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Facilitators and Barriers to Medicaid Doula Benefit Implementation in California: Perspectives From Managed Care Plans and Risk-Bearing Organizations

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A B S T R A C T

Introduction: Medicaid coverage of doula services is increasing as a policy strategy to reduce maternal health inequities in the United States. However, early adopter states struggled to offer accessible, equitable Medicaid doula benefits when implementation began. California began covering doula services through its Medicaid program, Medi-Cal, in 2023. Managed care plans (MCPs) and risk-bearing organizations (RBOs) play an important role in ensuring pregnant and birthing people can access doula support through Medicaid benefits.
Materials and Methods: Between 2021 and 2022, we conducted 14 interviews with MCP and RBO staff ($n = 20$) representing a total of 14 MCPs and RBOs. Data were analyzed in two stages: 1) rapid assessment process and 2) using the Consolidated Framework for Implementation Research (CFIR) to identify specific facilitators and barriers to Medi-Cal doula benefit implementation.
Results: We identified 10 facilitators and 16 barriers across the five CFIR domains. Results indicate a general lack of familiarity with doula care and highlight the importance of relationship building with doulas and collaboration among plans.
Conclusions: In California, these findings can help guide improvements to emerging implementation challenges and evaluation efforts. Our findings can also help other states in the planning and Medicaid doula benefit design process.

Perinatal doula support is an evidence-based intervention to improve maternal health and health care experiences. As trained birth workers, doulas provide emotional, physical, and informational support throughout pregnancy and other reproductive health experiences (Bey et al., 2019). Doulas bridge gaps in care and help ensure health care providers listen and attend to patient concerns (Reed et al., 2023), which is especially important for Black, Indigenous, and other people of color, who experience higher rates of mistreatment during perinatal care in the United States (Vedam et al., 2019). Other documented benefits of doula

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support include reduced cesarean section rates, fewer preterm births, more positive birth experiences, and lower odds of postpartum depression/postpartum anxiety (Sobczak et al., 2023).

Doula support is not typically covered by health insurance and remains unaffordable to pregnant and birthing people who cannot afford the out-of-pocket cost. However, studies suggest doula support may be cost-effective, particularly for state Medicaid programs (Greiner et al., 2019; Kozhimannil et al., 2016). Given that Medicaid covers about 42% of births in the United States, advocates, policymakers, and researchers have identified Medicaid coverage of doula support as a promising strategy to reduce maternal health inequities (Black Mamas Matter Alliance, 2018; Kozhimannil & Hardeman, 2015; Sakala et al., 2020).

As of early 2024, 12 states and the District of Columbia have implemented Medicaid coverage of doula support (Chen, 2024). Notably, the first two states to offer Medicaid coverage of doula support, Oregon and Minnesota, struggled to offer accessible, equitable benefits when implementation began (Everson et al., 2018; Kozhimannil et al., 2015). Implementation challenges included low reimbursement rates, lack of availability of a culturally congruent doula workforce, and lack of awareness about doulas and Medicaid coverage of doula services among the general public and health systems (Everson et al., 2018; Kozhimannil et al., 2015). Doulas also encountered difficulties navigating the Medicaid system and becoming enrolled providers (Everson et al., 2018; Kozhimannil et al., 2015). Although some initial challenges in Oregon and Minnesota have been addressed in recent years (Chen, 2024), doulas, policymakers, and researchers have developed recommendations to help other states implementing Medicaid doula benefits avoid similar pitfalls (Bey et al., 2019; Goodman & Arora, 2022; Safon et al., 2023).

In California, the 2021–2022 state budget included funding for coverage of doula services through Medi-Cal, the state's Medicaid program, which covers almost 40% of approximately 420,000 births every year in California (CDC & NCHS, 2021). In September 2021, the California Department of Health Care Services (DHCS) began working with stakeholders to develop the doula benefit, which went into effect in January 2023 (DHCS, 2023a).

Managed care plans (MCPs), which administer health coverage for a majority of Medicaid beneficiaries in California and many other U.S. states (Hinton & Raphael, 2023), play an important role in ensuring pregnant and birthing people can access doula support through Medicaid benefits. MCPs implement new benefits, build a network by contracting with providers, and process claims. MCPs also establish contracts with risk-bearing organizations (RBOs), physician-controlled entities that arrange health care services for a health plan's members (DMHC, n.d.). Given that more than 80% of those insured by Medi-Cal in California receive their care through MCPs (Simon, 2020), understanding the perspectives of MCPs and RBOs regarding the Medi-Cal doula benefit can yield important insights for benefit implementation. The purpose of this study was to identify potential facilitators and barriers to the implementation of California's new Medi-Cal doula benefit. Prospective identification of facilitators and barriers can help health plans, policymakers, and researchers tailor implementation strategies and increase the likelihood of successful implementation.

