DOULA BENEFIT IMPLEMENTATION REPORT

July 2025

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

Beginning on January 1, 2023, the Department of Health Care Services (DHCS) added doula services to the list of preventive services covered under the Medi-Cal program as part of Assembly Bill 133 (Committee on Budget, Health, Chapter 143, Statutes of 2021). AB 133 coincided with Senate Bill 65 (Skinner, Chapter 449, Statutes of 2021), the California "Momnibus" Act legislation that aims to improve maternal and infant health outcomes among Medi-Cal members—especially Black/African American and Native American/Alaska Native members who are disproportionately impacted by racial discrimination, disparities and inequities in health care access, services and delivery. Doulas provide various types of support (e.g., health care navigation, evidence-based education, development of birth plans etc.) during pregnancy, labor and delivery, miscarriage and abortion and up to one year postpartum.

Under the W&I Code, Section 14132.24 (c), DHCS must publish an implementation report on its website by July 1, 2025. This report evaluates the implementation of the doula benefit for the first 18 months of implementation by addressing the number of members utilizing doula services and provides a numerical comparison of birthing outcomes between Medi-Cal members who utilized doula support and those who did not. The report also identifies barriers to access and includes recommendations from the Doula Implementation Stakeholder Workgroup to DHCS and the Legislature.

This report leverages a mixed methods approach to address these requirements by using quantitative analysis undertaken by DHCS and qualitative interviews by contracted researchers from the University of California, Berkeley to identify access and other barriers to doula services. Findings from the early implementation of the Medi-Cal doula benefit show low, but steadily increasing, utilization. This trend aligns with DHCS' typical expectation of a three to five year ramp up for new benefits to be fully implemented. After implementation of the benefit was delayed from January 1, 2022, to January 1, 2023, to provide additional time for DHCS to work with stakeholders to finalize the benefit and provide additional time for managed care plans to implement, DHCS proposed legislation that extended the deadline for this report from July 1, 2024, to July 1, 2025. This helped ensure that there would be enough data to effectively capture utilization during early implementation of the benefit.

There was wide variation in doula utilization by county and by Medi-Cal managed care plan. The benefit has also had some early success in reaching the priority populations outlined in Senate Bill 65—specifically Native American or Alaska Native, Native Hawaiian or Other Pacific Islander and Black or African American members. Members who used the benefit valued the support and advocacy provided by their doulas.

Members who had a doula present at birth had higher odds of attendance at their postpartum visit compared to a matched group of members who did not use Doulas. Members and stakeholders (e.g., doulas, hospital staff, Medi-Cal managed care plan staff) identified several barriers including limited awareness, confusion about the doula role, and language access issues. Stakeholders also highlight a need for more streamlined and simplified processes for enrolling doulas as providers, contracting with managed care plans and billing for services. Community based organizations (CBOs) play a vital role in both outreach and technical assistance for these processes but face challenges due to limited funding. Stakeholders recommend increasing support for CBOs, sharing best practices and using collaborative approaches to improve health care providers, hospitals and Medi-Cal managed care plan staff' knowledge of the benefit. The main goal of this report is to highlight early lessons learned from implementation of the benefit, identify barriers to benefit utilization and inform actions DHCS, managed care plans, hospitals and the Legislature can take to expand awareness and improve equitable access to the benefit.

The Doula Implementation Stakeholder Workgroup was created pursuant to Senate Bill (SB) 65 [adding section 14132.24 to the Welfare and Institutions Code (WIC)] to help inform development of a report to the Legislature with data on Medi-Cal members' use of doula services and recommendations to reduce any identified barriers to doula services. The Workgroup developed recommendations specific to DHCS, Medi-Cal managed care plans (MCPs), hospitals and the State Legislature. Recommendations from the Doula Implementation Stakeholder Workgroup to DHCS include establishing a new doula stakeholder workgroup to advise on implementing recommendations and sharing best practices among MCPs and hospitals. Additional recommendations from the Workgroup for DHCS call for the creation of a doula specific dashboard with key performance indicators, launching an awareness campaign for the benefit, enforcement of clear guidelines for MCPs and distribution of ramp up funding to MCPs for CBOs and independent doula providers. DHCS notes that some of the Workgroup recommendations require additional resources to implement and, as such, DHCS would need to consider these recommendations within the broader state budget framework. For MCPs, stakeholder priorities include creating doula specific contracts, simplifying and speeding up contracting processes and increasing responsiveness by designating staff to assist with questions from Doulas and members. Hospitals were encouraged by stakeholders to adopt, and share established best practices (e.g., Doula admission policies) to better integrate Doulas into maternity care settings. Finally, key recommendations from the Workgroup to the State Legislature include funding pilot

initiatives and grant programs to help increase doula enrollment, along with the development of a web-based doula directory.

BACKGROUND

The California Momnibus Act (Senate Bill 65, signed into law October 4, 2021) seeks to improve maternal and infant health outcomes among Medi-Cal members, especially Black/African American and American Indian/Alaska Native pregnant, birthing, and postpartum people who are disproportionately impacted by racial discrimination, disparities and inequities in health care access, services, and delivery. As part of this effort, AB 133 enacted Medi-Cal coverage for doula services which provides culturally affirming, continuous support throughout the perinatal period for pregnant, birthing and postpartum people, and for abortion or miscarriage.

The Department of Health Care Services (DHCS) first started working in the fall of 2020 to develop doula services as a Medi-Cal benefit to improve maternal and birth outcomes, particularly in disadvantaged communities. Since doula services are not regulated by California statute, DHCS convened a doula workgroup starting September 16, 2021, and engaged in extensive stakeholder engagement to develop the benefit, including provider qualifications, and added doula services to the list of preventive services covered under the Medi-Cal program on January 1, 2023. DHCS submitted State Plan Amendment (SPA) 22-0002 to the Centers for Medicare and Medicaid Services (CMS) and received federal approval on January 26, 2023. Doulas could start submitting applications to enroll as Medi-Cal providers starting January 1, 2023, and start contracting with plans once DHCS approved their application.

Doula services are available in fee-for-service Medi-Cal and through Medi-Cal managed care plans. Due to federal Medicaid regulations for preventive services, doula services must be recommended by a physician or other licensed practitioner. To increase access to the doula benefit, DHCS Medical Director, Dr. Karen Mark issued a standing recommendation on November 1, 2023, fulfilling the federal requirement for a recommendation to initiate doula services. As a result, Medi-Cal members do not need to separately obtain a recommendation for the below services.

Medi-Cal's doula benefit covers the following services:

- One initial visit
- Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits

- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
- Up to two extended three-hour postpartum visits after the end of a pregnancy
- Up to nine additional postpartum services that may be provided with a second recommendation from a licensed provider

Doulas provide various types of support during the perinatal period, including during pregnancy, at labor and delivery, for miscarriage and abortion, and up to one year postpartum. Services include guidance, health care navigation, evidence-based education (for prenatal, postpartum, childbirth, and newborn/infant care), lactation support, development of a birth plan, and linkages to community-based resources.

Based on existing research, doula support may influence engagement in health care and maternal health outcomes related to the birthing experience, including reduced rates of cesarean sections (Fernandes et al., 2022; Kozhimannil et al., 2016), increased rates of vaginal births after prior cesarean sections (Lemon et al., 2024), greater prenatal care engagement (Falconi et al., 2022; Ogunwole et al., 2021) and higher postpartum visit attendance (Falconi et al., 2024). However, there is very limited published existing evidence that suggests doula support has a direct impact on clinical conditions such as gestational hypertension or pre-eclampsia, which are more strongly tied to underlying medical factors and may not be significantly altered by the presence of doula support alone.

As part of Senate Bill 65, a Doula Implementation Workgroup was created to provide feedback to:

- Ensure doula services are available to Medi-Cal members who are eligible for and want doula services
- Minimize barriers and delays in payments to Medi-Cal enrolled doulas
- Make recommendations for outreach efforts so that all Medi-Cal members who are eligible for services are aware of the option to use doula services
- Make recommendations to reduce any identified barriers to doula services

Doula Implementation Workgroup meetings were held publicly between March 30, 2023, and May 9, 2025. Stakeholders who were part of the Workgroup (as designated by state law) included doulas, health care providers, consumer and community advocates, Medi-Cal managed care plans, county representatives, and other stakeholders with experience with doula services (full list of members linked on our website). To allow time for the doula benefit to be implemented before discussing evaluation of the benefit, the

Workgroup initially met quarterly for the first 15 months, then met bimonthly from September 2024 through January 2025, and then monthly in March, April, and May 2025. While the Workgroup meetings were open to the public and all attendees could comment in the chat, only Workgroup members had the ability to speak during stakeholder meetings.

DHCS selected 30 representatives from the affinity groups identified in WIC section 14132.24, including nine doulas, three health care providers, four consumer and community advocates, seven health plan representatives, four county representatives, and three other stakeholders with knowledge and experience in doula services. In addition, DHCS developed a Co-Design Team made up of 17 members of the Workgroup to help develop topics/discussions for stakeholder meetings to meet the intent of the legislation for Workgroup meetings, discuss policy, and work through concerns. The Co-Design team included seven doulas. With support from the California Health Care Foundation (CHCF), RACE For Equity (R4E) served as a meeting facilitator for the Co-Design and Workgroup meetings.

Objectives

In accordance with the W&I Code, Section 14132.24 (c), DHCS is required to publish an implementation report on its website no later than July 1, 2025. This report examines the implementation of the doula benefit by addressing the number of Medi-Cal members utilizing doula services and identifying any barriers that impede access. The report is required to include the following components:

1. Number of members utilizing doula services, broken down by race, ethnicity, primary language, health plan and county.
2. Numerical comparison of the birthing outcomes of Medi-Cal members who receive doula services with those who do not, including (but not limited to) rates of cesarean delivery births, maternal or infant mortality, other maternal morbidity and breast/chest feeding outcomes.
3. Identification of barriers that impede access to doula services in the prenatal, labor and delivery, and postpartum periods, and recommendations to the department and Legislature to reduce any identified barriers.

To address the legislative requirements listed above, this report leverages a mixed methods approach. First, a quantitative analysis was undertaken by DHCS to address the first two components (i.e., number of members utilizing services and comparison of

birth outcomes). Second, DHCS contracted with researchers from the University of California Berkeley: Cassondra Marshall, Anu Manchikanti Gómez and Ashley Nguyen, to conduct a qualitative study aimed at identifying barriers that impede members access to doulas. The methodology and the results of each analysis are summarized in the following two sections. Recommendations from the Workgroup are also included in a later section following a discussion of study results and prior efforts by DHCS to address stakeholder concerns.

QUANTITATIVE STUDY RESULTS

The quantitative analysis was completed by DHCS and addresses the first two legislatively required components: the number of members who utilized doula services (broken down by race/ethnicity, primary language, Medi-Cal managed care plan and county) and a numerical comparison of birth outcomes of Medi-Cal members who received doula services and those who did not. Preliminary results from this analysis were presented to the Doula Implementation Workgroup on April 11, 2025, and informed Workgroup recommendations.

Study Design and Methodology

To assess the number of members utilizing doula support (broken down by race/ethnicity, primary spoken language, Medi-Cal managed care plan and county of eligibility), the number of members and visits with specific medical billing codes (i.e., Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes) appearing in fee-for-service claims and Medi-Cal managed care encounters submitted to DHCS (either directly or via a Medi-Cal managed care plan) were counted. It should also be noted that because claims/encounter data was utilized for this analysis, our numbers may not align with other reported utilization data such as plan-reported data. Doula use was defined for the exploratory data analysis as having any encounter with a doula (e.g., birth support or visit) between January 1, 2023, and June 30, 2024.

For the numerical comparison in birth outcomes of Medi-Cal members who received doula services and those who did not, members who received doula services were matched to non-users who were similar in terms of their likelihood of receiving the benefit through propensity score matching. This propensity score matching was based on characteristics that included race/ethnicity, primary language, Medi-Cal managed care plan, county, presence of obesity (i.e., BMI >30), smoking status, presence of

substance use/substance use disorder, advanced maternal age (35+), having twins, triplets or other multiples, and diagnoses of asthma, compromised immune system, cardiovascular disease, or pre-existing Type I or Type II diabetes. For this birth outcomes analysis, doula use was defined as members having any doula support at their birth (e.g., vaginal, cesarean etc.), regardless of the amount of time the doula was present.

Aggregate data from January 1, 2023, to June 30, 2024, was used for all analyses and the data was accessed on February 5, 2025. This specific time period was chosen to allow for a sufficient number of claims to be processed and included in the analyses due to the report being required to be posted on the DHCS website one year later. These data come from the internal DHCS Management Information/Decision Support System and includes medical claims/encounters and demographic information about members enrolled in Medi-Cal.

Findings

Key Takeaways

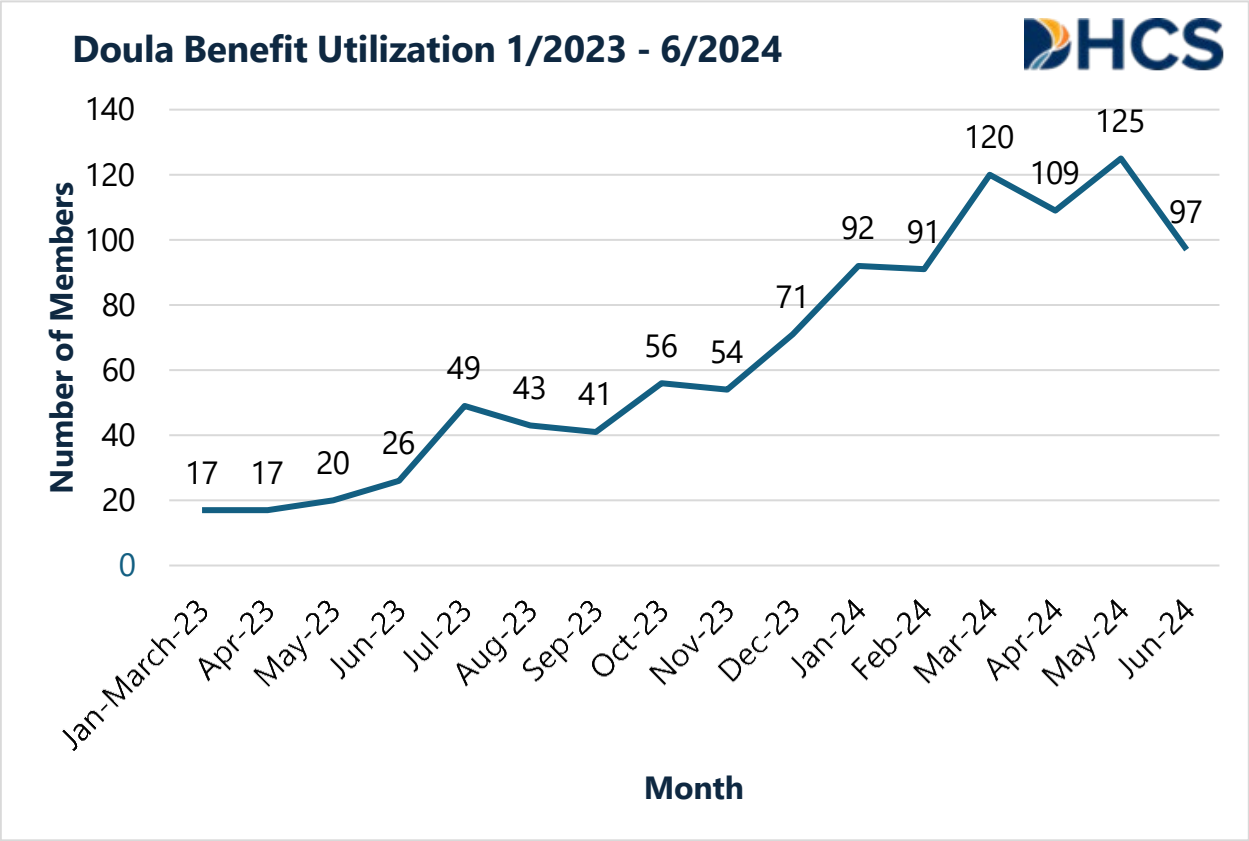
- Doula benefit usage was low, but increased steadily between 1/2023 – 6/2024
- Doula utilization rates were highest among White, American Indian or Alaska Native and Native Hawaiian or Pacific Islander, and Black/African American in comparison to Hispanic/Latino and Asian members
- Compared to matched non-doula users, doula users had:
  - 3 times more prenatal visits with healthcare providers on average
  - More than 3 times higher odds of attending a postpartum visit with providers on average

Doula Support Utilization by Month

From January 1, 2023, to June 30, 2024, there were 1,028 unique Medi-Cal members who utilized one or more doula services. Doula benefit usage (defined by the first encounter with a doula) was assessed by month and shows a general upward trend in overall utilization. The slight dip in utilization for the month of June 2024 may be largely attributed to claims/encounters lag (e.g., the time delay between when a Medi-Cal member receives a health care service and when the claim or bill is received, processed,

and loaded into DHCS' systems) because the data was accessed February 5, 2025; June 2024 claims may have still been arriving in DHCS data systems.

Figure 1: Members Initiating Doula Care by Month



Data Source: Management Information System/Decision Support System- DHCS Data Warehouse

Dates Represented: 1/1/2023 – 6/30/2024 | Date Downloaded: 2/5/2025

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Doula Support Utilization by Service Type

Overall utilization by birth service shows that Medi-Cal members utilizing doula support gave birth vaginally (72%), by cesarean (23%), and as a vaginal birth (5%) after cesarean. Less than eleven members received doula support for abortion or miscarriage (exact number suppressed due for privacy). For specific numbers see Table A.1 in Appendix A.

Doula Benefit Utilization by Visit Type

Additional descriptive statistics of doula support by encounter included the number of initial visits, prenatal visits, births, postpartum visits and extended postpartum visit claims.

Table 1: Number of Doula Paid Claims/Encounters by Visit Type

Type of Health Care Encounter	Number of Encounters Billed by Doulas
Initial Visits	32
Prenatal Visits	54
Births	886
Extended Postpartum Visits	1464
Postpartum Visits (Other)	28

Notes: Postpartum Visits (Other) refers to postpartum visits that were not extended visits. Initial Visits are defined as the first prenatal visit with a doula billed after a confirmed pregnancy.

Doula Benefit Utilization by Member Race/Ethnicity

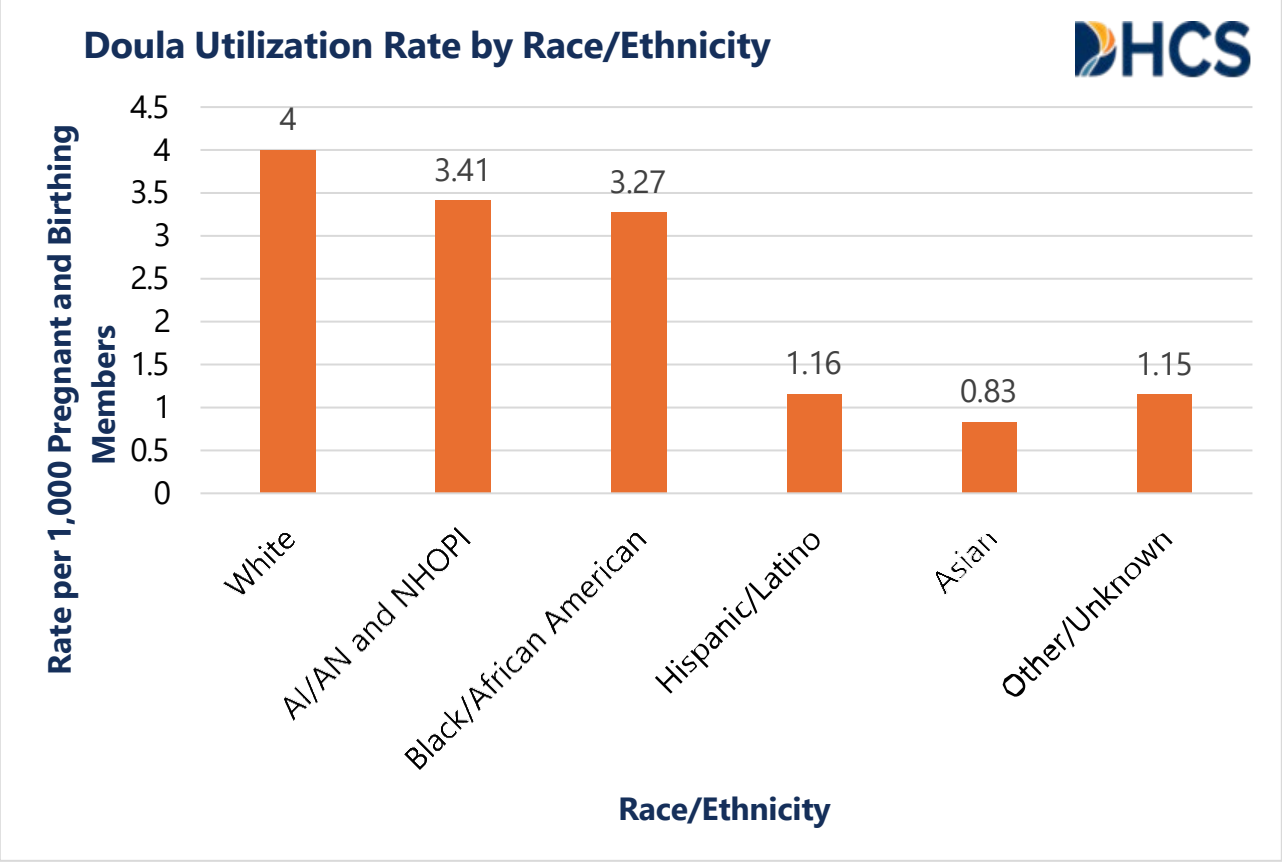
To compare doula utilization across racial/ethnic groups of pregnant and birthing individuals in California, DHCS calculated the rate of use per every 1,000 pregnant and birthing Medi-Cal members. This allows us to account for differences in group size amongst different racial/ethnic categories[1].

The highest rate of doula utilization was among those who identify as White with 4 doula users out of every 1,000 pregnant and birthing people (71,601 total), American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander with 3.41 doula users out of every 1,000 pregnant and birthing people (3,228 total), and 3.27 doula users out of every 1,000 pregnant and birthing people among those identify as Black or African American (45,233 total). One result of using this method is that large racial and ethnic groups (e.g., Hispanic or Latino) may not actually have the highest rates of doula

[1] Race/ethnicity categories were created such that if a member indicated that they were Hispanic or Latino (even if they chose other selections) they would be counted as Hispanic or Latino. The category "Other/Unknown" includes those that identify as "Other Race" and those who did not indicate a race/ethnicity.

use, even if the number of doula users in these groups seems high at first glance. For a full list of specific numbers see Table 2. Figure 2 shows that the benefit has had some early success in reaching priority populations (e.g., American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander and Black or African American members) outlined in Senate Bill 65.

Figure 2: Race/Ethnicity of Doula Users



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Notes: AI/AN = American Indian or Alaska Native. NHOPI = Native Hawaiian or Other Pacific Islander. American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander were combined due to small counts. Other/Unknown includes those that indicated "Other Race" and those who did not indicate a race/ethnicity.

Table 2: Doula Utilization by Race/Ethnicity

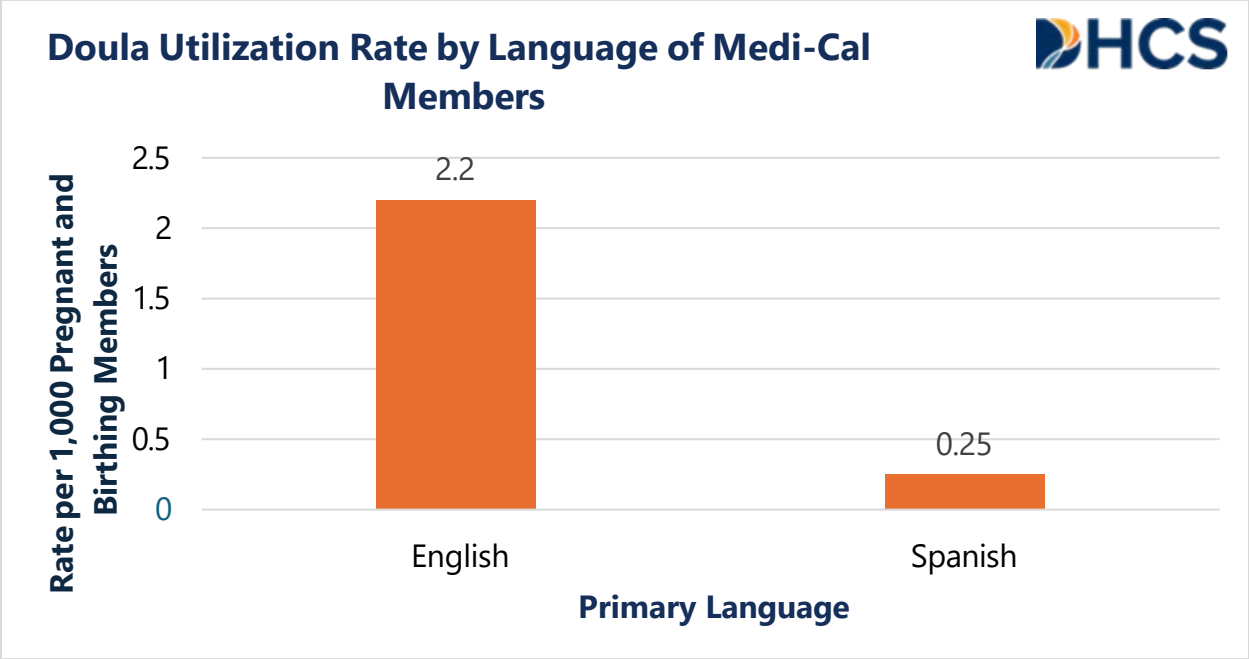
Race/Ethnicity	Number of Doula Users	Total Pregnant and Birthing People	Rate per 1,000 Pregnant and Birthing People
White	286	71,601	4
American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander	11	3,228	3.41
Black or African American	148	45,233	3.27
Hispanic or Latino	412	353,683	1.16
Asian	24	28,845	0.83
Other/Unknown	146	127,323	1.15

Notes: Other/Unknown includes members that chose "Other Race" and those who did not indicate a race/ethnicity. American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander doula users were combined due to small counts.

Doula Benefit Utilization by Primary Spoken Language

Doula users who spoke English as their primary language had the highest rate of doula utilization at 2.2 for every 1,000 pregnant people (982 doula users out of 445,654 total pregnant and birthing people who spoke English as their primary language), followed by those who spoke Spanish as their primary language (39 doula users of 157,441 pregnant and birthing people who spoke Spanish) (see Figure 3). Doula users who spoke "Other" languages (i.e., Armenian, Russian) with counts less than 11 were suppressed for privacy. For specific numbers see Table 3.

