HEALTHSMART

INNOVATIVE INSIGHTS INTO MODERN HEALTHCARE

Q2 2020

FEATURED ARTICLES

THE FUTURE OF HEALTHCARE

TELEHEALTH TAKEAWAYS AND LESSONS LEARNED

ADVIS PETS MAKE THE BEST COWORKERS

SPOTLIGHT

FRED ASTAIRE DANCE STUDIOS

advis YOUR SMART HEALTHCARE CONSULTANTS

MILLION mask MOVEMENT

THANK YOU TO OUR HEALTHCARE HEROES!

advis

YOUR SMART HEALTHCARE CONSULTANTS

A Note from Lyndean

The past quarter has been a time for heart-felt gratitude and deep reflection. Let's start with a simple thank you to all of our healthcare heroes. Our team at Advis cannot begin to express the gratitude we have for all of our clients and providers working on the frontlines against COVID-19. Throughout the country our clients and colleagues have reaffirmed their commitment to stand against systematic racism. Our healthcare institutions are evolving. It has been a distinct honor to assist your administrative teams during these challenging times.

Yet even as we celebrate healthcare workers everywhere, we must also mourn the victims. Scenes from the pandemic offer dramatic testimony to the importance of the social determinants of health. Well over 100,000 dead and counting- the elderly, the poor, people of color, people with co-morbidities and our own frontline healthcare workers. Our healthcare system must address systemic racism, poverty, homelessness, unemployment and violence as well. Our country's blatant disregard of the need for meaningful reforms that serve all people can no longer be tolerated. Our inadequate social organization costs too much money and way too many lives. Healthcare providers must be vigilant to ensure that social determinants of health are addressed in a substantive way.

As our country continues to endure the effects of the pandemic, racism, poverty, and gross inequality, I must nonetheless report that I continue to stand in awe of our Advis team and how it has performed during these challenging times. The support they have given our clients navigating crisis response has been truly impressive. Despite the strain and the challenges, the experts at Advis have continually exemplified the values we stand for by putting clients first, themselves second, while providing cutting-edge solutions to every pressing business and regulatory need imaginable.

In this issue, readers will see that Advis remains at the forefront of all COVID-19 updates and regulatory changes. We propose what is to come for American healthcare. Temporary flexibilities and regulatory changes abound, and we outline what is likely to persist into the new world of post-pandemic healthcare. The benefits of telemedicine have never been more apparent. We summarize how important this channel of medical care will continue to be. On a lighter note, we show off all of the Advis pets. They have kept our spirits high and in good company throughout the quarantine. And we discuss as well the Million Mask MOVEment initiative; it began with Advis in an effort to provide our clients and nationwide providers with personal protective equipment.

So, here's to all the everyday heroes. People who work tirelessly to keep our country strong and safe and healthy. We're about to enter a new world of healthcare. Hopefully it is a world where we are prepared and equipped for the medical, financial and social challenges ahead. We know we will be here to help.

Lyndean

Advis is Moving

Advis is thrilled to be moving into our new Tinley Park location in August! Find us at our new address:

ADVIS
7840 GRAPHICS DR
SUITE 100
TINLEY PARK, IL 60477

SPOTLIGHT

on Jake Beechy

Jake Beechy is a Senior Consultant at Advis and a vital team asset. We want to congratulate Jake for receiving his Master of Business Administration Degree with a concentration in Healthcare Administration from Benedictine University. Jake has added serious business acumen to his already formidable legal acumen. When Jake speaks, the team and his clients listen.

Jake's healthcare expertise focuses on Regulatory Compliance, Facility Development, Medicare Rules and Regulations, Governance, CON, and State Licensure Requirements. Jake works with our clients to ensure that compliance standards are met to better drive efficient operations for hospitals and healthcare systems alike. He is well versed in conducting feasibility studies for new hospital projects to ensure bottom-line success for those facilities.

