Healthcare Receivables Finance in the GCC: Turning Claims into Predictable Liquidity

A Controlled Borrowing-Base Framework for Claim Validity, Denials, Aging, Payer Concentration and Collections

Authored by Chennakeshav Adya, Independent Researcher

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Abstract

Healthcare providers across the Gulf Cooperation Council often deliver care before receiving full payment from insurers, third-party administrators or government programmes. The resulting receivable is not a conventional invoice. Its value depends on patient eligibility, benefit coverage, prior authorisation, clinical documentation, medical coding, contractual tariff, timely submission, payer adjudication, denial resolution, reconciliation and final settlement. A claim can move through several states before cash becomes legally and operationally available.

The region's digital claims infrastructure makes these states increasingly observable. Dubai's eClaimLink publishes standard data sets, payer and provider lists, coding references and denial codes.[1] Abu Dhabi's Department of Health claims adjudication standard defines full settlement, partial settlement and dismissal and requires traceable adjudication rules.[2] Its medical-billing standard covers eligibility, coding, submission, resubmission, reconciliation and follow-up.[3] Saudi Arabia's NPHIES platform defines eligibility, pre-authorisation, claims, re-adjudication, payment notification and payment confirmation transactions and groups more than 80 denial codes across benefit, clinical and operational categories.[4] These systems create structured evidence. They do not make every submitted claim collectible.

This paper develops a controlled borrowing-base framework for GCC healthcare receivables. It constructs a claims aging cube, denial waterfall, payer concentration map, borrowing-base model and cash-control architecture. It shows how a lender can reconcile clinical and billing evidence to collections, apply eligibility exclusions and reserves, monitor payer and service-line behaviour, and release liquidity without financing unverified claims or restricted cash.

Every claim amount, denial rate, aging profile, advance rate, reserve, collection period, facility size, interest rate and timing assumption in the worked examples is an illustrative management assumption created solely to demonstrate the method. The examples are not forecasts, valuations, offers, investment recommendations or descriptions of an identified provider, payer or transaction. Actual financeability depends on current law and regulation, executed provider and payer contracts, claim-level evidence, licensing, data protection, tax, accounting, insolvency, security, financing terms and credit approval.

JEL Classification: G21, G23, G28, G32, I11, I13

Keywords: GCC, healthcare, receivables finance, medical claims, borrowing base, denials, payer concentration, cash control, factoring, working capital

1. Define the receivable before financing it

A healthcare receivable begins with an episode of care and becomes cash only after a chain of clinical, contractual and administrative conditions is satisfied. The lender should underwrite that chain rather than treating the provider's accounts-receivable ledger as a pool of ordinary invoices.

The claim should be traced from patient registration, eligibility confirmation and authorisation through encounter documentation, diagnosis and procedure coding, tariff application, claim submission, acknowledgement, adjudication, resubmission, reconciliation, payment notification and bank receipt. Each stage has a date, owner, system record and possible exception.

The legal debtor should be identified precisely. An insurer, third-party administrator, government programme, employer, patient or other sponsor can bear different portions of one encounter. A third-party administrator may process a claim without assuming ultimate payment risk. A payer group can contain several legal entities. The borrowing base should use the entity contractually responsible for payment.

The provider's right to payment should also be distinguished from expected reimbursement. A submitted claim can be incomplete, late, unauthorised, miscoded, priced above contract, duplicated or outside benefits. A claim acknowledged by an electronic platform is not necessarily admitted by the payer. A payment notification is stronger evidence than mere submission, while actual collection remains the strongest evidence for historical calibration.

The facility purpose should be defined. Receivables finance can fund payroll, medicines, consumables, rent and other operating working capital while verified claims mature. It should not hide persistent operating losses, finance disputed acquisitions, replace regulatory capital or support distributions when the borrowing base is deteriorating.

2. Map the full claim-to-cash cycle

The first diligence product should be a claim-to-cash map for each jurisdiction, payer, service line and system. It should show eligibility, pre-authorisation, encounter, documentation, coding, submission deadline, adjudication, denial response, resubmission, reconciliation, settlement and payment.

Dubai's eClaimLink provides standard data sets and lists for facilities, clinicians, payers, services, medicines and denial codes.[1] The presence of common fields and codes supports reconciliation across provider, payer and financing systems. The lender should still test whether the provider's source records populate the fields accurately and whether updates are implemented on time.

Abu Dhabi's adjudication standard describes automated simple and complex edits, provider access to adjudication guidelines and the payer decision between full settlement, partial settlement and dismissal.[2] The lender's data model should retain the reason, amount and date of each adjudication outcome. A net receivable cannot be reconstructed if the provider overwrites earlier claim versions.

Saudi NPHIES defines transactions for eligibility, authorisation, claims, re-adjudication, amendment, status inquiry, payment notification and confirmation.[4] It also distinguishes benefit, clinical and operational denial categories. This structure supports a state-based borrowing base in which advance rates can rise as a claim moves from submitted to accepted to scheduled

for payment.

