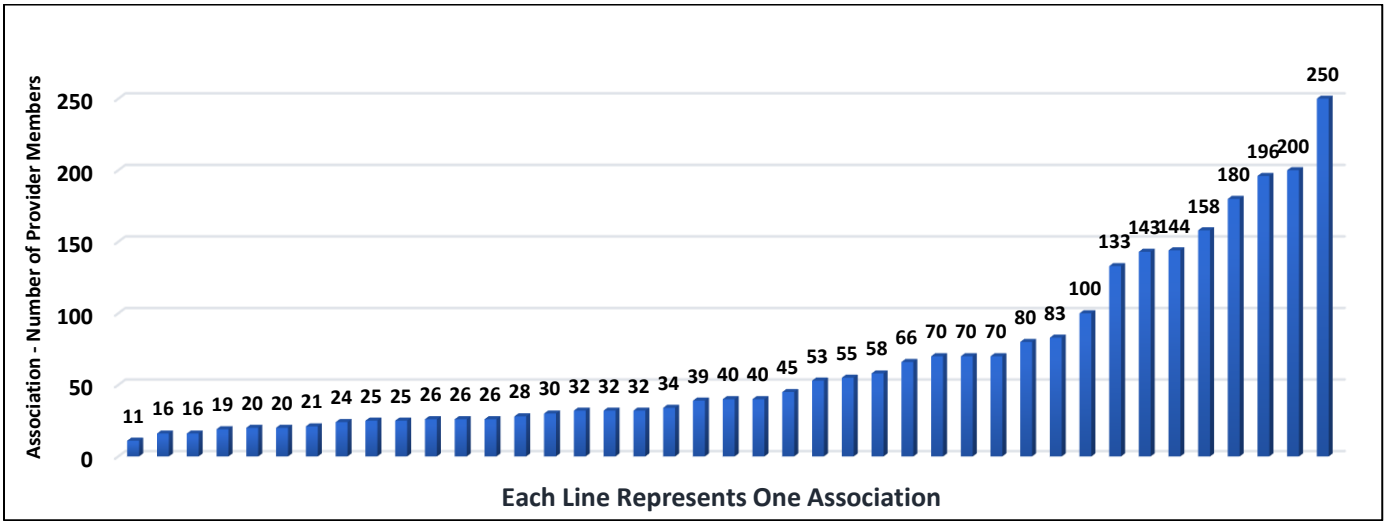
2019 ASSOCIATION EXECUTIVE SURVEY DATA

The National Council conducts periodic surveys of its state and regional association members. In 2019, survey data was completed by 41 state and regional associations (representing all ten regions and 2,736 provider organizations – 82% of the National Council's total membership). Data were collected from August through October 2019. The survey looks at association membership, eligibility, recruitment and renewals, as well as the association itself. These data are inclusive of services provided by the associations' membership, organizational diversity and political activity, budgets and the association executive director position.

PART 1: Association Membership

Association Members
The majority of associations have more than 35 members.



Respondents: 41 (100%)

Average # of Provider Members: 67
Median: 40

High: 250 provider members (Region III)
Low: 11 provider members (Region IV)

Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region II: New Jersey, New York, Puerto Rico, US Virgin Islands
Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region V: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region VII: Iowa, Kansas, Missouri, Nebraska
Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region IX: Arizona, California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands, Trust territory of the Pacific Islands
Region X: Alaska, Idaho, Oregon, Washington

REPORT (1/15/2020)
Please contact Neal Comstock with any questions/comments.

Affiliate, Vendor, Corporate, or Non-provider member category

Associations were asked if they have affiliate/vendor/corporate partner members or other non-provider members. The total numbers across the 38 responding associations are presented below.

Other Member Categories	Total*
Affiliate/Vendor/Corporate partner members	354
Other Non-Provider members	957

Respondents: 38 (93%). One outlier of 8,000 other non-provider members was removed from the calculation.

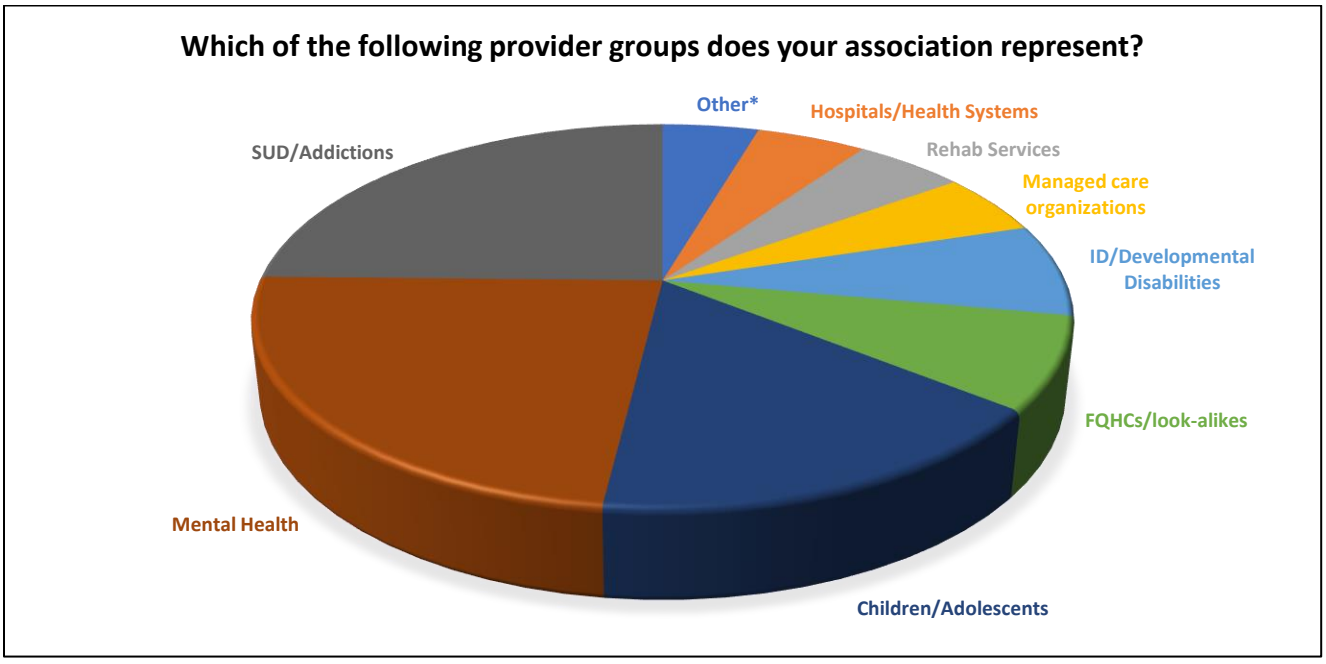
Total number of unduplicated individuals served by the association's members each year

4,913,913

Sixty-three percent (63%) of responding associations indicated that their membership serves nearly five million unduplicated individuals annually.