Additionally, Jake assists healthcare providers by analyzing and preparing state licensure/CON applications and provider-based attestations. He works with our clients to ensure compliance with Medicare and Medicaid billing and reimbursement requirements to capture maximum reimbursement.

Prior to joining Advis, Jake served as an Associate Attorney at a Chicagoland law firm specializing in personal injury and worker's compensation. Along with recent completion of his MBA degree from Benedictine University, Jake received his J.D. from Northern Illinois University College of Law and a B.A. in Communication from the University of Illinois, Urbana-Champaign.

EVENT UPDATE

Golf Outing Cancelation

Due to the unfortunate circumstances of COVID-19, and for everyone's health and safety, Advis has decided to cancel the 2020 Annual Golf Outing and Healthcare Seminar.

We are so disappointed that our annual event cannot be staged this year. The Golf Outing is an event we always look forward to and hope you do, too.

We may not be able to gather at Olympia Fields Country Club this year, but we would love to keep the tradition going and still provide a learning experience with practical and detailed information for our valued clientele. At Advis we provide an innovative approach to all we do. Be on the lookout for further details regarding an upcoming webinar.

For questions, please contact Sade Larkin at **slarkin@advis.com**.

NEW HIRE

Hannah Pfaff

Hannah Pfaff is Advis' new Marketing Coordinator. During her time with Advis so far, Hannah has excelled. She continues to successfully integrate her knowledge of marketing with the healthcare market. She assists many of our consultants daily by contributing her writing and marketing expertise to numerous client projects. Hannah manages the production process and content for all of Advis' Marketing efforts, including our newsletter, case studies, and e-mail blasts. She collaborates almost daily with our communications and public affairs team at Serafin and Associates.

Prior to joining Advis, Hannah worked as a Marketing Project Manager for 3 years at a creative marketing firm. She received a Bachelor degree in Public Relations and Psychology from the University of Central Arkansas.

DOING OUR PART

Million Mask Movement

FRED ASTAIRE DANCE STUDIOS

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MILLION mask MOVEMENT

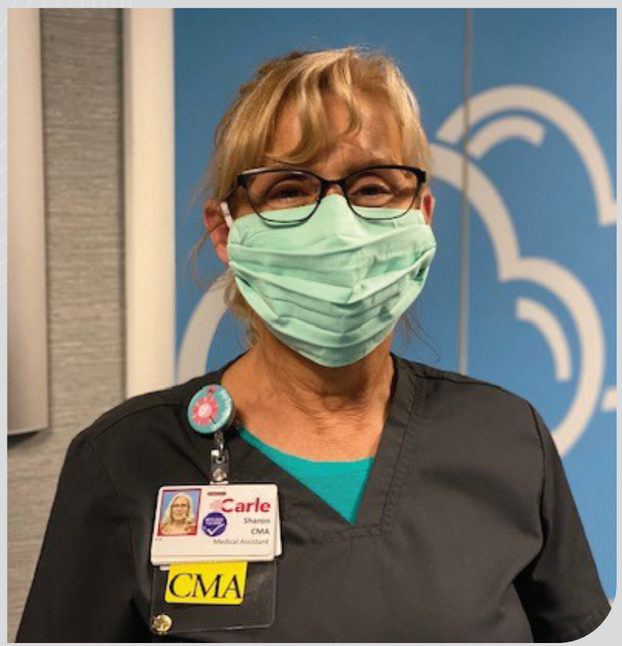
THANK YOU TO OUR HEALTHCARE HEROES!

Advis President and CEO, Lyndean Brick, saw firsthand the protective equipment shortages our clients on the frontlines fighting COVID-19 were facing. She decided to act. Lyndean took her two great passions, healthcare and ballroom dancing, and combined them. Her unique contribution employs ballroom gown seamstresses to make protective masks for healthcare workers.