The map should include manual channels and exceptions. Government claims, overseas insurers, self-pay balances, package reconciliations and legacy contracts can sit outside the main exchange. Their evidence and payment behaviour should be analysed separately rather than assumed to follow the digital channel.

Table 1. Claim-state evidence and financing treatment

Claim state	Required evidence	Primary uncertainty	Indicative financing treatment	Monitoring field
care delivered	encounter, eligibility and clinical record	coverage, authorisation and coding incomplete	exclude	encounter date and responsible payer
coded and billable	completed documentation, codes and tariff	submission validity and contract edits	exclude or very low recognition	coding completion date
submitted	exchange acknowledgement and claim identifier	payer has not adjudicated	eligible only for proven low-denial pools with reserve	submission date and version
pending information	payer request and response deadline	documentation or data gap	exclude until cured	pending reason and aging
partially accepted	line-level adjudication and accepted amount	residual dispute and dilution	include accepted amount only	accepted amount and expected payment
denied, correctable	denial code, cure evidence and resubmission	cure success and time	exclude until re-accepted	denial root cause and resubmission date
denied, final	final rejection or expired appeal	no collectible value	exclude and write off	final disposition
payment notified	payer payment notification and reconciliation	timing, set-off or administrative delay	high eligibility subject to concentration	scheduled amount and date
collected	bank receipt allocated to claim	allocation and clawback	remove from base and apply cash waterfall	value date and account

Exact states and rights depend on the relevant payer contract and jurisdiction.

3. Build the claim-level data spine

A borrowing base requires a stable claim identifier that links the clinical event, billing record, payer response, general ledger and bank receipt. The lender should receive the claim history, not only the current balance.

Minimum data include provider entity, facility, patient pseudonymous identifier, payer, third-party administrator, policy or programme, service line, encounter date, authorisation, diagnosis, procedure, billed amount, contract amount, patient share, submission date, claim version, payer acknowledgement, adjudicated amount, denial code, resubmission, payment notification, cash receipt, credit note, write-off and dispute status.

Sensitive clinical and personal data should be minimised for financing. The lender needs enough information to validate claim existence, eligibility and performance without receiving unnecessary patient details. Data access, processing purpose, storage, transfer, retention, deletion

and incident obligations should be documented under the applicable health and privacy regime.

The claim tape should reconcile to the accounts-receivable subledger, general ledger and audited or reviewed financial statements. Opening claims plus new billed claims minus collections, credits, write-offs and transfers should equal closing claims. Differences should be explained by claim versioning, patient-share reclassification, payer settlement or accounting cut-off.

Bank receipts should be allocated at claim or settlement-statement level. Unallocated cash can make the ledger appear older than economic reality or conceal that collections relate to claims outside the financed pool. A lender should require a dated allocation process and exception queue.

4. Construct a claims aging cube

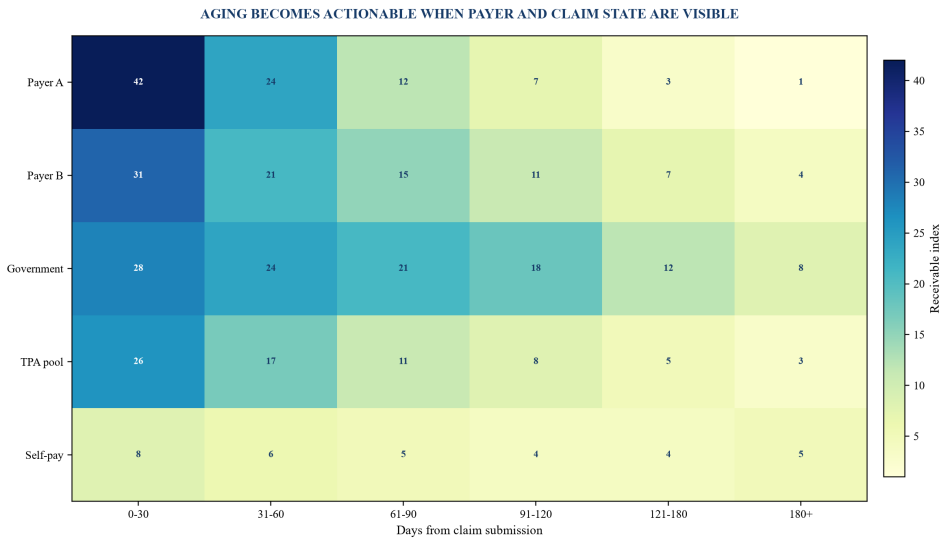
Simple aging by invoice date can obscure where risk sits. A claims aging cube adds payer, service line, claim state, denial reason, facility and submission cohort. The lender can then see whether old balances are concentrated in one payer, one coding process or one service.

Several clocks matter. Days from encounter to coding measure provider readiness. Days from coding to submission measure billing operations. Days from submission to first adjudication measure payer processing. Days from denial to resubmission measure cure discipline. Days from acceptance to payment measure settlement. Days from encounter to cash measure the complete working-capital cycle.

The borrowing base should choose a contractual and empirically useful aging start. Encounter date captures the full provider cycle but can penalise legitimate coding and submission periods. Submission date aligns with the payer claim but can reward delayed provider billing. A combined test can require both maximum encounter age and maximum submitted age.