Associations Represented by Service Type

This chart represents the type of providers, by service type, the associations represent. Proportions represent the proportion of the total responses.



Respondents: 41 (100%)

*Other categories include criminal justice, recovery courts, prevention coalitions, physical disabilities and aging, regional behavioral health authorities, and Tribal

Nearly half of Associations (48%) noted that the types of provider groups the association represents (as identified above) changed over time. The following changes were reported:

Region	Collated Reasons for Change in Provider Group(s)
Region I	More mental health and FQHC members reflecting efforts to integrate; We are the product of a merger in 2016 between an organization focused on providers and one that had fewer providers but many other organizations.
Region II	Added Allied Membership category; Broader now; New types of groups, like CCBHCs
Region III	Addiction services became a much more significant focus beginning 2014 when addiction services came under our Department of Behavioral Health; Membership has grown by 25% in last 3 years. Incoming members largely in SUD and child welfare fields; The addition of IDD providers several years ago; The association continues to grow and add divisions (Physical Disabilities and Aging is the most recent example).
Region IV	As our state transitions our Medicaid system- our organization needs to serve the interests of treatment organizations more that we have in the past. All of this happened under state contracted behavioral health MCOs before- but that is now transitioning out of the state system; Decrease in number from CMHCs (from 14 to 11); We went from exclusively state contracted SUD (until 2012) to any state contract OR non-profit with an interest in SUD advocacy.
Region V	SUD providers came on in 2012; While Behavioral Health is our primary focus, in the last several years we have added several members that provide services beyond Behavioral Health (e.g., services for the Aging, Child welfare, FQHC, ID/DD, Domestic Violence).
Region VII	Since 1983, it has gone from IDD/residential, added employment providers, then merged with the community mental health centers (CMHCs) in 2007
Region IX	We added the MCO organizations for the integrated care contracts for general mental health/substance use (GMH/SU) one year ago. We always had the Regional Behavioral Health Authorities (SMI) as members. We have more members than in the past because of the changes in our behavioral health system; We have increased the number of members doing only mental health and/or education services

Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region II: New Jersey, New York, Puerto Rico, US Virgin Islands
Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region V: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region VII: Iowa, Kansas, Missouri, Nebraska
Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
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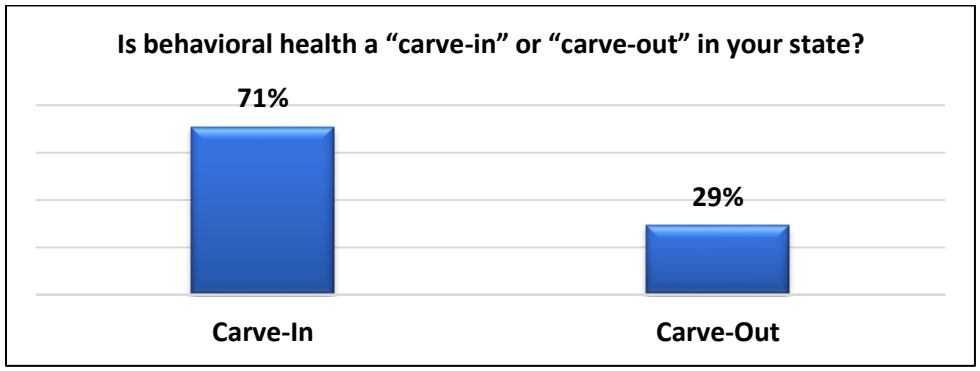
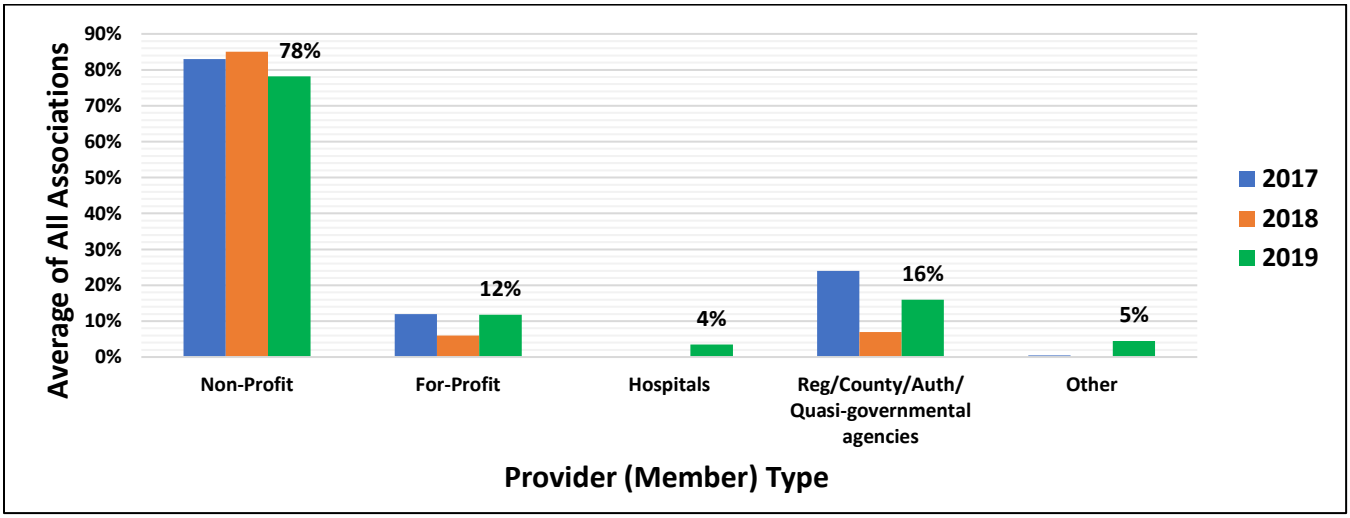
Managed Care
Associations that identified as a Managed Care state (n=24) reported that the average term of the master contract with the state was between one and six years (average: 4 years).



Provider (Member) Type
The associations were asked to report their provider (member) organizations' type (non-profit, for-profit, etc.). More than one option could be selected.



2019 Respondents: 39 (95%)
***Hospitals category wasn't provided until 2019 Survey*

Do any of your members have an IPA?
Thirty-seven percent (37%) of responding associations indicated that their members have an IPA. Of those, 77% have contracts.

37%

REPORT (1/15/2020)
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Member/Provider Organization Leadership: Executive Director / CEO Diversity
This chart represents the proportion of member Executive Directors / CEOs from cultural/ethnically diverse backgrounds.