Lyndean called upon Fred Astaire Dance Studios, including Dancing with the Stars alum Tony Dovolani, and the dance industry's ballroom dress makers, Dore Designs, Dance America, and Creative Canopy, to partner with Advis and start the Million Mask MOVEment. Together, we manufactured and distributed high-quality protective masks for healthcare workers. The masks produced by this program cover the helped to extend the lifespan of N95 masks.

The masks were produced by eight seamstresses at Dore Designs in Cape Coral, Florida, three seamstresses at Creative Canopy in San Francisco, and three seamstresses at Dance America in Margate, Florida. The seamstresses worked six days a week to produce masks and ship daily.

Along with our partners we were able to produce and deliver tens of thousands of masks to hospitals across the country. During this time of national crisis, Advis is grateful to have been a part of the Million Mask MOVEment, and supported our heroes combatting this pandemic.



LIFE AFTER COVID-19:

The Future of Healthcare

The COVID-19 pandemic has disrupted almost all aspects of life for the average American. It's done the same for the American healthcare industry. The way we think about preventative health, emergency preparedness, and innovation in healthcare innovation has all been upended. What changes already underway are going to stick? What changes are still to come? Will the Social Determinants of Health be universally recognized for what they are: Determinative? The Times are very uncertain. Nonetheless, Advis has identified three distinct areas where American healthcare can safely anticipate major change post-pandemic.

TELEHEALTH

The growth in telehealth has been astounding. The growth in the demand for telehealth has been huge. As a result, the telehealth industry has been advanced a decade into the future overnight. Numerous innovations in how telehealth/telemedicine is administered and billed both now and in the future are underway. Telehealth reimbursements are already increasingly approved by insurers as a result of new HHS regulations and industry partnerships. Healthcare practices are quickly adopting new telehealth policies to better assist patients attending appointments. Telemedicine has grown exponentially and is poised for continued quick growth. In the near future, due to telehealth's ability to help providers deliver high-quality healthcare at lower cost, expect it to keep growing. There will be widespread support to make permanent the sweeping regulatory changes that brought about this telehealth revolution.

Hand-in hand with expanding Telehealth services comes increasing demand for new IT services. Fast Healthcare Interoperability Resources (health IT structures that are able to capture health data regardless of source/format and make it reachable across the care continuum) are projected to increasingly gain traction among health vendors. In addition to delivering care remotely via telehealth, health systems are in the process of acquiring programs which both manage and analyze operational and patient data in order to better guide policies, track performance and outcomes, and provide greater efficiency. Artificial intelligence and machine learning technology will increasingly manage the more "mundane" aspects of healthcare so that providers will have more time to spend with patients. These developments may seem like wishful thinking, but the COVID-19 pandemic has highlighted the industry's need for this technology and tech companies are working hard to fill the gap.

However, the path to widespread implementation of telehealth and new health IT will not be easily traversed. A number of privacy concerns regarding the use of existing and potential communications platforms persist. Additionally, poor implementation of multiple telehealth services would generate huge data flows that are neither useful nor easily maintained. There are also barriers to the widespread utilization of telehealth due to past practices and federal regulations. Be that as it may, the push for widespread telehealth coverage has galvanized the healthcare and tech industries to rethink their IT possibilities.

FINANCIAL PLANNING

The second major change that the healthcare industry will undergo is in financial planning. Health systems' existing financial models for 2020 have been demolished due to both the increased need for emergency department and intensive care beds, and elective surgeries that have been postponed or cancelled entirely. Many small hospitals and practices in underserved communities are experiencing heavy financial losses; as a result of the pandemic, they will either close or merge with larger health systems.

Another likely driver of uncertain financial planning will be the role of labor costs. The healthcare workforce is quickly changing as a result of the huge strain placed on providers and the entire healthcare system at every level due to the COVID-19 pandemic. Expect retirements and fewer new entrants to the job market all contributing to possible staffing shortages. Moreover, having successfully staffed the front lines in the fight against COVID-19, the bargaining power of healthcare workers will be at an all-time high. The entire system is crying out for renegotiation. It will be no different for the workforce.