Age buckets should be calibrated from claim-level liquidation. The lender should calculate how much of each historical bucket was eventually collected, diluted or written off and how long collection took. A ninety-day claim can remain strong under a slow government programme, while a ninety-day claim under a thirty-day insurer contract can signal dispute.

Figure 1. Illustrative GCC healthcare claims aging cube



Hypothetical index amounts demonstrate segmentation and are not observed provider data.

5. Convert denials into a recoverability waterfall

A denial rate alone does not measure value. Some denials are administrative and curable. Others reflect missing authorisation, benefit exclusion, clinical necessity, contractual tariff, duplicate submission, coding error, late filing, fraud concern or final non-coverage. Each category has a different cure rate, cost and collection time.

The provider should maintain the original denial code, internal root cause, responsible department, resubmission deadline, action, new claim version, outcome and cash receipt. Denial codes should not be overwritten when a claim is resubmitted. The lender needs the path from first submission to final settlement.

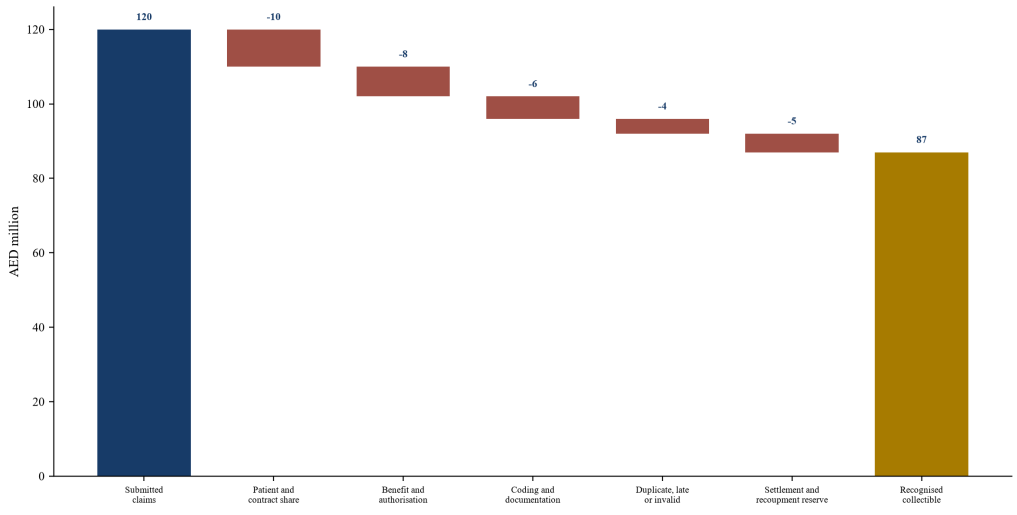
The denial waterfall begins with submitted claims. It deducts patient share, contractual pricing differences, ineligible benefits, missing authorisation, coding and documentation errors, duplicates, late claims, expected settlement deductions and final disputes. Correctable claims can re-enter eligibility only after the required evidence is provided and the payer acknowledges the revised claim.

Saudi NPHIES groups more than 80 denial codes into benefit, clinical and operational categories, including authorisation, eligibility, price, coding, dosage and time.[4] CHI's provider reconciliation form requires service-level rejection details and a defined period for supporting information or objections.[5] These records support line-level dilution analysis.

Abu Dhabi's framework likewise distinguishes adjudication outcomes and provides rules for recovery of payments previously made.[2][6] A reserve should therefore cover both initial dilution and later recoupment or set-off risk.

Figure 2. Illustrative healthcare denial waterfall

THE BORROWING BASE USES EXPECTED COLLECTIBLE VALUE, NOT BILLED VALUE



Hypothetical AED million amounts demonstrate recoverability adjustments.

Table 2. Denial root-cause and credit treatment

Denial category	Typical evidence	Potential cure	Borrowing-base treatment	Management action
eligibility	policy response, member and encounter record	correct identity or payer where valid	exclude until payer accepts	front-end eligibility control
authorisation	authorisation request, approval and service match	obtain or prove existing approval where permitted	exclude disputed amount	align scheduled care and authorisation
benefit	policy terms and clinical service	limited if service is excluded	exclude final non-covered amount	patient disclosure and benefit check
coding	clinical record, diagnosis and procedure code	correct code with coder review	exclude until clean resubmission	coding quality programme
documentation	signed notes, reports and discharge record	complete permissible missing evidence	exclude pending claim	encounter closure control
tariff or contract	payer contract, package and price list	reconcile line or package	include only undisputed contract amount	contract master governance
duplicate	claim history and version	cancel duplicate, retain valid original	exclude duplicate	version and resubmission control
late filing	encounter and submission timestamps	appeal only if contract permits	exclude unless accepted	submission service-level target
clinical necessity	guideline, record and payer rationale	medical appeal where supported	exclude pending adjudication	clinical documentation and review
fraud or misuse concern	audit record and investigation	fact dependent	exclude entire affected pool where material	investigation, disclosure and remediation

Cure rates and timing should be calculated from the provider's own claim history.