Figure 3: Primary Spoken Language of Doula Users



Data Source: Management Information System/Decision Support System- DHCS Data Warehouse

Dates Represented: 1/1/2023 – 6/30/2024 | Date Downloaded: 2/5/2025

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Table 3: Doula Utilization by Primary Spoken Language

Language	Number of Doula Users	Total Pregnant and Birthing People	Rate per 1,000 Pregnant and Birthing People
English	982	445,654	2.2
Spanish	39	157,441	0.25

Doula Benefit Utilization by Medi-Cal managed care plan and County of Eligibility

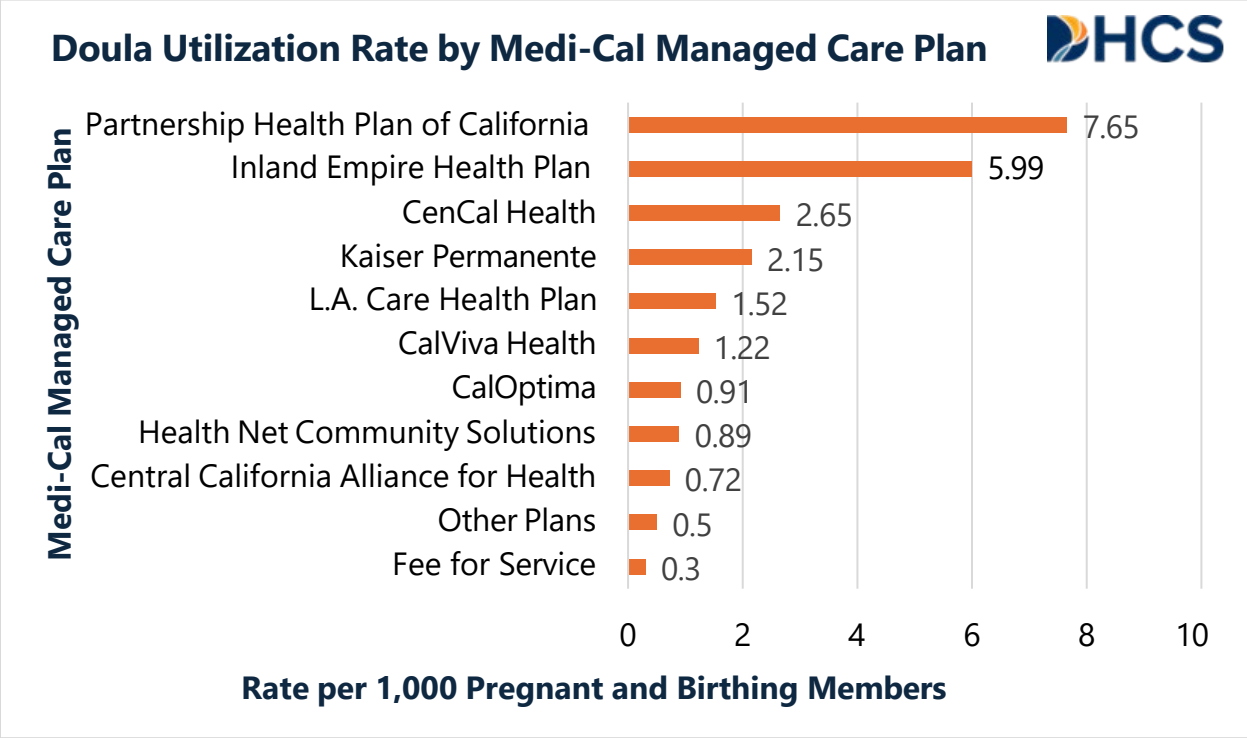
To account for differences in county of eligibility and Medi-Cal managed care plan size, we examined the rate of doula benefit utilization per 1,000 pregnant people by Medi-Cal managed care plan and county of eligibility. Medi-Cal managed care plans and counties are listed from highest to lowest utilization. Please see Table 4 and Table 5 for full list and specific rates.

Medi-Cal managed care plans with the highest rates of utilization included: Partnership Health Plan of CA and Inland Empire Health Plan (Figure 4).

Counties with the highest rates of utilization included Humboldt, Nevada, Shasta, San Luis Obispo, Sonoma, San Bernardino, and Riverside (Figure 5).

Counties with zero utilization of the doula benefit between 1/1/23 and 6/30/24 included Alpine, Amador, Colusa, Del Norte, Glenn, Imperial, Inyo, Lassen, Mono, Monterey, Napa, Plumas, San Benito, Sutter, Sutter/Yuba, Berkeley City and Tri-City.

Figure 4: Doula Benefit Utilization by Medi-Cal Managed Care Plan



Data Source: Management Information System/Decision Support System- DHCS Data Warehouse

Dates Represented: 1/1/2023 – 6/30/2024 | Date Downloaded: 2/5/2025

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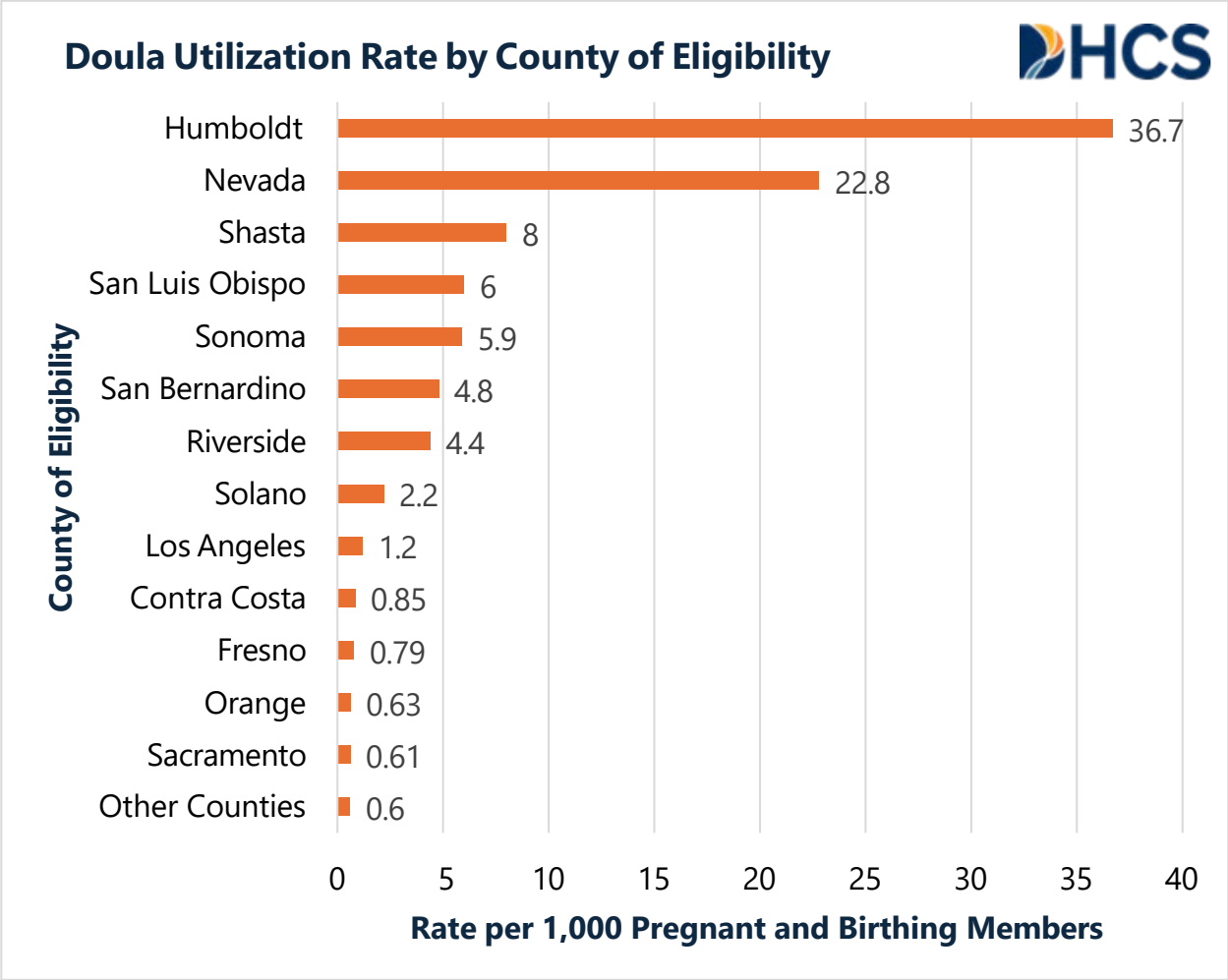
Notes: "Other Plans" refers to plans with counts less than 11 that were suppressed for privacy including Alameda Alliance for Health, Anthem Blue Cross Partnership Plan, Anthem Blue Cross, Blue Shield of California Promise, California Health and Wellness Plan, Community Health Group, Contra Costa Health Plan, Gold Coast Health Plan, Health Plan of San Mateo, Kern Health Systems, Molina Healthcare of California, San Francisco Health Plan and Santa Clara Family Health Plan.

Table 4: Utilization by Medi-Cal Managed Care Plan

Medi-Cal Managed Care Plan	# of Doula Users	Total Pregnant and Birthing People	Doula User Rate per 1,000 people
Partnership Health Plan of California	217	28,375	7.65
Inland Empire Health Plan	371	61,944	5.99
CenCal Health	28	10,583	2.65
Kaiser Permanente	51	23,728	2.15
L.A. Care Health Plan	126	83,005	1.52
CalViva Health	25	20,418	1.22
CalOptima	26	28,431	0.91
Health Net Community Solutions	46	51,662	0.89
Central California Alliance for Health	14	19,476	0.72
Other Plans	89	171,477	0.5
Fee for Service	35	139,321	0.3

Notes: "Other Plans" refers to plans with counts less than 11 that were suppressed for privacy including Alameda Alliance for Health, Anthem Blue Cross Partnership Plan, Anthem Blue Cross, Blue Shield of California Promise, California Health and Wellness Plan, Community Health Group, Contra Costa Health Plan, Gold Coast Health Plan, Health Plan of San Mateo, Kern Health Systems, Molina Healthcare of California, San Francisco Health Plan and Santa Clara Family Health Plan.

Figure 5: Doula Benefit Utilization by County of Member Eligibility



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Notes: "Other Counties" refers to counties with counts less than 11 that were suppressed for privacy and include Alameda, Butte, Calaveras, El Dorado, Kern, Kings, Lake, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Placer, Santa Barbara, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sierra, Siskiyou, Stanislaus. Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo and Yuba.

Table 5: Doula Utilization by County of Eligibility

County	# of Doula Users	Total Pregnant and Birthing Members	Doula User Rate per 1,000 People
Humboldt	92	2,506	36.7
Nevada	23	1,008	22.8
Shasta	25	3,124	8
San Luis Obispo	19	3,183	6
San Bernardino	217	44,991	4.8
Sonoma	36	6,144	5.9
Riverside	181	41,362	4.4
Solano	15	6,833	2.2
Los Angeles	194	168,553	1.2
Fresno	21	26,620	0.79
Contra Costa	12	14,083	0.85
Orange	25	39,469	0.63
Sacramento	18	29,325	0.61
Other Counties	127	171,986	0.6

Notes: "Other Counties" refers to counties with counts less than 11 that were suppressed for privacy and include Alameda, Butte, Calaveras, El Dorado, Kern, Kings, Lake, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Placer, Santa Barbara, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sierra, Siskiyou, Stanislaus. Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo and Yuba.

Comparison of Maternal Health Outcomes: Doula Users vs. Non-Users

To conduct a comparison of maternal health outcomes, propensity score matching was used to create a comparison group of doula non-users who gave birth (n = 886) that matched with doula users who gave birth with a doula present (n = 886) between January 1, 2023, and June 30, 2024. Births were defined as having a doula present for the live birth as indicated by claims/encounter data. Propensity score matching is a method that researchers use to create fair comparisons between groups by matching

individuals with similar characteristics to reduce bias. Doula use for the outcome analysis was defined as having a procedure code that indicated doula support for a birth outcome (e.g., vaginal, cesarean or vaginal birth after cesarean). Matching of users and non-users accounted for characteristics that would predict benefit utilization including race/ethnicity, primary spoken language, Medi-Cal managed care plan, county of eligibility, presence of obesity, smoking status, presence of substance use/substance use disorder, advanced maternal age (35+), having twins, triplets or other multiples, and diagnosis of asthma, compromised immune system, cardiovascular disease, pre-existing Type I or Type II diabetes, preeclampsia, gestational hypertension, and gestational diabetes. These characteristics were used both to create the matched comparison group and to control for potential confounding in the outcome analysis where appropriate. Maternal health outcomes could not be stratified by race/ethnicity, primary language, county, and Medi-Cal managed care plan due to small sample sizes and suppression requirements for privacy. A summary of comparisons and results is shown in Table 6.

Table 6: Comparison of Outcomes between Doula Users vs. Non-Users

Maternal Health Outcomes	Results
Birth via Cesarean Section	*No significant differences in odds of having a cesarean between doula users and non-users.
Maternal Morbidity	*No significant differences in the odds of having gestational hypertension during pregnancy or at delivery, and pre-eclampsia during pregnancy, at delivery or postpartum between doula users and non-users.
Number of Prenatal Visits	Doula users attended an average of 13.63 prenatal visits, compared to 5.73 visits among non-doula users. *Doula users who had a doula present during birth had on average 3 times more prenatal visits with health care providers than non-doula users (B = 3.83, $p < .05$).
Postpartum Visit Attendance	Doula users attended an average of 3.66 postpartum visits, compared to .94 visits among non-doula users. *Doula users who had a doula present during birth had 3 times higher odds of attending a postpartum visit than doula non-users (OR: 3.31 95% CI: 2.58 – 4.25).

Notes: Results marked with an asterisk (*) represent adjusted comparisons that controlled for potential confounding (e.g., health conditions etc.).

Limitations

There are several important limitations to consider when reviewing the results of the maternal health outcome analysis. First, our analysis of maternal health outcomes is limited to those who utilized doula support very early on in the benefit's implementation.

Second, data on infant mortality were not included due to lack of data availability. Infant mortality is defined as the death of an infant before the infant's first birthday (CDC,

2024). Therefore, production of this vital statistics data would need to take place at least one year after June 2024 (i.e., the end of our time period for analysis). Additionally, DHCS is a data user of CDPH Birth Cohort Data. The Birth Cohort Data represents infant birth-death linkage—such that the file is produced after both birth for a given year and death file for the following calendar year are finalized. The estimated release of 2023 data by CDPH will not occur until 2026 and similarly the release of the 2024 Birth Cohort Data would not be until 2027.

Third, data on breast/chest feeding outcomes were not available due to limitations of ICD-10 codes not being reliably used in clinical practice. Additionally, maternal mortality could not be included in our outcomes analysis because there was no maternal mortality in the doula user group. The rate of maternal mortality (i.e., pregnancy related death as indicated by maternal mortality cause of death via ICD 10 code) of all pregnant and birthing members who did not use doula support (n = 637,392) was approximately 0.08 deaths per 1,000 people (51 deaths total) between January 1, 2023, and June 30, 2024.

Lastly, while Senate Bill 65 mandates the inclusion of a numerical comparison of birthing outcomes (e.g., maternal morbidity) between doula users and non-users, it is imperative to note the limitations of this approach. Specifically, there is limited empirical evidence that doula support directly impacts clinical conditions, such as gestational hypertension and pre-eclampsia. These conditions are more strongly tied to underlying medical factors and are likely not significantly altered by the presence of doula support alone.

Doula Support and Odds of Birth via Cesarean Section

There were no significant differences in the odds of having a cesarean section between doula users and non-users.

Although, the overall sample size was sufficient to detect differences in cesarean birth outcomes, the relatively small number of doula users limited the precision of these estimates. A higher rate of cesarean birth was observed among doula users compared to all birthing non-doula users; however, this unadjusted comparison likely reflects differences in clinical and demographic risk factors. To account for these differences, comparisons were made using a matched sample of doula and non-doula users adjusting for key factors related to cesarean birth. In this adjusted analysis, no significant difference was found, suggesting that the initial observed differences may have been due to underlying factors (e.g., health status) rather than an effect of doula support.

While doula support has been shown in the scientific literature to be valuable during labor with some research showing support by doulas to be associated with lower

cesarean rates for both the general population (Bohen et al., 2017; Falconi et al., 2022; Fernandes et al., 2022) and for those who use Medicaid (Kozhimannil et al., 2016), the need for a cesarean section in this analysis may be driven by medical necessity or individual preference despite having doula support

Doula Support and Odds of Maternal Morbidity

There were no significant differences in the odds of having gestational hypertension (high blood pressure) during pregnancy or at delivery, and pre-eclampsia (high blood pressure with signs of kidney damage) during pregnancy, at delivery or postpartum between doula users and non-users.

Doula support has only been shown in very limited studies to be associated with decreased rates of gestational hypertension amongst the general population (Crawford et al., 2024) and no research to our knowledge currently exists on the relationship between doula support and reduced rates of pre-eclampsia.

Doula Support and Average Number of Prenatal Visits

Doula users attended an average of 13.63 prenatal visits, compared to 5.73 visits among non-doula users. After adjusting for potential confounders, Doula users had on average 3 times more prenatal visits with health care providers than non-doula users (B = 3.83, $p < .05$). Prenatal visits as an outcome were defined as the count of a member's prenatal appointments. Most doula users in our dataset received doula support only at labor/birth, not prenatally. Therefore, observed differences in prenatal visit counts may reflect pre-existing differences in healthcare engagement rather than the impact of doula support itself. It should also be noted that people who used doulas may have had a higher risk pregnancy and therefore also might need more prenatal appointments.

This finding is consistent with limited research on doula support showing that women who utilized doula support showed greater attendance at prenatal visits (Falconi et al., 2022) and pregnant individuals who interact with their doulas early in pregnancy are more engaged with their prenatal care (Ogunwole et al., 2021).

Doula Support and Odds of Postpartum Visit Attendance

Doula users attended an average of 3.66 postpartum visits, compared to .94 visits among non-doula users. After adjusting for potential confounders, Doula users had 3

times higher odds of attending a postpartum visit than doula non-users (OR: 3.31 95% CI: 2.58 – 4.25). Attendance at a postpartum visit was defined to include those who attended a visit with their health care provider within 7-84 days after delivery.

Limited research exists on the relationship between receiving doula care and attendance at the postpartum visit. According to a recent review by Falconi and colleagues (2024), receiving doula care was positively correlated with postpartum visit attendance for both Black and White birthing people. This finding is important considering most maternal morbidity and mortality occurs in the six weeks following births. Therefore, attendance at the postpartum visit is critical for identifying potential health problems before onset or an increase in severity occurs.

DOULA ENROLLMENT DATA

In addition to both the quantitative and qualitative results, DHCS shared doula enrollment data at prior Stakeholder Workgroup meetings on September 14, 2024, and March 14, 2025, and regularly updates doula enrollment on the doula webpage.

As of March 11, 2025, 609 individual doulas were enrolled with DHCS through the Medi-Cal provider enrollment online application; these are the group of "enrolled doulas" described below. Medi-Cal enrollment is a requirement to provide and bill for services to Medi-Cal members, whether they are in fee-for-service (FFS) or managed care. Once enrolled, doulas may choose to serve Medi-Cal FFS members, Medi-Cal managed care members, or both. For doulas seeking to serve Medi-Cal FFS members, once they are enrolled with Medi-Cal, they can immediately begin providing and billing for services.

For doulas seeking to serve Medi-Cal managed care members, once they are enrolled with Medi-Cal, they also need to separately contract with each individual Medi-Cal MCP in their geographical area. All twenty-four Medi-Cal MCPs have reported that they have executed contracts with doula individuals and/or groups.

As of January 2025, there were 609 executed contracts with 299 unique doula individuals and/or groups between the Medi-Cal managed care plans. There were also 274 pending contract execution with the Medi-Cal managed care plans.

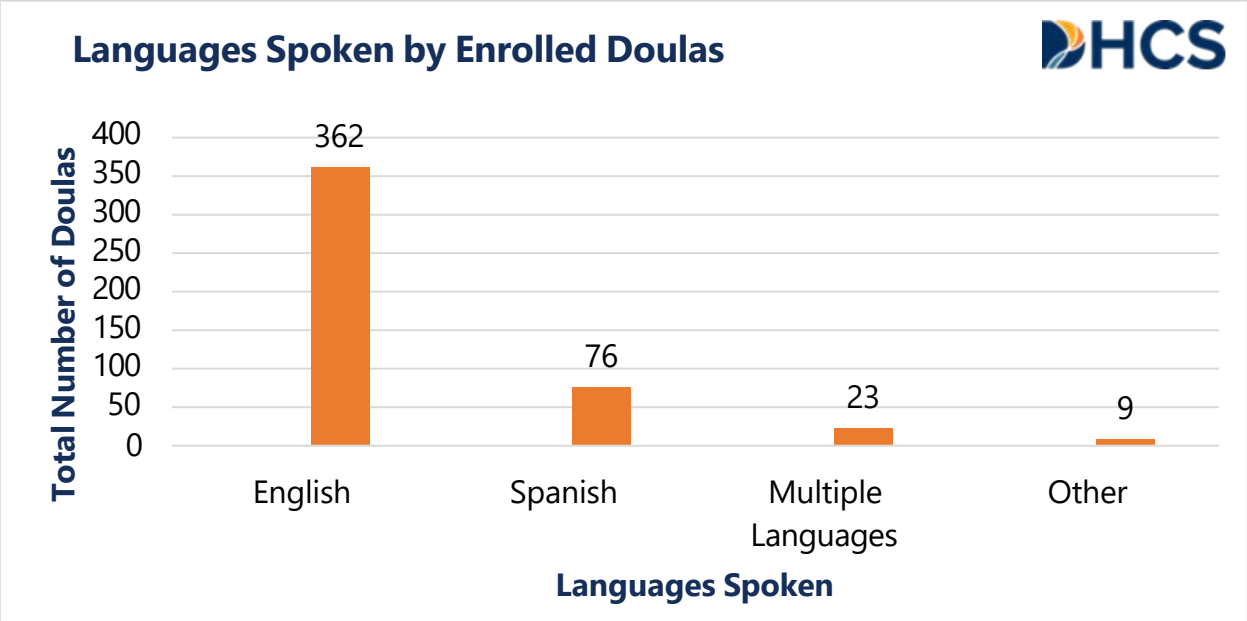
The Doula Directory listed enrolled doulas in 55 out of 58 California counties in March 2025. The 55 counties represent more than 99 percent of the state's population. Only Alpine, Imperial, and Inyo counties do not have any enrolled doulas listed in the directory. It should also be noted that some doulas in the directory serve multiple California counties, and the directory only includes doulas who responded to DHCS' request to be included.

Characteristics of Enrolled Doulas

Enrolled Doulas Languages Spoken

The majority of enrolled doulas spoke English and for those who indicated that they are bilingual, most spoke English and Spanish.

Figure 6: Languages Spoken by Enrolled Doulas



Data Source: Provider Enrollment Division

Dates Represented: 6/1/2023 - 5/ 21/2025| Date Downloaded: 5/21/2025

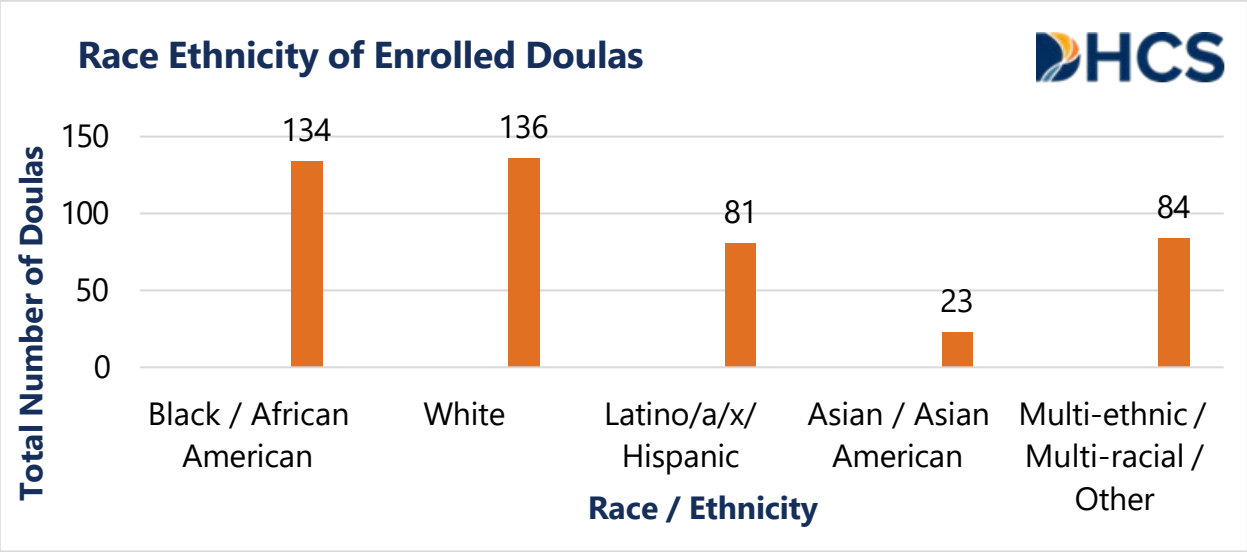
Prepared by the California Department of Health Care Services

Notes: The "other" language category includes up to five doulas who speak the following languages: American Sign Language, Arabic, Chinese, French, German, Hebrew, Hindi, Japanese, Mandarin, Persian, Portuguese, Somali, Telugu and Thai.

Enrolled Doulas Race/Ethnicity

Doulas self-reported race/ethnicity information described below in Figure 8. Many doulas only reported one race/ethnicity, but a substantial number reported more than one category (included in Figure 7 as "Multi-ethnic/Multi-racial/Other').

