(f) To enable Committee members to understand the frame of reference of the State's emergency medical response system and its related entities, the Committee shall be briefed on any studies and legislative audits of the components of the emergency medical response system conducted in the past 4 years.

(g) The Committee shall convene workgroups and shall invite the participation of and solicit commentary from all interested parties as necessary to assist the Committee in carrying out its duties under subsection (e) of this section.

(h) (1) The Committee shall submit reports in accordance with paragraph (2) of this subsection on its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, to the Senate Budget and Taxation Committee, Finance Committee, and Judicial Proceedings Committee, and the House Health and Government Operations Committee and Economic Matters Committee.

(2) The Committee shall submit an interim report on or before December 31, 2003, and a final report on or before December 1, 2004.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) (1) In accordance with the Emergency Medical System plan developed under § 13-509 of the Education Article, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) shall study whether a need exists for MIEMSS, with the approval of the State Emergency Medical Services Board, to enter into an agreement to designate an out-of-state adult trauma center located in the District of Columbia as a member of the State trauma system in order to ensure access of Maryland patients to appropriate levels of trauma care.

(2) In conducting the study required under paragraph (1) of this subsection, MIEMSS shall review the effect that any agreement with an out-of-state trauma center may have on State trauma centers, including:

(i) the extent to which duplication of services may exist;

(ii) the ability of State trauma centers to achieve and sustain the patient volumes necessary for:

1. optimal outcome;

2. cost efficiency;

3. maintenance of expertise;

4. quality of care;

5. research activities; and

6. health service provider education; and

(iii) the effect on quality of patient care that may result from reduced patient volume.