Materials and Methods

Recruitment

As part of a larger study on payer investment in doula services in California (Marshall et al., 2023), we purposively sampled MCPs and RBOs in the state. Our sampling frame was MCPs and RBOs in California. With guidance from experts familiar with the health care purchaser landscape in California, we developed a list of potential MCPs and RBOs to recruit from. When creating the list, we chose MCPs and RBOs with varying membership sizes located throughout California. Recruitment emails were sent to MCP and RBO leaders. Recipients of the recruitment e-mail could ask someone else at their organization to participate in an interview, and more than one person could participate. Using snowball sampling, participants were also asked to identify key stakeholders from other MCPs and RBOs whose perspectives were important to include in our study.

Interviews

We developed two semi-structured interview guides (one for MCPs and one for RBOs) informed by a review of the literature and conversations with experts with knowledge of health plans, benefit design, and doula support. Between September 2021 and February 2022, we conducted 14 interviews with MCP and RBO staff members ($n = 20$) representing a total of 14 MCPs and RBOs. Multiple MCP and RBO staff members were permitted to participate in a single interview. Participants provided verbal consent prior to each interview. All interviews were conducted via phone or videoconference, audio-recorded, and professionally transcribed. Two members of our research team then reviewed each transcript to remove identifiers. To protect participant confidentiality, we report limited descriptors of participants and their respective MCPs and RBOs. Participants received a $45 gift card incentive if they were eligible to accept. The Committee for the Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

Analysis

We conducted our analysis in two phases. First, we used a rapid assessment process (RAP), a team-based, intensive mode of qualitative data analysis, to familiarize ourselves with the data and identify high-level themes (Hamilton, 2013). We created a summary template with neutral domains matched to interview questions. We then used the template to write a summary of each interview. We transferred summary templates to an individual-level data matrix to synthesize key data across participants and domains. Last, we created group-level memos to synthesize findings and inductively identified facilitators and barriers.

Next, using a deductive approach, we aimed to identify specific facilitators and barriers to implementing the Medi-Cal doula benefit using the Consolidated Framework for Implementation Research (CFIR). The CFIR is a deterministic framework designed to guide systematic assessment of multilevel implementation contexts to identify factors that may influence intervention implementation and effectiveness (Damschroder et al., 2009). Although most commonly applied to the implementation of interventions in health care settings, the CFIR can be used to identify implementation factors that influence large-scale health policy initiatives (Rankin et al., 2016; Strehlenert et al., 2019).

The CFIR has five major domains—intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation—and 39 constructs and subconstructs. These constructs have been shown to be important in planning for and developing implementation strategies (King et al., 2010). We conceptualized the intervention as

the Medi-Cal doula benefit and associated regulatory requirements. The provision of doula support is a core component of the intervention. The inner setting consists of the MCP's or RBO's structure and culture, and the outer setting refers to individuals or entities outside the MCP or RBO, such as pregnant and birthing people, community-based organizations, hospitals, state and local government, and external policies. Individuals involved with the implementation process include MCP and RBO employees. When applying the CFIR, we noted that the inner and outer settings overlap, as the line between these domains is not always clear (Damschroder et al., 2009).

The CFIR guided coding, analysis, and reporting of the findings. We created a codebook using CFIR domains, each domain's corresponding constructs, and "facilitator" and "barrier" codes. Using Dedoose coding software (SocioCultural Research Consultants, 2022), A.N. and C.E.Y. coded the same five transcripts individually. After coding each transcript, coders completed a summary template, organized by CFIR domains and constructs and divided into sections for facilitators and barriers. Coders then met with C.M. to discuss discrepancies in code applications. Next, we divided the remaining nine transcripts between A.N. and C.E.Y., who met frequently to discuss coding each transcript. After coding was complete, A.N. reviewed all transcript summaries and drafted descriptions of each potential facilitator and barrier. C.M. then thematically described each CFIR domain and synthesized the facilitators and barriers within each domain. All members of the study team reviewed and approved the final results.

Results

Most MCP and RBO participants occupied one of three roles: chief medical officer, medical director, or program manager. More than half of participants were physicians, with some specializing in obstetrics and gynecology or pediatrics. A few MCPs had piloted doula programs. MCPs and RBOs varied in membership size and served members across the state, including Northern and Southern California and coastal and inland areas. Most participants were aware of DHCS's plans to roll out a new Medi-Cal doula benefit; however, at the time of their interviews, they had not received guidance from DHCS about how the benefit would be structured.

Using the CFIR, we identified 10 facilitators and 16 barriers to implementing the Medi-Cal doula benefit (Table 1). Results are organized by CFIR domain; each domain is described thematically and summarizes the barriers and facilitators.

