii. Proof of disability income, if applicable.
 - viii. Reasonable proof of other declared expenses.
 - ix. Reasonable proof of unemployment such as statement from the Office of Unemployment Insurance or a statement from current source of financial support, if applicable
2. Individuals cannot be denied financial assistance based on failing to provide information and/or documentation not required and identified in this policy.

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3. A department operating programs under a grant or other outside governing authority may continue to use a government-sponsored application process and associated income scale.
4. Referral of patients for financial assistance may be made by any member of the Provider Healthcare System staff or medical staff, including physicians, nurses, financial counselors, business office staff, social workers, case managers, chaplains, and religious sponsors, and third party collection agencies. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
 - a. Designated staff will meet with and/or contact patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - b. Each Clinical or Business Unit will designate a person(s) responsible for collecting Financial Assistance applications and forwarding the applications in the current approved process (Appendix B). These staff can be but is not limited to Financial Counselors, Patient Access Staff, Admissions Staff, Office Assistants, Patient Service Representatives, and Customer Service Representatives.
 - c. If a patient account has been assigned to a collection agency and the patient or guarantor request financial assistance or appears to qualify for financial assistance, the collection agency shall notify the Provider Healthcare System Business Office and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to Provider Healthcare System Business Office for review and determination and shall place the account on hold for 45 days pending further instruction from Provider Healthcare System Business Office. If the collection agency receives the Financial Assistance application in error from the patient they will forward the application in the currently approved process (Appendix B).
 - d. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the designee will forward the application and documentation to the Provider Healthcare System Business Office Director(s) or Senior Director of Revenue Cycle.
 - e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor or designee and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
5. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
 - a. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
 - b. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);
 - c. Include reasonable efforts by Provider Healthcare System to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
 - d. Take into account the patient's available assets, and all other financial resources available to the patient; and
 - e. Include a review of the patient's outstanding accounts receivable for prior services rendered, the patient's payment history, accounts placed in bad debt except those accounts on which a lawsuit has been filed and a judgment obtained, and any projected medical expenses.
6. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any

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point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six (6) months prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

7. Provider Healthcare System values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly and Provider Healthcare System shall notify the patient or applicant in writing within 30 days of receipt of a completed application. If additional documentation and information is necessary to make a determination on an application, the business office designee will contact the patient/applicant.


D. Financial Assistance Available:

1. Services eligible under this Policy will be made available to the patient in accordance with financial need as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination.
 - a. Patients whose family income is at 200% or below of the FPL and they do not own Liquid Assets in excess of \$10,000, which would be available to satisfy their Provider Healthcare System bills, are eligible to receive care discounted at 100% of gross charges.
 - b. Patients whose family income is between 201% and 300% of the FPL and they do not own Liquid Assets in excess of \$10,000, which would be available to satisfy their Provider Healthcare System bills, are eligible to receive care discounted at 85% of gross charges.
 - c. Patients whose family income is between 301% and 400% of the FPL and they do not own Liquid Assets in excess of \$10,000, which would be available to satisfy their Provider Healthcare System bills, are eligible to receive care discounted at 70% of gross charges.
2. Financial assistance shall only be applied to all outstanding balances for eligible services owed to Provider Healthcare System including balances owed to Provider Healthcare System employed physicians operating under this policy.

E. Amounts Generally Billed:

1. Once a patient has been determined by Provider Healthcare System to be eligible for financial assistance, that patient shall not be charged more than the Amounts Generally Billed (AGB) for emergency or other medically necessary care provided to individuals with insurance covering that care as required by federal law.
2. The AGB is determined using the "look-back method" at the Provider Healthcare System.
3. The AGB calculation is as follows:
 - a. AGB percentages are calculated annually for each Provider Healthcare System entity by dividing the sum of certain claims paid by Medicare fee-for-service and private insurers by the associated gross charges for those claims.
 - b. The AGB for emergency and medically necessary care provided to a financial assistance eligible individual is determined by multiplying gross charges for that care by one or more AGB percentages.
 - c. The AGB is calculated by reviewing all past claims paid in full to Provider Healthcare System for emergency and medically necessary care by Medicare fee-for-service and all private health insurers, including co-insurance, copayments, and deductibles, during a specified twelve month period.
4. AGB percentages are applied by the 120th day after the end of the 12-month calendar year period the hospital facility used in calculating the AGB percentages. Current applicable calculation can be found in Appendix D.
5. Provider Healthcare System does not bill or expect payment of gross charges from individuals who qualify for financial assistance under this policy.