6. Measure payer concentration across several dimensions

Payer concentration should be measured by gross billed claims, eligible receivables, monthly collections, old balances, denials, disputes and payment notifications. One payer can represent thirty per cent of current receivables and sixty per cent of balances older than 120 days.

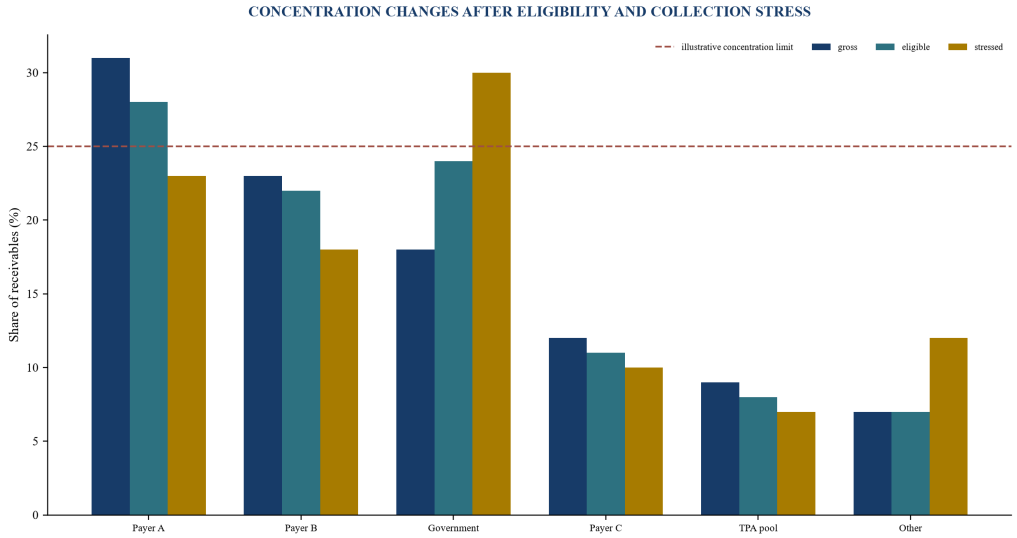
Legal counterparty and administrator should be separated. Several branded plans can settle through one insurer or government entity. One administrator can process claims for multiple insurers. A parent guarantee should not be assumed without documentation.

Concentration also exists within service lines and facilities. A payer can be strong for outpatient claims and slow for high-value inpatient packages. A government programme can pay reliably and on a longer cycle. The lender should apply limits to the stressed collectible amount, not only to invoice face value.

The payer score should include financial capacity, regulatory status, contract term, termination, network status, adjudication behaviour, denial rate, settlement history, dispute, set-off rights and days to cash. Public ratings or financial statements can support capacity where available, but the

provider's own collections establish transactional behaviour.

Figure 3. Illustrative payer concentration map



Hypothetical percentages compare gross, eligible and stressed receivables.

7. Reconcile contractual price before applying an advance rate

Healthcare billing can begin with a list price and settle under a negotiated tariff, package, diagnostic-related group, discount, capitation rule or other arrangement. The lender should finance the contractual collectible amount rather than the provider's gross charge master.

The contract master should record payer, plan, facility, service, tariff, package, effective date, authorisation rule, filing deadline, payment period, audit, recoupment, dispute, set-off and termination. Changes should be version controlled. The billing system should apply the contract effective on the encounter date.

Packages need special care. Individual claim lines can be priced at zero within a package while the major code carries the price. Saudi NPHIES guidance refers to package pricing and standard code sets.[4] A line-level borrowing base should preserve the package relationship so that zero-priced components are not treated as missing revenue and the package is not double counted.

Retrospective discounts, volume rebates and settlement agreements create dilution. Historical dilution should be calculated as gross submitted less final cash, separated into contractual adjustment, denial, credit note, write-off and recoupment. A reserve should cover the higher of recent experience, stressed experience and known unresolved settlement exposure.

8. Test historical liquidation by cohort

Static-pool analysis follows a month of submitted claims until it is collected, diluted or written off. It avoids the distortion caused when new claims continually enter the ledger. Each cohort should be analysed by payer, facility and service line.

The lender should calculate cumulative cash at 30, 60, 90, 120, 180 and 270 days from submission. It should also calculate final dilution and unresolved balance. Recent cohorts can be compared at the same age with older cohorts. A deterioration in a sixty-day collection curve can trigger action before year-end aging appears abnormal.

Resubmission can reset system timestamps. The original submission date should remain available, and the borrowing base should prevent artificial rejuvenation. A claim that has been denied and resubmitted three times should not appear as a new thirty-day claim.

Seasonality should be tested around holidays, policy renewals, government budgets, medical peaks and payer settlement cycles. Acquisitions, new facilities and new payer contracts should form separate cohorts until sufficient evidence exists.