Contributing to the rising costs of labor will be workers seeking behavioral health treatment both during and after the pandemic. Health systems will need to develop and implement strategies to identify and treat mental health concerns in their employees to avoid severe burnout, post-traumatic stress, depression, and suicide risks. After the pandemic slows down, health systems and other social service businesses will need to modernize their workforce models to adjust for the influx of medical/nursing students and retired doctors who were brought in as a result of the pandemic.

After the pandemic slows, there's a chance that a small number of healthcare systems move toward capitation or other value-based care plans in order to protect themselves from future financial uncertainty and instability. These payment plans would allow providers to focus on providing the most efficient and effective care rather than on how much they are being reimbursed. But at the rate healthcare systems are currently hemorrhaging revenue, it seems more likely that the industry may need to return to the fee-for-service system rather than experiment with value-based care (as VBC has a higher financial risk they simply will not be able to afford). Proposed IPPS Payment updates are likely to bolster this trend.

Similarly, post-pandemic, federal and state governments are likely to play a larger role in the provision of healthcare. Considering that federal support from the CARES Act and other stimuli are helping keep many hospitals open, that the government would have more bargaining power with the healthcare industry post-pandemic seems reasonable. This leverage may be seen in new regulation ranging from the Feds seeking mandatory PPE stockpiles and strict regulations on the discharge and transfer of SNF patients to a renewed push at minimum staffing ratios at the State level.

There will be a loud but unsuccessful movement for the passage of some form of Medicare For All (M4A). 27.5 million Americans do not currently have health insurance. 45% of uninsured adults say the high cost of coverage is the main reason they remain uninsured. In the Senate and House Medicare for All Bills, M4A would have comprehensive benefits, no premiums, lifetime enrollment, be financed by taxes, replace all private health insurance (including the current Medicare program); and all state-licensed, certified providers who meet eligible standards can apply. As a result, M4A is an attractive option to people who are currently struggling to afford or access healthcare due to the COVID-19 pandemic. M4A supporters also argue that a single-payer healthcare program would be less expensive for the healthcare system overall. And because of the vast sums flowing from the Feds through the existing system, aren't we there by default? People will be asking, "Why pay the equivalent of M4A and not receive the benefits?"

Medicare For All has been stalled in Congress for months, but an increasing number of interest groups and elected officials are calling for these bills to be revisited. Nonetheless, the chance that M4A will be passed within the year is highly unlikely: several political and economic considerations involved in a single-payer system remain hotly contested; and, it's an election year. For example, arguments have been made that the COVID-19 pandemic has been "as bad" or worse in countries with socialized/single-payer healthcare compared to the United States. Medicare For All currently has 50.9% Democratic support in the House, and 29.8% Democratic support in the Senate. A significant push toward a new system will have to come from below, from the grassroots, if M4A is ever to become a reality in America. What seems more likely in the near term is wide-spread support to fix what ails our system through focus on the social determinants of health.

SOCIAL DETERMINANTS OF HEALTH (SDOH)

The pandemic has made clear to everyone that our current levels of inequality are a danger to our national health and security. And the health of those on the bottom is especially at risk. The status quo is simply unacceptable. Even before the pandemic, public health experts were emphasizing that the efficacy of recovery efforts long-term hinges on how leaders address health inequities and the systemic issues that cause them. Simply put, at-risk communities and at-risk populations have experienced a disproportionate impact from the COVID-19 pandemic. For example, a recent report from the Centers for Disease Control and Prevention tracking COVID-19 activity in 14 states found African Americans made up 33% of hospitalized coronavirus cases, despite accounting for only 18% of the total population in those areas. Although healthcare systems, payers, and HHS had been working to expand SDOH benefits long before the COVID-19 pandemic, there needs to be continued discussion on how providers and regulators can make structural changes to the health system to improve the healthcare safety net, as well federal, state, and local governments. Big business will play a significant role, too.