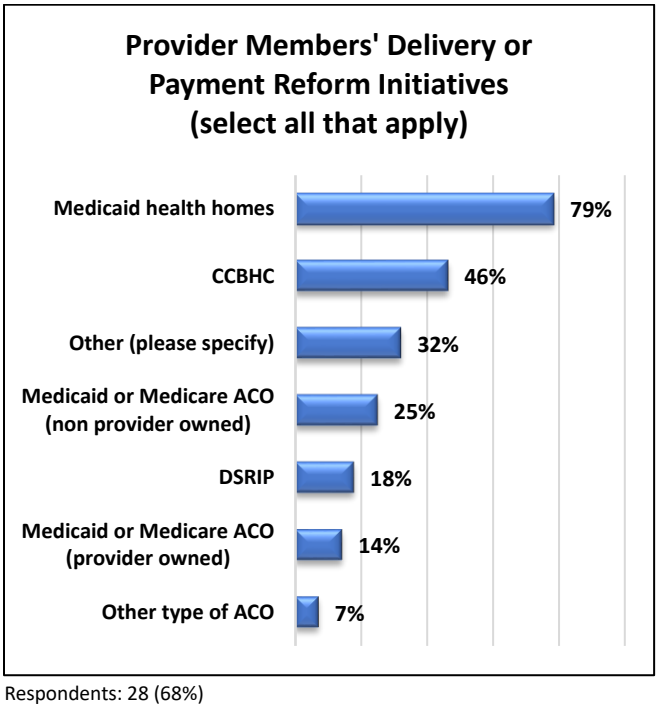
Female	**46%**
African American / Black	8%
American Indian / Alaska Native	1%
Asian	1%
Caucasian / White	82%
Latino / Hispanic	3%
Native Hawaiian or other Pacific Islander	0%

Respondents: 30 (73%)

Payor Mix/Revenue of Member Organizations
This chart represents the payor mix (% of organization revenue) for association members/provider organizations. Twenty-five percent of respondents noted that the revenue distribution has changed significantly over the past year (e.g., due to increased STR/SOR funding; less grants / more Medicaid and commercial insurance; shift to primarily Medicaid reimbursable services; continued push for diversification of revenue stream).

Respondents: 24 (59%)

Participations in Delivery or Payment Reform Initiatives
Associations were asked if any of their members/provider organizations participate in any delivery or payment reform initiatives.



Respondents: 28 (68%)

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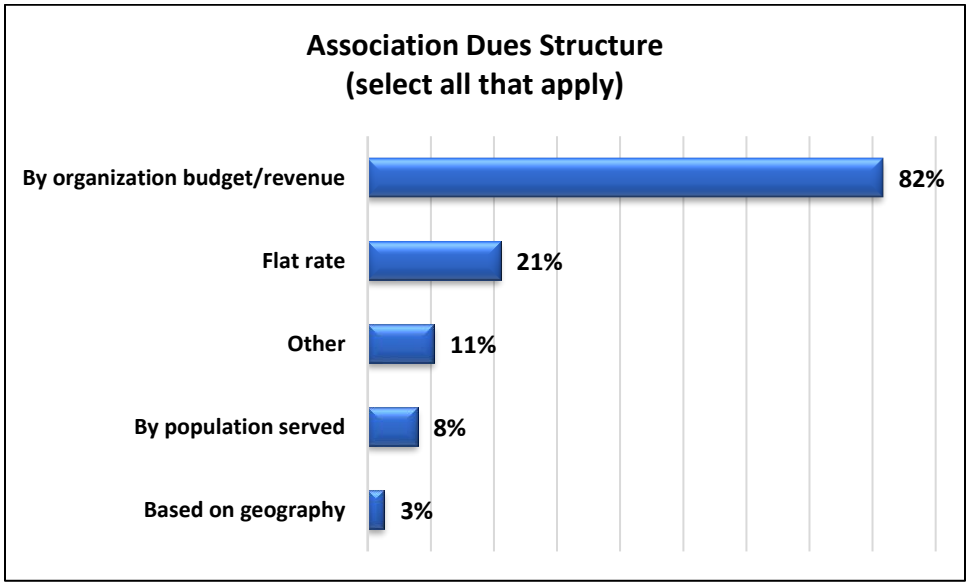
Association Membership Dues

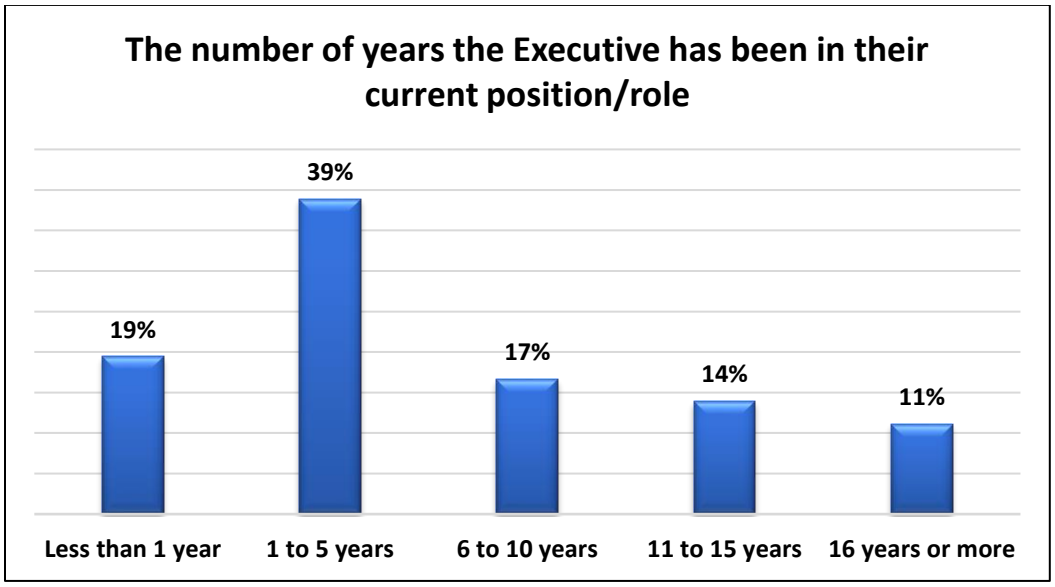


Respondents: 38 (93%)