Table 3. Illustrative claim-cohort liquidation analysis

Submission cohort	Cash by day 30	Cash by day 60	Cash by day 90	Cash by day 180	Final dilution	Credit interpretation
established quarter 1	38%	66%	82%	94%	5%	reference performance
established quarter 2	36%	64%	81%	93%	6%	broadly stable
growth quarter 3	31%	57%	74%	89%	8%	slower adjudication and higher denial
new payer launch	22%	44%	63%	83%	11%	separate reserve and concentration cap
government programme	12%	31%	54%	88%	4%	slower but historically lower dilution
high-value inpatient	19%	42%	61%	80%	13%	package and authorisation review

Hypothetical percentages demonstrate same-age comparison.

9. Define eligible receivables precisely

Eligibility should be a claim-level rule applied consistently. The receivable must belong to an approved provider and payer, arise from a completed eligible service, have required eligibility and authorisation evidence, be coded and submitted within deadline, use the applicable contractual price, remain undisputed and fall within age and concentration limits.

Common exclusions include self-pay balances without proven collection, related-party claims, duplicate or late claims, final denials, missing documentation, unapproved services, suspended payer contracts, claims subject to fraud or material audit, credit balances, capitation outside the agreed treatment, restricted government claims and receivables already assigned or pledged.

Partial eligibility should be supported at claim-line level. If a payer accepts AED8,000 of a AED10,000 claim, the borrowing base should include no more than the accepted or empirically collectible portion. A top-down haircut applied to the total pool can conceal specific disputed claims.

Cross-border and multi-jurisdiction pools should be segregated. Assignment, notice, priority, data and enforcement differ. The UAE's Federal Decree-Law No. 16 of 2021 permits transfers of current and future receivables that are described sufficiently and establishes registration-based third-party effectiveness and priority.[7] Transaction counsel should confirm how those

provisions apply to the provider, payer contract, notice and proposed security.

10. Build the borrowing base from expected collectible value

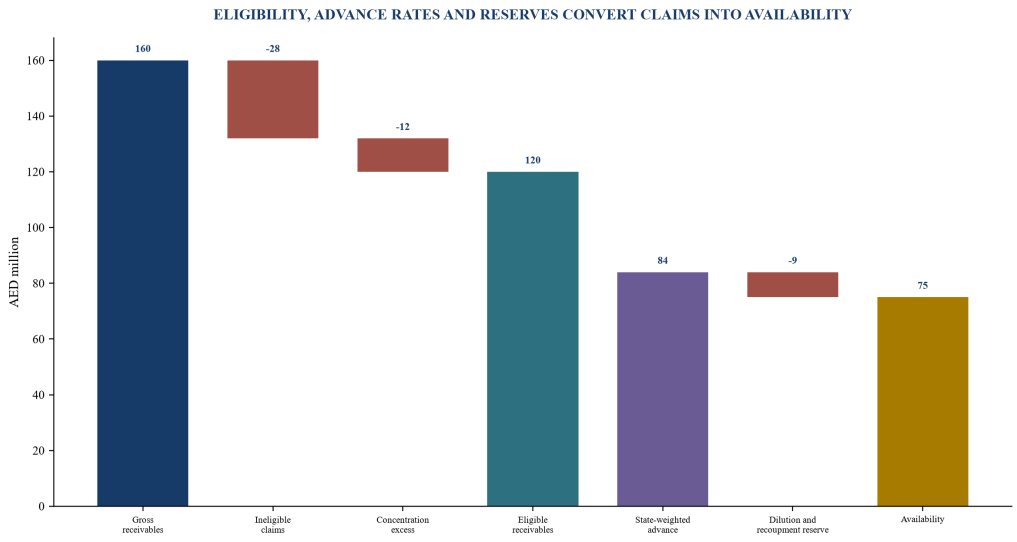
The borrowing base starts with eligible receivables at contractual or accepted value. It then applies advance rates and subtracts reserves. An advance rate reflects the time and uncertainty between the current claim state and cash. A submitted claim can receive a lower rate than a payment-notified claim.

Reserves should cover dilution, concentration, recoupment, disputes, slow aging, missing information, taxes, account leakage and other senior claims. A dynamic reserve can rise when denial, aging or concentration deteriorates. Availability should be the lower of the borrowing base and the committed facility limit.

The lender should recalculate at least monthly and more frequently for a revolving facility with rapid collections. The provider should deliver a claim-level certificate and source extracts. Independent testing should select claims from several payers, states, service lines and age buckets and trace them to clinical, contractual and cash records.

Over-advances should be cured through cash retention, new eligible receivables or repayment within a short defined period. A dispute or ineligible claim discovered after funding should be removed immediately. The facility should not wait until the next scheduled certificate when a material payer suspension or regulatory event occurs.

Figure 4. Illustrative healthcare receivables borrowing base



Hypothetical AED million amounts and advance rates demonstrate the method.