Intervention Characteristics: Doula Support Can Improve Outcomes, but Lack of Integration Into the System and Benefit Design May Pose Challenges

We identified one key facilitator and numerous barriers related to intervention characteristics. The perception of the quality and validity of the evidence supporting doula services was identified as both a potential facilitator and barrier. Most participants perceived that the doula benefit will contribute to improved maternal and infant health outcomes among members. Participants cited existing research demonstrating the benefits of doula support, including fewer cesarean sections and preterm births and positive birth experiences. Some participants anticipated that MCP and RBO leaders will be more compelled to invest time and resources into the doula benefit if there are opportunities to improve outcomes and reduce costs. However, a minority of participants described the body of research about doula support as insufficient. Some were not aware of the available research showing the benefits of doula support and associated cost savings. One of these participants reported that the quality of evidence *"will influence our level of enthusiasm for making the benefit available in a meaningful way."*

A few participants held the overall belief that the benefit would have limited impact on health outcomes and addressing health disparities, although they had different rationales. First, a participant did not anticipate the benefit would lead to a change in clinical outcomes. Another participant reported that the plan's Medi-Cal membership typically experiences positive maternal health outcomes, stating: *"This is a quality improvement principle. If you start off with high quality, it's hard to see an improvement."* Last, a participant who was supportive of expanding access to doula support noted that not every person will want a doula:

> "It would be great to see some impact on disparities, but I don't know if the doula [benefit], if it's going to scale enough to show that."

Additional barriers within this domain related to the entities involved in benefit development, the complexity of benefit implementation, and how much the benefit can be adapted to meet local needs. There was some concern that the benefit design could lack the expertise of key stakeholders, such as doulas and former doula clients, and thus undermine the impact of the benefit for pregnant people. In addition, a few participants expressed concern that DHCS would develop an overly prescriptive benefit. Citing past experiences implementing well-intentioned Medi-Cal initiatives mandated by the legislature, a participant reported: *"The desire to do something does not mean that you're going to create a policy that works."* The participant cautioned that initiatives developed in the legislature can lead to impractical state guidance.

Additional barriers within this domain are factors related to the benefit that participants felt would create implementation challenges. These included a limited doula workforce that may not allow for cultural and racial concordance for a health plan's membership, a potentially burdensome patient enrollment process (e.g., a state requirement for prior authorization from a clinician), and that doulas will have to navigate a complex managed care system. Doulas may struggle to determine which entities to contract with in their regions, which is not always straightforward. For example, an MCP may delegate certain responsibilities, such as building a provider network and billing, to subcontracted health plans or RBOs.

Participants also noted that doulas and doula organizations may not be familiar with MCP and RBO processes, such as contracting and billing. If doulas are unable to establish contracts or submit claims due to the complexities of navigating these processes, it will hinder their ability to serve members while being compensated through Medi-Cal reimbursement.

Outer Setting: There Is a Need for Collaboration and Strategic Alignment, and to Address Challenges Presented by Medi-Cal Policies and Doula-Clinician Relationships

One facilitator of doula benefit implementation in the outer setting centered on MCPs' and RBOs' networks with external partners. Participants anticipated that they would work with community-based organizations, government entities, and federally qualified health centers to help promote the doula benefit to Medi-Cal beneficiaries and thus facilitate

Table 1
Potential Facilitators and Barriers to Implementing the Medi-Cal Doula Benefit, Organized by CFIR Domains and Constructs

CFIR Domain*	CFIR Construct; Subconstruct*	Barrier or Facilitator
Intervention characteristics	Facilitators	
	• Evidence strength and quality • Cost	• Doula support has a robust evidence base with respect to outcomes and cost-effectiveness
	Barriers	
	• Source	• Benefit design could lack community input • Doula benefit could be overly prescriptive and fail to work in practice
	• Adaptability • Complexity	• Benefit could be challenging to implement in practice due to limited doula workforce
	• Complexity	• Doulas may encounter barriers when working with MCPs, RBOs, and independent physician associations • Burdensome enrollment processes would create barriers for members who want to access the doula benefit
	• Evidence strength and quality	• Perception that research showing the benefits of doula support and cost savings is lacking • Perception that the doula benefit will have limited impact on health outcomes
Outer setting	Facilitators	
	• Cosmopolitanism	• MCPs' ability to network and collaborate with external partners
	• External policy and incentives	• CalAIM could make it easier to contract with doulas • Existing statewide efforts to expand the doula workforce
	Barriers	
	• External policy and incentives	• Low reimbursement rates could hinder doulas' interest in becoming Medi-Cal providers • Cumbersome process to become a Medi-Cal provider
	• Implementation climate†	• Health care system may be resistant to doula presence
	• Patient needs and resources	• Limited knowledge about doula support among membership • Medi-Cal coverage of doula services could impact doula-client relationship
Inner setting	Facilitators	
	• Implementation climate • Readiness for implementation	• MCPs with pilot programs possess implementation-ready climates
	• Networks and communication • Readiness for implementation	• Established relationships with doulas and community-based organizations could contribute to a strong provider network
	• Structural characteristics • Networks and communication • Culture	• MCPs are highly experienced at implementing new Medi-Cal benefits
	Barriers	
	• Readiness for implementation; access to knowledge and information	• MCPs' ability to prepare for the benefit depends on availability of state guidance • Limited knowledge about doula rates and doula types could impact MCPs' understanding of the benefit and potential providers
	• Implementation climate; relative priority • Readiness for implementation; available resources	• Competing priorities will impact the resources MCPs dedicate to the doula benefit
Characteristics of individuals	Facilitators	
	• Knowledge and beliefs about the intervention • Self-efficacy • Individual state of change	• Individual staff champions possess positive attitudes about doula support
Process	Facilitators	
	• Engaging	• Intentionally engaging relevant stakeholders to facilitate benefit awareness
	• Reflecting and evaluating	• Evaluating doula pilot programs helped MCPs gain buy-in for the benefit
	Barriers	
	• Engaging	• Promoting the benefit solely through existing MCP communication channels may not reach intended audiences