Figure 7: Race/Ethnicity of Enrolled Doulas



Data Source: Provider Enrollment Division

Dates Represented: 6/1/2023 - 5/ 21/2025 | *Date Downloaded: 5/21/2025*

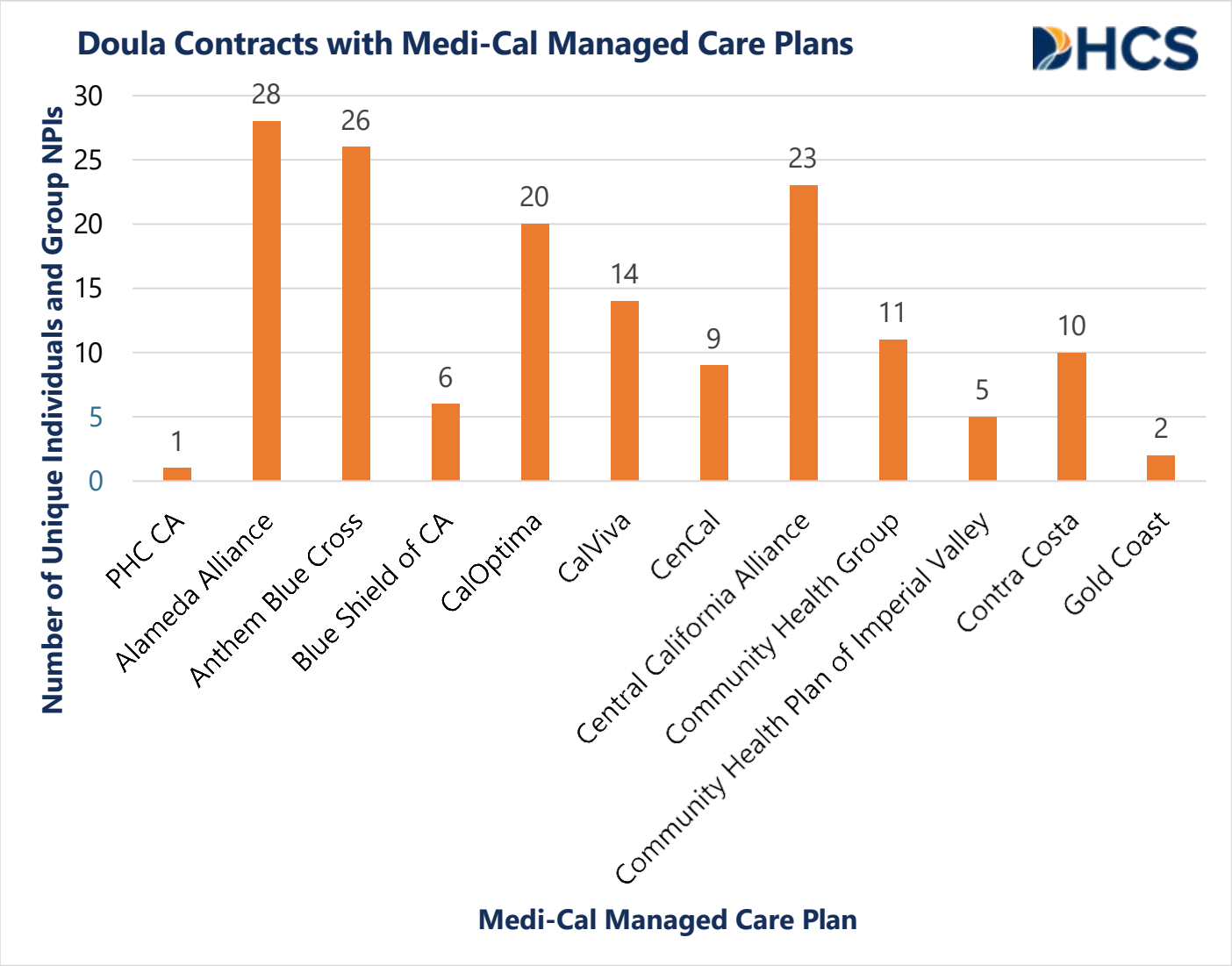
Prepared by the California Department of Health Care Services

Notes: Not all doulas reported ethnicity information.

Contracted Doulas by Plan

As of March 2025, Kaiser Permanente and Health Net Medi-Cal managed care plans reported the most executed contracts with doulas (individuals and group) (see Figures 8 and 9).

Figure 8: Doula Contracts by Managed Care Plan as of March 2025

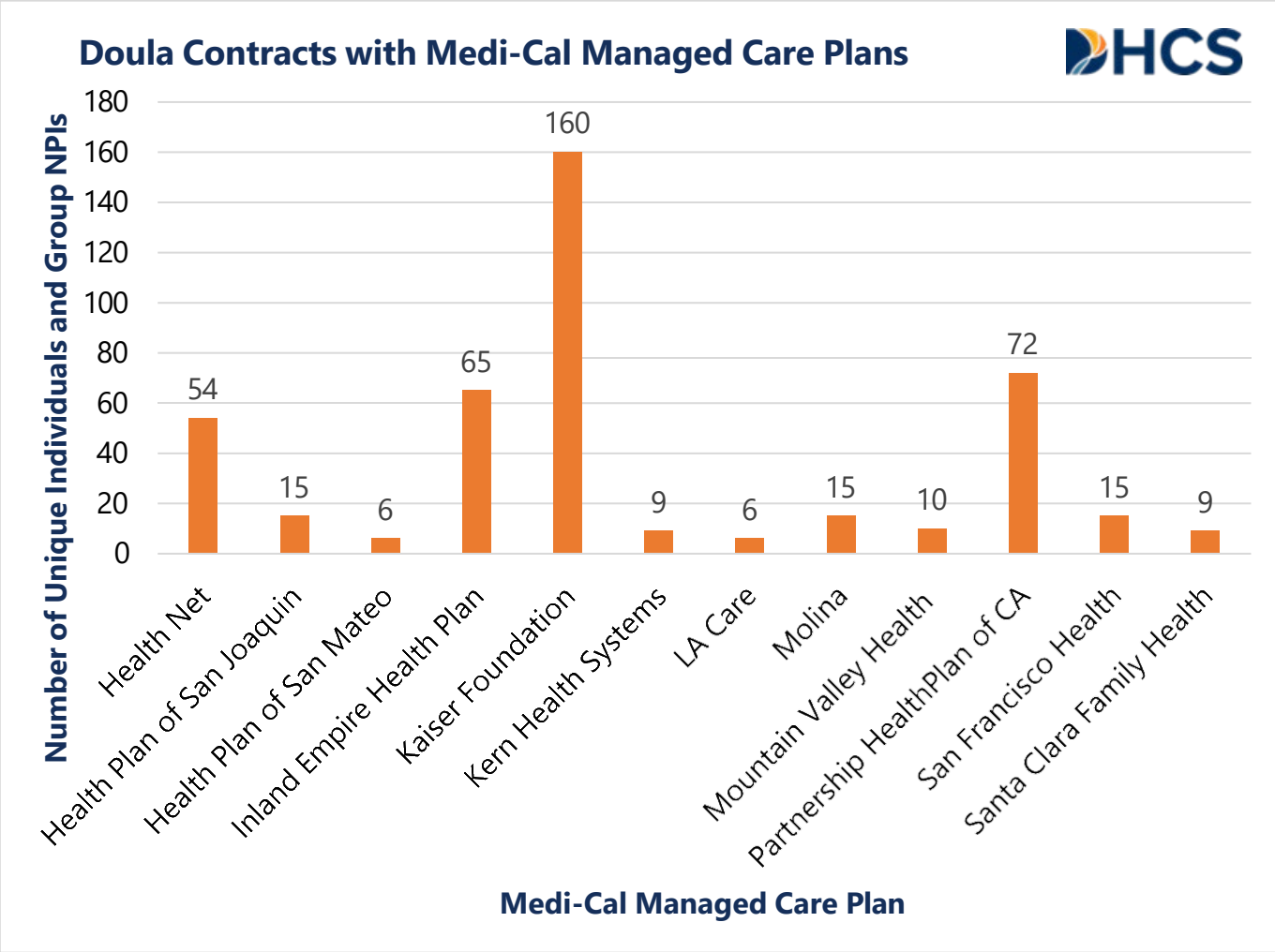


Data Source: Managed Care Quality Monitoring Division

Dates Represented: 6/1/2023 - 5/ 21/2025 | Date Downloaded: 5/2/2025

Prepared by the California Department of Health Care Services

Figure 9: Doula Contracts by Managed Care Plan as of March 2025



Data Source: Managed Care Quality Monitoring Division

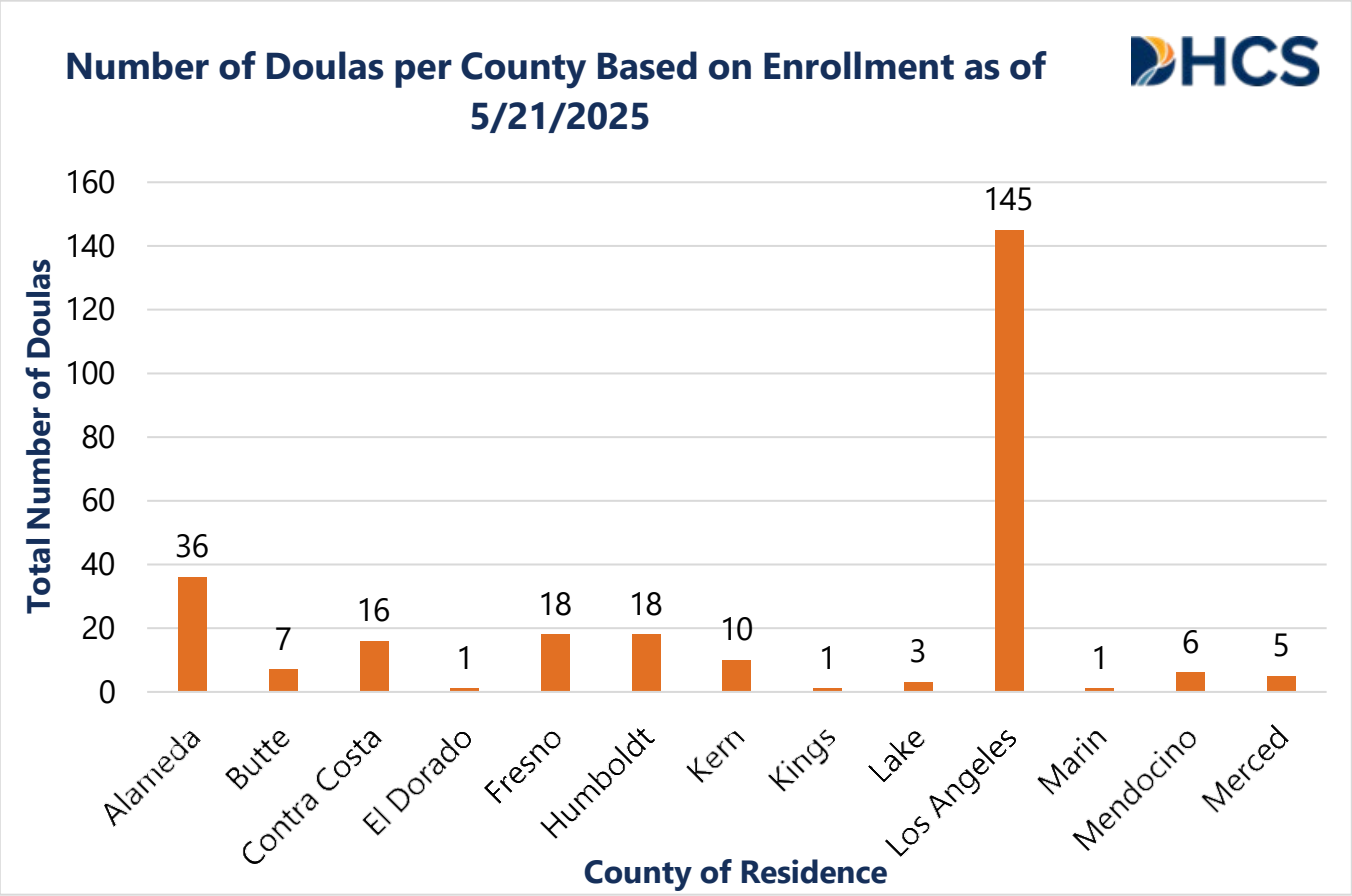
Dates Represented: 6/1/2023 - 5/ 21/2025 | Date Downloaded: 5/2/2025

Prepared by the California Department of Health Care Services

Enrolled Doulas by County

Los Angeles, San Francisco, Riverside, and Sacramento counties had the most enrolled doulas.

Figure 9: Doula Service Area by County

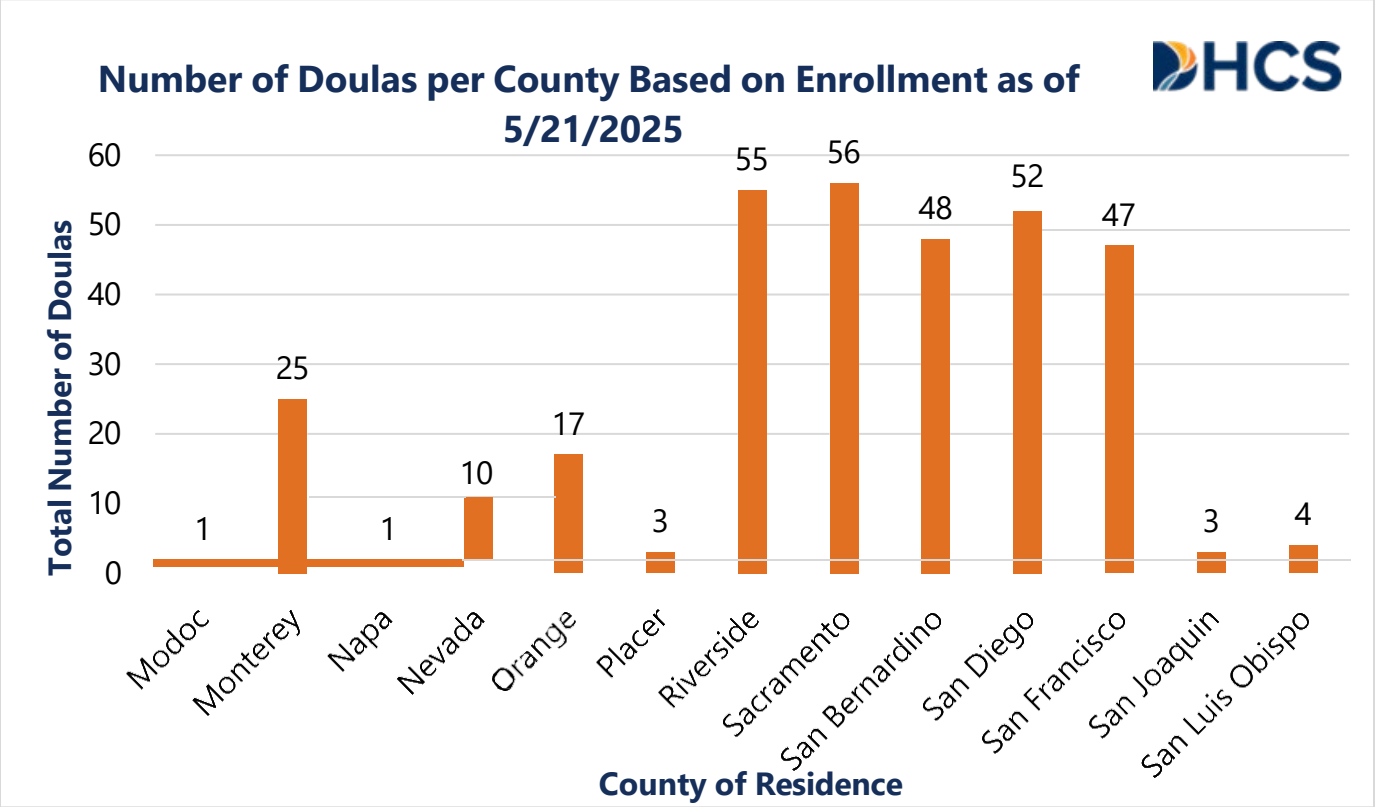


Data Source: Provider Enrollment Division

Dates Represented: 6/1/2023 - 5/ 21/2025| Date Downloaded: 5/21/2025

Prepared by the California Department of Health Care Services

Figure 10: Doula Service Area by County (Continued)

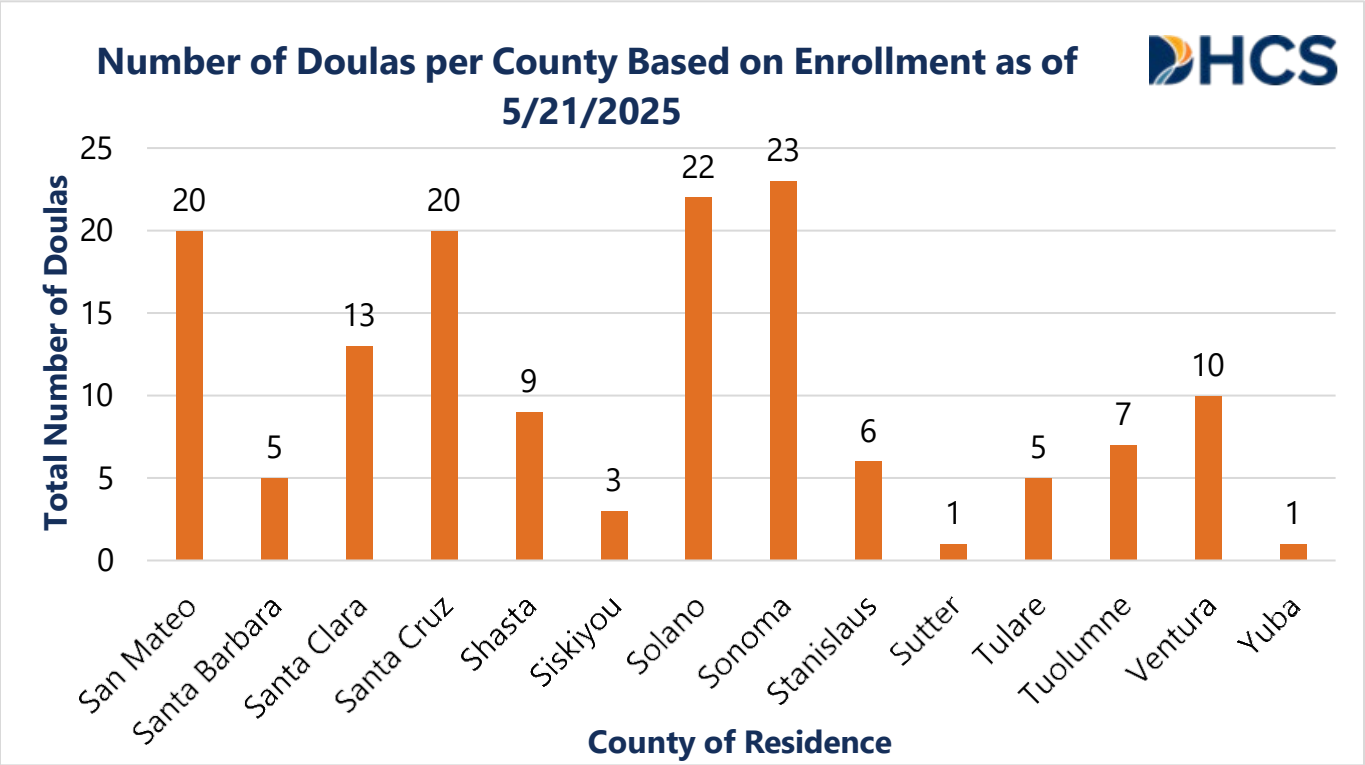


Data Source: Provider Enrollment Division

Dates Represented: 6/1/2023 - 5/ 21/2025 | Date Downloaded: 5/21/2025

Prepared by the California Department of Health Care Services

Figure 11: Doula Service Area by County (Continued)



Data Source: Provider Enrollment Division

Dates Represented: 6/1/2023 - 5/ 21/2025| *Date Downloaded: 5/21/2025*

Prepared by the California Department of Health Care Services

QUALITATIVE STUDY RESULTS

Findings: Facilitators and Barriers

Through semi-structured interviews with Medi-Cal members (*n* = 46), doulas (*n* = 16), Medi-Cal managed care plan staff (*n* = 7), and hospital staff (*n* = 4), UC Berkeley researchers identified facilitators and barriers related to Medi-Cal doula benefit implementation. Due to the limited number of interviews with certain interviewee groups (e.g., Medi-Cal managed care plan and hospital staff), these findings may not fully capture the facilitators and barriers encountered by these groups.

Awareness of Doulas and the Medi-Cal Doula Benefit

Awareness of doulas and the Medi-Cal doula benefit is essential for Medi-Cal members to access and utilize the service effectively. To support benefit implementation, Medi-Cal

managed care plan staff and health care providers should also be familiar with doulas and the details of the Medi-Cal doula benefit.

Facilitators:

- Personal motivation to find a doula and/or interest in doula support led Medi-Cal members to discover information about the Medi-Cal doula benefit.
- Word of mouth facilitates increased awareness about doulas and the Medi-Cal doula benefit. For example, when Medi-Cal members have positive experiences with doula support, they tell other people, including via social media.
- Medi-Cal members learned about doulas and/or the Medi-Cal doula benefit through personal networks, health care providers and hospital/clinic staff, Medi-Cal managed care plans, Black Infant Health, and CBOs. For example, promotional materials from managed care plans contributed to Medi-Cal members' basic *knowledge* of the benefit. However, to promote *use* of the benefit, promotional materials may need to include more information about what doulas do and how to find a doula.
- Medi-Cal managed care plans are engaging in internal education about doula services and the Medi-Cal doula benefit across multiple departments (e.g., contracting, claims, health education). Awareness about doulas and the benefit can help managed care plan staff better engage doulas during credentialing, contracting, and billing processes. However, doulas report managed care plan staff often do not know what doulas do or are unfamiliar with the details of the benefit, suggesting gaps in knowledge among managed care plan staff persist. Similarly, Medi-Cal members report their managed care plan's member services did not share accurate information about the benefit.
- Medi-Cal managed care plans, CBOs, and the California Hospital Association are educating hospital/clinic staff and health care providers about the Medi-Cal doula benefit.

Barriers:

- Medi-Cal members lack awareness and have misconceptions about doulas. For example, some members did not know the difference between a midwife and a doula, assumed doulas only support out-of-hospital births, and perceived doula support as something for the wealthy or privately insured. Additionally, members may not know doulas provide postpartum support, which impacts benefit utilization during the postpartum period.

- There is a need for culturally-tailored information about doula support, specifically for Spanish-speaking populations and Native American communities.
- There is a lack of awareness about the Medi-Cal doula benefit among Medi-Cal members.
- Awareness of the Medi-Cal doula benefit is lacking among health care providers, and Medi-Cal managed care plans report that some health care providers resist doulas and refuse to recommend doula services to patients.
- Health care providers may not know a patient's insurance status, which complicates efforts to identify which patients can utilize the Medi-Cal doula benefit.
- Medi-Cal managed care plans do not always know a member is pregnant until after birth due to global billing practices, which limits a managed care plan's ability to inform members about the benefit prenatally.
- If hospital staff only interact with Medi-Cal members during labor and delivery, they may not share information about the Medi-Cal doula benefit due to the perception that the benefit is not useful after childbirth. This may curtail opportunities for hospital staff to share the benefit covers postpartum doula support.
- The standing recommendation for doula services (issued by DHCS Medical Director Dr. Karen Mark in November 2023) was designed to eliminate barriers to benefit use. However, Medi-Cal members, doulas, health care providers, and Medi-Cal managed care plans may not be aware of the recommendation, potentially complicating access to the doula benefit by adding unnecessary approval processes.

Finding a Doula

Once Medi-Cal members decide to utilize the Medi-Cal doula benefit, they must find a doula who meets their personal needs, which could include geographic proximity, speaking the same language, and/or shared lived experience. Additionally, Medi-Cal doula providers typically need to be contracted with the member's Medi-Cal managed care plan to receive reimbursement for services.[2]

[2] Some managed care plans offer Letter of Agreements/Single Case Agreements, which would allow a non-contracted doula to serve a Medi-Cal member. Additionally, a minority of Medi-Cal members are enrolled in fee-for-service Medi-Cal, not Medi-Cal managed care. In this case, the doula would only need to be an enrolled Medi-Cal doula provider.

Facilitators:

- Friends, family members, health care providers, hospital/clinic staff, Medi-Cal managed care plans, Black Infant Health, and CBOs helped Medi-Cal members find Medi-Cal doula providers. Members found doulas when these individuals or organizations provided contact information for Medi-Cal doula providers or directly referred them to a specific doula.
- Doulas who are at capacity or are not enrolled as a Medi-Cal doula provider refer Medi-Cal members to other doulas in their communities.

Barriers:

- There are not enough doulas enrolled as Medi-Cal providers and contracted with Medi-Cal managed care plans statewide, which could make it difficult for Medi-Cal members to find a doula. Specifically, in some counties there are not enough Medi-Cal doula providers who offer in-person support, and in rural areas, telehealth is not always feasible (e.g., poor cell reception and limited Internet access), which potentially impacts equitable access to doula care.
- Some Medi-Cal members who tried to find a doula describe the process as stressful and frustrating. If finding a doula is difficult, it can deter members from pursuing doula support.
- Referral processes facilitated by Medi-Cal managed care plan and health care providers to connect Medi-Cal members to doulas are lacking. Some managed care plans and health care providers are working with doulas to establish referral pathways to address this barrier.
- The DHCS doula directory is not user-friendly. Although it helped some Medi-Cal members find doulas, it deterred others.
- Medi-Cal managed care plan provider directories may not have sufficient information about Medi-Cal doula providers (e.g., race/ethnicity, language spoken) to help members find a doula who fits their needs.
- Some doulas do not want their personal contact information publicly displayed on Medi-Cal managed care plan provider directories or the DHCS doula directory. This can hinder Medi-Cal members' efforts to find a doula.

Medi-Cal Doula Provider Availability

California must have a robust doula workforce to support benefit implementation. Without efforts to recruit, credential, contract with, and retain doulas, there will not be enough doulas to support Medi-Cal members who wish to use the Medi-Cal doula benefit. Therefore, doulas must be well-supported to ensure workforce sustainability

and to realize the benefit's promise. Additionally, for the benefit to work, doulas must successfully complete the Medi-Cal provider enrollment online application, contract with Medi-Cal managed care plans, and get reimbursed for their work.

Interest in Becoming a Medi-Cal Doula Provider

Barriers:

- Some doulas may not be interested in becoming Medi-Cal providers due to the complex process, distrust in the government, and/or insufficient reimbursement rates, especially in rural areas where doulas must travel hours to reach clients.

Building and Sustaining Medi-Cal Managed Care Plan Provider Networks

Facilitators:

- To prepare for the Medi-Cal doula benefit, CBOs and other organizations aimed to increase the number of doulas in the workforce by training new Black and Indigenous doulas. Additionally, some Medi-Cal managed care plans invested in efforts to grow the doula workforce. However, it takes time for newly trained doulas to complete the Medi-Cal provider enrollment online application and contract with managed care plans, delaying the availability of Medi-Cal doula providers.
- CBOs support the development of the Medi-Cal doula workforce by offering training and technical assistance to doulas enrolling as Medi-Cal providers, credentialing and contracting with Medi-Cal managed care plans, and billing for services.
- Some Medi-Cal managed care plans have an onboarding process for doulas, dedicated staff members to assist doulas during credentialing, contracting, and billing processes, incentives for doulas to contract, and/or offer recurring office hours to provide doulas with ongoing support. Notably, doulas describe appreciating when managed care plans have dedicated support staff who are responsive to their concerns.
- CBOs facilitate opportunities for doulas to receive mentorship and peer support. This support is vital to doula workforce sustainability because it helps grow the skills and confidence of inexperienced doulas and provides an opportunity for doulas to debrief with their peers about their experiences in the field.

