**SENATE JUDICIARY COMMITTEE**
**Senator Thomas Umberg, Chair**
**2025-2026 Regular Session**

SB 297 (Hurtado)
Version: April 10, 2025
Hearing Date: April 29, 2025
Fiscal: Yes
Urgency: No
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## SUBJECT

Valley fever Screening and Prevention Act of 2025

## DIGEST

This bill requires an adult patient receiving primary care services in specified health care settings to be offered a valley fever screening test, if certain conditions apply, and followup care if the patient tests positive. The bill provides that no liability attaches for a health care provider's failure to comply with these requirements.

## EXECUTIVE SUMMARY

Valley fever is an invasive fungal disease that cannot be reliably distinguished from other causes of respiratory illness by signs or symptoms alone. It is commonly misdiagnosed and inappropriately treated. Valley fever affects approximately 10,000 to 20,000 people each year. Most of these reported cases occur in California and Arizona.

To respond to this increased incidence of valley fever in certain California communities, this bill requires patients to be offered valley fever screening tests based on screening indications recommended by the latest national clinical practice guidelines, to the extent these services are covered under the patient's health insurance, and certain conditions are met. There are reporting requirements for state and local health entities and provisions related to health care coverage. Relevant to this Committee's jurisdiction, no liability attaches for a health care provider's violation of this bill's provisions regarding screening tests.

This bill is author-sponsored. It is supported by the City of Avenal and various health care organizations, including the Kern Medical and Saint Agnes Medical Center. It is opposed by the California Medical Association and County Health Executives Association of California. This bill passed out of the Senate Health Committee on a vote of 10 to 0.

## PROPOSED CHANGES TO THE LAW

Existing law:

1) Provides that any person who violates specified portions of the Health and Safety Code, or who willfully or repeatedly violates any rule or regulation adopted thereunder, is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine or by imprisonment, or by both the fine and imprisonment. (Health & Saf. Code § 1290.)

2) Establishes the Department of Public Health (CDPH), directed by a state Public Health Officer (PHO), to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health and licensing of health facilities, as specified. Gives the PHO broad authority to detect, monitor, and prevent the spread of communicable disease in the state. (Health & Saf. Code § 131050 and § 120130 et seq.)

3) Exempts various types of clinics from licensure and regulation by CDPH, including any place or establishment owned or operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, and any clinic operated as an outpatient department of a hospital. (Health & Saf. Code § 1206.)

4) Requires every health care provider, knowing of or in attendance on a case or suspected case of a disease on the list of reportable diseases and conditions, to be reported as required to CDPH. (17 C.C.R. §§ 2500, 2593, 2641.5- 2643.20, and 2800-2812.)

5) Requires an adult patient who receives primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting where primary care services are provided, to be offered a hepatitis B screening test and a hepatitis C screening test, to the extent these services are covered under the patient's health insurance, based on the latest screening indications recommended by the USPSTF, unless the health care provider reasonably believes that specified conditions apply, including that the patient is being treated for a life-threatening emergency or the patient lacks capacity to consent to such tests. (Health & Saf. Code § 1316.7.)

This bill:

1) Provides, commencing January 1, 2028, that an adult patient who receives primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting where primary care services are provided, and that is in a high-incidence region for valley fever, as identified by CDPH, shall be offered a valley fever screening test, to the extent these services are covered under the patient's health

insurance, based on the latest screening indications recommended by the latest national clinical practice guidelines, unless the health care provider reasonably believes that one of the following conditions applies:

a) The patient is being treated for a life-threatening emergency.
b) The patient has previously been offered or has been the subject of a valley fever screening test, unless the health care provider determines that it should be offered again.
c) The patient lacks capacity to consent to the test.
d) The patient is being treated in the emergency department of a general acute care hospital, as defined.

2) Requires a health care provider, if a patient accepts the offer of the screening test and the test is positive, to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care.

3) Clarifies that it does not affect the scope of practice of any health care provider or diminish any authority or legal or professional obligation of any health care provider to offer a valley fever screening test, or to provide services or care for the patient of a valley fever screening test.

4) Provides that a health care provider that fails to comply with these requirements shall not be subject to any disciplinary actions related to their licensure or certification, or to any civil or criminal liability, because of the health care provider's failure to comply with these requirements.