Abbreviations: CalAIM, California Advancing and Innovating Medi-Cal; CFIR, Consolidated Framework for Implementation Research; MCP, managed care plan; RBO, risk-bearing organization.

* Damschroder et al., 2009.

† In our analysis, the health system, including hospitals and providers, is in the outer setting of the CFIR. However, this barrier has characteristics of implementation climate, an inner setting subconstruct.

implementation. Some participants also expressed a willingness to collaborate with other MCPs to develop a *"systemic approach"* to the benefit. These participants believed that the alignment of workflows and requirements across MCPs could help avoid confusion among doulas who work with multiple health plans.

External policies and initiatives were identified as both facilitators and barriers. The California Advancing and Innovating Medi-Cal (CalAIM) initiative, an ongoing multi-year plan to improve health outcomes and advance health equity using Medicaid waivers, will allow MCPs to more easily offer nonmedical services (e.g., housing support, medically tailored meals, and peer support) (CHCF, 2021). Several participants cited CalAIM as a potential facilitator and reported that the infrastructure built through the initiative could make it easier to contract with doulas. Another facilitator centered on existing statewide efforts to expand the doula workforce. A few participants noted that nonprofits and government entities, such as public health departments, are prioritizing doula trainings to expand the doula workforce, which participants recognized as a need. With respect to external policies that serve as potential barriers, participants cited specific Medi-Cal policies, including *"ridiculously"* low reimbursement rates and the cumbersome, bureaucratic process to become a Medi-Cal provider. Participants noted Medi-Cal reimbursement rates have previously hindered their ability to attract other provider types.

Several additional barriers in the outer setting were identified. Most participants perceived that doulas do not fit into existing workflows in clinical environments, noting that if health care providers are resistant to doulas or unfamiliar with the benefits of doula support, it could impact their willingness to help promote the benefit. In addition, because of COVID-19 safety protocols, participants reported some hospitals do not consistently allow doulas to attend births, or they place other restrictions on doula attendance. A few participants anticipated that accessing doula services through a health plan could negatively impact doula-client relationships. People usually rely on trusted sources, such as family, friends, or community organizations, for doula recommendations or research and interview doulas before hiring someone they connect with. One participant stated:

> "[If you are] hiring this person, they are working with you and for you. When your health plan is paying for it, then you lose some privacy."

Inner Setting: MCP and RBO Familiarity With Doula Support and Experience Working With Doulas May Facilitate Implementation, but Competing Priorities May Present Challenges

Given that MCPs are highly experienced at implementing new Medi-Cal benefits, some participants identified health plans' existing structures and processes (e.g., departments to contract with providers, set rates, and oversee billing) as a facilitator to implementing the doula benefit. Another facilitator in the inner setting is having established relationships with doulas and doula organizations, which can help MCPs build a network in a timely manner.

Potential barriers within the inner setting of the MCP or RBO included competing institutional priorities and limited knowledge about doula rates and doula types. Most participants lacked knowledge about doula rates and specific models of care. Participants were unfamiliar with the community-based model of doula support, which is seen as a promising intervention with respect to health disparities (Bey et al., 2019). Participants were also unfamiliar with full-spectrum doula support, which the Medi-Cal benefit covers and includes support during abortion, miscarriage, stillbirth, the prenatal and postpartum periods, and labor and delivery (Goodman & Arora, 2022). Several participants said health plan capacity and competing priorities will impact the resources MCPs dedicate to the doula benefit. Most cited the CalAIM initiative as an ongoing priority that will take precedence over implementing the doula benefit. Limited state guidance could also potentially hamper an MCP's ability to prepare for the benefit. At the time of data collection, participants reported receiving minimal information from DHCS about the benefit despite a fast-approaching implementation date, and most said they would not begin preparing for the benefit until they received official guidance.