Barriers:

- CBOs lack sustained funding to provide ongoing technical assistance related to the Medi-Cal doula benefit and support workforce development.
- CBOs interested in enrolling as group providers and billing on behalf of doulas need funding and technical assistance. Notably, some CBOs are not interested in taking on billing responsibilities due to concerns about delayed payments from Medi-Cal managed care plans. For example, if CBOs do not get reimbursed in a timely manner after submitting claims, the CBO cannot pay doulas.
- Doulas face financial hurdles when enrolling as Medi-Cal providers, and Medi-Cal managed care plan contracting and billing processes can be cost-prohibitive and time-consuming. To address this barrier, some Medi-Cal managed care plans and CBOs have covered certain costs (e.g., CPR certification, HIPAA training, administrative time) for doulas to enroll as Medi-Cal providers and contract with plans.
- Doulas lack familiarity with Medi-Cal managed care plan credentialing, contracting, and claims submission processes, which were not built with non-traditional providers in mind. At the same time, managed care plans are not accustomed to supporting non-traditional Medi-Cal providers. Notably, some managed care plan staff members are sharing best practices related to the Medi-Cal doula benefit with peers from other plans.
- Credentialing and contracting are lengthy, complicated processes, delaying the availability of Medi-Cal doula providers to Medi-Cal members. Although some Medi-Cal managed care plans have tried to simplify certain aspects of these processes (e.g., developing a doula-specific contract template), doulas still face barriers navigating the managed care system.

Reimbursement for Medi-Cal Doula Services

Barriers:

- Some doulas are not receiving timely and accurate payments from Medi-Cal managed care plans. Doulas report they have not been paid for services provided, including instances when their claims have been denied.
- Medi-Cal managed care plans reported they received incomplete guidance from DHCS when implementing the targeted rate increase, which boosted reimbursement rates for eligible providers, including doulas. DHCS communication about the targeted rate increase caused confusion among doulas, who expected increased rates before managed care plans had necessary guidance.

Doulas in Clinical Settings

Clinical settings must be receptive to doula presence so doulas can support Medi-Cal members in hospitals, birth centers, and clinics. If hospital administrators, health care providers, and hospital/clinic staff do not welcome or support doulas, it could impact benefit utilization.

Facilitators:

- Some hospitals have collaborated with doulas to educate health care providers about doula support and improve access for doulas trying to support their clients (e.g., creating a special badge that allows doulas to bypass the security line). Importantly, some CBOs have developed relationships with hospitals and created trainings for health care providers to address negative perceptions of doulas.

Barriers:

- Although some health care providers champion doula support, others are not supportive of doulas or the Medi-Cal doula benefit. Resistance to doulas within clinical settings can impact whether doulas can support clients, especially during labor and delivery.
- Some hospitals do not allow doulas to support clients during triage and/or in operating rooms for cesarean births.
- Doulas shared concerns that clinics and hospitals will train/hire their own doulas. Notably, some doulas do not want to work for a medical institution because of the perception that they would be beholden to the institution before their clients.

Findings: Medi-Cal Members

Key Takeaways

- Interviewees who used the Medi-Cal doula benefit often had prior knowledge of doulas and strongly desired doula support. Among those who did not use the benefit, almost all interviewees reported that if they had known about the benefit, they would have been interested in utilizing doula support.
- Social networks, including family, friends, and social media, often influenced interviewees to seek doula support and use the benefit. Medi-Cal managed care plans and health care providers both helped and hindered interviewees' attempts to use the benefit.
- When promoting the Medi-Cal doula benefit, interviewees noted it is imperative to tell members early in pregnancy and share information about how to find a doula.

About the Interviewees

UC Berkeley researchers conducted 46 interviews with Medi-Cal members who were pregnant between January 1, 2023, and June 30, 2024, including 25 members who used the Medi-Cal doula benefit and 21 who did not use the benefit.

Medi-Cal Members Who Used the Doula Benefit

All Medi-Cal members who used the doula benefit and participated in an interview identified as women, and the average age was 32 (range: 24-46). Interviewees identified as Black/African American, White, American Indian/Native American/Indigenous, Hispanic, Latinx, or of Spanish origin, and Asian; a few interviewees reported more than one race/ethnicity. The majority of interviewees identified as Black or African American. Almost all interviewees were married, in a committed relationship, or single. Most interviewees were heterosexual/straight, but some were bisexual.

Interviewees lived across 10 counties and received health care through 11 Medi-Cal managed care plans during the period in which they were eligible to use the Medi-Cal doula benefit. Inland Empire Health Plan, Kaiser Permanente, L.A. Care Health Plan, and

Partnership HealthPlan of California were the most commonly reported managed care plans.

Interviewees received doula support during pregnancy (96%), labor and delivery (88%), and/or postpartum (96%). Most interviewees reported giving birth in a hospital setting. Most interviewees had a vaginal birth, and just under half of interviewees gave birth for the first time.

Medi-Cal Members Who Did Not Use the Doula Benefit

All Medi-Cal members who did not use the doula benefit and participated in an interview identified as women, and the average age was 29 (range: 20-40). Interviewees identified as Hispanic, Latinx, or of Spanish origin, Black/African American, American Indian/Native American/Indigenous, and White, and a few interviewees reported more than one race/ethnicity. The most commonly reported racial/ethnic groups were Hispanic, Latinx, or of Spanish origin and Black or African American. Most interviewees were married or in a committed relationship. All interviewees were heterosexual/straight.

Interviewees lived across 14 counties and received health care through 13 Medi-Cal managed care plans during the period in which they would have been eligible to use the Medi-Cal doula benefit. Partnership HealthPlan of California was the most commonly reported Medi-Cal managed care plan. Notably, two interviewees were unsure of their specific Medi-Cal managed care plan membership.

For their most recent births, all interviewees gave birth in a hospital, and just over half of interviewees had a cesarean section. Several interviewees had not given birth prior to their most recent pregnancy.

Familiarity with Doula Support

Prior knowledge of doula support was more common among interviewees who had utilized the Medi-Cal doula benefit. Among interviewees who utilized the doula benefit, some of the interviewees had used doula support during a prior pregnancy. A few of these interviewees obtained doula support through a Medi-Cal managed care plan's pilot doula program, while others had privately hired a doula and paid the out-of-pocket fee. Other interviewees described hearing about doula support from a friend or family member.

Among interviewees who did not utilize the doula benefit, some were familiar with doula support. Most commonly, these interviewees reported reading about doulas online and learning about doulas on social media (e.g., TikTok, Instagram, and YouTube).

Interviewees who had not used the benefit but had heard of doulas before described a few common misconceptions, which may have influenced their decision not to pursue doula support. These interviewees did not know the difference between a midwife and doula or described the assumption that doulas only support home births, not hospital-based births, including cesarean deliveries. For example, an interviewee expressed interest in doula support but described thinking that meant she would have to give birth at home:

> *"It was something that I read that Medi-Cal was going to start having doula support. That was something that I had always wanted, but I had figured since it was my first baby, that it would be smarter to just do it in the hospital just in case anything happened. … I thought for some reason it would be safer."*

Interviewees perceived that doula services were typically utilized by wealthy individuals or individuals with private insurance. Several interviewees who had and had not used the doula benefit shared this perception. An interviewee who did not use the doula benefit stated:

> *"I had heard of [doulas] before, but I didn't know it was available for Medi-Cal. I thought it was for people, not to sound rude or anything, but people that had money, who had private health insurance and stuff like that."*

The word "doula" did not resonate with most Spanish-speaking interviewees, potentially due to its limited use in their communities. None of the Spanish-speaking interviewees had used the doula benefit. Some of these interviewees equated doula services to other services they had heard of or experienced, such as home visits and monthly educational calls offered through a hospital called "pláticas."

Familiarity with the Medi-Cal Doula Benefit

Interviewees discovered Medi-Cal covered doula support through family and friends, searching online, health care providers and other hospital/clinic staff, their Medi-Cal managed care plan, Black Infant Health, and CBOs. A few interviewees knew about the benefit but did not use it. However, among interviewees who did not use the benefit, most did not know it existed.

Interest in doula support motivated interviewees to seek more information, which led to knowledge about the Medi-Cal doula benefit. Several interviewees were unaware that Medi-Cal covered doula services when they started searching for a doula online, which led them to information about the benefit. A few interviewees did not know about the benefit but called their Medi-Cal managed care plan's member services to inquire about doula services. Such calls typically led to more information about the

benefit. For example, an interviewee who was interested in doula support reported a family member encouraged her to call member services to ask about pregnancy-specific benefits:

> *"I asked them if they covered [doula services]. … The woman who answered, she put me on hold and everything, and then she came back and she was like, 'Oh yes, there's a few doula services we have.' She was surprised."*

Promotional materials from Medi-Cal managed care plan contributed to interviewees' knowledge of the Medi-Cal doula benefit. A few interviewees learned about the benefit after receiving information in the mail from their Medi-Cal managed care plan, such as a flyer or an Evidence of Coverage document, which details covered benefits. Notably, one interviewee described receiving a letter in the mail from her Medi-Cal managed care plan about the doula benefit, but the letter did not explain what doulas do or how to find a doula.

Learning about the Medi-Cal doula benefit made a difference for interviewees who wanted a doula but were unable to afford one. When these interviewees found out Medi-Cal covered doula services, they often started looking for a doula. One interviewee who paid out of pocket for a doula during her first pregnancy described how it would not work financially for her second pregnancy:

> *"I felt like it was a lot of money for me to pay when I had some prior experience. But I have quite a few friends who are in the doula space, and labor, delivery, all those kind of things. … They told me that Medi-Cal had just started a doula program. I was like, 'What are you talking about? I've never heard about this.' I immediately called my insurance and said, 'Is this thing real? If it is, can you put me on a list? What do I have to do?'"*

Knowledge of the Medi-Cal doula benefit did not always translate to accessing doula support. Two interviewees who wanted to utilize the Medi-Cal doula benefit during their pregnancy were unable to find doulas. Additionally, two interviewees learned about the benefit when they were in the one-year postpartum period. Although these interviewees were still eligible to use the benefit, they did not pursue doula support during the postpartum period.

Desire for Doula Support

Among interviewees who used the Medi-Cal doula benefit, there was a strong desire for doula support. Interviewees sought doula support because they wanted someone to advocate for them, help them find their voice and gain control of the birth process, and protect them from potential harm. Specifically, a few Black interviewees

described being fearful of birth, which they connected to disproportionately higher rates of maternal mortality among Black pregnant, birthing, and postpartum people. A Black interviewee also emphasized the importance of having a support person who did not work for the hospital:

> *"Having somebody who isn't part of the hospital but is directly focused on me and my birthing experience, I think was super, super important. Just understanding that Black maternal health, that we have a higher mortality rate. That's something that I'm not wanting to risk, especially now that I have another child that I need to go back to."*

Interviewees also described doula support as a balm for traumatic or negative health care experiences. Several interviewees had experienced pregnancy loss or an infant death, and some interviewees described experiences of inadequate or inappropriate health care. An interviewee who had a traumatic birth during the COVID-19 pandemic described her rationale for pursuing doula support:

> *"It was the most horrible experience that I've ever had. They wouldn't let anybody in. It was very lonely. I felt like-- just very pressured, a lot of pressure while I was giving birth. … It just made it very stressful, very hard for me. This time around I knew I wanted a peaceful pregnancy, so I was looking very hard like, 'Hey, anybody know about a doula?'"*

Interviewees who did not have a strong support system also cited this as a reason for pursuing doula support. Lastly, some interviewees hired a doula because it was their first pregnancy, and they wanted an informed guide to support them throughout the process.

When informed about the Medi-Cal doula benefit, interviewees who did not use the benefit were interested in doula support. Interviewers shared information about doulas and the doula benefit with interviewees who did not use doula support. Almost all interviewees reported that if they had known about the benefit, they would have been interested in utilizing doula support for their most recent pregnancy.

Most interviewees reported it would have been nice to have personalized, one-on-one support from a doula during pregnancy, childbirth, and the postpartum period. A doula could have helped them be more informed during pregnancy and prepared for birth. A few interviewees noted health care providers can be intimidating, and it is difficult to ask providers questions during short or rushed appointments. Additionally, when talking about their prenatal and postpartum care, a few interviewees reported asking their providers questions and stated their answers were often brief or uninformative. The ability to ask doula questions appealed to certain interviewees:

> *"Sometimes I wouldn't want to call [the medical office's advice line] for a long time because I know it was nothing urgent. I think just having that level of support during my pregnancy to ask questions, if they possibly know. [Doulas are] not a medical person, but they could just have insights."*

A few interviewees reported that a doula may have been able to help them navigate the health care system. An interviewee who had recently transitioned from private insurance to Medi-Cal experienced lackluster prenatal and postpartum care. She described how a doula could have supported her:

> *"If Medi-Cal gave me a doula, I feel like a doula would have more knowledge about how to navigate Medi-Cal when it came to postpartum and things of that nature. I feel I would've been a little more informed about how to navigate it and sometimes also accountability, too. Someone to say, 'Hey, I think you should follow up with this.' Or 'How are you feeling? That's not normal. You should contact your doctor,' and stuff like that."*

Several interviewees described ways in which a doula could have helped advocate for them during labor and delivery. Although one interviewee described her birth experience as positive, she would have appreciated having "another voice in the room":

> *"I'm starting to remember parts of what I wanted during my birth. I wanted to keep my umbilical cord. … Unfortunately, I didn't use my voice in that instance. During this pregnancy, I wish I had."*

Notably, many interviewees reported experiencing perinatal anxiety or postpartum depression. Some of these interviewees reported they would have appreciated speaking to a doula about these experiences. An interviewee described struggling to understand her own experiences with postpartum depression and stated having a doula could have given her someone to talk to:

> *"I'm pretty sure doulas have seen postpartum depression before. I've never dealt with it, so I didn't really know how to go about it or what to do."*

Even interviewees who described having personal support networks and/or positive experiences with health care providers expressed interest in doula support. An interviewee who had a "beautiful", yet isolating pregnancy experience envisioned how a doula could have fit into her support team:

> *"I feel like a doula is somebody that really could be a personal support person, like that something that I really needed at the time. You're not always going to want to speak to your mother or your baby's father about what's going on, what you're feeling."*

A few interviewees described doula support as "unnecessary" or shared reservations about doula support related to privacy. For example, an interviewee reported that although she would have appreciated doula support while recovering from a cesarean in the hospital, she was uncomfortable with the idea of having a stranger come to her home during the postpartum period. Another interviewee had access to doula services through her clinic but reported she felt good during her pregnancy and did not need additional support. Notably, this interviewee seemed to view additional appointments as burdensome.

Pathways to Finding Doula Support Through Medi-Cal

Interviewees who pursued doula support covered by their Medi-Cal managed care plan described taking multiple pathways to find a doula. Some pathways led to dead ends, prompting the interviewee to pursue another pathway or give up on their search. Although most interviewees who tried to find a doula were successful and several reported positive experiences, some interviewees described the process as stressful and frustrating.

Helpful Pathways

Helpful pathways led to the interviewee obtaining contact information for potential doulas who accepted their Medi-Cal managed care plan or being contacted by a potential doula directly.

Friends and family members were instrumental in some interviewees' efforts to find a doula. Oftentimes, the friend or family member did not directly connect the interviewee to a doula but helped them find someone who could. For example, an interviewee saw a year-old post on Facebook about getting a doula through a CBO. When she tried contacting the organization, no one responded until the interviewee's grandmother stepped in:

> *"My grandma just went out of her way. She knew I was pregnant. She knew this was something I really wanted. She was like, 'Okay, I'm going to figure it out.' … It took her literally two days. The lady reached out to me directly via voicemail. She was like, 'Hey, I got your grandma's voicemail. I saw she sent an email as well. When can we talk to start going over potential [doula] candidates?'"*

Online searches and social media helped some interviewees find a doula. Some interviewees successfully found a doula who accepted Medi-Cal after searching online, crowdsourcing on Facebook, or seeing a doula's ad on Instagram. Although it was often unclear which websites interviewees found and used in their searches, one interviewee

stated the website allowed her to search for doulas by Medi-Cal managed care plan, which she found helpful.

Physicians, midwives, nurses, and hospital/clinic staff gave some interviewees a list of potential doulas to contact, directly referred them to a specific doula, or gave them a flyer with a number to call. Some interviewees reported that the provided lists specifically included doulas who accepted their Medi-Cal managed care plan.

Several interviewees contacted their Medi-Cal managed care plan, which provided contact information for doulas in the plan's network. Although most of these interviewees called member services, one interviewee contacted a nurse available through her managed care plan who she spoke to throughout her pregnancy.

Local Black Infant Health programs and doula-related organizations helped interviewees find a doula. A few interviewees attended virtual sessions hosted by Black Infant Health, and the session moderator shared information about how to contact doulas who accepted Medi-Cal. One interviewee reported a case worker at Black Infant Health connected her to two potential doulas. Similarly, a few interviewees contacted doula collectives, agencies, or programs, which put them in touch with doulas who accepted their Medi-Cal managed care plan.

Inefficient Pathways

Inefficient pathways prompted interviewees to try another pathway, try the same pathway again, or give up on their search.

Some health care providers did not share information about the Medi-Cal doula benefit when asked about doula support. Providers stated the clinic/hospital did not offer doula services or that they did not provide referrals to doulas. Notably, some interviewees reported Medi-Cal managed care plan marketing materials suggested they speak with their provider about doula support. When these interviewees asked their providers, they were unhelpful. Additionally, an interviewee reported her physician advised her to wait until later in pregnancy to find a doula, which may have contributed to her being unable to use the benefit.

Some Medi-Cal managed care plan staff provided inaccurate information or were unable to help the interviewee find a doula. An interviewee reported calling member services to ask about the doula benefit, but the Medi-Cal managed care plan staff member told the interviewee it was not a covered service. Another interviewee acknowledged the benefit was fairly new when she reached out to her managed care plan four months before her due date. Member services was initially unable to provide information about doulas in the managed care plan's network. The interviewee

continued to call, which led to her getting connected to a doula within weeks of her due date:

> *"I kept following up with them. I kept following up every month, every week. I kept calling them, basically."*

Two interviewees were unable to find a doula who accepted their Medi-Cal managed care plan. For example, an interviewee lived in a county neighboring Los Angeles County, and most doulas she found were contracted with health plans for Medi-Cal members in Los Angeles. None of the doulas she found in her county accepted her Medi-Cal managed care plan.

DHCS doula directory is not user-friendly. One interviewee reported contacting DHCS about the benefit, and a staff member sent her a link to the DHCS doula directory. The interviewee described the directory as inaccessible and was unable to use it to find a doula.

Local doulas or CBOs were unable to provide services. After seeing a CBO's advertisement for doula services near her local hospital, an interviewee contacted the organization multiple times. The interviewee attended childbirth education classes through the organization. After asking about doula services repeatedly, a staff member eventually told her the organization was unable to provide doula support. The interviewee described feeling misled by the organization's marketing. Additionally, two interviewees who contacted doulas directly reported some doulas did not respond or briefly engaged with them before ceasing communication.

Finding Doulas Who Met Members' Individual Needs

Doula matching was rare. Only a few interviewees worked with a doula collective, doula agency, or maternal health program that facilitated matching them to potential doulas based on interviewees' personal preferences, such as wanting a doula who shared their race or ethnicity or had children of their own. In some cases, interviewees were able to view doula profiles, which included information about the doula's background and experience.

Some interviewees communicated personal preferences to their Medi-Cal managed care plan's member services. Sometimes the Medi-Cal managed care plan staff members were able to provide contact information for doulas who met the interviewee's needs. However, this was not always possible. After requesting doulas who were Black, a Black interviewee reported the Medi-Cal managed care plan staff member did not have that information but encouraged her to look up the potential doulas provided online.

Interviewees interviewed potential doulas. Before deciding to work with a specific doula, many interviewees reported asking the doula questions about their experience and approach to birth and sharing information about themselves and what they envisioned for their pregnancy, birth, and/or postpartum experiences. Interviewees described assessing whether their personalities aligned with the doula, and an interviewee reported consulting her partner before deciding. One interviewee encouraged Medi-Cal members to prepare a list of questions when interviewing doulas, ask what the doula would do in worst-case scenarios, clearly state member expectations of the doula, and look at reviews if the doula has an online presence.

When interviewees found out about the Medi-Cal doula benefit impacted their ability to find a doula who met their needs. Some interviewees only spoke to one doula before agreeing to work with them. Two of these interviewees described going with the first doula they found because they were concerned they would not be able to find another doula through Medi-Cal before their birth.

The timing of when interviewees learned about the benefit and then found a doula impacted the number of visits interviewees had with their doula prior to labor. About half of interviewees reported finding a doula during their second trimester of pregnancy. Less than a quarter of interviewees found their doulas in the third trimester, and in one case, an interviewee agreed to work with a doula after she had given birth. Although some interviewees did not seem to mind finding a doula later in pregnancy, a few reported they would have liked to connect with a doula earlier.

At times, interviewees' preferred doulas were unavailable due to the doula being busy with other clients. In one instance, this precluded an interviewee from having racially concordant doula support, which she preferred.

Informing Health Care Providers About Doula Support During the Prenatal Period

Some interviewees reported telling a health care provider about their doula during the prenatal period. Most of these interviewees perceived their provider's reaction as positive, but some providers seemed apprehensive or unsupportive. One interviewee's providers asked to speak to the doula to better understand the doula's role:

> *"At first, they were like, 'Oh, our hospital, we'll have to ask more questions about that.' Then after a while, they came around because she told them who she was and who she worked with, so they were a little bit more understanding because I know certain hospitals are used to doulas and then certain hospitals aren't."*

During the prenatal period, another interviewee informed her hospital that she would have a doula at her birth, and a staff member suggested she email the doula's certification so it could be documented in the interviewee's chart.

Asking providers for a written recommendation to use doula support created barriers. A few interviewees who gave birth in early 2024 asked their prenatal health care provider to complete a recommendation form so they could receive doula support through Medi-Cal. One interviewee reported that her OB-GYN refused. Another interviewee reported clinic staff told her she would need to pay $25 to get the form signed:

> *"After that appointment, I'm crying in the parking lot. I'm telling my husband, 'I just want a doula. This is so stupid.'"*

Experiences with Doula Support Among Interviewees Who Used the Medi-Cal Doula Benefit

Many interviewees reported positive relationships with their doulas, with some describing their doula as a friend or family member with nurturing and motherly qualities (e.g., older sister, aunt, grandma). When asked what made their doulas a good fit for them, many interviewees reported their doulas were encouraging, empathetic, caring, and non-judgmental. Some interviewees cited the doula's experience level and knowledge about and holistic approach toward pregnancy, birth, and postpartum. Several interviewees also described feeling connected to their doulas due to shared lived experience, such as living in the same neighborhood or also being a parent. Specifically, many Black interviewees appreciated that their doulas were also Black.

When asked what did not make their doulas a good fit, a few interviewees reported their doulas' schedules impacted their availability. Additionally, one interviewee shared that she wished her doula's office was closer to her home so they could have met in person more frequently. Although the doula offered to come to the interviewee's home, the interviewee described being unable to host due to family hardships. Lastly, two interviewees reported their decisions did not always align with their doula's advice.

Prenatal Doula Support

Among interviewees who had a doula during the prenatal period, all interviewees met with their doula in person or virtually at least once prior to giving birth. Interviewees reported varied communication with their doula prenatally, with some spending more time than others due to factors such as finding a doula late in pregnancy, interviewee preferences, and doula availability.

During prenatal visits with their doula, interviewees got to know their doula, asked questions and shared concerns related to pregnancy, birth, and postpartum, and developed a birth plan. Doulas also reviewed educational materials and shared information about pregnancy based on interviewees' needs, such as tips for managing morning sickness and other physical discomforts and ideas for nutritious meals and exercise routines. Two interviewees reported their doula accompanied them to prenatal medical appointments.

Resources

A few interviewees reported their doula connected them to or told them about resources, such as:

- Baby supplies
- Breast pumps
- Transportation available through health plan or bus passes
- Pregnancy or postpartum support groups
- Maternal health programs
- Community events

Interviewees reported discussing their birth preferences with doulas, who often provided information about pain management options, birthing positions, breathing techniques, and what to expect at the hospital, including what might happen in the event of an induction or cesarean. In some cases, interviewees' partners also attended doula visits.

Several interviewees shared past pregnancy, loss, birth, and postpartum experiences with their doula. This seemed to help interviewees process past experiences, verbalize how they wanted their next birth to be different, and/or prepare for the postpartum period.

Importantly, some interviewees described how their doula provided emotional support during pregnancy by listening to their concerns and letting them know they were not alone. One interviewee stated:

> *"We talked about a lot. … If I needed anything and everything, she always made it a point and a fact to let me know that she was going to be there. Indeed, she was and she still is."*

Finally, two interviewees described receiving doula support during the prenatal period that did not meet their expectations. First, an interviewee reported that her doula was often unavailable and requested phone sessions instead of in-person meetings, potentially due to the distance between the doula and interviewee's homes. Second, an interviewee reported meeting her doula only once in person prior to giving birth. The doula told the interviewee to contact her as needed, but the interviewee did not know what to say and wished the doula had laid out a clearer plan for the prenatal period.

Labor and Delivery

Interviewees who had a doula during labor and delivery described mostly positive experiences with the support they received. Doulas tended to interviewees' needs, advocated for them or encouraged them to advocate for themselves, informed them about their rights, and provided physical and emotional support during labor and delivery. In some cases, doulas adjusted the physical environment by dimming the lights in the hospital room, playing music, or requesting noise be kept to a minimum. A few interviewees reported their doula did not provide sufficient support. In these cases, interviewees described instances in which the doula arrived late, did not provide verbal encouragement, or did not recognize when the interviewee was overwhelmed.

Most interviewees stated their doula was integral to their birth experience and helped them feel more at ease. Importantly, interviewees shared that if the doula had not been there, they may have felt lost while giving birth, caved to pressure to have interventions they did not want, or their baby's health would have been compromised. When describing her birth story, an interviewee highlighted the importance of her doula's advocacy:

> *"I felt like it would've went badly if [my doula] wasn't there because when it came time to where [my son] was already crowning, they came and checked me, and they're like, 'Oh, it looks like we could already see his head. It's time for you to push.' At the same time, they had another patient that was also ready to give birth, but she wasn't on the epidural, so they tended to her first because she was in a lot of pain. I was just left there with the nurses and then my doula. [The health care providers] were … telling me to wait. My doula was like, 'No, she needs to start pushing now.' She helped me through the beginning of it and was walking me through the pushes and stuff. It was her and the nurses, and she was kind of leading the nurses. Then the doctor didn't come in until halfway through it."*

Doulas engaged with health care providers by distributing interviewees' birth plans and relaying interviewees' needs when necessary. Notably, several interviewees reported their health care providers worked collaboratively with their doula, and some health care

providers and doulas seemed to know each other. However, a few interviewees observed nurses and physicians were sometimes resistant to the doula's presence or suggestions.

In addition to their doula, most interviewees had at least one other support person present at their birth. Interviewees reported their doula guided and involved their partners during labor and collaborated with family members to better support them.