PART 2: Association Executive

Association Members

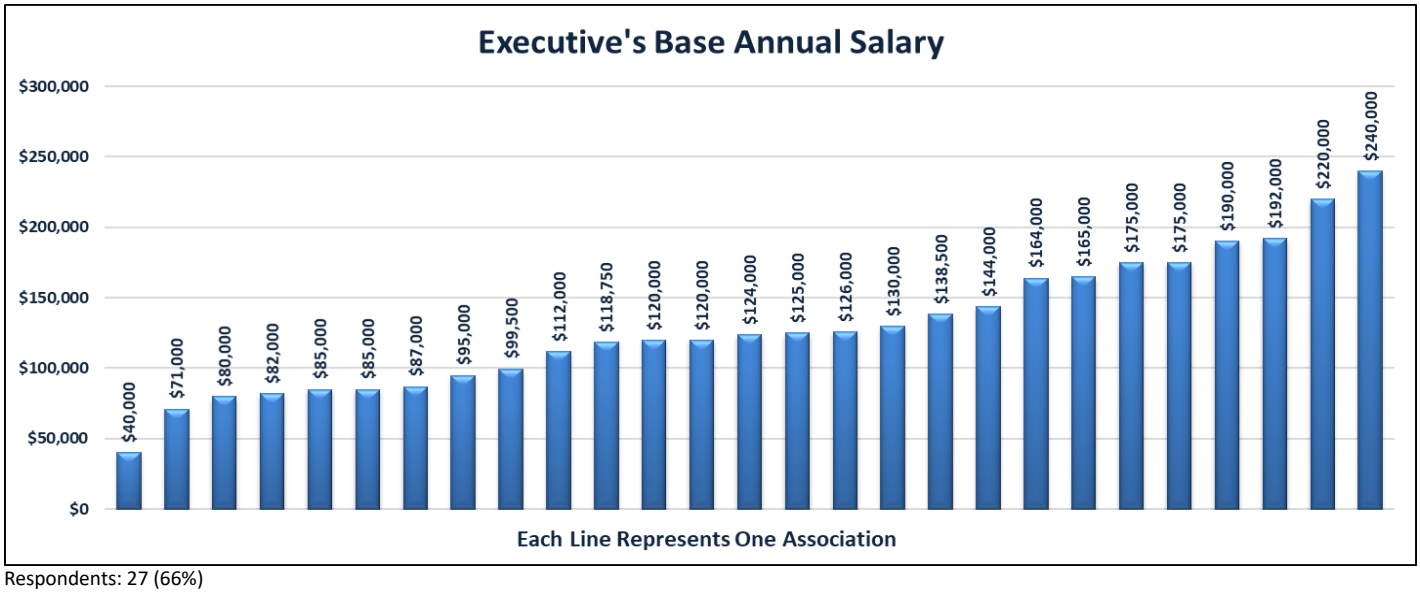
The majority of associations have been in their current position/role for 1-5 years.



Respondents: 36 (88%)

Association Executive Salary

The average Association Executive's reported base annual salary is **$129,769**



Respondents: 27 (66%)

Region	Association Executive's average base annual salary
I	$133,000
II	$117,500
III	$115,167
IV	$125,950
V	$142,000
VI	*
VII	$135,333
VIII	$81,000
IX	$192,500
X	$138,500

**Missing data*

Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region II: New Jersey, New York, Puerto Rico, US Virgin Islands
Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
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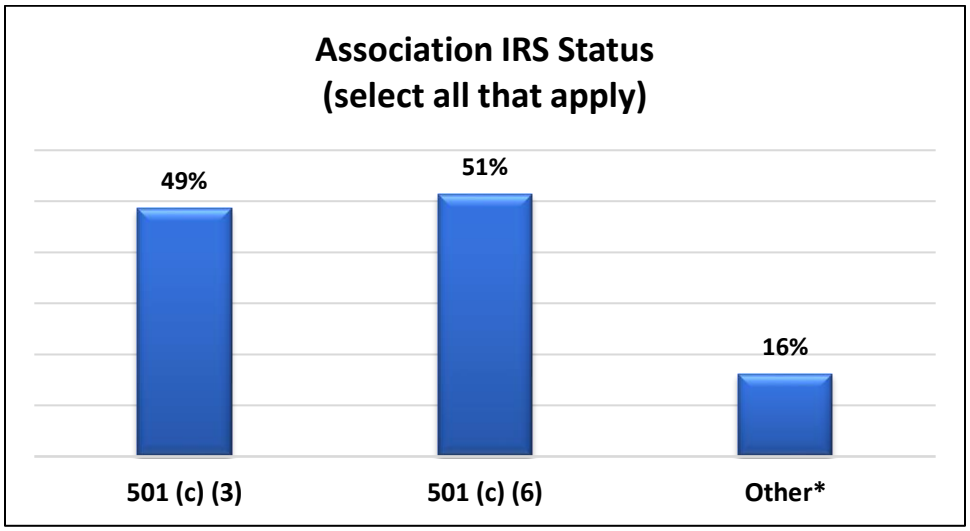
PART 2: Association Characteristics



Respondents: 37 (90%)

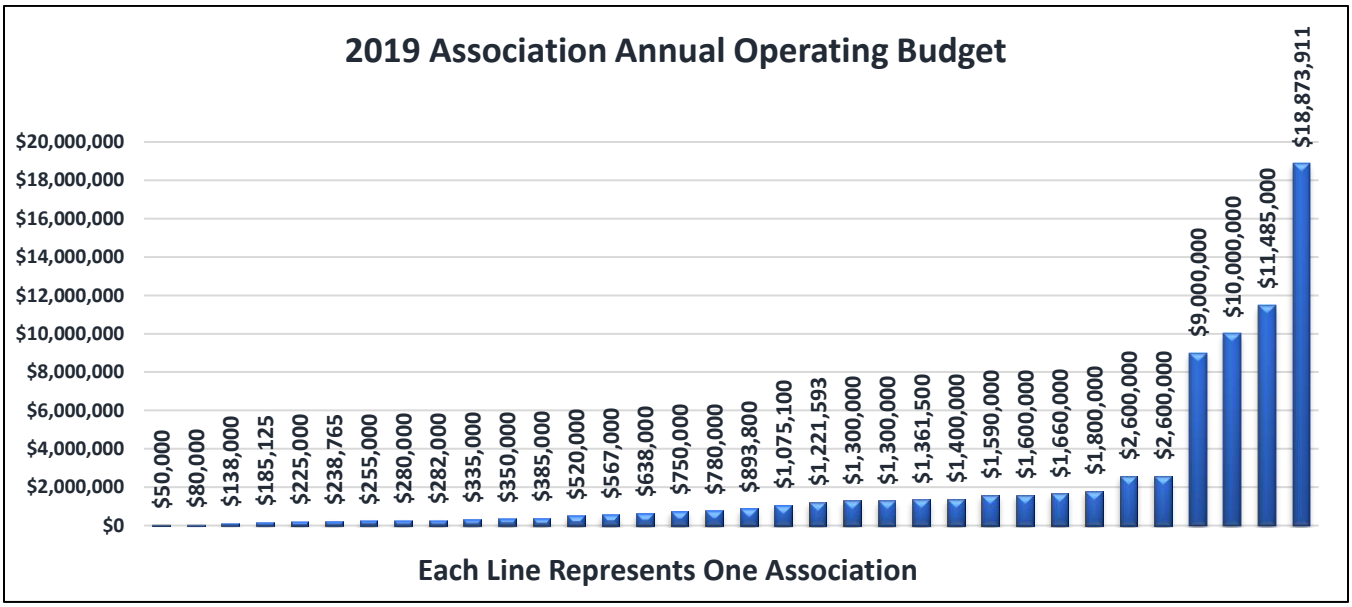
*Other included 501(c)4 and 504(c)3.