A final facilitator is an organization's overall climate and readiness for implementation. Some participants described their MCPs as having unique, implementation-ready climates due to previous experience piloting doula programs, which participants signaled will translate to the doula benefit. These MCPs had leaders who were supportive of investing resources into developing pilot programs, which gave participants an opportunity to build institutional knowledge within health plan networks. To facilitate collaborative working relationships between health care providers and doulas for the pilots, participants in these MCPs reported introducing hospital administrators and clinicians to doulas. Further, these participants identified ways to overcome challenges faced in other states with Medicaid benefits. These included setting rates informed by doulas and existing research and providing technical assistance for doulas who may not be accustomed to working with health plans.

Characteristics of Individuals: Staff Doula Champions Are Necessary

Within the characteristics of individuals, staff champions who possess positive attitudes about doula support were identified as a key facilitator. Participants who possessed in-depth knowledge about doula services described being driven to help the benefit succeed within their MCP's network and at the state level. These participants strongly believed the benefit will have a positive impact on pregnant and birthing people and infants in California.

Process: Intentional Stakeholder Engagement, Benefit Promotion, and Benefit Evaluation Are Critical to Implementation

To achieve individual and organizational level use of the doula benefit, MCPs and RBOs will need to engage in an active change process (Damschroder et al., 2009). Participants identified using intentional stakeholder engagement to promote the benefit as a facilitator. Participants who oversaw doula pilot programs described using targeted techniques to engage members and providers, including partnering with external organizations, attending community events, conducting outreach calls to members, meeting with providers, and introducing providers to doulas. A few participants who did not have pilot programs described a willingness to educate providers and health care institutions about doula support and the benefit. Conversely, promoting the benefit solely through existing communication channels is a potential barrier. A few participants reported that simply including language about the benefit in the evidence of coverage packet that is mailed to members or mentioning it during provider meetings would not lead to widespread benefit awareness. Notably, when asked if they would use other

strategies to promote the benefit and educate members and providers about doula support, some participants reported they would not or would do so only if DHCS required them to.

Another facilitator related to the process was program evaluation. Participants from MCPs that had doula pilot programs described the importance of collecting member success stories and continually seeking and listening to doula feedback. However, some of these participants reported that data collection (e.g., tracking hours, documenting client encounters) was a challenge for many doulas.

Discussion

Based on data collected at the cusp of implementation, this study identified potential facilitators and barriers to the implementation of a doula benefit through a state Medicaid program, from the perspective of MCPs and RBOs. Overall, our findings indicate there are numerous potential barriers to benefit implementation that can be proactively addressed by MCPs and RBOs, including a general lack of familiarity with various models of doula support. Findings also indicate there are important lessons to be learned from MCPs that have had doula pilot programs and highlight the importance of relationship building with doulas and community-based doula organizations and collaboration among health plans and other stakeholders.

Several of the facilitators and barriers we identified are consistent with the limited literature that has explored payer perspectives on doula support. In a qualitative analysis that also used the CFIR, Gebel et al. (2024) conducted multiple focus group discussions with 20 participants from four hospitals and two payers implementing community doula support in Massachusetts. Similar to our findings, participants described the importance of evidence demonstrating the impact of doula support, identified organizational culture as a barrier or facilitator to implementation, and noted the importance of high-level champions (Gebel et al., 2024).

Additional research focused on Medicaid doula benefit implementation in Oregon and Minnesota, the first two states to cover doula services through Medicaid. In Oregon, key informants from coordinated care organizations (CCOs) reported internal leadership support for doulas and contracting with community-based doula organizations led to successful integration of doulas into CCOs (Everson et al., 2018). In our study, participants highlighted the importance of cultivating leadership support and indicated that staff champions may help garner internal buy-in. In addition, we found MCPs that have existing relationships with doulas and community-based organizations may be well-positioned to build a robust provider network for the Medi-Cal benefit. In Minnesota, doulas struggled to become enrolled providers with managed care organizations and were required to provide services under the supervision of licensed clinicians, which created confusion among doula program administrators (Kozhimannil et al., 2015). Similarly, participants in our study anticipated that doulas may encounter barriers working with MCPs and RBOs and noted that developing a benefit without input from doulas could create barriers. Minnesota managed care organizations reported promoting the doula benefit by including information in evidence of coverage documents, provider notices, and member newsletters (Kozhimannil et al., 2015). Our findings suggest MCPs in California may use similar communication methods, but more active outreach will likely be needed to raise awareness about the benefit among providers and members.

One novel finding from this analysis is the potential for Medicaid coverage to impact the doula-client relationship. Distrust of the health care system (Armstrong et al., 2006) among some clients could translate to a lack of trust in doulas who contract with health plans that provide insurance through the state and federal government. Health plans and doulas may consider strategies to support the development of trusting doula-client relationships, such as providing clarity around doulas' obligations to the health plan and partnering with trusted community-based organizations to promote the benefit.