5) Requires CDPH to annually analyze and identify regions with high rates of valley fever using public health surveillance data. Requires CDPH to publish its first list of high-incidence regions for valley fever by March 1, 2027.

6) Requires CDPH to provide (local health departments) LHDs in high-incidence regions with detailed infection data and standardized screening protocols for valley fever.

7) Requires CDPH to develop and distribute evidence-based training materials on valley fever detection, diagnosis, and treatment for health care providers.

8) Requires LHDs in high incidence areas to conduct outreach to health care providers and the general public to raise awareness of valley fever risks, symptoms, and prevention strategies.

9) Requires LHDs to annually report to CDPH, including the confirmed cases of valley fever.

10) Requires health plans, insurers, and Medi-Cal, after June 1, 2027, to cover valley fever screening tests in high-incidence regions. Prohibits deductibles, coinsurance, copayments, or any other cost-sharing requirement on this coverage, except as provided. Requires the Medi-Cal mandate to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

11) Requires CDPH, by January 1, 2030 and every two years thereafter, to evaluate the effectiveness of the valley fever screening and prevention program and report its findings to the Legislature.

## COMMENTS

1. Author's comment

According to the author:

> Valley fever is a growing public health crisis, yet too many cases go undiagnosed for too long. SB 297 ensures that Californians in high-incidence regions receive the early detection and care they deserve. By 2027, the California Department of Public Health will identify the hardest-hit areas, giving communities the data they need to act. County health departments will standardize screening protocols and work with local health officers to educate providers and the public.
>
> For too many, a simple test could mean the difference between a quick recovery and years of misdiagnosis. That's why, starting in 2028, primary care providers in high-risk regions must offer Valley fever screenings to adults. No one should have to choose between affordability and their health—so beginning in 2027, insurance plans, including Medi-Cal (pending federal approval), will cover these tests without cost-sharing.
>
> Public health should be proactive, not reactive. SB 297 strengthens California's response by requiring ongoing program assessments and legislative reports to ensure effectiveness. By equipping communities with better data, removing cost barriers, and prioritizing early detection, this bill takes a critical step toward reducing the devastating impact of Valley fever. Californians deserve a healthcare system that catches Valley fever early—before it catches them.

2. This bill requires health care providers to offer valley fever screening tests under certain circumstances

According to the U.S. Centers for Disease Control and Prevention (CDC):

> Coccidioidomycosis (Valley fever) is an invasive fungal disease that often presents as community-acquired pneumonia (CAP) in primary and urgent care settings. It is endemic in parts of the U.S. and the world.
>
> Coccidioidomycosis cannot be reliably distinguished from other causes of respiratory illness by signs or symptoms alone. It is commonly misdiagnosed and inappropriately treated with antibiotics—up to 70% of patients may receive inappropriate antibacterial drugs. In highly endemic regions for coccidioidomycosis, erythema nodosum is commonly the presenting symptom.
>
> Testing for coccidioidomycosis may be considered on the initial patient encounter or at a secondary visit, depending on situational factors.[1]

There are roughly 10,000 to 20,000 cases of valley fever reported to the CDC each year with most cases occurring in Arizona and California. From 2017 to 2022, California had roughly 7,000-9,000 cases.[2]

This bill, in relevant part, seeks to identify the incidence of valley fever in certain California communities and to get treatment for infected patients more systematically by requiring specified health facilities to provide valley fever screening tests to adult patients based on the latest screening indications recommended, and to provide followup care or referrals, as specified.

The goal is to expand the response to unidentified outbreaks, not to punish health care professionals. Therefore, the bill specifically provides that health care providers that fail to comply are not subject to any disciplinary actions related to their licensure or certification, or to any civil or criminal liability for such failure.

This approach closely models that carried out in AB 789 (Low, Ch. 470, Stats. 2021), which requires similar screenings at these facilities for hepatitis B and C, and AB 2132 (Low, Ch. 951, Stats. 2024), which requires such screenings for tuberculosis.

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[1] *Testing Algorithm for Coccidioidomycosis* (May 10, 2024) CDC, https://www.cdc.gov/valley-fever/hcp/testing-algorithm/index.html#:~:text=Recommended%20test%20methods,characteristics%20of%20test%20at%20facility. All internet citations are current as of April 14, 2025.

[2] *Reported Cases of Valley Fever* (April 24, 2024) CDC, https://www.cdc.gov/valley-fever/php/statistics/index.html.