When asked why that/those IRS status(es) was/were selected, respondents noted the following:

501 (c) (3) only
history 40 years ago
Broader focus of work initially. Board frequently discusses status and potential need to change.
501(c)(4) and PAC dissolved due to under-utilization.
This was decided when we were founded in 1972.
The bulk of our members are nonprofit.
That's how it was incorporated, and we haven't changed it.
To enable the agency to apply for grants.
We were formed as a 501 (c)3 in 1967.
501 (c) (6) only
For our lobbying and intergovernmental work
Legal advice as to association status
Trade and lobby
Not sure - I assume because it has been seen as a trade association
Our revenue is based on dues from mental health revenue
501 (c) (3) and 501 (c) (6)
FBHA 501 (c)(3) for Association policy work and membership; Services 501 (c)(3) for foundation and state grants and contracts; Advocacy 501 (c)(6) for advocacy work
Established as a non-profit to accept grants and a trade association for lobbying
We are a 501 c 6 trade association with a wholly owned subsidiary Family Service Council of Ohio that is a 501 c 3
C-6 for membership and flexible policy/political work; C-3 for services for field and access to government, grant funds, and tax-deductible donations
501 (c) (4) only
We are a trade association
Selected at founding of association in 1980. NJPRA is the only State-wide association to work with a lobbying firm and we highlight that to our membership as a benefit.
501 (c) 3 only
For lobbying purposes

Association Annual Operating Budget

The total average 2019 association budget is **$2,229,994** (n=34).
The total average 2020 association budget is **$2,342,314** (n=30).
For associations that provided budget for 2019 and 2020 (n=30), the average budget increased by $7,447 in 2020.



Respondents: 34 (83%)

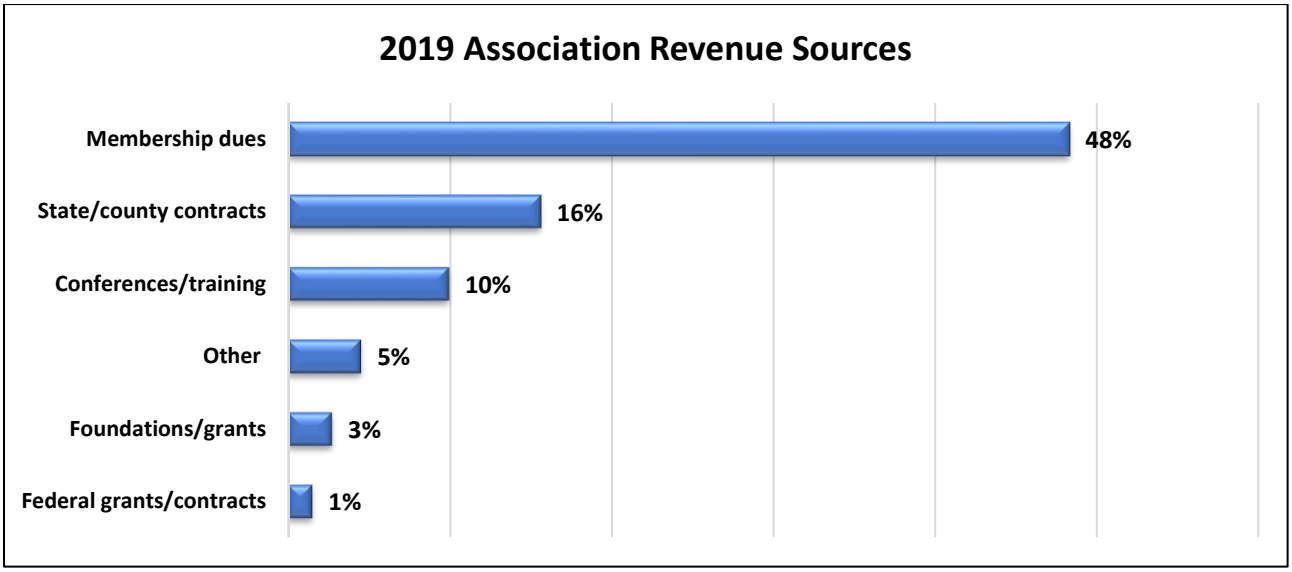
How many total FTEs does the Association currently have? (average per organization)*

6

* *Two outliers (2,000 and 6,500) were removed from the calculation.*

2019 Association Revenue Sources

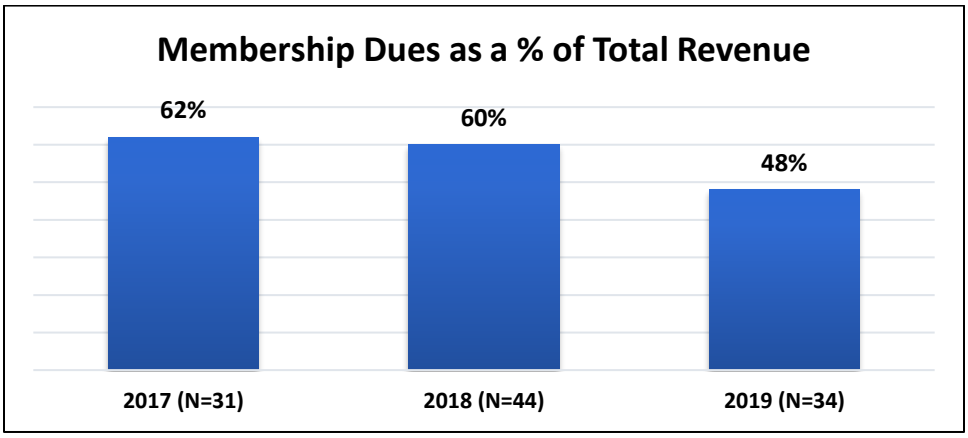
The average for all reporting association revenue source (as a percent of overall budget)



Respondents: 34 (83%)

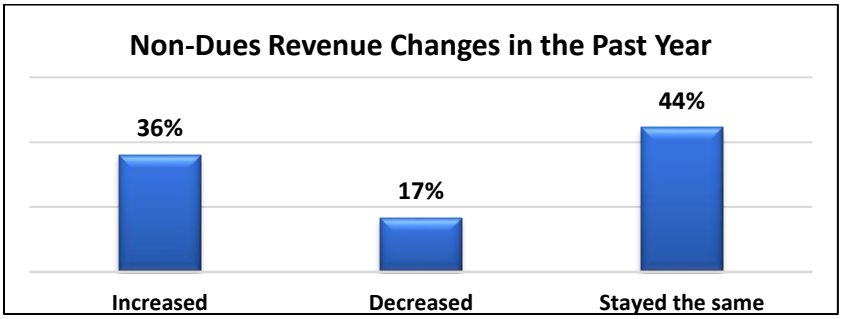
Historical: Member Dues as a % of Total Revenue

Calculating the average of all reporting associations (below), the percent of revenue from membership has remained relatively stable, with a 12% decrease from 2018 to 2019.



Changes in Association Non-Dues Revenue

Respondents were asked if their non-dues revenue was stable, increasing, or decreasing.