Data for this study were collected before DHCS finalized the doula benefit and issued official guidance to MCPs in late 2022. Encouragingly, some of the potential barriers identified in our study have been addressed. For example, participants in this study expressed concern about the benefit design lacking community input. However, DHCS convened the Medi-Cal Doula Services Advisory Workgroup, which met monthly from September 2021 to January 2023 and included doulas, advocates, clinicians, researchers, and MCP representatives (DHCS, 2022). Initially, DHCS struggled to collaborate with doulas (Lange, 2021) but ultimately addressed some concerns. For example, California will not require clinical supervision of doulas, which was a point of discussion during early workgroup meetings (Lange, 2021). Another example relates to Medi-Cal reimbursement rates. Participants identified a structural issue with Medi-Cal's low fee-for-service reimbursement rates. Low reimbursement rates negatively impact provider participation and beneficiary access (Ford & Michener, 2022; Tatar et al., 2016), and participants anticipated the issue would hinder doulas' interest in enrolling as Medi-Cal providers. It is still too early in the implementation process to determine whether reimbursement rates will significantly impact doula participation. The initially proposed Medi-Cal rates for doula services were low compared with other states, but DHCS changed course after receiving stakeholder feedback (Bluth, 2022). In addition, the rates for doula services increased 1 year into benefit implementation as part of a broader, targeted plan to increase Medi-Cal rates for providers (DHCS, 2023b).

Strengths and Limitations

This study is one of few to explore implementation of a Medicaid doula benefit from the perspective of health plans. Key strengths include the participation of MCPs and RBOs that varied in membership size and geographic region served and a rigorous analytic process, which involved an initial rapid analysis and subsequent deductive coding and analysis process, guided by an implementation science framework, to identify specific facilitators and barriers. However, this study has some limitations. First, this analysis is based on the perspectives of only two of the many stakeholder groups that are involved in benefit implementation. Many of the study participants were chief medical officers and medical directors who oversee a host of health plan functions and may not have been intimately aware of their health plans' relationships with doulas. Further, the focus specifically on California and the Medi-Cal program limits generalizability to other contexts. In addition, given the nature of qualitative research and our purposive sampling strategy, it is not possible to generalize our findings across all MCPs or RBOs in the state. Finally, although the CFIR is a comprehensive tool for examining implementation in multilevel contexts, there are some limitations to its use. The

Table 2
Key Suggestions for Managed Care Plans and Risk-Bearing Organizations

1. Increase familiarity with full-spectrum and community-based doula support and available research related to doula support.
2. Build relationships with doulas and doula organizations in coverage areas.
3. Train doulas about how to submit claims and provide ongoing technical support.
4. Foster doula champions at multiple levels within a health plan or risk-bearing organization.
5. Promote positive relationships between doulas and maternity care providers and hospitals.
6. To identify areas for health plan improvement, seek feedback from members who use doula services and doulas who support members through the Medi-Cal benefit.
7. Partner with community organizations to invest in growing a culturally diverse doula workforce.

original version of the CFIR used for this analysis does not make explicit health equity considerations, which are particularly important for interventions with the goal of reducing health inequities. In addition, some have noted that the outer setting domain may not adequately capture the complexity of contextual factors influencing implementation outside of clinical settings (Allen et al., 2021; Warner et al., 2021); this may be relevant for state-level policy initiatives. The updated CFIR addresses these concerns somewhat, with a greater focus on equity in implementation and additional constructs in the outer setting domain (Damschroder et al., 2022). Appendix Table 1 indicates the updated CFIR domains and constructs most similar to the ones used in this analysis. We note that our analysis captured all facilitators and barriers identified in the initial RAP.

Implications for Policy and Practice

Moving forward, our findings suggest there are several barriers that MCPs, RBOs, and other stakeholders can address as implementation progresses (Table 2). Given our finding that CalAIM is a top priority for health plans that may take precedence over implementation of the doula benefit, MCPs and RBOs should explore synergies between CalAIM and the doula benefit, particularly as CalAIM begins to focus on birth equity. Our findings suggest MCPs and RBOs can also contribute to fostering positive relationships between hospital staff and doulas and expanding the doula workforce. Notably, some barriers will be easier to resolve. For example, the provision of technical assistance for doulas to contract with MCPs may be organized in the near term, while supporting the development of positive relationships among hospitals, clinicians, and doulas will likely be a longer-term strategy that may require significant organizational and culture change.

Conclusion

This analysis suggests that collaboration and partnership, stakeholder engagement, relationship building, strategic alignment, and a willingness to learn can support the implementation of the Medi-Cal doula benefit. As implementation proceeds, findings from our interviews with MCP and RBO staff members can help guide improvements to emerging implementation challenges. Our findings can also provide an initial roadmap to monitor and evaluate benefit rollout, which our results suggest is an important part of the implementation process. Future research should be conducted to assess a holistic perspective of implementation successes and challenges from all stakeholders, especially doulas and clients. Beyond California, these findings can help other states that may be considering or already implementing a Medicaid doula benefit in the planning and benefit design process.