Two interviewees' doulas were unable to be by their side during birth due to the hospital's one-person limit in the operating room. Ahead of a scheduled cesarean section, an interviewee's doula followed her to the operating room and waited to see her after the birth. Another interviewee gave birth vaginally in an operating room in case the medical team needed to transition to a cesarean. The interviewee chose the baby's father as her support person but indicated it would have been nice to also have her doula present:

> *"Now looking back, I would've just preferred [the doula] to be there from beginning to end, but if I had an option, I would want to be normal where both people could be there. That would be like my ideal is that I had both of them."*

Additionally, a few interviewees' doulas did not attend their births. One interviewee stated her labor progressed quickly. Another interviewee forgot to call her doula but described sharing the birth plan they developed with health care providers, who respected her wishes. Lastly, an interviewee's doula did not show up at her birth and sent a less experienced doula who was helpful but stayed for a short period of time.

Postpartum Doula Support

Postpartum doula support varied depending on the interviewees' life circumstances and preferences, the doula's approach, and availability. For example, a few interviewees indicated they wanted to be alone with their family for a few weeks before their doula visited, while other interviewees saw their doula within one week of giving birth. Notably, most interviewees reported their doulas checked in via text and phone throughout the postpartum period.

Doulas visited most interviewees at their homes, and some doulas brought food, tea, and other small gifts. Most interviewees described talking to their doulas about their emotional well-being and challenges they were facing. Some doulas assisted with household tasks, such as washing the dishes or holding the baby while the mother cooked. Several interviewees reported their doulas offered information or shared resources related to mental health, newborn care, and breastfeeding.

Many interviewees intended to breastfeed and described leaning on their doulas for guidance. Doulas provided support by sharing their own experiences with breastfeeding, referring interviewees to lactation consultants, and troubleshooting challenges related to latching or milk supply. Notably, several interviewees struggled while breastfeeding, and two of these interviewees described feeling conflicted about telling their doula they needed to switch to formula.

When asked if their doula encouraged them to seek mental health support, several interviewees reported their doula offered referrals or educational resources related to mental health. Most of these interviewees appreciated the information but declined the referral because they did not need mental health support or because they already had a therapist and/or psychiatrist. However, a few interviewees reported their doula encouraged them to reach out to their existing therapist. An interviewee described what happened after she told her doula how she was feeling on the phone:

> *"I was being really, really emotional and just crying over everything, and she told me that that was normal, that was expected. … I had a therapist already, but she told me to talk to my therapist about it, and I did. The therapist referred me to a postpartum support group."*

In several instances, interviewees reported their doulas encouraged them to attend postpartum medical appointments or speak to health care providers about specific issues they were dealing with. For example, an interviewee described how her doula encouraged her to continue therapy and ask her midwife for medical advice:

> *"I told her about how sore I felt for sure. But since she's not a midwife or a doctor, I think that it was outside of her expertise to know what was going on. She definitely advised me to talk to my midwife about it."*

Two interviewees reported they did not go to postpartum check-ups, partially due to poor experiences with their health care providers during the prenatal period. Additionally, an interviewee who went to postpartum check-ups told her doula she was disappointed in her obstetrician. The doula recommended another obstetrician, and the interviewee switched providers.

Although interviewees were not asked to recall the exact number of prenatal and postpartum visits they had with their doula, some interviewees seemed to have more support throughout the postpartum period than others. Notably, a few interviewees reported having a generally positive postpartum experience and feeling well supported by family. When these interviewees were unable to find another time to meet with their doula, they seemed comfortable moving on.

Some interviewees also described how communication with their doula evolved as the postpartum period progressed. A few interviewees reported their doula told them to reach out if they needed anything, and they still text occasionally. However, one interviewee reported a "disconnect" in her relationship with a doula, and their communication fizzled during the postpartum period.

Promoting the Medi-Cal Doula Benefit

When asked for ideas about how to promote the Medi-Cal doula benefit and doula support, interviewees who had and had not used doula support offered several suggestions. Table C.1 in Appendix C highlights interviewees' messages for other Medi-Cal members who are considering doula support.

When promoting the Medi-Cal doula benefit, interviewees noted it is imperative to share information about how to find a doula, potentially by providing a user-friendly directory. The directory should allow Medi-Cal members to filter by Medi-Cal managed care plan and other attributes, such as the doula's race/ethnicity, language spoken, and geographic location. One interviewee stated:

> *"I think it's one thing to know that it's covered, but it's a whole other thing to be, 'Here's a directory and these are the ones we work [with].'"*

Timing of Medi-Cal doula benefit promotion is critical. A few interviewees stressed that Medi-Cal members should be told about the benefit as early in their pregnancy as possible. Additionally, one interviewee suggested members be informed about the benefit multiple times before and after birth.

Health care providers should verbally share information about the Medi-Cal doula benefit or give patients flyers during prenatal appointments. Clinics and hospitals could have posters or flyers hanging on the wall.

Medi-Cal managed care plans should share information about the doula benefit via mail, email, personal calls from health educators or health plan nurses, and by including details on the plan's website and app. Most interviewees who did not use the doula benefit reported they would have liked if their Medi-Cal managed care plan shared information about doula support.

Word of mouth will help raise awareness about the Medi-Cal doula benefit. Several interviewees who used the doula benefit reported telling friends and other moms on social media. Some even described recommending their doula to others. Additionally, a few interviewees reported they intend to share information about the benefit with people they interact with through their work.

Promote the Medi-Cal doula benefit on social media. Interviewees often suggested TikTok, Instagram, and Facebook. Two interviewees said television ads would be useful. One interviewee noted that, to build trust, ads should feature people who have used doula support and look like her.

Create opportunities for Medi-Cal members to interact with doulas. A few interviewees reported it would be helpful for members to speak with doulas to learn more about their work and the benefit. These interviewees suggested that doulas could be present in clinic waiting rooms, attend community events, or even call members directly.

Share information about the Medi-Cal doula benefit through social services. Some interviewees suggested posting flyers at county offices for social services and sharing information about the benefit through Women, Infants, and Children (WIC).

Findings: Doulas

Key Takeaways

- Doulas have to navigate complex, bureaucratic, and costly processes to serve Medi-Cal members through the benefit, and these challenges may serve as a deterrent to enrolling as a Medi-Cal provider and contracting with Medi-Cal managed care plans.
- CBO leaders understand the needs of the doula workforce and provide critical support to doulas enrolling as Medi-Cal providers and contracting with Medi-Cal managed care plans. However, CBOs lack sustainable funding.
- Although there are some efforts to create more doula-friendly hospital environments, barriers persist. Some interviewees reported hospitals do not welcome or support doulas, which impacts Medi-Cal member access to the benefit.

About the Interviewees

UC Berkeley researchers conducted interviews with 16 doulas, including 10 CBO leaders. Most interviewees were Black/African American or identified as Native American and/or Indigenous. A few interviewees reported more than one race/ethnicity.

All interviewees had experience as doulas; however, a few interviewees focused on CBO operations and had taken a step back from providing direct client support. All interviewees who did not lead CBOs were working as doulas in their communities.

Less than half of interviewees had enrolled as a Medi-Cal doula provider and contracted with at least one Medi-Cal managed care plan. One interviewee had enrolled as a Medi-Cal doula provider but had not yet contracted with any managed care plans.

Other interviewees had not yet enrolled as a Medi-Cal doula provider through the Medi-Cal provider enrollment application, although most stated they intend to do so in the future. Among these interviewees, several expressed a desire to go through the process to better support other doulas in their communities. One interviewee stated: *"For me the value is going through something so I can tell somebody else how to get through it."*

Laying the Groundwork

Before Medi-Cal started covering doula services, most CBO leader interviewees were already working to expand access to doula support across California. Several CBO leaders reported being involved in doula pilot programs, advocating for or drafting legislation aimed at expanding access to full-spectrum doula services (e.g., Assembly Bill 2258 from 2019-2020 and Senate Bill 65 from 2021-2022), and participating in strategic workgroups. CBO leaders also described efforts to bolster and support the doula workforce through trainings aimed at increasing the number of Black doulas and by creating opportunities for mentorship and ongoing training.

A few CBO leaders emphasized the importance of the doula pilot programs[3] funded by managed care plans or counties through the California Department of Public Health's Perinatal Equity Initiative (PEI). Through the pilots, CBO leaders described establishing initial reimbursement rates for doula services and increasing knowledge of doula

[3] *Prior to the Medi-Cal doula benefit, there were at least 10 doula pilot programs across eight counties in California: Alameda, Contra Costa, Fresno, Los Angeles, Riverside, Sacramento, San Bernardino, and San Francisco.*

support within managed care plans and among health care providers and the general public.

Developing the Medi-Cal Doula Benefit

CBO leaders played a critical role in the development of the Medi-Cal doula benefit. Most CBO leaders reported regularly attending meetings for the DHCS-convened Workgroup and some were Workgroup members.[4] A subset of Workgroup members comprised the Co-Design team, which provided DHCS with subject matter expertise and additional guidance.

Although some CBO leaders described being skeptical of DHCS and the intention behind the benefit, they decided to participate in the Workgroups to protect the doula profession, hold systems accountable, and create long-lasting change. By participating in the Workgroups, a few CBO leaders reported they were able to uplift concerns from the broader doula community.

CBO leaders who were actively involved in developing the benefit reported encountering challenges while working with DHCS. A CBO leader described how they believed early Workgroup meeting conversations were one-sided and that DHCS did not engage in active conversations with doulas. CBO leaders also reported that initial conversations about potential reimbursement rates for the doula benefit "deeply undervalued the support doulas provide."[5] A CBO leader noted there were many times when Workgroup members needed to advocate for DHCS to take a different approach if they wanted the Medi-Cal doula benefit to succeed:

> *"… there were so many stages where it felt like, 'We don't know if this is going to work.' At the beginning, when the pay was little, we were like, 'This won't work with the pay that way.' There was a lot of advocacy as well to get the pay where it is."*

Despite initial challenges, most CBO leaders reported that DHCS and Workgroup members now have a "mutual respect" for one another. Several CBO leaders reported DHCS staff and Workgroup members now listen to one another, which has helped when DHCS facilitates meetings with doulas and other organizations, such as the California Hospital Association. Notably, a CBO leader reported that DHCS staff advise other organizations to respect Workgroup member expertise.

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[4] DHCS convened a stakeholder workgroup to support the Medi-Cal doula benefit. The Medi-Cal Doula Implementation Workgroup began meeting in 2023 and ended in May 2025; this workgroup mainly addressed barriers to Medi-Cal member benefit utilization.

[5] Medi-Cal's rates in 2023 and the current rates are available in the Frequently Asked Questions for Doula Providers: Reimbursement.

Implementing the Medi-Cal Doula Benefit

Doula Availability Through Medi-Cal

To access the doula benefit through Medi-Cal managed care, Medi-Cal members would need to find a doula who is enrolled as a Medi-Cal provider, contracted with their managed care plan, and accepting clients. Ideally, the Medi-Cal member would find a doula who meets their personal needs. All interviewees identified hurdles to making this vision a reality for Medi-Cal members who want a doula.

Doulas must navigate complex, bureaucratic, and costly processes to serve Medi-Cal members through the benefit. Although some interviewees reported doulas encounter challenges when enrolling as a Medi-Cal provider through the Medi-Cal provider enrollment application, issues most commonly arose when working with Medi-Cal managed care plans.

Interviewees identified financial barriers associated with provider enrollment, contracting, and billing processes, such as the cost of meeting local requirements like obtaining a business license, CPR certification, liability insurance, and paying for a billing clearinghouse or a biller. Most interviewees noted the time spent navigating complex systems is unpaid. However, one interviewee reported a Medi-Cal managed care plan offered financial incentives to doulas who contracted with the plan.

Next, some interviewees reported credentialing and contracting with Medi-Cal managed care plans can be a lengthy, complicated process. These interviewees reported contracting takes too long, which impacts the number of doulas available to support Medi-Cal members, and contracts sometimes include language that does not apply to doulas.

Additionally, a few interviewees described encountering challenges when billing Medi-Cal managed care plans, with some claims being denied and others not being paid in a timely manner. Two interviewees emphasized that unlike physicians, many doulas are handling billing on their own, which should be factored into reimbursement rates:

> *"The doctors themselves are not necessarily doing the medical billing. They hire people to do it for them. Doulas, we're like a one-person business. We have to do all this work just to get paid. That's something that DHCS did not incorporate in the rates of how many hours we're spending."*

A few interviewees also reported not being reimbursed at the targeted rate increase that went into effect in 2024 for eligible contracted providers.[6] One CBO leader reported appealing denied claims takes time, so the CBO has used its own funding to ensure doulas get paid, which not all CBOs can do:

> *"There has been times where we just fronted our doulas the money on our end, and we're just trying to recoup from the insurance companies. There's sometimes where we're like, 'We're never going to get paid for that.'"*

Another interviewee who works full time as a doula reported asking for personal loans while waiting for claims to be paid. The interviewee described how delayed payments contribute to burnout:

> *"There's definitely those moments where I'm like, 'Oh my gosh, I do all this work, all these hours, and just for a promise to get paid.' Of course, the satisfaction is there that I could show up for my community, but in times of burnout, I really want to take a pause."*

Some doulas may not be interested in becoming a Medi-Cal doula provider. As more doulas learn about barriers to becoming a Medi-Cal doula provider and working with Medi-Cal managed care plans, interviewees reported some may be deterred from serving Medi-Cal members through the benefit. One interviewee stated: *"It's cleaner to just do the birth for free than to jump through all the hoops of Medi-Cal."* Another interviewee noted that for doulas who only take a few clients a year, it may not be worth their time to become a Medi-Cal doula provider.

Losing the "Heart" of Doula Work

A few interviewees expressed concern the Medi-Cal doula benefit would have unintended consequences, such as creating unnecessary oversight, medicalizing the doula workforce, and turning doula work into a chore rather than a calling.

Additionally, a few interviewees reported doulas may not be interested in becoming a Medi-Cal provider due to distrust in the state and concerns about Medi-Cal defining

[6]DHCS implemented Targeted Rate Increases for primary care, obstetric, and non-specialty mental health services effective for dates of service on or after January 1, 2024. The rate increases applied to eligible providers, including doulas who were contracted with Medi-Cal managed care plans. DHCS gave Medi-Cal managed care plans until December 31, 2024, to pay their contracted providers the targeted rate increase.

what a doula can do. One interviewee who was not providing doula services through the benefit stated:

> "*I do not think that the state should … get to decide who and what a doula is for a birth worker. There is absolutely a huge part of my identity and my practice that is a decolonial approach and a reclamation of traditional knowledge.*"

Efforts to increase the number of Black and Indigenous doulas are underway, but it will take time for newly trained doulas to become Medi-Cal doula providers. A few CBO leader interviewees reported training new doulas in recent years and preparing for future trainings. However, newly trained doulas cannot become Medi-Cal doula providers right away. First, doulas must gain experience by supporting clients at births.[7] Then, doulas must go through Medi-Cal provider enrollment and Medi-Cal managed care credentialing and contracting processes. One interviewee described how the decision to enroll as Medi-Cal doula provider requires careful thought. More than a year after leading a doula training, the interviewee reported most trainees are still deliberating and learning about the required steps to become a provider:

> *"I believe there is some contemplation, some pre-contemplation. There are people that have got through. It's just a few that I know of. Mainly everyone is still in that process. The anticipation is everyone wants to do it, but what does it take?*"

CBO leaders who facilitated doula trainings reported using strategies aimed at increasing the number of Medi-Cal doula providers. For example, certain CBOs asked training applicants to attest they were interested in enrolling as Medi-Cal providers and offered free trainings. Additionally, CBO leaders incorporated information about the Medi-Cal doula benefit in their trainings and continued to support doulas as they began supporting clients, enrolling as Medi-Cal providers, and contracting with managed care plans.

Doula availability in rural areas may limit Medi-Cal member access to the benefit. An interviewee who serves Native American communities in rural areas reported clients tend to prefer in-person support, which may be difficult for doulas to provide due to distance. The interviewee also noted virtual doula services may not be an option for Medi-Cal members who live in areas without reliable cell phone service or Internet. Notably, another interviewee who drives hours to see clients reported declining to provide services through Medi-Cal because the initial reimbursement rates did not cover

[7]To become a Medi-Cal doula provider through the Training Pathway, doulas are required to complete a minimum of 16 hours of training and support a minimum of three births.

transportation costs, the length of prenatal and postpartum visits, and administrative time.

Ongoing Technical Assistance and Support for Doulas

To overcome challenges related to Medi-Cal provider enrollment and working with Medi-Cal managed care plans, interviewees reported the doula workforce needs significant technical assistance. Additionally, to avoid burnout among Medi-Cal doula providers, the workforce must be well-supported through mentorship and peer support.

Some Medi-Cal managed care plans are not providing sufficient technical assistance or support to doulas during contracting and billing processes. Before the benefit rolled out, a CBO leader interviewee described a collective assumption among doulas engaged in the DHCS Workgroup meetings that Medi-Cal managed care plans would develop a process to support doulas as they contract with plans to serve Medi-Cal members. At the time of these interviews, the benefit had been in place for about two years, and most CBO leaders shared the perception that Medi-Cal managed care plans had not developed doula-friendly processes. Notably, one interviewee reported it was easier to work with managed care plans that had dedicated support staff who were responsive to doulas' concerns.

CBO leaders understand the needs of the doula workforce and are providing critical support as doulas enroll as Medi-Cal providers, credential and contract with Medi-Cal managed care plans, and navigate billing. All CBO leader interviewees reported conducting trainings to walk doulas through each step required to serve Medi-Cal members and be reimbursed for their work. Trainings were held in person and virtually, and topics included the Medi-Cal provider enrollment application process, contracting with Medi-Cal managed care plans, and billing. A few CBO leaders also reported hosting regular office hours, so doulas have a place to ask peers questions and air frustrations while navigating processes related to the benefit. Importantly, one CBO provides a managed care contract review service to help doulas better understand what they would be agreeing to. Further, a few CBO leaders reported that when doulas are unable to communicate with managed care plans due to their schedules, CBOs have stepped in to get answers for them.

A few CBO leaders reported doulas sometimes get discouraged by the enrollment, contracting, and billing processes. These CBO leaders stressed the importance of "handholding" doulas through these complex processes and noted that without support, doulas may give up, which would negatively impact the number of doulas available to serve Medi-Cal members through the benefit. An interviewee who successfully enrolled as a Medi-Cal provider and contracted with managed care plans described the value of having support from a CBO:

> *"Having a community of birth workers that I could rely on and help me, support me throughout this process. They were basically holding my hand throughout the whole process."*

Some Medi-Cal managed care plans are seeking guidance from CBO leaders. Several CBO leaders described engaging with local managed care plans to troubleshoot issues doulas encounter during credentialing, contracting, and billing processes. Importantly, a few CBO leaders advocated to be paid as consultants after managed care plan staff continually requested advice. An interviewee recognized that managed care plan staff need support to help the benefit succeed but stated doulas must be compensated for providing expertise. The interviewee described a conversation with managed care plan staff:

> *"We can't make ourselves available for the rest of our lives for monthly meetings or biweekly meetings to talk about what you want to do with doulas. Either you're going to contract with us to consult so that you're paying up for our time, or you have to just be on the [public DHCS Workgroup meeting calls] and figure it out like everybody else."*

After providing feedback to managed care plans, a couple CBO leaders reported certain plans were able to resolve some issues. However, other CBO leaders perceived that plans had not utilized their feedback to improve processes.

CBOs facilitate opportunities for mentorship and peer support for doulas, which is vital to workforce sustainability. One CBO leader described the importance of providing "care for the care providers" by creating "safe outlets" for community-based doulas, who are often from the communities they serve:

> *"If we consider the fact that the majority of community-based doulas are the same people that are the community-based clients, then we have double the exposure to the bias and to the disparities in care. There is a burnout rate among doulas of about five years. If we lose the doulas, then we lose the support for the community members."*

Medi-Cal Doula Benefit Promotion

Most CBO leaders reported their organizations were not actively promoting the doula benefit to Medi-Cal members due to the limited number of Medi-Cal doula providers. Specifically, given the importance of culturally competent doula support, some CBO leaders described hesitancy around promoting the benefit when there are not enough Black and Brown doulas contracted with Medi-Cal managed care plans in their communities.

Additionally, one CBO leader's organization is still building infrastructure to bill as a group provider and is not yet providing direct services. Although the CBO conducts outreach to raise awareness about doula support, the CBO cannot offer doula support to community members:

> *"We have been trying to balance the education with the fact that we're not fully launched yet … We don't want to have a line of moms who need support, and then we're not ready to connect them yet to a doula, and we're not ready to bill for them."*

However, a couple CBO leaders reported talking about the Medi-Cal doula benefit informally when they meet pregnant people or promoting it by tabling at local events, such as a community health fair, and sharing information on their websites and social media.

A few interviewees reported DHCS and Medi-Cal managed care plans should be responsible for promoting the Medi-Cal doula benefit and educating the public about doula support. One CBO leader described an expectation some doulas had of DHCS and managed care plans:

> *"We expected that the state and the managed care plans would immediately institute a very robust effort to educate people. We were very prepared to support in those efforts, but we also recognized that we were not resourced enough to take that on independently."*

Another interviewee reported some Medi-Cal members who inquire about doula services "don't know exactly what a doula does." The interviewee described taking time to educate members but stated DHCS should be doing more to raise awareness about doula support.

Word of mouth through trusted community members may facilitate benefit promotion. For example, in close-knit rural communities, if information about the benefit is shared, word may travel. One Native American interviewee noted: *"The people that get out the information are the mothers and the grandmothers."* Further, after learning about the Medi-Cal doula benefit, a couple interviewees reported telling others:

> *"It wasn't talked about or brought up until I had started telling everybody, and they were like, 'What? Oh my God.' I'm like, 'Yes. You can have the same service. You don't even have to be rich no more.'"*

Connecting Doulas and Medi-Cal Members

Interviewees enrolled as Medi-Cal doula providers reported Medi-Cal members have reached out to them directly to inquire about doula support. Medi-Cal members found doulas' contact information through multiple pathways, including the DHCS doula directory and local health care providers. One interviewee reported having relationships with local midwives, while another reported a local hospital gives patients a list of Medi-Cal doula providers in their area. However, when Medi-Cal managed care plans, hospitals, and clinics do not facilitate the referral process, an interviewee reported it can be difficult to find clients in their community:

> *"You're responsible for your own business and clients. What would that mean? Me tabling and going in the street and asking people, 'Are you on [managed care plan]?' Standing in front of the hospital local to me and handing out my business card?"*

Doulas refer clients to each other due to limited capacity and an inability to provide services through the benefit. One interviewee described being saturated with requests for doula services from Medi-Cal members who found them through the DHCS doula directory. When at capacity, the interviewee reported trying to connect the members to other doulas:

> *"I try my best to create community with folks or birth workers that are enrolled to take Medi-Cal. I'll even text the doulas like, 'Hey, do you have room for this month?' I do my best in making the client feel like, 'Hey, there's some hope. Sure, I can't take you, but hopefully somebody can.'"*

Similarly, a couple interviewees who were not contracted with Medi-Cal managed care plans reported receiving inquiries from Medi-Cal members and referring them to other doulas.

Interactions with hospitals, clinics, and health care providers

A few CBO leaders reported participating in efforts to raise awareness about doulas and the Medi-Cal doula benefit among health care providers. Such efforts included collaborating with Medi-Cal managed care plans to develop presentations for health care providers and speaking to OB-GYNs interested in increasing doula utilization among patients. However, one CBO leader reported local clinics and hospitals were unresponsive or declined offers to educate health care providers.

Although there are some efforts to create more doula-friendly hospital environments, barriers persist. Some interviewees reported hospitals do not welcome or support doulas, which impacts Medi-Cal member access to the benefit. One CBO leader recognized efforts made by DHCS, Medi-Cal managed care plans, and professional associations to address barriers to doula presence in hospitals. However, the CBO leader reported individual providers will still create barriers:

> *"That needs to trickle all the way down to your anesthesiologist, who's like, 'I don't know what a doula is. They're not allowed in.' Or the nurse who's like, 'You're considered a visitor. Visiting hours are over.' Even when [certain issues related to the Medi-Cal doula benefit] are fixed, that member, that mom, that family can still lose out on the benefit because of the ignorance of a medical provider at the birth."*

A few CBO leaders reported building relationships with hospitals over the years and collaboratively addressing issues, such as ensuring doulas are not classified as visitors and are able to support their clients in triage. Importantly, one CBO leader described developing trainings for health care providers to address negative perceptions about doulas. Other reported efforts to improve doula-hospital relationships included hospital tours for doulas, "meet the doula" events, and direct lines of communication between doulas and hospital leaders.

Suggestions to Improve Medi-Cal Doula Benefit Implementation Among Doula Interviewees

Interviewees shared a handful of suggestions to improve Medi-Cal doula benefit implementation. Interviewees also identified best practices to address challenges facing the doula workforce, which are highlighted in Appendix C (Table C2).

Fund a variety of CBOs throughout the state to support the doula workforce and directly serve communities. Although most CBO leaders pieced together funding to support Medi-Cal doula benefit implementation, they reported needing sustained funding to continue these efforts. Notably, some CBO leaders continued to offer technical assistance to doulas after such funding ended, and one CBO leader did not receive any funding but tried to support doulas in their community anyway. Without CBO support, doulas may face even more barriers trying to enroll as Medi-Cal providers and contract with managed care plans

Ensure Doula Programming Is "Community-Led"

A few interviewees reported hospitals, clinics, and other organizations with existing infrastructure may try to hire and train doulas and bill for their services. An interviewee described how this would detract from grassroots efforts and suggested these entities support "the people in the community that have already been doing this and uplift their work."

Two CBO leaders also noted philanthropists stopped funding community-based doula programs after the Medi-Cal doula benefit was announced, which disrupted their ability to serve pregnant, birthing, and postpartum people. Although the Medi-Cal doula benefit created a new funding stream for doulas, these CBOs did not have the funding required to build infrastructure, evolve their programs, and operationalize billing as a group provider. A CBO leader stated philanthropists must continue to fund efforts to support community-based doula programs:

> *"I just feel that from a CBO point of view, we came with solutions, we're the experts, we're the ones who care most, stand up most, and are here to amplify the voices of families and the doulas, and yet the funding isn't really coming our way to continue this work."*

Medi-Cal managed care plans should simplify and streamline credentialing, contracting, and billing processes while educating staff about doulas and the Medi-Cal doula benefit. To alleviate some of the barriers doulas face when working with managed care plans, interviewees made the following suggestions:

- Medi-Cal managed care plans should not require doulas to submit documents that DHCS verified during the Medi-Cal provider enrollment process.
- Contracts should be simple and doula specific.
- Reimbursement rates should account for time spent doing administrative work and traveling to see clients. Medi-Cal managed care plans could also develop incentives for doulas to receive additional funds to cover these costs.
- Medi-Cal managed care plans should have a straightforward onboarding process for doulas, provide training on how to submit claims, and offer ongoing billing support.
- Billing should be simplified, and claims should be paid on time and at the correct rates.
- Medi-Cal managed care plan staff members should be educated on what doulas do and the Medi-Cal doula benefit, including knowledge of the targeted rate increase.
- Each Medi-Cal managed care plan should have a clear point of contact for doulas. If there is turnover, the plan should communicate a new point of contact to doulas.
- Medi-Cal managed care plans should hire doulas as staff members or consultants to provide subject matter expertise and feedback.