Respondents: 36 (88%)

Association Operations – Fundraising

The majority of associations (86%) do not have a fundraising plan. Those that have a fundraising plan engage in:

- Diversifying and growing revenue through membership growth, affiliate/vendor income growth and event growth, as well as provider network revenue
- Developing Innovation Center, Gala, Scholarship, Research.
- Increase membership and consulting jobs
- Building out associated 501c3 as a training and TA arm of the organization and have a fund development plan to bring in $150K in foundation/corporate funding to support this work
- Membership recruitment and retention plans.
- Planned fundraising/sponsorships for supporting events

Association Operations – Board

How many individuals serve on the Association's Board of Directors?

Associations have an average of 19 individuals serving on the Association's Board of Directors.

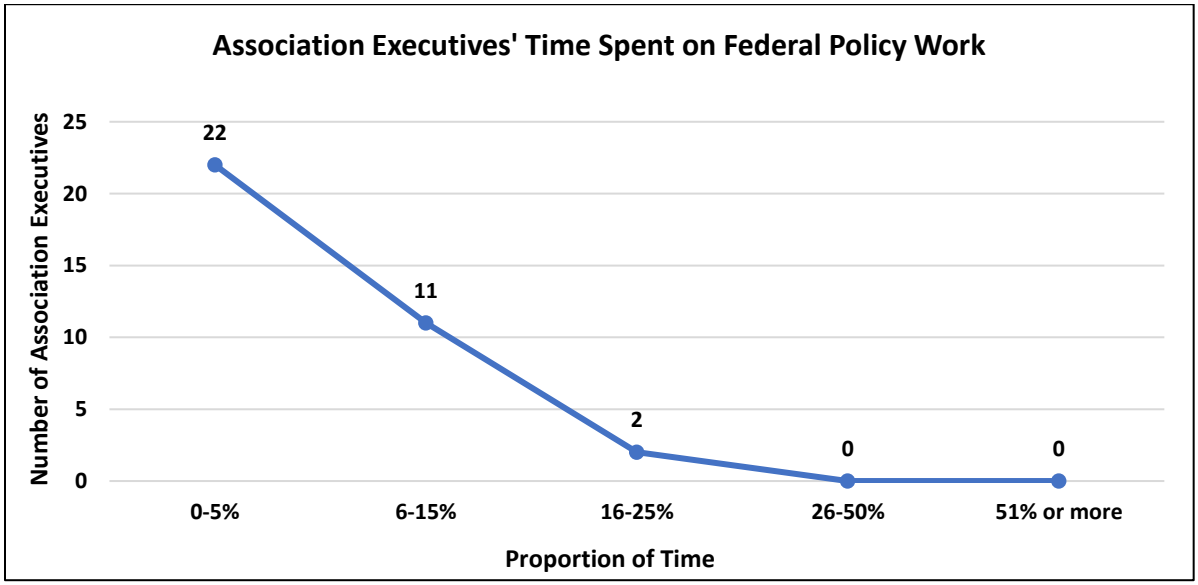
19

Ninety-two percent of associations **do not** have a provision in the Bylaws for representation of a consumer on the Board.

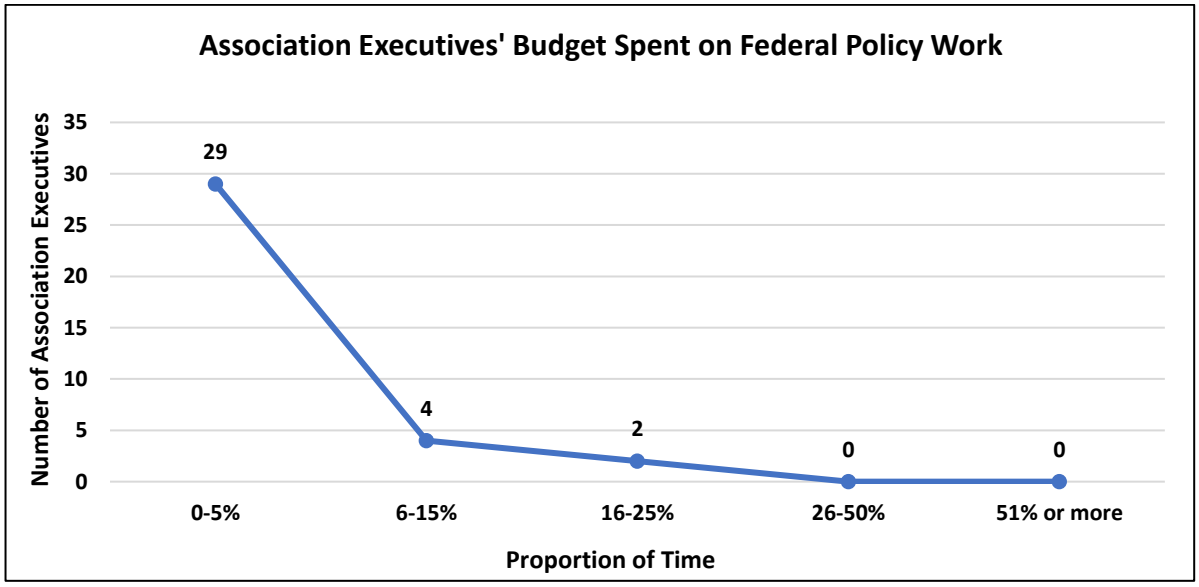
More than half (65%) of associations have term limits on their board, with term limits ranging from one year to nine years.

PART 3: Association Operations – Policy/Lobbying

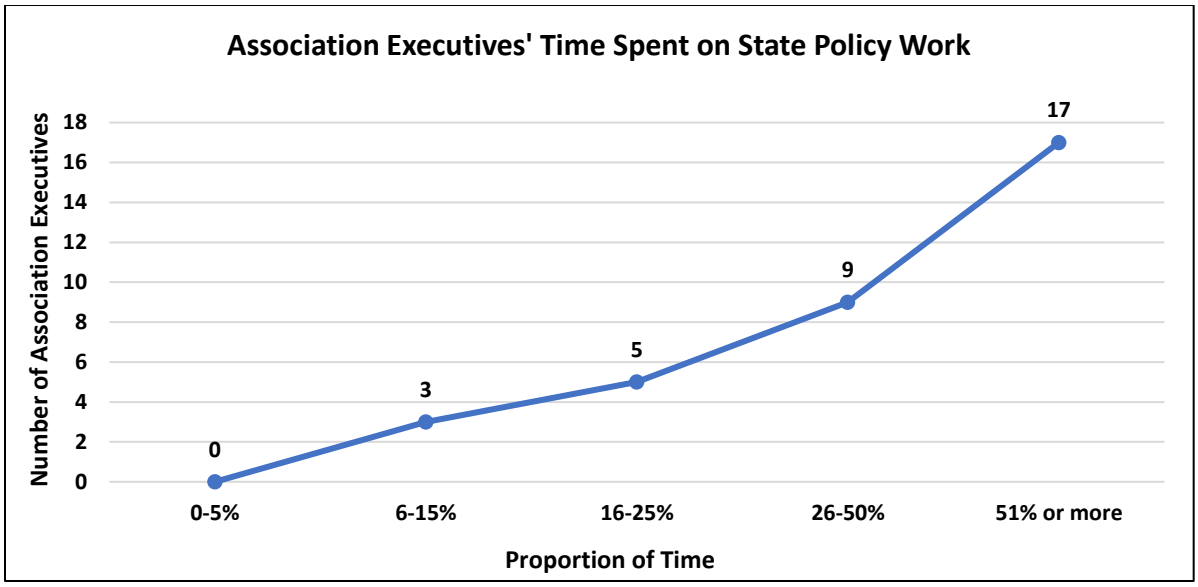
A range of individuals lead policy work at Associations, including the Executive Director, CEO, President, contract lobbyists, policy advocates, Vice President of Public Policy, and Division Directors. An average of two additional staff support policy work.