CRediT authorship contribution statement

Cassondra Marshall: Writing – review & editing, Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Ashley Nguyen:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis, Data curation. **Clara E. Yang:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Anu Manchikanti Gómez:** Writing – review & editing, Funding acquisition, Formal analysis, Conceptualization.

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Data Availability

Due to privacy and confidentiality concerns, the data are not publicly available. The participants of this study did not give consent for their data to be shared publicly.

Supplementary Data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.whi.2024.05.006.

References

Allen, M., Wilhelm, A., Ortega, L. E., Pergament, S., Bates, N., & Cunningham, B. (2021). Applying a race(ism)-conscious adaptation of the CFIR framework to understand implementation of a school-based equity-oriented intervention. *Ethnicity & Disease*, 31(Suppl 1), 375–388. https://doi.org/10.18865/ed.31.S1.375

Armstrong, K., Rose, A., Peters, N., Long, J. A., McMurphy, S., & Shea, J. A. (2006). Distrust of the health care system and self-reported health in the United States. *Journal of General Internal Medicine*, 21(4), 292–297. https://doi.org/10.1111/j.1525-1497.2006.00396.x

Bey, A., Brill, A., Porchia-Albert, C., Gradilla, M., & Strauss, N. (2019). Advancing birth justice: Community-based doula models as a standard of care for ending racial disparities. In. *Ancient Song Doula Services; Village Birth International; Every Mother Counts* (pp. 33). https://everymothercounts.org/resources/advancing-birth-justice-community-based-doula-models-as-a-standard-of-care-for-ending-racial-disparities-2/.

Black Mamas Matter Alliance. (2018). *Black Mamas Matter: Advancing the human right to safe and respectful maternal health care*, 86. http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf.

Bluth, R. (2022). *Medi-Cal will cover doulas at more than twice California's initial proposed rate*. California Healthline. Retrieved November 22, 2022, from https://californiahealthline.org/news/article/medicaid-doulas-twice-initial-rate/.

CDC & NCHS. (2021). National Vital Statistics System, natality on CDC WONDER online database [dataset]. http://wonder.cdc.gov/natality-expanded-current.html.

CHCF. (2021). CalAIM Explained: A five-year plan to transform Medi-Cal. Retrieved November 2, 2023, from https://www.chcf.org/publication/calaim-explained-five-year-plan-transform-medi-cal/.

Chen, A. (2024). *Doula Medicaid project: February 2024 state roundup*. National Health Law Program. https://healthlaw.org/doula-medicaid-project-february-2024-state-roundup/.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research

findings into practice: A consolidated framework for advancing implementation science. *Implementation Science: IS*, 4, 50. https://doi.org/10.1186/1748-5908-4-50

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user feedback [Supplemental material]. *Implementation Science*, 17(1), 75. https://doi.org/10.1186/s13012-022-01245-0

DHCS. (2022). Medi-Cal doula services advisory workgroup. Retrieved July 7, 2022, from https://www.dhcs.ca.gov/services/medi-cal/Documents/Doula-Stakeholder-Workgroup.pdf.

DHCS. (2023a). Doula services as a Medi-Cal benefit. Retrieved November 2, 2023, from https://www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx.

DHCS. (2023b). Calendar year 2024 Medi-Cal targeted rate increases provider webinar. Retrieved May 10, 2024, from https://www.dhcs.ca.gov/Documents/12-19-23-Presentation-Materials.pdf.

DMHC. (n.d.). Risk bearing organization (RBO) frequently asked questions. Retrieved November 1, 2022, from https://www.dmhc.ca.gov/licensingreporting/riskbearingorganizations/rbofrequentlyaskedquestions.aspx.

Everson, C., Crane, C., & Nolan, R. (2018). *Advancing health equity for childbearing families in Oregon: Results of a statewide doula workforce needs assessment*. Oregon Doula Association. https://www.oregon.gov/oha/EI/Documents/Doula%20Workforce%20Needs%20Assesment%20Full%20Report%202018.pdf.

Ford, T. N., & Michener, J. (2022). *Medicaid reimbursement rates are a racial justice issue*. https://doi.org/10.26099/h5np-x425

Gebel, C., Larson, E., Olden, H. A., Safon, C. B., Rhone, T. J., & Amutah-Onukagha, N. N. (2024). A qualitative study of hospitals and payers implementing community doula support. *Journal of Midwifery & Women's Health*. https://doi.org/10.1111/jmwh.13596. Advance online publication.

Goodman, S., & Arora, A. (2022). *The importance of full-spectrum doulas to reproductive health and justice*. National Partnership for Women & Families, 30. https://www.nationalpartnership.org/our-work/resources/health-care/maternity/our-communities-hold-the-solutions.pdf.

Greiner, K. S., Hersh, A. R., Hersh, S. R., Remer, J. M., Gallagher, A. C., Caughey, A. B., & Tilden, E. L. (2019). The cost-effectiveness of professional doula care for a woman's first two births: A decision analysis model. *Journal of Midwifery & Women's Health*, 64(4), 410–420. https://doi.org/10.1111/jmwh.12972

Hamilton, A. B. (2013). *Qualitative methods in rapid turn-around health services research*. VA HSR&D Cyberseminar Spotlight on Women's Health. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/780-notes.pdf.

