UNC Hospitals Cary Campus
Project ID #J-012636-25
Comments on Behalf of Duke University Health System

Duke University Health System, Inc., which operates Duke University Hospital ("DUH"), submits these comments regarding the application filed by University of North Carolina Hospitals (Project ID #J-012636-25) for acute care beds at UNC Hospitals Cary Campus ("UNC"). That application does not satisfy the applicable statutory and regulatory criteria, is not the comparatively superior project in this comparative review, and should be disapproved.

Background

UNC originally applied and was approved for a "small community hospital" that would provide a different experience to the larger facilities in the service area. It has filed and been awarded beds in two further iterations, for an approved total of 102 beds. It now proposes an additional 34 beds, which would create a hospital with 136 beds. Each new iteration of this project takes it further from what was originally approved based on a stated need for a small facility to serve low acuity patients in a community setting, and ever closer to Wake County rather than the service area population it proposes to serve. Despite this, UNC simply relies on the same rationale it presented for a 40-bed hospital. In the meantime, the patients, including those from the service area, who relay on Duke University Hospital as a trauma center and regionally and nationally recognized provider of tertiary and quaternary care need access to beds as quickly as possible.

UNC relies on the same basic assumptions as it used in its earlier applications for this facility and claims that because they were found to be reasonable for a smaller facility at a different location using older data, those same assumptions should not be questioned. The Agency has an obligation, however, to evaluate those assumptions and resulting projections for reasonableness for this project. As set forth below, the assumptions are not reasonable and do not support this application.

UNC Does Not Establish A Need For Additional Capacity

UNC's attempts to document a need for its additional bed capacity rely on factors that are not related to the project it proposes.

As a threshold matter, the need in the 2025 SMFP is based on acute care patient days from FY 2023 and projected forward four years to FY 2027. Thus, the need outlined in the 2025 SMFP reflects the expected demand in 2027 – while including previous need determinations and undeveloped beds as part of the inventory. In fact, UNC has been approved for beds, and now seeks additional beds, for a facility that will not come online until 2032. UNC's project does not meet the need reflected in the plan and leaves service area residents without adequate bed capacity in the interim period.

In Section C of the Application, UNC bases its need argument in large part on the fact that the service area including Durham County has had the third highest number of bed need determinations in the past 6 years. This seeks to coopt the utilization of Duke University Hospital to support a need for a very different proposal.

SMFP Bed Need Determinations – Durham County Service Area

SMFP	DUH Bed Deficit	Need Determination	UNC Application	UNC Approval	DUH Application	DUH Approval
2021	79	40	40	40	40	0
2022	141	68	34	34	68	34
2023	127	0	--		--	
2024	160	38	38	28	38	10
Total		**146**		**102**		**44**

The need determinations in each of these years has been generated solely by Duke University Hospital. Moreover, since 2022, the bed deficits within the DUHS system have been offset by prior need determinations that have been awarded primarily to UNC. Accordingly, Duke University Hospital's bed deficit simply continues to grow unabated and unaddressed. In the 2025 SMFP, DUH's bed deficit has now reached at 238 beds, with a resulting need determination of 82 beds. Awarding additional beds to UNC now for implementation in 2032 cannot, and will not, address that deficit.

UNC also bases its application on a purported need to serve Durham County patients. However, UNC acknowledges that only a "plurality" – i.e., less than half – of the Durham County service area acute care days are driven by the needs of Durham County patients (UNC Application page 65). The remainder of those patients come from outside the county, specifically to access the quaternary, tertiary, and specialty hospital services that UNC specifically states it will not provide. The high percentage of patients that access services the county from other regions is not, contrary to UNC's contention, evidence of need for its own proposed project for a small "community" hospital that is projected to serve primarily Durham County patients.

UNC also specifically states that "the proposed project is being developed to ensure that Durham county residents, many of whom leave Durham County to access inpatient care at a NC facility have local access to a UNC Health hospital." (See Application p. 146). However, patient origin reports for Durham County patients seeking care at UNC Hospitals in Orange County or Rex Hospital in Wake County reflect that UNC's approved project already has the capacity to accommodate such volume.

Durham County Patients at UNC Facilities

Year	UNC Hospitals (Chapel Hill/ Hillsborough)	Rex Hospital (Raleigh/ Holly Springs)	Total
2019	2557	357	2914
2020	2384	385	2769
2021	2426	348	2774
2022	2313	471	2784
2023	2342	455	2797

Source – 2020-2024 patient origin reports (Acute Care Hospital Admissions: Patient Origin by Facility)

This volume has declined since 2019 and has held essentially flat since 2020. Even if 100% of this volume were to be shifted from UNC Hospitals and Rex to the new facility, UNC's previously approved bed capacity is more than sufficient to accommodate it. In any event, as discussed further below, much of Durham County is closer to UNC facilities in Orange County, and a significant shift of patients to a smaller hospital offering a narrower scope of services farther from home is unlikely.