Table 4. Illustrative borrowing-base calculation

Component	AED million	Treatment	Evidence
gross healthcare receivables	160	starting ledger balance	reconciled claim tape and ledger
patient share and self-pay exclusion	(8)	excluded	patient responsibility and collection history
denied, disputed or incomplete	(11)	excluded	line-level adjudication and pending queue
age and filing exclusion	(6)	excluded	original encounter and submission dates
other ineligible or pledged	(3)	excluded	assignment, related party and legal review
payer concentration excess	(12)	excluded above cap	legal-payer aggregation
eligible receivables	120	state and payer weighted	eligibility certificate
weighted advance amount	84	average 70% after state weights	historical liquidation and contract
dilution and recoupment reserve	(6)	reserve	recent and stressed dilution
operational and account reserve	(3)	reserve	cash-control and exception analysis
borrowing availability	75	subject to facility limit	lender certificate and testing

Hypothetical amounts require provider-specific calibration.

11. Calibrate advance rates by claim state and payer

A single advance rate is simple and can be blunt. State-weighted advance rates reflect the stronger evidence created by adjudication and payment notification. Payer-specific overlays reflect historical collection and concentration.

Submitted clean claims can receive a conservative rate where the payer, contract, denial history and data quality are strong. Pending-information and denied claims should generally receive no advance until cured. Accepted claim lines can receive a higher rate. Payment-notified claims can approach the rate applied to short-dated confirmed receivables, subject to set-off and recoupment.

The advance rate should also reflect time. A newly accepted claim may be stronger than an old accepted claim whose scheduled payment has been missed. Aging and claim state should therefore interact. The lender can create a matrix by state and days since submission or acceptance.

Historical loss alone is insufficient. Operational disruption, contract renegotiation, payer distress, regulatory audit or cyber incident can change future performance. The advance rate should include a forward-looking overlay and should fall automatically after defined triggers.

12. Create a cash-control architecture that respects healthcare flows

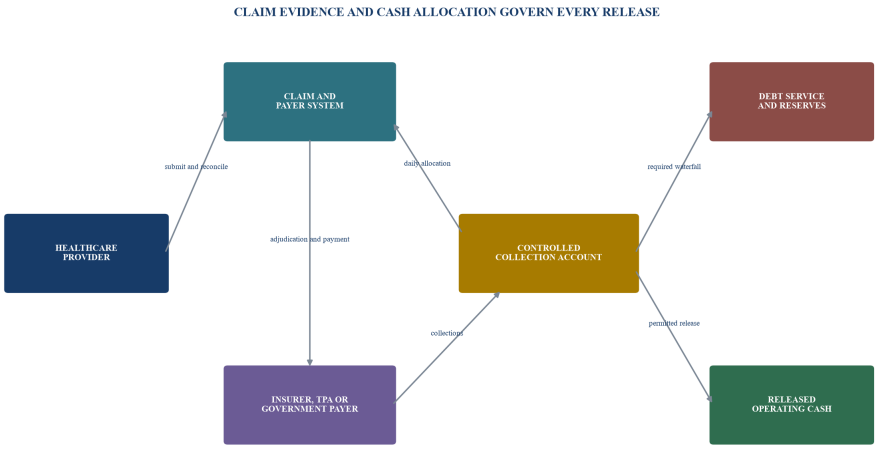
Collections should flow to a designated account subject to lender control or an agreed waterfall, depending on applicable law, contract and payer practice. Payer notices should identify the correct account and preserve patient and regulatory requirements.

The account structure should separate receivable proceeds from patient deposits, restricted government money, escrow, charity funds, VAT or tax liabilities and other amounts unavailable for debt service. A daily reconciliation should allocate receipts to settlement statements and claims.

The waterfall can first retain taxes, patient refunds or other agreed senior amounts, then cure any over-advance, pay interest and required amortisation, replenish reserves and release surplus to the provider while no trigger exists. During a trigger, surplus can remain trapped until the borrowing base and liquidity tests recover.

Payers can use set-off or recoupment against future payments. The lender should understand whether a controlled account captures gross collections before set-off and whether the payer can deduct across facilities, contracts or legal entities. The borrowing base should aggregate the corresponding exposure.

Figure 5. Illustrative healthcare receivables cash-control architecture



Legal and operational implementation requires jurisdiction-specific advice and payer confirmation.

13. Design covenants around claim deterioration

Minimum liquidity and maximum utilisation should sit alongside claim metrics. Eligible receivables, advance rate, concentration and reserves define availability. Financial covenants should use cash available after recurring capital expenditure, taxes and required clinical operations.

Operational covenants can monitor encounter-to-submission days, clean-claim rate, first-pass acceptance, denial rate, resubmission time, collection days, unallocated cash and aged pending claims. Payer covenants can monitor concentration, termination, suspension, dispute and missed settlement.

Data-quality covenants should cover missing identifiers, changed submission dates, unreconciled ledger differences and claim versions. A material reporting defect should stop new advances until corrected because the lender cannot calculate availability reliably.

Compliance covenants should require current provider licences, payer contracts, coding standards, data protection, fraud controls and prompt disclosure of regulatory correspondence,

audits, recoupment notices and material patient complaints.