Hinton, E., & Raphael, J. (2023). *10 Things to know about Medicaid managed care*. KFF. Accessed October 25, 2022, from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

King, D. K., Glasgow, R. E., & Leeman-Castillo, B. (2010). Reaiming RE-AIM: Using the model to plan, implement, and evaluate the effects of environmental change approaches to enhancing population health. *American Journal of Public Health*, 100(11), 2076–2084. https://doi.org/10.2105/AJPH.2009.190959

Kozhimannil, K. B., & Hardeman, R. (2015). *How Medicaid coverage for doula care could improve birth outcomes, reduce costs, and improve equity*. Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/forefront.20150701.049026/full/.

Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth*, 43(1), 20–27. https://doi.org/10.1111/birt.12218

Kozhimannil, K. B., Vogelsang, C. A., & Hardeman, R. R. (2015). *Medicaid coverage of doula services in Minnesota: Preliminary findings from the first year interim report to the Minnesota Department of Human Services*. Minnesota Department of Human Services.

Lange, A. (2021). *'The state needs to listen to Black women'. Why doulas aren't happy with California*. The Sacramento Bee. Retrieved July 7, 2022, from https://www.sacbee.com/news/california/article255204991.html.

Marshall, C. J., Nguyen, A., Yang, C., & Gomez, A. M. (2023). Understanding barriers and facilitators to payer investment in doula care in California. https://www.share.berkeley.edu/_files/ugd/7ee60a_cd3211244e244ee3b59dd758efbb5140.pdf.

Rankin, K. M., Kroelinger, C. D., DeSisto, C. L., Pliska, E., Akbarali, S., Mackie, C. N., & Goodman, D. A. (2016). Application of implementation science methodology to immediate postpartum long-acting reversible contraception policy roll-out across states. *Maternal and Child Health Journal*, 20(Suppl 1), 173–179. https://doi.org/10.1007/s10995-016-2002-4

Reed, R., Nguyen, A., Armstead, M., Cuentos, A., Mystic, M.-I., Arcara, J., Jackson, A. V., Marshall, C., & Gomez, A. M. (2023). "An extra layer of pressure to be my best self": Healthcare provider perspectives on how doulas foster accountability and bridge gaps in pregnancy-related care. *SSM - Qualitative Research in Health*, 3(100259), 1–8. https://doi.org/10.1016/j.ssmqr.2023.100259

Safon, C. B., McCloskey, L., Gordon, S. H., Cole, M. B., & Clark, J. (2023). Medicaid reimbursement for doula care: Policy considerations from a scoping review. *Medical Care Research and Review: MCRR* 10775587231215221. https://doi.org/10.1177/10775587231215221

Sakala, C., Hernández-Cancio, S., Coombs, S., Essoka, N., & Mackay, E. (2020). *Improving our maternity care now: Four care models decisionmakers must implement for healthier moms and babies*. National Partnership for Women & Families. https://nationalpartnership.org/wp-content/uploads/2023/02/improving-our-maternity-care-now.pdf.

Simon, M. (2020). *Medi-Cal explained: Maternity care*. CHCF. 10. Retrieved November 2, 2022, from https://www.chcf.org/wp-content/uploads/2020/09/MediCalExplainedMaternityCare.pdf.

Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The effect of doulas on maternal and birth outcomes: A scoping review. *Cureus*, 15(5): Article e39451. https://doi.org/10.7759/cureus.39451

SocioCultural Research Consultants. (2022). *Dedoose, web application for managing, analyzing, and presenting qualitative and mixed method research data (9.0.54) [Computer software]*. SocioCultural Research Consultants, LLC. https://www.dedoose.com/.

Strehlenert, H., Hansson, J., Nyström, M. E., & Hasson, H. (2019). Implementation of a national policy for improving health and social care: A comparative case study using the Consolidated Framework for Implementation Research. *BMC Health Services Research*, 19(1), 730. https://doi.org/10.1186/s12913-019-4591-2

Tatar, M., Paradise, J., & Garfield, R. (2016). *Medi-Cal managed care: An overview and key issues*. KFF. Retrieved February 22, 2023, from https://www.kff.org/medicaid/issue-brief/medi-cal-managed-care-an-overview-and-key-issues/.

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., & Declercq, E. (2019). The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health*, 16(1), 77. https://doi.org/10.1186/s12978-019-0729-2

Warner, G., Kervin, E., Pesut, B., Urquhart, R., Duggleby, W., & Hill, T. (2021). How do inner and outer settings affect implementation of a community-based innovation for older adults with a serious illness: A qualitative study. *BMC Health Services Research*, 21(1), 42. https://doi.org/10.1186/s12913-020-06031-6

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