DHCS should provide technical assistance for CBOs enrolling as group providers. A CBO leader suggested DHCS develop a webinar specific to group providers and provide additional support as needed.

There may be a need to "normalize" doula support in Native American communities. Specifically, one Native American interviewee who had experience implementing health-related initiatives reported a need to meet "people where they are" and share the benefits of resources, such as doula support. The interviewee described the importance of "reframing" when sharing information.

> *"When I talked about breastfeeding at a … meeting with elders, they're like, 'Oh, we don't talk about breastfeeding. That's not appropriate.' I'm like, 'We're talking about health. It's very much a part of our health. For thousands of years, that's what we did.' It's just bringing the teaching back."*

Other interviewees echoed the importance of talking to people in their communities about what doula support is and dispelling perceptions that doulas are for "hippies" or wealthy people.

In addition to the Medi-Cal member's evidence of coverage, Medi-Cal managed care plans can develop comprehensive guides to promote doula support and other benefits available to Medi-Cal members who are expecting or new parents. A CBO leader reported communicating this suggestion to Medi-Cal managed care plans so members do not have to "hunt for what's available":

> *"The response back that we get from our payers is, 'Oh, that's such a good idea, but we already have all that. All you have to do is call member services.' What we keep explaining to them is, 'No. If you don't know what the benefit is, you don't know to ask for it.'"*

Use a collaborative approach to educate hospitals, clinics, and health care providers about doulas and the Medi-Cal doula benefit. Several interviewees reported health care providers need to be educated about doulas and the Medi-Cal doula benefit so they can share information with their patients. One interviewee reported health care providers at a local hospital asked doulas to come in and talk about their work, which created an opportunity for clinicians and doulas to get to know one another as peers.

Findings: Medi-Cal Managed Care Plans

Key Takeaways

- Interviewees described the importance of understanding that doulas are unique providers. Some interviewees reported working with colleagues to adapt Medi-Cal managed care plan processes to meet doulas' needs.
- Most interviewees reported their Medi-Cal managed care plan had conducted outreach to find local doulas interested in joining their provider network. Challenges to building a provider network included a small doula workforce in some areas and doulas who were not interested in enrolling as Medi-Cal doula providers. Notably, an interviewee identified delayed payments for doula services as an issue that may impact doula interest.
- Efforts to promote the Medi-Cal doula benefit to hospitals and clinics are underway, but interviewees reported some health care providers are resistant to doula support. Additionally, Medi-Cal managed care plans can remind hospitals about recommendations related to doula presence in hospitals but may not be able to adequately enforce such policies.

About the Interviewees

UC Berkeley researchers interviewed seven staff members from five Medi-Cal managed care plans that serve Medi-Cal members in different parts of the state, including urban and rural areas. Broadly, all interviewees were involved in implementing the Medi-Cal doula benefit at their respective Medi-Cal managed care plan. All interviewees reported at least one person from their managed care plan regularly attended DHCS-convened workgroup meetings.

Implementing the Medi-Cal Doula Benefit

Interviewees described initial Medi-Cal doula benefit implementation as challenging, partially due to the learning curve faced by Medi-Cal managed care plan staff and

doulas. Notably, one interviewee viewed the benefit as a catalyst for systems change and reported benefit implementation is a "work in progress":

> *"It's larger [than a] benefit. It's about health equity. … It's also about changing systems. It's a heavy lift of changing systems, and I think we're going in the right direction. Bit by bit, I think we're getting there, but it's more than a benefit."*

Interviewees also described other factors that contributed to a challenging implementation process. Most interviewees reported DHCS did not always provide necessary guidance, which delayed aspects of benefit implementation. Additionally, all interviewees reported their Medi-Cal managed care plan had experienced successes and challenges with contracting and claims.

Internal Education Related to the Medi-Cal Doula Benefit

Most interviewees reported educating Medi-Cal managed care plan staff about doula services and the Medi-Cal doula benefit, a critical step to benefit implementation. Staff education prepared departments related to contracting and claims to work with doulas. Additionally, educating member-facing departments (e.g., health education, case management) primed managed care plan staff to share information about doulas and the benefit with members.

Building a Medi-Cal Doula Provider Network

Medi-Cal managed care plan staff conducted outreach to find local doulas interested in joining the plan's network. Interviewees described engaging doulas in multiple ways. Medi-Cal managed care plan staff contacted local doulas, including those listed on the DHCS doula directory, attended events hosted by doula collectives and CBOs, and met doulas at health plan-sponsored events aimed at reaching Medi-Cal members (e.g., community baby showers). Through these interactions, staff members were able to share information about how doulas could begin the managed care plan's contracting and credentialing processes. However, as provider networks grew and more doulas approached managed care plans about contracting, a few interviewees reported cutting back on outreach.

Challenges to building a provider network included a small doula workforce and limited interest in serving Medi-Cal members through the benefit. Two interviewees reported certain coverage areas have more doulas than others, mirroring issues Medi-Cal managed care plans face with other provider types. Additionally, one interviewee described reaching out to the limited number of doulas in the plan's region and discovering most are not interested in serving clients through the doula benefit, which would reduce the amount of time doulas have to serve private-pay clients.

To build a provider network, some Medi-Cal managed care plans invested in efforts to support and grow the Medi-Cal doula workforce. Investments included funding CBOs to help doulas become Medi-Cal providers and hosting or providing stipends for HIPAA and CPR trainings, which doulas must complete to enroll as providers. Notably, one interviewee reported their managed care plan considers funding requests from community-based doula organizations and collectives on an "as-asked basis," stating:

> *"Given that doulas are of and for the community, it's hard for the health plan to step in and just create something."*

Adapting to Meet Doulas' Needs

Interviewees described the importance of understanding that doulas are unique providers and identifying ways to adapt Medi-Cal managed care plan processes to meet doulas' needs. Interviewees reported most doulas have not worked with managed care plans before, and credentialing, contracting, and billing processes were not built with non-traditional providers in mind. At the same time, supporting non-traditional providers was new for Medi-Cal managed care plans, too. One interviewee stated:

> *"Working with a health plan is challenging, and this is a provider group that's never done it before. We've never really had an experience where we've had to help a provider be a provider from a Medi-Cal standpoint."*

To better understand the doula workforce, another interviewee reported putting "ourselves in the doula provider's shoes" and "allowing doula providers to teach us."

Understanding aspects of the doula perspective helped some interviewees identify opportunities to improve managed care plan processes. For example, some interviewees described developing onboarding processes for doulas, including on-demand and live webinars, and trying to simplify credentialing and contracting processes (e.g., developing a doula-specific contract template). Notably, a few interviewees were still refining Medi-Cal managed care plan processes to address barriers reported by doulas.

Additionally, to help doulas navigate Medi-Cal managed care plan processes, some interviewees described building communication pathways between doulas and staff members and providing technical assistance related to submitting claims:

- **Doula inbox:** A few interviewees reported creating a centralized inbox for all doula-related inquiries. Interviewees at managed care plans with doula-specific inboxes stated staff members familiar with doulas regularly monitor the inbox and respond to questions and concerns accordingly. If a staff member cannot resolve

an issue independently, they would connect the doula to someone from another department who can.

Designated point of contact: A few interviewees described assigning each doula a point of contact within a managed care plan. Points of contact meet with doulas on an ad hoc basis and during set check-in times throughout the year.

Training on claims submission: A few interviewees reported managed care plan staff members train doulas on how to submit claims and ask doulas to share their first few claims with plan staff so they can address potential issues.

Ongoing engagement with doula network: A few interviewees reported hosting regular group meetings with doulas to discuss ongoing issues, highlight opportunities, or allow doulas to meet health plan staff from other departments.

Paying Claims

The timing of DHCS guidance impacted Medi-Cal managed care plan preparation for processing claims. For example, two interviewees reported receiving codes vital to the claims process after the benefit went live. Additionally, an interviewee reported managed care plans received "incomplete information" related to implementing Medi-Cal's targeted rate increases, which boosted reimbursement rates for eligible doula providers.

Further, the interviewee felt DHCS' approach to sharing information about the targeted rate increase with doulas was ill-timed, leading doulas to expect increased rates before managed care plans had necessary guidance. Therefore, doulas were not compensated the amount they expected, leaving them frustrated with managed care plans. The interviewee stated:

> *"I think that there was a setup for poor communication around it because I believe the doula [community] was assured that they would be accessing higher rates as of a certain date that was unrealistic."*

Delayed payments impact doulas' livelihoods. One interviewee reported supporting a doula who had not been paid for services provided a year ago. Although the Medi-Cal managed care plan's leadership had stepped in to resolve the issue, the interviewee identified delayed payments as a barrier to doulas providing services through the Medi-Cal doula benefit, stating:

> *"[Doulas] rely on these incomes, too. Being able to make ends meet as a Medi-Cal doula is nearly impossible."*

Medi-Cal Doula Benefit Promotion

Promoting the Benefit to Medi-Cal Members

Medi-Cal managed care plans are promoting the Medi-Cal doula benefit to members in a variety of ways. Most interviewees described promoting the benefit using typical communication channels, such as including information about the benefit in member newsletters, on the managed care plan's website and social media accounts, and through mailed materials. Interviewees also reported incorporating information about the benefit into the managed care plan's existing pregnancy-related materials and programs. Importantly, interviewees shared less traditional, more community-oriented approaches to benefit promotion:

- Hosting, attending, and/or sponsoring local events, such as community baby showers or "meet the doula" opportunities, to share information about doula services and the benefit
- Working with trusted community partners and doulas to promote the benefit
- Giving interested doulas flyers to hang in community spaces and at high-volume obstetric offices
- Developing a promotional campaign featuring member experiences with doulas

Doulas are facilitators to benefit promotion. One interviewee highlighted the power of having doulas who are from the communities they serve:

> *"Our doulas live and work in this community, they grew up in this community, they grew up in this region. Their friends and family members are here. They become so well-known in the areas that they live. … One person in the community is like, 'Oh, I used so and so for my birth and she's really great.' Then they educate somebody on what a doula is, and then their friend will use the same doula, and then their friend will use the same doula. Then before you know it, their friends are all asking for doulas. It's really the doulas that are the driving factor for members using doula services."*

Medi-Cal managed care plans may not know a member is pregnant, making it difficult to promote the benefit prenatally. Specifically, an interviewee reported managed care plans do not always know a member is pregnant until after birth due to global billing by the health care provider to the plan for services provided during pregnancy, delivery, and the postpartum period, which has implications for the timing of benefit promotion. Although the interviewee's managed care plan incentivizes providers to inform the plan earlier, it is not required. The interviewee noted members sometimes

call their managed care plan to ask what services are available during pregnancy. In these instances, member services could share information about the benefit.

Promoting the Benefit to Hospitals, Clinics, and Health Care Providers

Efforts to promote the Medi-Cal doula benefit to hospitals and clinics are underway, but some health care providers are resistant to doula support. All interviewees reported sharing information about the benefit with hospitals and clinics through a variety of communication channels, including during webinars and meetings with health care providers. In some instances, interviewees collaborated with CBOs to promote the benefit to health care providers.

Interviewees described receiving mixed responses about the benefit from hospital and clinic staff and health care providers. One interviewee stated:

> *"Some of our hospitals are hugely supportive, very familiar with the context of doulas prior, and very welcoming. Others are not. Others identify doulas as being a fringe benefit. The physicians are often lamenting that doulas may make as much money as they do for a delivery, and the hospital administration may be hesitant to have doulas participate in care."*

Interviewees from another Medi-Cal managed care plan reported local doulas and Medi-Cal managed care plan staff have hosted trainings that highlight how health care providers and doulas can work collaboratively. The interviewees described getting pushback from physicians, who are "flat-out refusing to provide doula recommendations." Importantly, Medi-Cal members no longer need their physician or other licensed provider to provide a written recommendation for most doula services due to the standing recommendation issued by DHCS Medical Director Dr. Karen Mark on November 1, 2023.

Connecting Doulas and Medi-Cal Members

Medi-Cal managed care plan provider directories may not have sufficient information about the Medi-Cal doula network. Most interviewees reported member services can connect members to doulas using the managed care plan's public provider directory based on geography; however, only one interviewee stated definitively that member services could filter by race/ethnicity and language spoken.

Additionally, one interviewee reported doulas may not want to be listed in provider directories due to privacy concerns. For example, in order to be listed in the interviewee's managed care plan provider directory, doulas must agree to share their place of business, which is often their home address.

Lastly, two interviewees reported provider directories may not accurately depict the number of doulas available to members. First, an interviewee reported their provider directory is not up to date, so managed care plan staff members have to do "more hands-on work" to connect Medi-Cal members to doulas. After a member expresses interest in doula support, the interviewee described contacting doulas directly to assess their availability before linking the member to a doula. However, the interviewee reported this is not sustainable:

> *"We are working on making it more of a self-serve process. We want to be there for support, but honestly, we don't have the staffing to keep managing it as manually as we're doing right now. The goal is to get the directory updated with more doulas to choose from and send our members to the directory so they can choose and contact the doula of their choice."*

Second, another interviewee expressed concerns that doulas listed on some managed care plans' provider directories cannot provide in-person support because they are based in another area of the state. The interviewee stated:

> *"These doulas were providing virtual consultations, and that's not necessarily what a birthing person wants. I don't want to FaceTime my doula while I'm in labor. … It's a pretty small network when you look at the actual group that can physically serve this area. It makes the network look bigger than it is, even though they can't technically serve our population. I think it inflates the numbers that a lot of the health plans have."*

One interviewee described working with local hospitals to develop referral pathways between members and doulas. The interviewee reported health care providers reached out to the managed care plan because they were interested in how they could utilize doulas to better support patients at higher risk. Managed care plan staff then helped establish partnerships between hospitals and local doulas.

Addressing Feedback Related to Doula Presence in Hospitals

Medi-Cal managed care plans can remind hospitals about recommendations related to doula presence in hospitals, but plans may not be able to adequately enforce such policies. After getting negative feedback from doulas about specific hospitals, a few interviewees described communicating their managed care plans' expectations to hospital administrators. Notably, one interviewee reported managed care plans have limited power when enforcing policies related to doula presence in hospitals.

> *"Then they remind me that actually as hospitals, they have the opportunity to write their own policies, and they're not wrong. There's on one hand what DHCS has told*

them they must do, and then there's actually what administratively as a private entity that they can do as well. There's a lot of gray area. We don't really wield [power] as a health plan. … What are our opportunities as a health plan to encourage hospitals to accept a service that they don't believe in? Are we going to stop contracting with them?"

Doula Presence in Hospitals

- All Plan Letter (APL) 23-024 states Medi-Cal managed care plans must work with their network hospitals/birthing centers to ensure Medi-Cal members do not face barriers when Medi-Cal doula providers accompany them to prenatal visits, labor and delivery, and postpartum visits.
- The California Department of Public Health issued All Facilities Letter (AFL) 25-13 to provide hospitals with useful information and recommendations related to the Medi-Cal doula benefit.

Suggestions to Improve Medi-Cal Doula Benefit Implementation Among Medi-Cal Managed Care Plan Interviewees

Medi-Cal managed care plans may need more staff to support the Medi-Cal doula benefit and provide technical assistance for doulas. One interviewee reported the benefit has "become larger than plans may have imagined" and noted increased staffing would be helpful. Further, an interviewee filling an "unofficial doula liaison" role at their managed care plan stated it would be helpful to have a formal staff position aimed at training doulas on managed care plan processes.

Identify opportunities to streamline processes for doulas across Medi-Cal managed care plans. Given that every managed care plan has a slightly different approach to credentialing, contracting, and claims submissions, one interviewee reported doulas would benefit from a more "streamlined pathway" to become Medi-Cal doula providers and contract with managed care plans. Importantly, another interviewee described meeting with peers from other managed care plans to identify and share best practices.

Medi-Cal managed care plans may need support developing strategies to increase health care provider acceptance of doula support. One interviewee expressed a desire for guidance related to educating health care providers about how doulas can benefit the birth care team. The interviewee described how this can be particularly difficult with experienced health care providers:

"In our area there are providers that have been around for a really long time, and it's hard to change ideas."

Uplift positive experiences between managed care plan staff and doulas. Specifically, one interviewee who has collaborated with doulas hoped to "eliminate this health plan versus doula dynamic." The interviewee added:

"There are people in the health plans there to help and who believe in doulas. To make it more of a working relationship rather than adversarial."

Findings: Hospital Staff

Key Takeaways

- Although all interviewees knew Medi-Cal covered doula services, they were unsure about the details of the benefit. For example, interviewees did not know the benefit covered doula support during the postpartum period or in instances of miscarriage and abortion.
- Interviewees reported mostly positive relationships between hospital staff and doulas but identified tension points, which interviewees attributed to a lack of understanding about the doula role and differing perspectives on birth and decision-making. Interviewees also described efforts to collaborate with doulas and improve hospital access.

About the Interviewees

UC Berkeley researchers conducted interviews with four hospital staff members who either worked in a labor and delivery department or birthing center. Most interviewees were nurses or certified midwives, and some held leadership roles.

Familiarity with Doulas

All interviewees were familiar with doulas and recognized the benefits of doula support, particularly during labor and delivery. Importantly, some interviewees

viewed doulas as beneficial for continuity of care and patient advocacy, with one sharing doulas provide an "extra voice" for patients during labor and delivery.

Relationships Between Hospital Staff and Doulas

Interviewees mostly described positive working relationships between staff and doulas at their hospitals. One interviewee stated staff work "hand in hand" with doulas, and another interviewee reported doulas are considered part of the care team:

> *"It's very important in our model of care for the patient and their support people to [have an] active voice and know that their part in this medical team is the most important. If a doula is part of that team, then they become one of the most important people to that birthing circle."*

Interviewees also identified tension points between staff and doulas. Interviewees attributed such tension to lack of understanding about a doula's role, the perception that doulas are trying to "take over" when advocating for clients, and differing perspectives on birth and decision-making. Interviewees also noted staff may be uneasy around doulas they have not met before because they do not know what to expect. One interviewee stated:

> *"In general, the attitude is still somewhat hesitant towards [private doulas] because they all just have different relationships with how they interact with the medical staff. Some of them are very anti-establishment, if you will, which I am. I love that. It rubs some people the wrong way."*

Additionally, one interviewee observed the type of support doulas provide varies, and it is not possible for health care providers to know what the doula and client previously agreed upon for labor support. The interviewee stated they would like to see more "uniform" doula services, and expressed a desire to develop a hospital-based doula program that would allow staff to "vet" doulas and set expectations. The interviewee stated:

> *"Currently, whomever walks into the hospital, we don't know the training they've had and what services they will provide to our patients. We have limited information about the doulas that are coming to the hospital. We can only trust that since they have evidence of doula training and doula services, that they know what they're doing. If we have our pool of doulas and we have a way of vetting them, I think it would be a better service to our patients."*

Strategies to Find Common Ground Between Doulas and Nurses

- One interviewee facilitated a meeting between an experienced doula and nurses, which created an opportunity for nurses to ask questions and learn more about the doula's perspective.
- To address differences in the moment, an interviewee stated they ask to speak with the doula privately to better understand the doula's perspective and relationship with their client and identify ways to "work together as a team."

Familiarity with the Medi-Cal Doula Benefit

Although all interviewees knew Medi-Cal covered doula services, they were unsure about the details of the benefit. For example, interviewees did not know the benefit covered doula support during the postpartum period or in instances of miscarriage and abortion. Nonetheless, most interviewees expressed excitement about expanded access to doula support and noted the Medi-Cal doula benefit will allow patients to build relationships with doulas prenatally. One interviewee described how established relationships between doulas and clients can help health care providers during labor and delivery:

> *"A lot of our patients are coming from community clinics, so we've never seen them before, and they've never seen us before. They're meeting me for the first time so I start building the trust at that meeting. If they have someone that they've had a relationship with during their pregnancy that they trust, that makes them feel better. It helps them during labor."*

Interviewees described learning about the Medi-Cal doula benefit from multiple sources, including via colleagues and through information shared during a California Hospital Association webinar.[8] Most interviewees reported they had not received information about the benefit from Medi-Cal managed care plans. These interviewees stated they rarely interact with health plans, and it is not common for nurses to know about specific Medi-Cal benefits. Notably, one interviewee who worked at a hospital with a volunteer doula program[9] reported a Medi-Cal managed care plan shared information about how doulas can enroll as Medi-Cal doula providers but did not provide details about what the benefit covers.

Promoting the Medi-Cal Doula Benefit to Medi-Cal Members

Patients often receive prenatal and postpartum care outside the hospital, creating few opportunities for hospital staff to promote the benefit prenatally. Two interviewees reported mainly seeing patients during labor and delivery, and one interviewee noted it did not seem worthwhile to inform patients about the benefit during the intrapartum period. However, these interviewees reported their hospitals offer childbirth education classes and/or postpartum support groups, suggesting there are still opportunities to promote the benefit at hospitals where patients only give birth.

One interviewee reported colleagues partnered with local doulas to educate patients attending pregnancy-related appointments about the benefit. The interviewee noted health care providers may not have time to share information about doulas during appointments, but they can provide a warm handoff if a doula is nearby.

Health care providers may not know when patients are Medi-Cal members. Specifically, an interviewee stated health care providers are not always aware of the patient's health coverage (i.e., if the patient is uninsured or has Medi-Cal or private insurance), which could limit the provider's ability to identify which patients would have access to the Medi-Cal doula benefit.

Hospital Doula Policies

Although certain hospitals had policies for volunteer doula programs, no hospitals had adopted broader doula policies. Notably, one interviewee reported drafting a

[8]The California Hospital Association hosted a webinar on June 6, 2024 entitled, "Doula Access in Hospitals: What the Law Requires."

[9] Hospital-based volunteer doula programs typically offer patients doula support throughout labor and delivery and shortly after childbirth. With these programs, doulas are hospital volunteers who commit to supporting birthing people during specified shifts. Hospitals with volunteer doula programs often require volunteers to attend hospital-based trainings.

doula policy after attending a California Hospital Association webinar, but the policy is still under review.

Interviewees also shared specific polices related to doula presence that were smaller in scope. For example, in one interviewee's hospital, doulas are not considered visitors. Another interviewee reported doulas are permitted to support clients during scheduled cesarean sections.

One interviewee reported doula policies would not be necessary if health care providers were more open to collaborating with doulas. The interviewee described working closely with the leader of a local doula program to develop special badges that allow doulas to bypass long security lines so they can reach their clients quickly.

OVERVIEW OF QUANTITATIVE AND QUALITATIVE RESULTS

Table 8: Summary of Qualitative and Quantitative Findings

Category	Key Findings & Challenges
Doula Benefit Utilization	» Overall utilization of the benefit was low, with a steady increase in usage between January 1, 2023 and June 30, 2024 » Aligns with DHCS' typical 3–5-year rollout timeline for new benefits » Highest rates of utilization among American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander, White, and Black or African American members » Wide variation in doula utilization by county and Medi-Cal managed care plan
Member Experience	» Members who used the benefit valued support and advocacy provided by their doulas, and described them as supportive, empathetic and non-judgmental » Members reported stronger connections with doulas who shared similar lived experiences or had racial/cultural concordance » Some members had challenges

Category	Key Findings & Challenges
	obtaining information from Medi-Cal managed care plan representatives and healthcare providers » Late awareness of the benefit impacted member's ability to find doulas that met their needs
Awareness of the Doula Benefit	» Members learned about the benefit via social media, family/friends, providers, Medi-Cal managed care plans, community-based organizations, and Black Infant Health programs » There were several issues regarding awareness of doula services and the benefit (e.g., confusion with midwives, belief doulas only support home births or wealthy individuals, or do not support cesarean births)
Language and Cultural Accessibility	Most members using the benefit are English speakers » Language barriers for non-English speakers (particularly Spanish speaking communities), and the term "doula" is not familiar to some » Need to tailor outreach and education about the doula benefit for Native American or Alaska Native communities (e.g., reframing messaging to reflect community/cultural values)

Category	Key Findings & Challenges
Prenatal & Postpartum Doula Support	» Low prenatal visit utilization with doulas among members who used the benefit » Members reported benefits from prenatal doula support, including emotional support and birth preparation » Some members noted lack of structure and clarity in prenatal sessions with their doulas » Geographic distance and virtual-only options created barriers » Higher utilization postpartum visits with doulas among members who used the benefit compared to prenatal visits with doulas » Doula users had 3 times higher odds of attending a postpartum visit (with healthcare providers) than a matched group of non-doula users. Attendance at the postpartum visit is critical for identifying potential health problems before onset or an increase in severity occurs.
Doula Workforce	» Some health plans and CBOs assist doulas with onboarding, training, and billing » Doulas reported that the process to enroll as a provider is costly, complex and bureaucratic » Standard contracts do not fit doula needs, creating further complexity

Category	Key Findings & Challenges
Medi-Cal Managed Care Plan & Provider Role	» Some health plans and providers shared information (e.g., flyers, lists) and referred members » Some health plans created onboarding processes for doulas and have dedicated staff members to assist doulas during contracting and billing (e.g., holding regular office hours for doulas) » Members reported limited assistance when trying to find a doula and inconsistent or delayed messaging about the benefit
Community-Based Organizations (CBOs)	» CBOs provide critical technical assistance, mentorship, and peer support to doulas » Most CBO efforts are unpaid or underfunded, limiting their capacity to support doulas and communities effectively
Hospital & Provider Engagement	» Some hospitals include doulas in provider education and created procedures to expand access (e.g., specific ID badges for doulas) » Providers recognize the value of doula support during labor but may not understand the full scope of the benefit (e.g., postpartum, miscarriage support)

RECOMMENDATIONS FROM THE WORKGROUP

DHCS Addresses Doula Stakeholder Workgroup Concerns

DHCS took multiple actions to address barriers brought up during Workgroup meetings prior to the completion of the Quantitative and Qualitative analyses and this report.

These efforts are further described in the following paragraphs.

DHCS Issues Standing Recommendation for Doula Services

To increase access to services, DHCS issued a standing recommendation on November 1, 2023, for doula services by DHCS Medical Director, Karen Mark, MD, PhD. This fulfills the federal requirement for a recommendation to initiate doula services and Medi-Cal members do not need to separately obtain a recommendation. Doulas may reference this standing order in their records for the Medi-Cal member.

Targeted Rate Increases for Eligible Doula Providers

Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a Managed Care Organization (MCO) Provider Tax effective April 1, 2023, through December 31, 2026. Subject to federal approval, MCO tax revenues will be used to support the Medi-Cal program including, but not limited to, new targeted provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote provider participation in the Medi-Cal program. DHCS included doula services in the Targeted Provider Rate Increase (TRI) for obstetric care. Rates are effective for services provided on or after January 1, 2024, in fee-for-service and for eligible network providers contracted with Medi-Cal managed care plans. The state of California has one of the highest reimbursement rates in the country for Doula Medicaid services (only surpassed by the state of Washington in January of 2025). Doulas were provided with a direct email address for any additional questions for DHCS regarding TRI at targetedrateincreases@dhcs.ca.gov.