The bill also requires CDPH to annually analyze and identify regions with high rates of valley fever using public health surveillance data and to publish its first list of high-incidence regions for valley fever on or before March 1, 2027. CDPH must also provide LHDs in high-incidence regions with detailed infection data and standardized screening protocols.

LHDs in high incidence areas are required to conduct outreach to health care providers and the general public to raise awareness of valley fever risks, symptoms, and prevention strategies and to also annually report to CDPH the number of confirmed cases of valley fever.

3. Stakeholder positions

The California Health Collaborative writes in support:

> Climate change is also contributing to Valley fever's rapid spread. Rising temperatures and prolonged droughts create conditions that allow Coccidioides fungus to thrive. As a result, communities and towns that have never before faced the threat of Valley fever are becoming hotspots for the disease. Valley fever is a persistent health challenge in the Western United States, particularly in California and Arizona, where the fungus thrives in hot and dry climates. Between 10,000 and 20,000 cases are reported annually in the United States. However, experts believe the true number is much higher due to under diagnosis. Valley fever has been found to affect many of the families our organization serves and would like to support in continuing to educate and prevent them from being exposed to Valley fever.
>
> Despite its growing prevalence, awareness of Valley fever remains low. Misdiagnosis is common, leading to delay in treatment and unnecessary suffering for patients. Public health agencies face significant challenges in tracking cases due to inconsistent testing and reporting practices.

Saint Agnes Medical Center explains the need for the bill:

> In the Central Valley, thousands of cases go unreported each year, leaving public health officials with an incomplete picture of the disease's true impact. As Valley fever becomes more widespread, the need for improved surveillance, education, and research into its management requires the upmost urgency.
>
> The threat of Valley fever isn't merely a problem for today, but it's a looming problem for the future. Proactive measures like SB 297 aim to tackle this issue by requiring the California Department of Public health to

> identify and share data on regions with high Valley fever rates, mandating screenings in high-incidence areas when medically necessary, and ensuring health insurance providers, including Medi-Cal, cover screenings at no additional cost to patients.

Writing in opposition, the California Medical Association argues:

> While we appreciate and support the author's intent to enhance early detection and treatment of Valley fever infections, CMA must oppose a mandate requiring physicians to offer Valley fever testing to all primary care patients in high-incidence regions. Unfortunately, this approach presents several concerns. First, this mandate overrides a physician's clinical judgment in determining whether testing is appropriate for a given patient. For context, Valley fever is typically a mild infection for most individuals, with 90 to 95 percent of those infected experiencing mild symptoms that resolve without testing or treatment. Only an estimated 5 to 10 percent of infected individuals experience worsening or severe symptoms requiring medical intervention, with those who have weakened immune systems or underlying health conditions being at the highest risk for developing severe symptoms.
>
> Additionally, mandating physicians to offer this testing would result in unnecessary screenings for asymptomatic individuals or those with mild symptoms, even when offering the test goes against clinical judgment.

**SUPPORT**

Altura Centers for Health
Aria Community Health Center
California Health Collaborative
City of Avenal
Kern Medical
Mycare Foundation
Saint Agnes Medical Center

**OPPOSITION**

California Medical Association
County Health Executives Association of California

**RELATED LEGISLATION**

Pending Legislation: SB 278 (Cabaldon, 2025) authorizes the sharing of HIV test information for the purpose of administering quality improvement programs designed

to improve HIV care for Medi-Cal beneficiaries, including value-based payment programs and healthy behavior incentive programs, as provided. SB 278 is currently in the Senate Appropriations Committee.

SB 504 (Laird, 2025) authorizes a health care provider of a patient with an HIV infection that has already been reported to a local health officer to communicate with CDPH or a LHO in order to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. SB 504 is currently in the Senate Appropriations Committee.

Prior Legislation:

SB 1333 (Eggman, Ch. 472, Stats. 2024) revised and recast existing law to permit CDPH and LHDs to disclose personally identifying information in public health records for the coordination of, linkage to, or reengagement in care, as determined by CDPH or a LHD.

AB 2132 (Low, Ch. 951, Stats. 2024) *See* Comment 2.

AB 789 (Low, Ch. 470, Stats. 2021) *See* Comment 2.

**PRIOR VOTES:**

Senate Health Committee (Ayes 10, Noes 0)

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