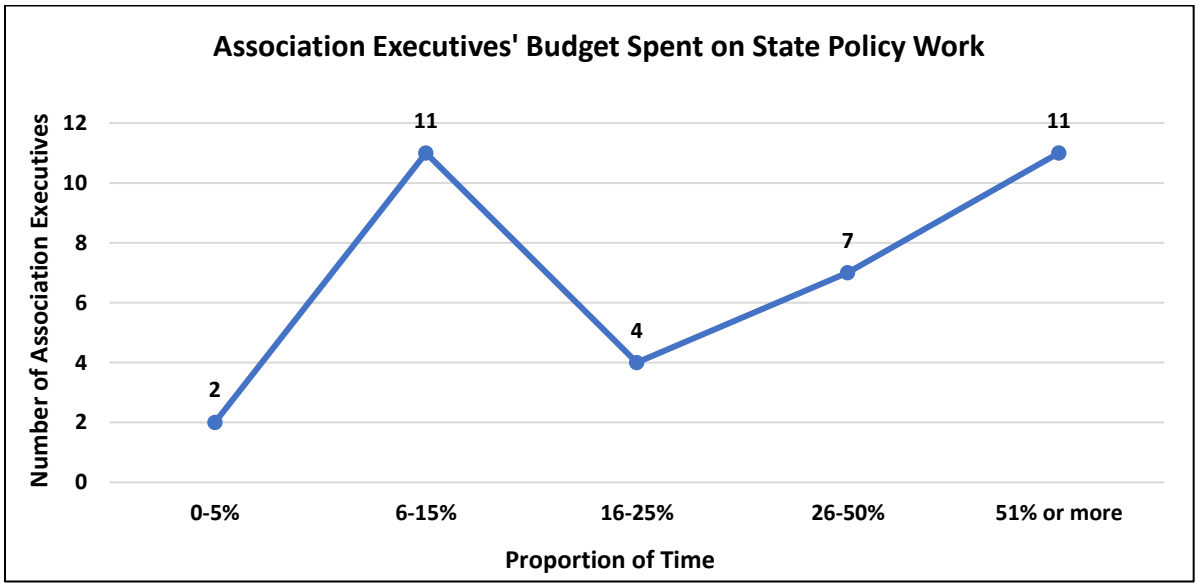
Respondents: 35 (85%)



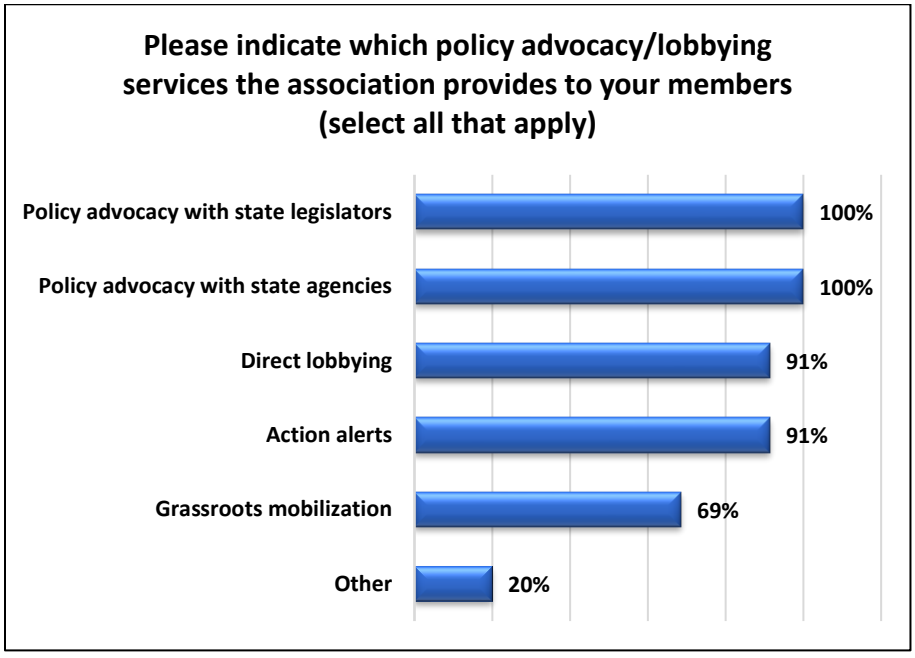
Respondents: 35 (85%)



Respondents: 34 (83%)



Respondents: 35 (85%)



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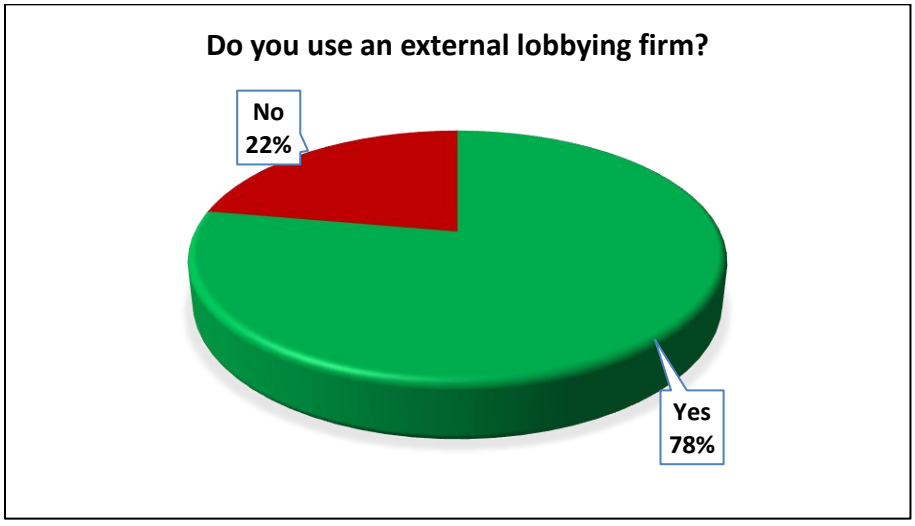

Respondents: 36 (88%)

If you use an external lobbying firm, what is the lobbyists' monthly retainer?
Based on data from 27 respondents, associations spend an average of **$4,207** to retain lobbyists each month.