As of January, certain Medicare Advantage (MA) plans have expanded coverage of supplemental benefits that address SDOH (such as Anthem BCBS and Humana). Examples of these benefits include home-based palliative care, home modifications for people with disabilities, diabetes education, and non-emergency medical transportation. Relatively few MA plan providers opted to provide enrollees with new SDOH supplemental benefits in 2019, but this number could increase in 2020 due to the increase of SDOH risk factors as a result of COVID-19 and the potential profitability of adding SDOH supplemental benefits. Humana's revenues increased nearly 18.9% in the first quarter of 2020 thanks to more seniors choosing Humana's private MA plans. CMS recently announced a 1.66% rate increase for Medicare Advantage plans in 2021, and issued its Contract Year 2021 Medicare Advantage and Part D Final Rule. This Final Rule focuses on finalizing prior proposals addressing COVID-19, and those proposals most helpful to MA and Part D plans in light of the June bidding deadline. Any proposals not addressed in this Final Rule will be addressed in a second Final Rule and will become applicable no earlier than January 1, 2022.

Furthermore, Healthcare systems have already been working independently to address SDOH risk factors in their target populations. As of March 2020, well over half of all health systems screened patients for SDOH risk factors. Many of these health systems are also piloting programs to tackle certain SDOH risk factors such as housing instability, food insecurity, and lack of transportation. Examples of pilot programs include adult daycare services, nutrition education, non-emergency medical transportation, health resource centers, and embedded inpatient and post-discharge patient support services. Healthcare systems are also partnering with community organizations and payers to mitigate SDOH disparities.

On the legislative end, several bills have been introduced that focus on addressing SDOH. H.R. 6561 (Improving Social Determinants of Health Act of 2020) would authorize the CDC to create and implement a SDOH program. S. 2896 (Social Determinants Accelerator Act) would authorize $25 million in Medicaid grants to state governments, and also task CMS, HHS, and other federal agencies with conducting community-based health programs to address SDOH. Both bills are currently stalled in committee.

(continued on page 8)

CONCLUSION

Collaboration between all stakeholders in the American healthcare system is essential to surviving COVID-19 and thriving in the aftermath of the pandemic. From pharmaceutical companies sharing proprietary compound libraries to financial reform of public health programs, new healthcare practices and cross-industry partnerships will have to be formed. For better or worse, those new programs and partnerships will shape our healthcare landscape for years to come. Telehealth is becoming the new standard practice rather than the exception to the rule. New IT is on the way. Health systems, payers, and the federal government, even big business, are all reassessing how healthcare should be paid for and who all should be covered. The Social Determinants of Health must become a priority rather than an afterthought. The workforce will press it's demands for appropriate levels of PPE and compensation. The system cannot simply reconstitute itself as it was. 2021 will be a year of significant change.

TELEHEALTH

The COVID-19 pandemic has pushed CMS to realize that there are more benefits to expanding telehealth services to Medicare and Medicaid than unanticipated side-effects. Telehealth has expanded greatly and patients continue to receive the quality care they demand and deserve. Although post-pandemic, CMS may not keep all of the changes published during these expansions, providers can very likely anticipate permanent changes to telehealth implementation and utilization and rely upon those changes going forward. The pandemic appears to have changed the delivery of modern healthcare forever. Telehealth is the great beneficiary.

Under the authority of the National Emergency Declaration of March 13th, CMS began issuing regulatory waivers and flexibilities to assist providers during the COVID-19 pandemic. That assistance included expanding the use of telehealth. The goal of expanding telehealth services was to ensure patients access to the care they need without entering healthcare facilities; and for providers to continue to provide quality care to patients without risking exposure to Covid-19. By increasing the use of telehealth, patients and providers practice social distancing and successful medicine without risking the well-being of either party by limiting their exposure to COVID-19.