Table 5. Illustrative covenant and remedy ladder

Indicator	Early warning	Trigger	Immediate response	Escalated response
clean-claim submission	declines below recent range	below agreed floor	root-cause report and enhanced testing	reduce advance rate
denial and dilution	trend rises	exceeds reserve assumption	increase reserve and stop affected pool	independent review and repayment
aging	slower cohort liquidation	old balance exceeds cap	exclude excess and trap cash	mandatory amortisation
payer concentration	approaches limit	exceeds limit	exclude concentration excess	payer-specific reserve or new funding limit
submission timeliness	backlog increases	filing deadlines at risk	daily backlog plan	affected claims ineligible
data reconciliation	minor exceptions	material tape-to-ledger difference	suspend certificate	independent reconciliation
payer contract	adverse negotiation	termination or suspension	stop affected advances	mandatory prepayment from collections
licence or regulatory event	inquiry or audit	suspension, material sanction or invalid claim process	freeze draws and notify lender	restructure or enforce as documented
controlled account	allocation delay	diversion or unauthorised change	cash trap and cure	event of default where material

Definitions, thresholds, cure and materiality require transaction-specific drafting.

14. Stress payer delay, denial and operating continuity together

Healthcare receivables risk can compound. A documentation backlog increases denials, slows collections and consumes staff time. A payer dispute can coincide with high medicine purchases and payroll. A cyber incident can interrupt submission and bank allocation. A regulatory audit can create recoupment while new advances stop.

The downside model should combine higher denial, lower cure, longer adjudication, delayed settlement, concentration haircut, recoupment and operating cost. It should show minimum liquidity, borrowing-base availability, over-advance, interest coverage and required management action by week and month.

The provider should identify essential clinical spending that cannot be cut without affecting care or licensing. Management action can reduce elective expansion, defer non-essential capital expenditure, improve coding support, renegotiate suppliers or add equity. It should not assume unsafe clinical reductions.

Reverse stress testing should identify the denial and payment-delay combination that creates an over-advance or minimum-liquidity breach. The early-warning covenant should activate before that point.

The stress should also distinguish a delay from a loss. A reliable government or insurer balance can create severe liquidity pressure while remaining collectible. The facility can respond through

lower availability, a dedicated slow-payer sublimit, longer tenor or more equity liquidity. A disputed balance with weak evidence requires an exclusion rather than extra time. This distinction prevents a lender from applying the same remedy to operational timing and fundamental collectability.

Management actions should be linked to claim operations. A temporary coding team can reduce an encounter backlog. Contract escalation can resolve repeated tariff errors. Clinical-documentation training can improve first-pass acceptance. Payer diversification takes longer and should not be credited before executed contracts and collected cohorts exist. Each action needs cost, owner, implementation date, evidence and forecast cash effect.

The lender should run a weekly thirteen-week liquidity forecast during a trigger. Collections should be drawn from claim-level expected dates and stressed by payer. Essential payroll, medicines, consumables, rent, tax and patient obligations should be shown separately. Availability should follow the recalculated pool, and any remaining gap should have a committed funding source or a defined reduction plan that preserves safe care.

15. Address recoupment and audit risk

Payers can review paid claims and seek recovery for duplicate, coding, documentation, benefit, fraud, misuse or other reasons under the relevant contract and rules. Abu Dhabi has published principles and procedures governing recovery of payment for healthcare services.[6] A lender financing collected claims still needs to consider future set-off against the remaining pool.

The provider should maintain audit notices, sampled claims, proposed findings, responses, final determinations, payment plans and set-offs. Exposure should be allocated by payer, facility, service line and period. Known amounts should be reserved in full where collection is probable and timing is near.

Historical recoupment should be included in dilution. Material open audits can justify a specific reserve or exclusion of the affected cohort. Fraud or misuse concerns can require a broader stop because they can affect payer relationships and regulatory standing beyond the sampled claims.

The financing documents should require prompt notice, information access and approval for material settlements where they affect collateral. The lender should avoid directing clinical or payer decisions and should preserve the provider's obligations to patients and regulators.

16. Separate provider operating risk from receivable value

A strong receivable pool can weaken if the provider cannot continue delivering care, coding claims or managing payer relationships. The lender should review licences, accreditation, clinician staffing, pharmacy and consumable supply, information systems, cyber-security, malpractice, quality events and business continuity.

Provider concentration by facility and service line matters. A licence suspension or equipment failure at one site can stop new claims. A key clinician departure can affect high-value services. A tariff or network change can shift patient volume.

The operating model should identify the minimum cash needed to keep care and billing functioning. Collections can lag for months after a disruption, and the borrowing base can decline immediately as new eligible claims fall. Minimum liquidity should reflect this gap.

Insurance policies should be reviewed for business interruption, cyber, professional liability, property and fidelity. Coverage exclusions, waiting periods and claim timing mean insurance is a secondary protection rather than ordinary debt service.

17. Structure security and assignment carefully

The security package can include assignment or charge of eligible receivables, collection accounts, insurance proceeds, relevant contracts and shares or assets where lawful and appropriate. The exact package depends on the jurisdiction, provider licence, payer contract and financier status.

UAE receivables law recognises transfers of current and future receivables and uses registration for effectiveness against third parties and priority.[7] The CBUAE Finance Companies Regulation includes factoring within the regulated framework for finance companies.[8] Transaction counsel should confirm licensing, registration, notice, set-off, priority and enforcement.