When asked to describe lobbyists' roles and responsibilities, Association Executives reported that:

Monthly retainer	Roles and Responsibilities
>$1,000 per month	Monitor legislation, facilitate connections, assist with strategy
	Directly lobbies a select number of bills, provides tracking and updates, and updates for members.
	Our lobbyist, MBI keeps NJPRA appraised of the release of bills, status of bills, arranges meetings with legislators; includes us in legislators' events as feasible. They have also supported access to Congressman Pallone for CCBHC-related meetings. MBI supports our association's mission and goals, as reflected in the monthly retainer that they extend to us.
$1,000 - $2,500 per month	Access and budget
	They assist in strategizing, develop relationships with legislators; explain to legislators what our organization wants/needs, and explain to us what obstacles elected officials face and how we may advance of request.
	Direct public policy work at legislative & executive branches.
	The lobbyists work with staff and members to determine legislative priorities. Lobbyists may draft bill language or bill amendments. Lobbyists with staff build relationships with elected officials and state agency staff. Lobbyists work with staff to determine strategy for advocacy efforts.
	Year around representation to State Legislature and committees.
$2,600 - $5,000 per month	Access to legislators, testimony when ED is unavailable, and partnering with other medical associations to further legislation.
	Work closely with CEO, Government Relations Committee and PAC to establish policy priorities. Provide access to legislative and executive leadership. Communicate progress toward goals to membership
	The lobbying firm helps us track legislation, participates in strategy discussions, does one-on-one lobbying as needed and communicates with certain legislators based on their relationships.
	Represent our interests and coordinate meetings with legislators, support our advocacy efforts, advise on strategy, identify specific individuals to contact, provide guidance on our PAC activities
	Monitor identified legislation, weekly legislative reports, attend monthly association meetings, works with senators
	obtain meetings with key legislators and their staff; governor's office, etc.
	Set up meetings with legislators and Governor's office, lobby individual legislators on our policy and budget priorities, participate in Legislative committee and assist with one-pagers, provide weekly summary of legislative activities
	Direct Lobbying, Committee Meetings, Strategy, Draft Language
	representation at the state legislature, assisting with the setting of yearly advocacy goals, co-leads the legislative committee, assists developing day on the hill, weekly legislative report in session and strategy as issues evolve.
	Action alerts, updates, schedule meetings, direct lobbying
$5,001 - $7,500 per month	Direct contact with Governor's office, legislature and state agencies. Services also extend to.NYC government and occasionally other local government.
	Political analysis and tactics, policy analysis and support, access to legislators, local/regional events, media strategies, and technical assistance.
	We employ lobbyists for both the city and state. They arrange meetings for us, provide background on elected officials, and keep abreast of changing politics.
$7,500 + per month	Daily contact with legislators and state officials; "opening doors" to policy makers; general healthcare consulting
	Access to legislators; specific lobbying on identified bills; budget items
	Policy guidance, access to key policy makers, support of policy and funding agenda, briefing FBHA and Advocacy Board of Directors
	connection with legislators and executive branch leaders; consultation with association staff on lobbying by association staff and association's grass roots advocacy; information gathering (often gathered via informal or otherwise exclusive sources)

Association Executives offered the following **best practices for using a lobbyist**:

Be clear about expectations up front; and limit what you ask them to do (i.e., do as much as you can yourself)
Clarity on roles and division of labor and clarifying the priority of the Associations needs as one of many contracted entities for the Lobbyist.
Define role of contract lobbyist
Ease of contact. I speak with our lobbyist all the time, off hours, weekends, texting, etc. I have used other firms where the ease of contact was more limited and it did not work.
Engage your members with the activities that you do with your lobbyist; have them participate in attending committee sessions, submitting testimony and talking to legislators and their staff. This win-win aids members to better understand the legislative process and the legislators understanding of our skills, capacities, challenges, and potential contributions to their districts.
Ensure that the responsibilities and nature of legislative reporting is spelled out in a written agreement. If the lobbyist has other clients - how will conflicts of interest or time demands be handled?
Establish clear expectations; clarify if there are any conflicts in their portfolio of clients and how these will be handled; meet early to discuss legislative agenda; seek regular guidance on policy moves, editorials, etc.; remember they work for you; have them report progress regularly
External lobbyists provide perspective in a broader political landscape and have relationship that extend beyond our sector that help open doors.
Frequent dialogue with lobbyist; knowing when to use the lobbyist to reach out to legislators and policy makers and when to make those connections yourself; regular consultation on lobbying and advocacy approaches.
It's crucial to have a lobbyist with at least an understanding of medical issues if a lobbyist with behavioral health specifically is not available. Too much time is wasted during the session trying to educate the lobbyist otherwise.
Keep engaged, set realistic goals
Lobbyist needs passion for health and human services work, spend a lot of time orienting (most don't have this background), go to many meetings together - starting with leading and then gradually becoming subject matter expert and following their lead in meetings.
Lobbyists are critical to the success of our advocacy work. Our lobbyists track bills and hearings for us, review and submit bill memos, and identify priority legislators and arrange meetings for us. They provide strategic support. We are a small organization operating in a state and city with fast-moving legislatures and budgets. Our lobbyists make our work more efficient and our strategies more effective.
Make sure that a contract lobbyist is giving the organization the required attention. Ours is fine, but some have been known to "log roll" issues or otherwise give short-shrift to clients that pay less.
Make them match the membership of the general assembly; as Missouri shifted politically, we shifted lobbyists
regular meetings, keeping them in the loop and vice versa, share lobbyist among similarly focused associations
Totally depends on the CEO, their abilities, their desire to be actively involved. I want to lead in this space, but this is me.
Understand what, if any, legal and ethical requirements your state has for disclosure and waiving of conflicts of interest between you and other groups contracted with an outside lobbyist.
Weekly policy meetings with lobbyists with staff and membership on phone. Annual public policy retreat. E-mail alerts and updates to members. Collaborations with other associations and their policy staff and lobbyists.

Does the Association have a PAC?
Based on data from 36 respondents, 78% of associations have a PAC. The average annual PAC budget is **$25,444**.

78%

Associations are raising money for the PAC in the following ways:

- Annual and continual campaign; silent auctions at association conference; golf outing
- Anyone who works at a member agency, is a board member of a member agency, or a family member of staff or board can contribute to the PAC. We outreach to members in several campaigns a year to solicit donations to the PAC.
- Appeals to the membership; annual golf tournament
- contributions
- Educational trainings.
- Individual member donations
- Monthly letter from members of PAC with fundraising ideas, discussion at monthly membership forum, direct mail request of member CEOs leadership
- Soliciting member contributions from Board and during our annual conference.
- Through association and member employee contributions