On November 3, 2023, DHCS issued updated APL 23-024 – Doula Services, which included guidance that MCPs must make payments in compliance with the clean claims requirements and timeframes outlined in APL 23-020 – MCP Contract and Timely Payments. In addition, timely and accurate payment requirements are part of DHCS' contract with plans. Some stakeholders requested that the doula APL reiterate the Corrective Action Plan process and what happens when a MCP is out of compliance.

DHCS also released All Plan Letter (APL) 24-007 on June 20, 2024, to provide guidance to Medi-Cal MCPs regarding TRIs, which are effective for dates of service on or after January 1, 2024. Medi-Cal MCPs were instructed to pay providers the new rates by December 31, 2024. Payment includes retroactive payment adjustments where necessary. DHCS also hosted a webinar regarding TRI for all eligible providers on July 17th, 2024.

Doula Directory

A directory of enrolled doulas is available on the DHCS webpage and is updated regularly. (Doula Directory).

As a companion resource to the Doula Directory, DHCS also developed an interactive Doula Density Graphic, which serves as a resource for members and stakeholders to show where doulas are located by county, provides a visual representation of the geographic distribution of doulas throughout the State, including highlighting where there may be more doulas available for members. The Doula Density Graphic serves as a tool for DHCS and stakeholders to identify potential areas where there may be a lack of doula participation in Medi-Cal (e.g., "doula deserts"), which can then be used for targeted education and outreach efforts.

Doula Enrollment, Credentialing, Contracting, and Billing

DHCS developed a dedicated webpage with resources for enrolling as a doula provider and billing for Medi-Cal covered doula services. DHCS has posted online the contact names, phone numbers, and email addresses for each Medi-Cal managed care plan regarding application, credentialing, contracting, and billing. DHCS shares the list of enrolled doulas and contact information with Medi-Cal managed care plans every month. Medi-Cal managed care plans also complete bi-monthly surveys sharing their progress in contracting with doulas and program implementation.

DHCS also created a new Medi-Cal Doula Provider Enrollment Checklist and flow chart to help doulas identify what documents they may need to enroll as a provider in the Medi-Cal provider enrollment online application.

Additional information about enrolling was made available at:
https://www.dhcs.ca.gov/provgovpart/pages/doula.aspx

Enrolling and billing information made available at:
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/doulas

Additional support was provided through contacting Doulabenefit@dhcs.ca.gov.

Claim Denials due to Gender Override

In response to previous stakeholder concerns raised around doulas experiencing denials for claims submitted for Medi-Cal members due to the member's gender, DHCS updated the Doula Provider Manual in March 2025 to clarify that Medi-Cal members of

all gender identities are entitled to receive doula services so long as they are medically necessary and meet all other requirements for Medi-Cal coverage. Additionally, DHCS updated the payment system to ensure fee-for-service doula claims process and pay appropriately regardless of the gender of the Medi-Cal member. DHCS also instructed the payment system team to automatically reprocess fee-for-service claims denied for this reason dating back to January 1, 2023.

Improving Access to Doula Services in Hospitals: All Plan Letter Updates and New All Facilities Letter Release

DHCS updated its All Plan Letter (23-024) for doula services on August 24, 2023, and later revised it on November 3, 2023, stating that Medi-Cal managed care plans must work with hospitals to ensure there are no barriers to access, and Medi-Cal managed care plans must work with their in-network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present. Additionally, DHCS also worked with the California Department of Public Health (CDPH) to develop an All Facilities Letter (25-13) to address doula access in hospitals, which CDPH released on March 24, 2025. Doulas were also encouraged to email DoulaBenefit@dhcs.ca.gov for assistance if denied access by a hospital.

Increasing Outreach to and Communication with Licensed Clinical Professionals regarding Doula Services

DHCS updated the doula webpage and FAQ with a position statement on research that supports doula services.

In addition to the Doula Implementation Workgroup, DHCS hosted several other regular forums to specifically address the Medi-Cal doula benefit and concerns/issues identified by the Workgroup, through the CA Doula Access Workgroup's Doula Feedback Form, and received via email. These include monthly meetings between DHCS, hospital associations (California Hospital Association, California Association of Public Hospitals, etc.), individual hospitals (e.g., Kaiser), and doulas, and monthly meetings between DHCS and the plan associations (California Association of Health Plans (CAHP) and Local Health Plans of California).

In response to stakeholder feedback that DHCS needs to conduct more direct outreach to licensed clinical professionals, particularly nurses and doctors who work in hospitals, to help increase access and remove barriers, DHCS has also recently connected with the

California Board of Registered Nursing (BRN) and the Medical Board of California (MBC). DHCS is hoping to present on Medi-Cal's doula benefit at one of the BRN's upcoming Nurse-Midwifery Advisory Committee (NMAC) meetings. Similarly, DHCS offered to present on the Medi-Cal doula benefit at one of MBC's upcoming forums and hopes to be able to do so in the future. The goal of this type of engagement is to help promote greater awareness and more effective interdisciplinary collaboration between nurses, physicians, and doulas as part of a Medi-Cal member's broader care team. DHCS is also working to develop and launch a new social media campaign to promote greater awareness around Medi-Cal's doula benefit. DHCS envisions that the campaign will also include some short video clips that will include DHCS Benefits Division leadership as well as real Medi-Cal member testimonials about their personal, lived experiences accessing and using doula services. DHCS published an outreach flyer in February 2025, titled "Doctors, Midwives, and Doulas: Finding the Right Care Team for Your Pregnancy," that highlights services that doulas provide. The flyer is available for providers, Medi-Cal managed care plans, and hospitals to share with Medi-Cal members and was shared with all doula stakeholders.

DHCS also responds to member comments and questions sent to DoulaBenefit@dhcs.ca.gov.

Recommendations from the Doula Implementation Workgroup

The Doula Implementation Workgroup discussed and voted on recommendations that were included in this report. As requested by the Workgroup, recommendations were divided into the following areas: 1) DHCS, 2) hospitals, 3) managed care plans, and 4) the state legislature. These recommendations represent items to be considered and discussed and not an agreement or commitment from any organization to implement them.

While section 14132.24 of WIC required the report to "identify any barriers that impact access [for members] to doula services … and make recommendations to the department and the Legislature to reduce any identified barriers," DHCS recognizes that challenges doulas face as Medi-Cal providers, including receiving reimbursement, can impact members by discouraging doulas from becoming Medi-Cal providers. As such, this report includes barriers that doulas have experienced. As noted previously in this report, doulas are initially overwhelmed by enrollment, contracting, and billing processes. Without support, doulas may give up enrollment in Medi-Cal, which would

negatively impact the number of doulas available to serve Medi-Cal members through the benefit.

DHCS' acknowledges that some stakeholders suggested some recommendations that are not included in this report or either being outside the scope of this report or not receiving full support from the represented affinity groups. One such recommendation was for a single statewide electronic medical record (EMR) and claims system to be used by all Medi-Cal managed care plans. Similar proposals for a statewide or national EMR have been made over the years without success. However, this report contains other recommendations that seek to address the overall concern to provide support to doulas with submitting claims. Other requests for DHCS to provide legal protection for doulas who provide services to members who have an abortion require legislation and are outside the scope of DHCS' authority. Additionally, DHCS also notes that some of the stakeholder recommendations would require additional resource and/or budget allocations to implement and, as such, DHCS would need to consider these recommendations within the broader state budget framework.

Recommendations to DHCS

Scope of DHCS authority: *Medi-Cal coverage and reimbursement policies, including establishing rates. DHCS holds contracts with Medi-Cal managed care plans (MCPs) and has the authority to enforce compliance with the provisions outlined in these contracts, such as ensuring timely payments, conducting trainings, requiring a grievance and dispute process, and resolving provider disputes. DHCS can issue All Plan Letters as an extension of the MCP Contract and provide additional guidance or requirements to MCPs. DHCS does not contract with hospitals.*

Recommendation 1.1

DHCS should update the All-Plan Letter (APL) for doulas with clear, enforceable guidelines for MCPs and follow-up with non-compliant MCPs.

The APL should include information about the following:

- Timely and accurate payments, including communication to contracted doulas to resolve denied or delayed payments; contact information for MCP personnel who can respond to reimbursement issues; and requirements for training doulas on submitting clean claims.
- Streamlined credentialing and contracting processes to eliminate redundancies that increase administrative burdens on doulas.
- Transparency and communication – MCPs should publish and maintain accurate information on provider portals, including contact information and number of doulas contracted with the MCP.

- » Requirements concerning providing clear instructions for submitting claims to the MCP.
- » Process for how doulas submit requests for providing nine additional postpartum visits and the process for approving additional visits.

On February 12, 2025, a coalition of doulas, advocates, community-based organizations, and other stakeholders sent a letter DHCS requesting immediate attention to issues that had been discussed during previous stakeholder meetings, with the most pressing concerns identified as 1) payment delays and denials, 2) credentialling process, 3) barriers to MCP contracting, and 4) provider support. Of particular concern was delays by some MCPs to pay doulas the 2024 targeted rate increase (TRI) for services provided after January 1, 2024.

Many doulas reported in early 2025 that they still had not yet been paid the 2024 TRI rates, and requested that DHCS take action, including issuing Corrective Action Plans against MCPs that had not yet fully implemented the TRI. The letter stated, "[t]o resolve this situation and improve the quality of this benefit, we request that [DHCS] issue a new [APL], which addresses these concerns and establishes clear, enforceable guidelines for MCP compliance (as well as consequences for non-compliance)" with timely and accurate payments, streamlined credentialing and contracting processes, transparency and communication, and accountability and enforcement. Many topics are addressed in other recommendations listed below.

"These compliance issues are exacerbating distrust among the doula workforce, which severely diminishes the willingness of doulas to participate in the Medi-Cal Doula Benefit despite going through the difficult and lengthy process of becoming contracted doula providers. The major concern is over how these deficits threaten the viability of the CA Doula Benefit by reducing the availability of critical perinatal support services for California families. The desired outcome is to increase access to doulas for Medi-Cal beneficiaries. However, until these matters are remedied and corrected, the opposite outcome of losing [Provider Application and Validation for Enrollment] (PAVE) approved doulas and potential doula providers become more apparent every day," according to the letter.

Recommendation 1.2

DHCS should form a new doula stakeholder workgroup to continue to work with stakeholders on their concerns to monitor implementation of recommendations. The new workgroup would share recommendations and best practices with stakeholders, including plans and hospitals. The workgroup would meet for two years and then be evaluated to determine if it would continue to meet.

As recently as March 2025, workgroup members expressed frustration that topics they have raised are still being worked on, including timely payments, hospital access, and time and difficulties with the credentialing processes, among other concerns.

Recommendation 1.3

DHCS should clarify its policy regarding doula services after unconfirmed pregnancies that ended in miscarriage or abortion.

While postpartum doula services are available to members for pregnancies that ended in miscarriage or abortion, some stakeholders expressed concern that doulas cannot receive reimbursement if a licensed provider never documented that the Medi-Cal member was pregnant so that the Medi-Cal managed care plans could not confirm whether the member is eligible for doula services.

Recommendation 1.4

DHCS should work with stakeholders to develop and distribute a new Frequently Asked Questions (FAQ) document about the available dispute resolution process and other options available to doulas when there is a dispute concerning payment or they seek technical assistance submitting claims.

Workgroup members frequently discussed difficulties they faced when a Medi-Cal managed care plan denies a claim and how to resolve a dispute.

Recommendation 1.5

DHCS should work with Medi-Cal managed care plans associations and individual Medi-Cal managed care plans to make up-to-date contact information for Medi-Cal managed care plans easily available regarding contracting and credentialing process, reimbursement, and claim denials.

"Transparency & communication" was one of the key recommendations in the February 12, 2025, Coalition Letter.

Recommendation 1.6

DHCS should distribute funding to MCPs, in a method similar to the California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Incentive Payment Program, for redistribution to community-based organizations (CBOs) and independent doula providers through ramp-up funding. This funding will be utilized to build infrastructure, train additional Medi-Cal doulas, provide technical assistance with the Medi-Cal provider enrollment online application and MCP enrollment and billing solutions.

As highlighted in UC Berkeley's qualitative research, CBOs played an important role in doula services even before it became a Medi-Cal benefit and have continued to support

doulas with training on becoming providers and submitting claims, but they have struggled with ongoing funding and some CBOs have reduced or eliminated their technical support for doulas However, doulas noted their important value in assisting doulas with training to become Medi-Cal providers and how to enroll and submit claims for reimbursement. Medi-Cal does not separately reimburse providers for time spent on administrative duties.

Recommendation 1.7

DHCS should develop and publish on its website a dashboard with input from doulas and other stakeholders that publicly shares key performance indicators measuring the success of benefit implementation, including number of doulas contracted with each MCP, disaggregated data for members, as well as information identified in Recommendation 3.6.

After the presentation of the quantitative data during the workgroup meeting on April 11, 2025, stakeholders requested that DHCS regularly publish information on doula utilization that would report on the number of Medi-Cal members using the benefit, the frequency with which members access services, the number of enrolled doulas, and the number of doulas contracted with MCPs. Stakeholders would work with DHCS to determine the elements and presentation of the data.

Stakeholders also requested that DHCS disaggregate the utilization demographic data for Medi-Cal so that they can better evaluate whether vulnerable populations like American Indian/Alaska Native members, are being adequately represented by enrolled doulas. Stakeholders also requested that DHCS disaggregate data to account better for people of mixed races.

Recommendation 1.8

DHCS should issue a standing order to pre-authorize additional postpartum visits because Medi-Cal members should be able to determine for themselves whether they want continued care for the first year after a pregnancy conclusion.

The standing recommendation issued by Dr. Karen Mark, DHCS Medical Director, authorizes services during labor and delivery as well as an initial visit, eight visits during either the prenatal or postpartum visit, and two extended postpartum visits, it does not include nine additional postpartum visits that are available with a new recommendation from a licensed provider. Some stakeholders said having a provider complete the form is "an additional burden on postpartum families to complete and submit yet another form" that should be eliminated.

Recommendation 1.9

DHCS should create a campaign to make more Medi-Cal members aware of the doula benefit.

As the qualitative research revealed, not all Medi-Cal members are aware of the benefit, particularly for Spanish-speaking members who may not be familiar with the term "doula." Medi-Cal members also commented on challenges finding a doula. Medi-Cal members that UC Berkeley interviewed suggested some best practices that could be implemented by DHCS, MCPs, hospitals, and licensed providers, including that health care providers should verbally inform members about doula services early in their pregnancy and give them flyers; hospitals and clinics could display posters on their walls about doula services; MCPs could share information about doula services via mail, email, phone calls from health educators or nurses, and provide information on the MCP's website and web-based apps; hospitals and MCPs could host events that allow pregnant members to meet doulas; and posters could be posted in county social service offices and at Women, Infants, and Children offices.

Recommendation 1.10

DHCS should continue to work with MCP associations and individual MCPs to identify and promote commonalities to streamline operations and reduce administrative burden for submitting claims and credentialing doulas.

A number of doulas have commented on the challenges navigating different claims systems used by MCPs as well as different credential processes and have expressed a desire for a statewide standard. However, as noted by the MCP associations – CAHP and LHPC – "provider networks need to reflect the needs and goals of the plans' community and that varies in a state as diverse as California." In addition, MCPs have developed their billing systems that work with their electronic medical records system. The MCP associations noted that MCPs continue to look for efficiencies in their credentialing and claims processes, and DHCS could further explore opportunities for better supporting MCPs in their efforts to streamline operations and reducing administrative burdens on doula providers.

Recommendation 1.11

Explore adding doulas as providers of ECM and Community Support (CS) services provided by MCPs under Cal-AIM and what would be necessary for doulas to provide these services, including training.

Recommendations for Hospitals

Scope of authority for hospital associations, including but not limited to California Hospital Association (CHA): *Hospital associations, including but not limited to CHA, are responsible for advancing the concerns and advocating on behalf of their respective member hospitals, which – depending on the specific hospital association – may include some or all of the more than 400 hospitals throughout California. However, no hospital association has the authority to require their respective member hospitals to follow specific guidance. Individual hospitals also have autonomy and their own scope of authority to make individualized decisions and policies to align with their business models and populations that they serve.*

Recommendation 2.1

Best practice: Hospitals are encouraged to incorporate doulas by reference into hospital visitation policies, including to the extent possible, supporting the Medi-Cal member during triage and in the operating room, and acknowledge them as part of the member's care. Hospitals should share this information with all staff with whom pregnant and postpartum individuals and doulas come in contact.
Hospital access was one of the first issues raised by doulas when the workgroup began meeting. Stakeholders said they experienced barriers that include, but are not limited to, doctors who did not want doulas in the labor and delivery room, staff not knowing what a doula was or that it was a covered Medi-Cal benefit, hospitals excluding doulas due to hospital limitations on the number of visitors a patient may have present (Ex: hospital policy limits two visitors per patient and the Medi-Cal member chooses a partner and family member), limited space in labor and delivery as well as operating rooms, and waiting for access into the facility. Some hospitals issue a doula specific badge to bypass security lines, although not all doulas support being issued badges. Some doulas recommend that if a member states that an individual is their doula, then the hospital should not require identification from the doula; however, there are legal requirements pertaining to privacy and security that would need to be observed and appropriately balanced.

As stated in AFL 25-13, both CDPH and DHCS acknowledge that there is sensitivity around doulas being considered "visitors," particularly when a doula accompanies a birthing individual into the hospital, and that CDPH and DHCS are only using this term to describe the category within written hospital policies and procedures that doulas can reference to better understand individual hospital practices. As such, the AFL recommends the following best practices for hospital patient visitation policies and procedures "to maintain patients' rights and foster a positive environment for birthing individuals, babies, and their families:"

- » Review patient visitation policies and procedures and update if necessary to specifically address doulas.
- » Exclude doulas from the visitor limit if the policies and procedures contain a restriction/limit on the number of visitors (e.g., if the hospital has a limit of two visitors, a doula should not count toward the visitor/support person limit).
- » Ensure FAQs for visitation policies are easily accessible (e.g., easy to locate on the hospital website and post or make copies available on hospital premises).
- » Provide training to hospital staff of all levels (e.g., administrative, clinical, and executive staff) on patient visitation policies and procedures to ensure appropriate implementation and to avoid any unnecessary restrictions/limitations on patients' visitation rights, including access to doulas in hospitals.

Recommendation 2.2

Best Practices: Hospitals are encouraged to partner with patients, doulas, doula collectives, and community-based organizations that support the integration of doulas into maternity care settings and ensure that staff and providers are aware that doulas are part of the birth team to care for the member.

In addition to sharing best practices for hospital access, the Workgroup recommends that hospitals develop policies and best practices for integrating doulas into maternity care settings more broadly. For example, some hospitals hosted meet-and-greets where doulas were able to get to know hospital staff prior to accompanying a pregnant member to the hospital. At the convening, doula providers were also provided with the opportunity to connect with the Maternal Mental Health Team and the Health Education Team that provide information about the services and resources that their teams provide, including an overview of ECM services for members. Some hospitals offer tours so that doulas could meet hospital staff and so hospital staff can better understand what services doulas provide; hosted "meet the doula" events; provided direct lines of communication between doulas and hospital leaders; and promoted doula services at childbirth education classes and/or postpartum support groups. Doula workgroup members strongly urge hospitals to get feedback from community stakeholders, such as Medi-Cal members and doulas, to build on those original recommendations. As a best practice, hospital could form community workgroups to jointly focus on improving utilization of doulas and ideas for improving on perinatal and mortality and morbidly.

Recommendations for Medi-Cal Managed Care Plans

Scope of Authority for Health Plan Associations including but not limited to LHPC and CAHP: *Health plan associations are responsible for advancing the concerns and advocating on behalf of their respective member MCPs, which – depending on the specific health plan association – may include some or all of the 24 MCPs throughout California. For example, is an association that represents and works on behalf of all 17 local, not-for-profit MCPs that serve 70 percent of Medi-Cal managed care enrollees in California. Similarly, CAHP is a statewide trade association that represents and works on behalf of public and private MCPs in California that provide coverage for more than 26 million Californians and supports MCPs through policy development, advocacy, and education. However, no health plan association has the authority to require their respective member MCPs to follow specific guidance. Individual MCPs also have autonomy and their own scope of authority to make individualized decisions and policies to align with their business models and populations that they serve.*

Recommendation 3.1

Best practice: MCPs are encouraged to work with doulas and plan associations to create Medi-Cal doula-specific contracts to simplify and speed up the process for doulas to contract with plans. Plans are also encouraged to share best practices regarding onboarding and technical assistance for contracting.

In order for doulas to contract with a MCP, they must first enroll through the Medi-Cal provider enrollment online application or a MCP's enrollment process and then go through the plan's credential process, as required by federal law, before they can contract with the MCP. This entails three distinct processes, each with its own requirements. However, doulas frequently commented that the contracts were often dozens of pages long, and written in technical language for licensed providers with sections that did not apply to doulas.

Some best practices that MCPs have developed include the following:

- Developed contracts specifically for doulas as Medi-Cal providers, which involves internal, external, and regulatory participation and ensuring legal and compliance considerations.
- Developed a modified contract addendum that outlines the legal requirements in layman's terms.
- Created a "Requirements for Doulas document" that reviews all necessary documents needed for contracting, as well as the contact information for their Provider Services and Credentialing Department and posted this information on the MCP's website.

- » Publicly posted a Doula Benefit Overview that supports doulas through the contracting.
- » Developed training for onboarding that is specific to doulas.
- » Designated people at the MCP who could provide technical assistance to walk doulas through the contracting process if they experienced problems.
- » Developed and posted a New Provider Orientation PowerPoint deck detailing timely access, services, provider portal, authorization, and member benefits. The MCP has also created a Provider Manual and Claims resource page on their website that reviews claim submission.
- » Provided a doula scholarship to help ease any financial burden of becoming a Medi-Cal provider and any administrative burdens during the contracting & credentialing process.

Recommendation 3.2

Best practice: Each MCP is encouraged to make easily accessible training that is tailored for doulas on how to submit a clean claim. MCPs are encouraged to revisit training series requirements for applicable participation by doulas, including review of denied claims, to tailor their trainings.

By contract and as outlined in All Plan Letter 23-020, MCPs are required to pay providers within 30 days of receipt of a "clean claim", which is defined in federal law as a claim that can be processed without obtaining additional from the provider or a third party. Doulas noted that they are new submitting claims and, unlikely many other provider types, often must fill out claims and submit them themselves, while other providers frequently hire billers to submit claims for them. While CBOs have sometimes been able to fill this gap, it would be helpful if MCPs developed training for their own processes that tailored specifically to doulas.

Recommendation 3.3

For increased responsiveness, MCPs are encouraged to designate staff who serve as contacts to assist doulas with questions regarding credentialling, contracting, reimbursement, and denied claims in a timely manner. MCPs are encouraged to establish expectations for how frequently designated email boxes are checked and the time frame when MCP staff are expected to respond to emails.

This recommendation supports Recommendation 1.5 for DHCS to make up-to-date contact information readily available to doulas. As noted previously, some doulas have had challenges finding the right person at a MCP to answer their questions regarding credentialling, contracting, reimbursement, and denied claims. To address these concerns, some MCPs have implemented best practices that include dedicated email mailboxes for doulas; assigning two specific staff people who are responsible for addressing concerns raised by doulas; setting up a dedicated claims queue that

processes claims submitted by doula; including doula claims in their regular internal audit rotation to ensure that claims are paid on time and if any issues arise, the MCP's Claims team collaborates closely with Provider Services to provide feedback and additional education to support proper billing practices.

Recommendation 3.4

Best Practice: MCPs are encouraged to accept the documentation that doulas submitted to DHCS for enrollment as part of the MCP's credentialing process and not require that doulas resubmit the same documentation to the MCP.

Before a doula can provide services to a Medi-Cal member of a MCP, they need to enroll with DHCS through the Medi-Cal provider enrollment online application (or the MCP, if the plan sets up its own enrollment process); fulfill the MCP's credential process, as required by federal law, the National Committee for Quality Assurance, and DHCS; and enter into a contract with the MCP. When enrolling with DHCS, doulas must submit required documents that demonstrate they have fulfilled DHCS' criteria to enroll through either the training or certificate pathway. Doulas have commented that their enrollment with DHCS should be sufficient for the MCP that they met enrollment requirements and are qualified to provide doula service, and they should not need to resubmit the same documents to the MCP during the credential process.

Recommendation 3.5

Best Practice: MCPs with high doula benefit utilization are encouraged to share best practices with other MCPs for connecting members with doulas.

Some MCP representatives noted that supporting non-traditional providers like doulas was new for MCPs and remains a work in process. Some MCP providers have been meeting with peers at other MCPs to share successful implementation strategies. In addition, Health Net, Molina, L.A. Care Health Plan, and Anthem jointly published a joint letter, "Health Plans Expect Network Hospitals to address the Role of Doulas in Birth Care Policies," on how maternity care policies and practices can respect the important role that doulas serve. The letter includes resources that hospitals can use to effectively integrate doulas in their care teams.

Recommendation 3.6

MCPs should report to DHCS for the dashboard on how many doulas have contracted with the MCP, submitted claims, and been paid for services provided; how many members have requested a doula, and how many utilized services. Plans should also share with DHCS and stakeholders on the types of challenges doulas

have shared with the plans, and the MCP's strategy and approach for resolving these challenges.
This recommendation supports recommendation 1.7 for DHCS to create and maintain a dashboard and additional information that is not available through claims or encounter data, as well as the fact that MCPs regularly inform DHCS on how many doulas with whom they have contracted with and how many contracts are pending approval.

Recommendations for the State Legislature

Scope of authority for the State Legislature: *The State legislature has rulemaking authority and consists of the Senate and the Assembly, which begin the process of authoring bills, which can become state laws if enacted.*

Recommendation 4.1

The state legislature should authorize funding for pilot programs and grants to organizations, including community-based organizations (CBOs), for training individuals to become doulas and submit claims to increase capacity in geographic areas with fewer doulas and for populations with the greatest health disparities. Funding for pilot programs should be prioritized for CBOs that work with families with high needs, particularly in counties with the worst perinatal outcomes and/or least access to perinatal care.
As noted extensively earlier in this report, CBOs have played an important role in the provision of doula services before Medi-Cal added doula services as a benefit, and they played an important role in implementation of the benefit by providing outreach and technical assistance to doulas, but they face difficulties in sustaining this support due to limited funding. The need is increasing as more doulas enroll as providers and with growing public awareness of the benefits doulas provide. CBOs who enroll as group doula providers can assist individual doulas by submitting claims on their behalf, but separate Medi-Cal funding is not available for administrative tasks or technical assistance.

With additional financial support, CBOs could help increase the number of trained doulas statewide and in areas of the state with fewer doulas, trained doulas who speak Spanish, and doulas who are American Indian/Native Alaska or Black or African American. CBOs could also work with populations that experience the greatest maternal health disparities, particularly in light of reports that American Indians who wish to become doulas have expressed challenges in meeting the enrollment requirements. Stakeholders also recommended funding for pilot programs to examine delivery of services that could improve perinatal outcomes and access to care.