Anti-assignment or consent provisions in payer contracts should be abstracted. Even where a transfer can be effective between transferor and transferee, payer defences, payment instructions and third-party priority need analysis. Government receivables may have additional restrictions.

Collateral descriptions should match claim data and legal entities. The lender should search for existing assignments, bank security, negative pledges and liens. Receivables already sold, pledged or subject to cash pooling should be excluded until priority is resolved.

18. Establish a controlled diligence path

The first fifteen days should map legal entities, facilities, licences, payers, administrators, claim systems, service lines, contracts, accounts and the proposed facility use. Management should deliver raw claim history, ledgers and bank receipts with data definitions.

Days sixteen to forty-five should reconcile claim cohorts, denial, aging, dilution, payer concentration, tariffs, recoupment and cash allocation. Samples should trace encounter evidence to cash. Legal and regulatory advisers should review assignment, security, notice, data and provider obligations.

Days forty-six to seventy should build the borrowing base, reserves, downside, facility size, covenant package and cash waterfall. The provider should test a shadow certificate using the proposed definitions. Exceptions should be resolved or explicitly excluded.

Days seventy-one to ninety should finalise security, account control, payer notices where applicable, reporting, independent testing and closing conditions. The first post-closing certificate should be rehearsed before funding.

Table 6. Ninety-day healthcare receivables financing workplan

Period	Primary work	Required output	Approval gate
days 1-15	entity, licence, payer, contract, system and account map	claim-to-cash architecture and data request	defined pool and purpose
days 16-30	tape, ledger, settlement and bank reconciliation	reconciled historical data spine	reliable identifiers and balances
days 31-45	aging, denial, cohort, concentration and recoupment	recoverability analysis	evidence-based exclusions and reserves
days 46-60	eligibility, advance rates, downside and liquidity	draft borrowing base and model	financeable base case and combined downside
days 61-70	assignment, security, notice, data and account review	legal and regulatory structure	enforceable and operational route
days 71-80	covenants, remedies, reporting and sampling	term sheet and certificate	definitions aligned across documents
days 81-90	closing evidence and shadow reporting cycle	final conditions and first certificate	controlled funding readiness

Timing depends on data quality, payer cooperation and legal requirements.

19. Use a credit committee gate that can say no

The credit paper should answer eight questions. Which legal payer owes each eligible claim? Which evidence establishes coverage, authorisation, coding, contract price and submission? How much was collected from comparable cohorts? Which denials are curable? How concentrated is the stressed pool? Which cash is restricted? How are assignment, account control and priority implemented? Which downside can the provider survive without harming care?

The facility should pause when claims cannot reconcile to cash, original submission dates are unavailable, payer identity is unclear, denial reasons are overwritten, provider licences or contracts are uncertain, patient or restricted money is counted as liquidity, assignment conflicts remain, or management cannot deliver a repeatable certificate.

The approval memorandum should list every management estimate, evidence gap, exclusion, reserve and condition. It should state which facts require a bring-down before closing and which milestones govern later availability.

Independent review should have a defined scope. Coding specialists can test sampled claims. Data reviewers can reproduce aging and cohorts. Legal advisers can review contracts and security. Finance reviewers can reconcile ledgers and cash. Management remains responsible for complete information and clinical compliance.

20. Turn the facility into a monthly operating discipline

The borrowing-base process can improve revenue-cycle management. A daily exception queue identifies missing eligibility, authorisation, documentation, coding and submission. A denial waterfall assigns root causes. A payer map directs contract and collection attention. A cash-control account forces timely allocation.

Finance, revenue cycle, clinical operations, coding, compliance and technology should own defined metrics. The monthly certificate should reconcile to the same source records used internally. Restatements should be visible and explained.

The lender should review leading indicators before availability falls. Encounter-to-submission time can signal future aging. First-pass acceptance can signal documentation quality. A rising pending-information queue can precede denial. Missed payment notifications can precede liquidity pressure.

A well-designed facility releases cash as claim evidence strengthens. It provides working-capital support while preserving payer, patient and regulatory obligations. It also gives management a transparent route from care delivered to cash collected.

Conclusion

Healthcare receivables in the GCC can support predictable liquidity when the financing follows the claim's legal and operational state. Gross billed value is an initial record. Collectible value emerges through eligibility, authorisation, documentation, coding, contract pricing, submission, adjudication, reconciliation and settlement.

The framework in this paper converts that process into a controlled borrowing base. It uses claim-level data, original timestamps, denial root causes, static-pool collections, payer concentration, state-weighted advance rates and explicit reserves. It separates restricted cash, captures proceeds in a controlled account and links deterioration to defined remedies.

The result is a financing structure that can support essential healthcare working capital while limiting advances against unresolved claims. Providers gain liquidity and operating visibility. Lenders gain traceable evidence, dynamic collateral value and an actionable early-warning system.

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About the Author

Authored by Chennakeshav Adya
Independent Researcher

Chennakeshav Adya researches corporate finance, private capital, investment banking and the financing of strategic infrastructure and operating platforms. His work translates market, contractual, technical and financial evidence into practical decision frameworks for boards, sponsors, investors and lenders.