As of April 30th, CMS has made three major expansions to telehealth regulations that ensure patients continue to receive necessary care during the pandemic. With each expansion, CMS provided additional flexibility regarding who can provide telehealth services, where they can be provided, and what technology is required to qualify as a telehealth service. Advis has prepared an overview of the expansions below. This overview is also a projection of the future of telehealth.

MARCH 17TH:
FIRST TELEHEALTH EXPANSION

CMS made the following two major changes regarding who is eligible to receive telehealth services and where they can receive those services.

1. The first change allowed **all Medicare beneficiaries to receive telehealth services** rather than restricting them to beneficiaries located in rural areas.

2. The second change made the **patient's home an eligible originating site**. Previously, CMS allowed patients to receive telehealth services only when located in a healthcare facility.

However, during this expansion, CMS has only allowed the providers to use codes associated with telehealth visits, virtual check-ins, and e-visits. Providers were still restricted in the type of services that could be provided to patients. Additionally, hospitals were not allowed to bill the originating site facility fee (HCPCS Q3014) for hospital outpatient department ("HOPD") visits where patients were at home. Hospitals could only bill the facility fee for an HOPD visit if the patient was in a healthcare facility.

MARCH 30TH:
SECOND TELEHEALTH EXPANSION

CMS added more services eligible to be provided via telehealth in the following areas:

- Emergency Department visits, Level 1-5;
- Initial and Subsequent Observation and Observation Discharge Day Management;
- Initial hospital care and hospital discharge day management;
- Initial nursing facility visits (all levels) and nursing facility discharge day management;
- Critical Care Services – Domiciliary, Rest Home, or Custodial Care services, new/established patients;
- Home Visits, New and Established Patient (all levels);
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent;
- Initial and Continuing Intensive Care Services;
- Care Planning for Patients with Cognitive Impairment;
- Psychological and Neuropsychological Testing;
- Therapy Services, Physical and Occupational Therapy (all levels); and
- Radiation Treatment Management Services.

Given the expansion of types of services that could now be provided, CMS also expanded the types of professionals who could provide telehealth services to include licensed social workers, physical therapists, speech-language therapists, and occupational therapists.

Regarding billing for these practices, CMS stated in its interim final rule that providers should bill as they would typically bill for services. This means providers would not be restricted to use place of service ("POS") 02 for codes located on the Medicare List of Telehealth Services Codes. Providers could use the POS they would typically use when furnishing services, which would allow physician offices to continue billing POS 11 and HOPDs to use POS 19 and 22 for telehealth services. Additionally, CMS created the new modifier 95 for practitioners to use to indicate that the service was furnished via telehealth.

APRIL 30TH:
THIRD TELEHEALTH EXPANSION

CMS is now allowing HOPDs to relocate to patient's homes. If hospitals do relocate HOPDs to patients' homes, then hospitals are able to bill the facility fee HCPCS Q3014 for the telehealth visit when the patient is located in their home. Only one relocation request is sufficient to make the relocation effective. Additionally, CMS stated that this change will be effective retroactively to March 1st, which allows hospitals to receive additional reimbursement for telehealth services previously provided.

To relocate an HOPD to a patient's home, the hospital must email its CMS Regional Office with the following information:

- The hospital's CCN;
- The address of the current HOPD;
- The address(es) of the relocated HOPD(s);
- The date which they began furnishing services at the new HOPD(s);
- A brief justification for the role relocation played in the hospital's response to COVID-19;
- Why the new HOPD location (including instances where the relocation is to the patient's home) is appropriate for furnishing covered outpatient items and services; and
- An attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.

Additionally, this expansion also allows hospitals to bill additional telehealth services on a UB, such as counseling, educational services, and therapy services, including when the patient is located in their homes. CMS also took into consideration the fact that many beneficiaries may not have technology that has video and audio capability. As such, CMS waived the video requirement for certain telephone evaluation and management services. Providers should consult the Medicare List of Telehealth Services Codes published by CMS to determine if a service can be provided through audio-only technology.