Recommendation 4.2

The legislature should authorize funding to create a web-based doula directory that includes obstetricians and midwives on its website that is user-friendly and that allows members to sort doulas by language, county, managed care plan, and specialties.

While the March 10, 2021, version of Senate Bill (SB) 65 included a requirement for DHCS to develop a directory of enrolled doulas and identified required elements for the directory, the enrolled version of SB 65 did not include a requirement for a directory. However, DHCS worked with the first doula workgroup to identify elements that should be included in a doula directory and first published a PDF version of the directory on the doula webpage on April 21, 2023.

Workgroup members suggested that the portal also include obstetricians, family physicians, nurse midwives, and licensed midwives for an integrated approach to the care team.

Response to recommendations for DHCS

Recommendation 1.1

DHCS issued All Plan Letter 23-024 (supersedes All Plan Letter 22-031 issued on December 27, 2022) for Doula Services on November 3, 2023. The purpose of the Doula Services All Plan Letter (APL) is to provide MCPs with guidance regarding, not limited to: covered and non-covered doula services; member eligibility criteria(s); documentation requirements; qualifications for providing doula services; provider enrollment consistent with APL 22-013 for Provider Credentialing/Re-Credentialing and Screening/Enrollment; billing, claims, and payments compliance with APL 23-020 for Requirements for Timely Payments of Claims; access requirements; DHCS monitoring; and effective for dates of service on or after January 1, 2023.

DHCS included doulas in the TRI for obstetric care, and issued APL 24-007 on June 20, 2024, to require MCPs to increase rates for more than 600 billing codes used for primary/general care, obstetric care, and non-specialty outpatient mental health services used by 11 different provider types by December 31, 2024.

DHCS is working on a provider directory APL to provide guidance to MCPs regarding updated provider directory requirements. The guidance is expected to include suggestions on how MCPs may include doulas in their provider directories.

DHCS will revisit APL 23-024 to address concerns raised in this report, if applicable.

Recommendation 1.2

DHCS acknowledges that despite many successes that have already occurred through collaborative work, there is still additional work needed to implement and monitor many of the recommendations, and a desire for DHCS to be transparent about the status for these issues. Therefore, DHCS remains committed to work with doulas and other stakeholders to address topics raised in the following recommendations. This recommendation calls for a two-year commitment, at which time DHCS and the stakeholders will evaluate the need for additional ongoing meetings.

The size and makeup of the new workgroup and meeting frequency would be jointly developed by DHCS and stakeholders.

Recommendation 1.3

Documentation of pregnancy is an important protection against potential fraud so that DHCS or a Medi-Cal managed care plans can confirm whether a member is eligible for doula services up to one year of postpartum care and even when the year-long eligibility period ends. While there are billing codes for abortion services, there might not be documentation of a pregnancy that ended in spontaneous miscarriage. To address this issue, the Workgroup recommends that DHCS consider how to address postpartum care for members whose pregnancy was not documented by a licensed provider. Some stakeholders also requested that DHCS identify steps that will protect members from being "criminalized for spontaneous or chosen pregnancy conclusions." However, providing legal protections is outside the scope of DHCS' authority and rests with the Legislature and Governor.

Recommendation 1.4

Although DHCS updated the FAQ for reimbursement on March 14, 2025 with information about the requirement for Medi-Cal managed care plans to have a provider dispute resolution mechanism and how to escalate the complaint to DHCS if they continue to face challenges, more information should be readily available to doulas who seek to resolve a denied claim, including different options available when plans are not being responsive or they request technical assistance with submitting claims. In addition, since Medi-Cal managed care plans are contractually required to have a dispute resolution process, some plans expressed concern about violating their own dispute resolution process if doulas do not first seek to resolve the dispute with the Medi-Cal managed care plans.

Recommendation 1.5

DHCS has maintained a contact list on the doula provider webpage, but doulas have noted that contact information can become outdated, or they do not hear back from Medi-Cal managed care plans regarding applications they submitted, the credentialing process, claim denials, and status of implementation of the targeted rate increase, among other issues. Medi-Cal managed care plan associations and individual Medi-Cal managed care plans have also noted that their websites are usually member-focused and contain contact information for their members, and suggested sharing contact information for doulas through different venues. Some Medi-Cal managed care plans have designated email mailboxes for doulas and/or staff to work directly with their contracted doulas. In addition, some representatives who attended workgroup meetings provided their contact information in the chat so that doulas who raised concerns about specific Medi-Cal managed care plans could reach out to them. DHCS also continues to work with Medi-Cal managed care plan associations (i.e., Local Health Plans of California (LHPC), California Association of Health Plans (CAHP)) as well as individual Medi-Cal managed care plans on the ways to collect and distribute this information in an efficient and timely manner. Note: This recommendation supports Recommendation No. 3.3 for Medi-Cal managed care plans.

Recommendation 1.6

The CalAIM Incentive Payment Program (IPP) supports the implementation and expansion of ECM, Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal MCPs. The incentives are orientated around the goals of member engagement and service delivery, including reaching new members, building sustainable infrastructure and capacity, promoting program quality, and creating equitable access for ECM Populations of Focus.

CBOs that are ECM/CS providers may access resources and technical assistance through CalAIM's Providing Access and Transforming Health (PATH). Limited on demand resources may also be accessible.

DHCS will be collaborating with a contractor to survey MCPs regarding best practices on how to include hub models to provide administrative support. Additional guidance is forthcoming.

Recommendation 1.7

In publishing enrollment figures, DHCS publicly reports enrollment by the following race/ethnicity categories: African-American, American Indian/Alaskan Native, Asian/Pacific Islander, Hispanic, White, and Not Reported. As part of the enrollment

application, applicants can select from additional categories – Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, and other. Individuals who are of Hispanic, Latino of Spanish origin can also select one or more of the following: Mexican, Mexican American, and Chicano; Salvadoran, Guatemalan, Cuban, Puerto Rican, or Other Hispanic, Latino, or Spanish Origin. Applicants who are members of a federally recognized American Indian or Alaska Native tribe can also list the name of their tribe, although tribal affiliation is not available for reporting. DHCS notes that reporting disaggregated information is determined by the number of doula users per race/ethnicity category. For example, the number of doula users who identified as American Indian or Alaska Native and Native Hawaiian or Pacific Islander was combined with "Other and Unknown Race/Ethnicity" in the current report due to having fewer than 11 doula users per category.

Recommendation 1.8

Medi-Cal members can use the Medi-Cal Doula Services Recommendation form that can be signed by any licensed provider to authorize the additional postpartum services. This form can be signed before the member gives birth. However, some stakeholders said that there is confusion about this form and some doulas are unsure about which form to use, if the MCP needs to approve it first, and other whether it's even needed.

Recommendation 1.9

To date, DHCS has taken various steps and engaged in work to help ensure that members are aware of the doula benefit:

- DHCS mailed a member notice to all Medi-Cal members in the first quarter of 2025 regarding the doula benefit.
- DHCS published a flyer, "Doctors, Midwives, and Doulas: Finding the Right Care Team for Your Pregnancy ," on its website in February 2025 for members and providers about maternity care that spotlights doulas. This flyer is available for providers to print and distribute to Medi-Cal members. It is available in English, Spanish, Traditional Chinese, Simplified Chinese, Korean, Tagalog, and Vietnamese.
- Evidence of Coverage documents, which are also known as member handbooks, are given annually to all Medi-Cal members in managed care that includes information about doula coverage.
- DHCS is adding doula coverage to the MyMedi-Cal pamphlets that are given to all newly enrolled members. The updated MyMedi-Cal pamphlet will be available later this year.
- DHCS is currently developing a social media campaign.

In addition to the already completed and ongoing work, DHCS recognizes that there are always opportunities to increase awareness of the doula benefit and is committed to continuing to explore options going forward.

Recommendation 1.10

DHCS will continue to work with MCP associations and individual MCPs to streamline operations and reduce administrative burden for submitting claims and credentialing doulas.

Recommendation 1.11

ECM and Community Supports are provided by MCPs through CalAIM to Medi-Cal members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services, while community supports are services that help address members' health-related social needs.

DHCS response to Recommendation 4.2 for Legislature

DHCS worked with the first doula workgroup to identify elements that should be included in a doula directory, including counties where they provide services, race/ethnicity, languages spoken, specialties, and areas of focus. Since many of the elements for the directory are not collected when doulas enroll through the Medi-Cal provider enrollment online application, including permission to publish contact information, DHCS emails each newly enrolled doula and requests their permission to include them in the directory along with data elements for the directory. About two-thirds of doulas respond and are included in the directory. DHCS seeks to update the directory on a monthly basis.

In response to requests that the directory be sortable by the different category, DHCS began publishing the directory as a sortable Microsoft Excel document in late 2024. However, after UC Berkeley's research identified that the directory is not user-friendly and not everyone has access to Excel, DHCS began publishing the directory in PDF and Excel formats. Enrolled doulas are also listed in the Open Data Portal maintained the California Health and Human Services, but it does not contain contact information nor the requested data elements that can help members choose a doula that best meets their needs. Starting July 1, 2025, DHCS will also start publishing a directory of enrolled fee-for-service providers, as required section 5123 of the Consolidated Appropriations

Act and described in State Health Official letter #24-003 for state Medicaid programs to have "accurate, updated, and searchable provider directories." This directory, however, will not have the data elements currently available in the DHCS doula directory. In addition, while some MCPs have directories for doulas, they may not include race/ethnicity, language(s) spoken by the doula, or their specialty, which in some cases has required MCP staff to do more hands-on work, which they note is not sustainable.

After the final Workgroup meeting on May 9, 2025, DHCS began working toward a user-friendly web-based doula directory that it could host on the DHCS website. While this new directory format would be searchable by county and display race/ethnicity, languages spoken, and specialties for each doula who responded to the survey for inclusion, DHCS would not be able to incorporate licensed practitioners into this directory. In addition, due a limit on the number of columns for display, DHCS expects that some content, such as specialties or languages, would be listed in individual cells rather than being listed separately.

CONCLUSION

In summary, implementation of the Medi-Cal doula benefit is an important step in progress towards improving maternal health equity and addressing disparities faced by Medi-Cal members. Although utilization of the benefit was still relatively low when the data was collected (i.e., 18 months after implementation), it has steadily increased. This trend aligns with DHCS' typical expectation of a three-to-five-year ramp-up for new benefits to be fully implemented. Members who used the benefit valued the support and advocacy provided by their doulas. Some Medi-Cal managed care plans and hospitals have implemented initiatives to expand member awareness, support doula enrollment, and enhance collaboration amongst doulas and health care providers. However, ongoing challenges—such as limited understanding of the benefit, misconceptions about doula support, administrative complexity regarding doula credentialling and contracting with plans, among others—must be addressed to improve access. Implementing the recommendations made by the Stakeholder Workgroup in this report will help DHCS, Medi-Cal managed care plans, hospitals and the State Legislature promote greater awareness of the benefit, implement existing best practices, streamline contracting and billing processes and better integrate doulas in maternal care settings. Furthermore, the recommendations included in this report will help to ensure that progress in improving access and increasing utilization of the benefit continues. Ongoing collaboration amongst stakeholders, DHCS, Medi-Cal managed care

plan and hospital representatives will be essential to advancing DHCS' goals for this benefit.

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APPENDICES

Appendix A

Table A.1: Doula Utilization by Birth Outcome

Doula Service	Number of Doula Users by Service
Vaginal Birth	639
Cesarean Birth	201
VBAC	46
Other/Unknown	622

Notes: VBAC = Vaginal Birth after Cesarean; Other/Unknown includes services designated as a doula service but did not include a specific procedure code including doula support at initial visits, prenatal visits, postpartum visits and extended postpartum visits. It also includes counts of abortion and miscarriage which were suppressed for privacy because the count was less than 11.

Appendix B. Qualitative Study Methods

Interviews with Medi-Cal Members

UC Berkeley researchers conducted interviews with 25 members who had utilized the Medi-Cal doula benefit and 21 members who were eligible but did not utilize the doula benefit. Four interviews were conducted in Spanish. All interviewed members were pregnant between January 1, 2023, and June 30, 2024, while covered by Medi-Cal. Interviews occurred between November 2024 and February 2025.

Recruitment

To assist UC Berkeley researchers in recruitment of Medi-Cal members for the qualitative study, DHCS staff compiled recruitment email lists for members who utilized doula services (doula users) and members who did not utilize the doula benefit (doula non-users). DHCS staff sent recruitment emails in both English and Spanish on UC Berkeley researchers' behalf. The recruitment email scripts were developed by UC Berkeley researchers and contained details about the study and a link to an eligibility survey where members could indicate their desire to participate in an interview. The survey included a consent form, basic demographic questions, and questions aimed at assessing whether members were eligible to participate in the study.

To be eligible to participate in an interview, members had to be aged 18 years or older, pregnant between January 1, 2023, and June 30, 2024, while covered by Medi-Cal, and be able to complete an interview in English or Spanish. Members were ineligible to participate in an interview if they were currently pregnant.

Doula users were eligible if they utilized any doula services between January 1, 2023, and June 30, 2024, regardless of pregnancy outcome. Exclusion criteria for doula non-users included pregnancies that resulted in miscarriage, spontaneous abortion, complications following termination of pregnancy, failed attempt termination of pregnancy, or ectopic or molar pregnancies. For both doula users and non-users, exclusion criteria included instances of maternal or infant death.

Using the inclusion and exclusion criteria outlined above, DHCS staff sent recruitment emails to members who had an email address on file with DHCS. If DHCS staff sent members a recruitment email, they were not included in subsequent rounds of recruitment. In total, DHCS staff sent four rounds of recruitment emails:

- The first round of recruitment emails was specific to doula users and doula non-users who identified as Black/African American or American Indian/Alaska Native; individuals who identified as more than one race/ethnicity were not excluded.
- The second round of recruitment emails was specific to doula non-users who identified as Black/African American or American Indian/Alaska Native; individuals who identified as more than one race/ethnicity were not excluded.
- The third round of recruitment emails was specific to doula non-users. There were no criteria for race/ethnicity.
- The fourth and final round of recruitment emails was specific to doula non-users who identified as American Indian/Alaska Native.

Members who met study eligibility criteria and indicated interest in participating in an interview could provide their contact information to UC Berkeley researchers. Using a purposive sampling strategy,[10] researchers contacted eligible members to schedule a 60-minute phone or Zoom interview. Researchers prioritized scheduling interviews with members who were Black/African American and American Indian/Alaska Native. As outlined in Senate Bill 65, these groups disproportionately face adverse maternal health

[10] Purposive sampling is a method that relies on researchers' subject-matter expertise and informed judgement to deliberately select participants who are most likely to provide meaningful insights and effectively address the study's objectives.

outcomes. The researchers additionally prioritized recruiting members who had given birth after DHCS began promoting the benefit in September 2023.

Interview Topics

UC Berkeley researchers developed tailored semi-structured interview guides for members who had used the benefit and those who had not used the benefit. Both guides focused on members' experiences during pregnancy, birth, and postpartum and included questions about members' support networks, interactions with health care providers, and suggestions for promoting the Medi-Cal doula benefit. Both guides also contained questions about whether members received information about the doula benefit from their Medi-Cal managed care plans. The interview guide for members who utilized the doula benefit included questions about how members learned about the benefit and found a doula, their motivations for seeking doula support, and their experiences utilizing doula support. The interview guide for members who did not utilize the benefit included questions about their familiarity with doula support and general interest in using doula support.

Interviews

Prior to conducting interviews, researchers reviewed the study consent form and answered members' questions before asking if the member consented to participating in the study and being audio-recorded. The consent form included an overview of the study's purpose, study procedures, risks or discomforts to study participation (e.g., small chance that confidentiality could be compromised), and details about the incentive. Additionally, the consent form included a description of confidentiality protocols and how study data could be used in the future. Lastly, when reviewing the consent form, researchers told members their participation in research was voluntary, and they could decline to take part in the study, answer any questions, or stop the interview at any time. Members provided oral consent and received an electronic copy of the consent form for their records. Members who completed an interview received a gift card incentive for their participation.

To protect confidentiality, researchers assigned each interviewee a unique code (e.g., p01) and did not address them by name during the interview. Access to the database linking the code to the interviewee is restricted to UC Berkeley researchers and stored in REDCap, a secure and HIPAA compliant web application. All audio-recordings from interviews were transcribed verbatim. Researchers checked each transcript for accuracy and removed identifiers.

Stakeholder Interviews

UC Berkeley researchers conducted interviews with three stakeholder groups involved in implementing the Medi-Cal doula benefit:

- **Doulas:** Doulas provide services offered through the Medi-Cal doula benefit and are therefore key to implementation. To capture doulas' perspectives, researchers interviewed 16 doulas, including doulas who held leadership roles at CBOs and doulas who identify as Native American or Alaska Native and/or Indigenous. Interviews occurred between November 2024 and March 2025. The rationale for focusing on these groups is two-fold. First, CBOs provide critical support to the doula workforce, and some doula CBO leaders have supported benefit design and implementation and participated in DHCS workgroups. Second, it was critical to include the perspectives of Native American/Indigenous doulas, who can provide culturally competent doula support to their communities.
- **Medi-Cal managed care plan staff:** Medi-Cal managed care plans are required to maintain and monitor sufficient provider networks within their service areas, including doula providers, so their members can access doula services through the Medi-Cal doula benefit. Importantly, doulas must enter into contracts with Medi-Cal managed care plans to receive reimbursement for services provided to Medi-Cal managed care members. Researchers interviewed seven staff members from five managed care plans. Interviews occurred in February 2025.
- **Hospital staff who work in labor and delivery departments:** Hospital policies and staff members' perceptions of and attitudes toward doulas impact how patients access doula services during pregnancy-related care. Researchers interviewed four staff members from four hospitals. Interviews occurred between February and March 2025.

Recruitment

UC Berkeley researchers used a purposive sampling strategy to recruit individuals from the three stakeholder groups described above. Researchers compiled an initial recruitment list informed by input from DHCS and subject matter experts, including members of the Co-Design Team, and doula feedback at Doula Implementation Stakeholder Workgroup meetings.

Researchers developed recruitment emails that contained details about the study and information about how to schedule a 60-minute phone or Zoom interview, if desired.

Researchers either emailed potential interviewees directly or asked individuals in their professional networks to send recruitment emails on their behalf.

To be eligible to participate in an interview, individuals had to self-identify as a member of one of the stakeholder groups, be aged 18 years or older, and be able to complete an interview in English.

Interview Topics

UC Berkeley researchers developed semi-structured interview guides specific to each stakeholder group. All interview guides included questions about the stakeholder's role and facilitators and barriers to Medi-Cal doula benefit implementation.

Doulas

Researchers developed two interview guides for doulas. The first guide focused on the experiences of doulas who were CBO leaders. The guide included questions related to the CBO's work prior to Medi-Cal coverage of doula services, experiences preparing for and implementing the doula benefit, and the impact of the benefit on CBOs.

The second guide focused on the experiences of doulas who were *not* CBO leaders. The guide included questions related to the individual's pathway to becoming a doula and experiences enrolling as a Medi-Cal provider, working with Medi-Cal managed care plans, supporting clients enrolled in Medi-Cal, and supporting clients in clinical settings.

Medi-Cal Managed Care Plan Staff

The interview guide for Medi-Cal managed care plan staff focused on whether the plan had worked with doulas prior to Medi-Cal coverage of doula services, preparation for the doula benefit, and experiences with building a provider network, contracting with doulas, claims, and promoting the benefit.

Hospital Staff

The interview guide for hospital staff focused on awareness of the Medi-Cal doula benefit, doula-specific hospital policies, efforts to promote the benefit, and familiarity with resources related to doula support in hospitals.

Interviews

Prior to conducting interviews, researchers reviewed the study consent form and answered stakeholders' questions before asking if the stakeholder consented to participating in the study and being audio-recorded. All audio-recordings from interviews were transcribed verbatim. Researchers checked each transcript for accuracy and removed identifiers. Stakeholders who completed an interview received a gift card incentive for their participation, if they were eligible to accept.

Analysis

UC Berkeley researchers employed a modified version of the Rapid Assessment Process (RAP) to analyze interview data (Hamilton, 2013; 2020). For each interview guide, researchers developed a summary template with neutral domains matched to interview questions. Soon after conducting an interview, researchers completed a summary template. Researchers reviewed each interview transcript and modified summaries if information was unclear or absent.

Then, researchers transferred summary templates to group-level data matrices to synthesize key data across interviewees and domains. Next, researchers reviewed the group-level data matrices to generate findings per interviewee group. Researchers then selected illustrative quotes from de-identified interview transcripts. Lastly, researchers reviewed the findings to identify key facilitators and barriers across the interviewee groups.

To protect interviewee confidentiality, counts of less than 11 were suppressed. Therefore, researchers did not report descriptors for Medi-Cal members (e.g., race/ethnicity, relationship status, sexual orientation, delivery method, etc.) and stakeholders using exact counts and percentages.

Limitations

The qualitative portion of this evaluation has several limitations. First, researchers were unable to explore the experiences of Medi-Cal members who used doula support before, during, or after abortion or miscarriage, partially due to low utilization of these services during the study time period. Second, given the nature of qualitative research and the use of purposive sampling, it is not possible to generalize these findings to all Medi-Cal members, doulas, managed care plan staff, and hospital staff across California.

Importantly, the primary objective of this evaluation was to explore and understand the experiences of Medi-Cal members who used and did not use the Medi-Cal doula benefit. However, California is a large, racially and ethnically diverse state, and Medi-Cal members speak a variety of languages. Although Medi-Cal member interviewees represented a variety of racial/ethnic groups and lived across 16 counties, more research is needed to capture the breadth of experiences among Medi-Cal members who used and did not use the benefit. Further, the Medi-Cal members who participated in interviews were all women and mostly identified as heterosexual/straight, suggesting a need to further explore benefit use among members with different gender identities and sexual orientations. Lastly, researchers only conducted interviews in English and Spanish.

The secondary objective was to identify factors that impact implementation, from the perspectives of stakeholders who facilitate or hinder Medi-Cal member access to the benefit. While researchers were able to explore this objective through interviews with doulas, managed care plan staff, and hospital staff, data collection was limited due to time and budget constraints. For example, researchers interviewed staff members from five Medi-Cal managed care plans, but there are 24 plans in the state. More research is needed to further explore the facilitators and barriers experienced, perpetuated, or created by these stakeholder groups.

Finally, implementing the Medi-Cal doula benefit is an evolving process. These findings only capture the experiences of Medi-Cal members and stakeholders during the first two years of benefit implementation. Notably, continued engagement with Medi-Cal members, doulas, Medi-Cal managed care plans, hospitals, and other stakeholders is needed to address barriers, which may change over time.

Appendix C

Table C1: Messages to Medi-Cal Members About Doula Support, From Members Who Used the Benefit

Before deciding whether doula support is right for you…	
Do your own research	*"Just doing the research and seeing if that's what you need. I can't say everyone should have a doula because there's some people that don't like other people in their space and in their business, so it's not for everyone, but definitely just do the research."*
Talk to doulas	*"I would say meet with the doulas, talk to them, because sometimes I feel like you're like, 'Oh no, I don't need one.' As soon as you talk to them you're like, 'You know what? You might actually be a huge help for me through this time.'"*

A doula can…	
Advocate for you	*"Because you can advocate for what you want, and you can also become more educated on the choices that you have."*
Support you	*"Just that there's more support out there and that they're not alone. There's help, and there's people there to ease their mind, give them a little break, not just physically, but mentally."*
	"[The postpartum journey is] also important when it comes to the doula. … Your doula doesn't just disappear after the baby comes, they're still there as a form of support."
Help you prepare	*"… going in prepared is extremely important, and [there] is no better way to prepare you than a doula. No matter what books you read, no matter what family and friends have been through themselves or their own experiences that they share with you, that's their experience. The book is not always going to give you as many details. Very rarely do the doctors and the nurses sit and explain to you."*

A doula is…	
Covered by Medi-Cal	*"For me, because it was offered by my insurance for free, I highly recommend it just because it does help you in a lot of ways. Just having that body there, it helps."*
	"I've told so many people that I know, I'm like, 'Please, if your insurance covers a doula, take advantage of that benefit by all means.'"

Table C2: Solutions to Challenges Raised by Doula Interviewees

Challenge	Solution
DHCS Stakeholder Workgroups	
Broader doula community needed to communicate challenges to DHCS and Medi-Cal managed care plans	Doulas and advocates developed the California Medi-Cal Doula Benefit Feedback Form in response to concerns about a lack of data from doulas and the challenges they face when trying to contract, bill, and provide services. Doulas and advocates created the form to systematize the collection of data from doulas. Interviewees reported using responses to the feedback form to communicate with DHCS and Medi-Cal managed care plans. Importantly, one interviewee noted the data presented from the feedback form was received more positively by DHCS than the anecdotal data that had previously been conveyed to DHCS from individual doulas, CBO leaders, and workgroup members.
Compensation for doulas' time and expertise during benefit development and implementation	The participation of doulas in the DHCS stakeholder workgroups was integral to the development and initial implementation of the benefit. Some doulas also spent additional time working with DHCS as members of the Co-Design team. One interviewee reported that the California Health Care Foundation (CHCF) noticed doulas were not being compensated for their contributions. In collaboration with DHCS, CHCF offered stipends to workgroup members who were on the Co-Design team to sustain their work.

Challenge	Solution
Supporting the Doula Workforce	
Financial barriers associated with enrolling as Medi-Cal doula providers and contracting with Medi-Cal managed care plans	A few interviewees who were CBO leaders reported investing in the doula community by providing mentoring opportunities and awarding stipends and scholarships to doulas to cover some of the costs associated with enrolling as a Medi-Cal doula provider and contracting with managed care plans. A further source of funding reported by one interviewee related to a $1,000 scholarship from a managed care plan to encourage doulas to contract with the plan.
Doula privacy concerns related to obtaining business licenses	Interviewees reported some doulas are concerned about sharing private information, such as their home address, to obtain a business license. One interviewee shared an innovative solution to navigate this challenge. The interviewee obtained a standing business license for their CBO, so all doulas in their network could be covered under it. Additionally, the same interviewee shared their organization conducts trainings and webinars to walk doulas through the business license application process.
Need to train, educate, and support more Indigenous doulas	A few Native American/Indigenous doula interviewees shared they attended Indigenous-centered doula trainings provided by First 5 Humboldt and First 5 Mendocino. First 5 Mendocino also facilitated a hospital tour for trainees. After the trainings, interviewees described meeting with other doulas in their training cohort to discuss their experiences navigating processes related to the Medi-Cal doula benefit (e.g., obtaining a business license and liability insurance).

Challenge	Solution
Lack of technical assistance and support for the doula workforce	One interviewee reported Los Angeles County Supervisor Holly J. Mitchell's office reached out to doulas and asked, "What would it look like for us to support the doulas in LA County?" Ultimately, the conversation contributed to the creation of the LA County Medi-Cal Doula Hub, which is funded by the county and philanthropic partners. The doula hub – which is a collaboration between Frontline Doulas, Diversity Uplifts, Inc., and the Los Angeles County Department of Public Health – provides doulas with technical assistance and supports workforce development.