F. Financial Assistance Denial Recourse:

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1. If the financial assistance application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor or designee will forward any application where reconsideration was requested to the Financial Assistance Evaluation Committee for final evaluation and decision.
 2. The Financial Assistance Evaluation Committee will have decision-making authority to approve or reject applications previously denied. It is expected that any application under reconsideration is approved or denied within 60 days from date request was received. The following members shall make up the Financial Assistance Evaluation Committee: Director of Patient Access/Admissions, Director of Patient Accounts, and Director of Professional Billing. The Committee may consult with the Senior Director of Revenue Cycle and/or the CFO/ Vice President of Finance for final determination of eligibility.
- G. Communication of the Financial Assistance Plan to Patients Within the Community:
1. Notification about financial assistance available from Provider Healthcare System, which shall include a contact number and website address, shall be disseminated by Provider Healthcare System by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the Conditions of Admission form, at care centers, admitting and registration departments, hospital business offices, Provider Healthcare System may elect. A summary of Provider Healthcare System's Financial Assistance Policy will be provided to patients upon intake or discharge and will be available to all patients upon request. Provider Healthcare System also shall publish and widely publicize a summary of this financial assistance care policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital/providers as Provider Healthcare System may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Provider Healthcare System.
 2. Notification of all Provider Healthcare System providers of emergency and medically necessary care, which shall include a determination about whether or not the financial assistance policy applies to the eligible provided services, shall be disseminated by Provider Healthcare System by various means, which shall include, but are not limited to, its publication on facility websites and included within this policy.
- H. Relationship to Collection Policies:
1. Information regarding the actions that Provider Healthcare System may take in the event of nonpayment is in a separate Self-Pay Collection Policy. Members of the public may obtain a free copy of this separate policy from Provider Healthcare System via the contact information listed below, in Section VII.
 2. The Self-Pay Collection Policy sets forth policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action). The policy takes into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from Provider Healthcare System, and a patient's good faith effort to comply with his or her payment agreements with Provider Healthcare System. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their medical bills, Provider Healthcare System may offer extended payment plans which may be managed and monitored by outside collection agencies. Provider Healthcare System will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient.

VI. RESPONSIBILITIES

- A. All appropriate staff members of the Provider Healthcare System are responsible for understanding the Financial Assistance conversation in accordance to their role.
- B. Business Office Management Personnel (Team Leader, Business Office Designee(s), Business Office Manager, and Business Office Director(s)):

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1. Are responsible to ensure timely submission of all Financial Assistance Applications to the Financial Assistance Review Committee for official determination.
 2. Timely adjustments are taken to all open patient balances with approved Financial Assistance.
- C. Financial Assistance Committee (Business Office Director(s), Director of Patient Access, and Business Office Designee(s)).
1. Using Appendix C Financial Assistance Review Committee Template, will determine the official approved or denied status to every patient with a submitted incomplete or complete application.
 2. If at any time escalation is needed to determine or review an approved or denied status the Financial Assistance Review Committee will have the Senior Director of Revenue Cycle and the Chief Financial Officer to make the final approved or denied decision.

VII. PROVIDER HEALTHCARE SYSTEM CONTACT INFORMATION


- A. Facility Name:
1. Johns Hopkins All Children's Hospital, Inc.
 2. Pediatric Physician Services, Inc.
 3. West Coast Neonatology, Inc.
- B. Contact Department:
1. Hospital Business Office Department # 6500002405
 2. Physician Business Office Department # 6500002400
- C. Phone:
1. Financial Assistance Direct Line: 727-767-3475
 2. Hospital Business Office Department Line: 727-767-4410
 3. Physician Business Office Department Line: 727-767-4488
- D. Website:
1. www.hopkinsallchildrens.org
 2. www.hopkinsallchildrens.org/financialassistance
- E. Physical Address:
- 501 6th Avenue South,
 - St. Petersburg, FL 33701
- F. Mailing Address:
- Johns Hopkins All Children's Hospital
 - Attn: Financial Assistance Dept # 2405
 - 501 6th Ave S
 - St. Petersburg, FL 33701

VIII. APPROVAL

Revision History:

- 8/14/2019- Editorial changes made.

Electronic Signature(s)	Date
Christopher Whitby	06/28/2019

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Thomas Kmetz	07/01/2019
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Johns Hopkins All Children's Hospital, Inc. (JHACH) is formerly known as All Children's Hospital, Inc. (ACH) and may be used interchangeably in this document.

IX. SUPPORTIVE INFORMATION

Related Documents:

- Request for Hospital Service Charges
- Reimbursement for Patient Care
- Emergency Medical Care FIN008
- Emergency Medical Treatment and Labor Act (EMTALA)
- Patient Evaluation Treatment or Transfer to Other Hospitals (PTCRE014).
- Signage, Flyers, Banners and Works of Art (SUPSR014)

Ownership:

- Finance

Subject Matter Expert's Title/Position (if applicable):

- Director, Hospital Business Office
- Director, Physician Business Office
- Senior Director, Revenue Cycle