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A "health maintenance organization" (HMO) is defined in section 4401 of the Public Health Law, Chapter 45 of the Consolidated Laws of the State of New York, to mean "any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan."

A "comprehensive health services plan" is defined in Section 4401 to mean "a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance of periodic charge."

"Comprehensive health services" are defined in Section 4401 to mean "all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services."

Section 4402 of the Public Health Law provides that "no person or groups of persons may operate a health maintenance organization or issue a contract to an enrollee for membership in a comprehensive health services plan without first obtaining a certificate of authority from the commissioner (of health)."

The Commissioner of Health may issue a certificate of authority pursuant to Section 4403 or 4403-a of the Public Health Law only if the applicant demonstrates that it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan, is financially responsible for the cost of providing comprehensive health services to enrollees and satisfies other conditions assuring quality of care, resolution or enrollee complaints, etc.

The HMO must make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO.

The HMO must make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

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