COVID-19 Telehealth Key Lesson

Although these expansions allow providers to conduct and be reimbursed for telehealth services during the pandemic, CMS has not indicated when or how much of the expansions will be reverted once the spread of the virus slows. At this point, for providers to anticipate any reversion to happen anytime soon, without permanent changes to telehealth regulations, is highly unlikely. The shift toward telehealth is in response to a pandemic. Healthcare providers are making it work. The data shows the number of telehealth visits increasing while patients are still receiving the care they need without risking exposure to the virus. And that, after all, is the point.

GIVING BACK

Advis in our Communities

It is in times of crisis that our responsibility to bolster our communities is important as ever. Our team at Advis values this responsibility. Community involvement and volunteering has fostered a thriving and positive environment inside and out of our corporate walls.

We are so proud of our team members working with organizations throughout Chicagoland to strengthen our communities!

AMANDA BOGLE

Chicago Coalition for the Homeless Associate Board

The Chicago Coalition for the Homeless is dedicated to advocating for public policies that curb and can potentially end homelessness. CCH leads campaigns and initiatives that target the lack of affordable housing and pushes for access to public schools, job opportunities, and support services.

BRYAN NIEHAUS

Joliet Area Community Hospice Board of Directors

Joliet Area Community Hospice (JACH) is a nonprofi t, community-based hospice, palliative care and bereavement services agency. JACH provides quality hospice care for adults and children diagnosed with a limited life expectancy, palliative care, and grief support services for family members and the community.

SUSAN MAUPIN

CASA of River Valley

The Court Appointed Special Advocate (CASA) of River Valley serves as a voice of abused and neglected children in the court system, provide information, and develop a more productive juvenile court process.

SYLVIE BRICK

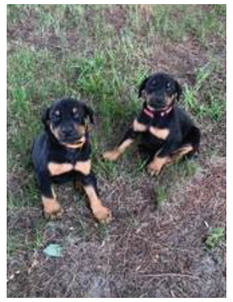
Erie Family Health Centers Associate Board

Erie Family Health Centers provide high quality and affordable medical, dental and behavioral healthcare to all in need, regardless of ability to pay. They support the health of people, families and communities.

ADVIS PETS

Make the best coworkers!

Transitioning to working from home has its challenges, but we are grateful to have our pets to keep us company. Studies show that the presence of pets decreases stress and promotes productivity, which is why we are so lucky to have them in our work-from-home spaces. At Advis, we love promoting our four-legged friends! Meet a few of them!



ARYA & MANDO

- **Monica's Dogs**
- 2 pure bred Doberman Pinchers
- Adopted them through her husband's client
- Will bring them home to their farm at the end of June

CLAUDE

- **Lyndean's Dog**
- Loves Radishes
- Snores LOUDLY
- Loves to chase the Roomba around the house

FLYNN

- **Andrea's Dog**
- Loves running around outside
- Nickname is Piggy because he snorts and grunts like a pig

MINNIE

- **Angela's Dog**
- Loves to sit and look out the front window and bark at all the other dogs walking by.
- 2 years old and was adopted from PAWS when she was 3 months old. She is a mutt, probably a Doxin/Terrier Mix

ROSIE

- **Bryan's Dog**
- Loves digging and her big sister dog Kayla
- Adopted during quarantine

RUBY & BEAU

- **Jake's Dogs**
- Ruby (brown) & Beau (black)
- They love watching rabbits destroy the plants in their back yard and not chasing them, apparently.
- They are both adult French Bulldogs but Beau (32lbs) is 2x the size of Ruby (16lbs)

VLAD & WALRUS

- **Chris's Pets**
- Vlad (Ferret) loves dragging plastic bottles around the apartment
- He chases Walrus the cat
- Walrus (Cat) loves chasing laser pointers
- He didn't meow at all during his year at the cat cafe before he was adopted. Now he doesn't go a day without yelling to wake everyone up and for attention.