Finally, UNC tries to bolster the need for its project based on the demographics of Durham County as a whole, including a description of the needs of the Black population of the county (see Application, p. 58). This need has no relation to the project that UNC is actually developing. As reported in US Census data and reflected in UNC's application, Black residents constitute more than 34% of the county's population (see https://www.census.gov/quickfacts/fact/table/durhamcountynorthcarolina/PST045224). By contrast, Black residents constitute only 7.4% of the population in 27519, the zip code on the Durham-Wake County border in which UNC has chosen to build a hospital (https://data.census.gov/table/ACSDP5Y2023.DP05?q=27519). Any unmet need for this population in Durham County will not be addressed by UNC's project.

UNC effectively describes a need for additional capacity to meet the demand for additional services at Duke University Hospital which generated the need; it cannot, however, leverage that need to support its own, wholly unrelated project.

UNC's Patient Origin Projections are Unsupported and Unreasonable

UNC does not adequately support its projections about patient origin as required by Criterion 3. UNC arbitrarily creates "regions" within Durham County in its presentation of need for its proposed additional beds, but then does not project utilization in any way to those regions. It is also striking that the actual zip code in which its facility will be located – 27519 – is not even included in any of these identified regions (See Application p. 62). This reflects the unavoidable fact that this facility will be in Cary, not Durham.

UNC's projections about the patients to come from Durham County are not supported. It is not reasonable to assume that a "community" facility on the Wake County border will serve the projected patient volumes from patients throughout Durham County. Patients throughout most of

Durham County are significantly closer to other facilities – including other UNC facilities – than to UNC-Cary. Even in 27707, one of the identified "South Region" zip codes that UNC states is underserved, is closer to UNC-Chapel Hill than to UNC-Cary.

Distance from Durham Zip Codes to UNC and DUH Facilities

Durham Zip Code	Miles to UNC-Cary (27519)	Miles to UNC-Chapel Hill	Miles to UNC-Hillsborough	Miles to Duke University Hospital
"South"				
27703	10.6	18.1	22.2	21.1
27713	3.7	10.6	18.5	16.0
27707	9.3	8.5	13.2	5.5
27709	3.0	12.7	21.2	11.2
"Central/West"				
27708	16.5	11.3	11.9	1.5
27705	18.9	11.1	8.2	4.4
27701	11.8	13.3	15.3	3.7
"North"				
27704	15.0	19.7	18.1	9.4
27712	20.8	22.4	16.4	7.6
27503	25.9	25.9	18.9	14.4

UNC's location does not support the assumptions that the facility will capture a share of patient volume from throughout the county. As described above, UNC's projections also greatly exceed the Durham County patient volume it currently sees at its Orange County facilities, although they are larger, have a broader scope of services, and are for most patients in the county, significantly closer.

It is also notable that UNC continues to rely on the same assumptions as its previous applications despite now planning to develop the facility in a new location. The facility's location is farther from the original site for patients from every zip code in Durham County except for 27713.

UNC's patient origin projections are also unreasonable because they fail to provide any detail for counties other than Durham, failing even to identify patients from the other counties in the defined acute care service area. The resulting patient origin projections are unreasonable. UNC has projected an unreasonable percentage of patients to come from "inmigration." This inmigration percentage is higher than it projected in previous applications, despite not projecting any increased

scope of services in this application, and cannot be supported simply by stating that it reflects a similar methodology to previous applications. This assumption cannot be accepted where, as here, it contradicts available data.

UNC claims "other" patients reflect inmigration from Chatham, Person, Granville, Caswell, Warren, and half of inmigrating days of care of Wake County (see Application, pp. 71-73). However, as documented in the state's most recent Patient Origin report, these counties constituted only 18.2% of inpatients at Durham County facilities, significantly less than the 30.4% inmigration assumed by UNC.

2023 Inpatients at Durham County Facilities

Wake County (times .5)	7022*.5 = 3511
Granville County	3234
Person County	2421
Chatham County	445
Caswell County	244
Warren County	469
Total Patients	56,601

2024 Acute Care Hospital Admissions: Patient Origin by County of Service
https://info.ncdhhs.gov/dhsr/mfp/pdf/por/2024/01-Destination_Acute-2024.pdf

UNC may try to claim that its inmigration projection is based on days of care, not patients. Criterion 3 requires projection of patient origin by patients, not days of care, and UNC projects 30.4% of patients to come from in-migration from the identified counties. This is unreasonable compared to actual publicly reported data about utilization of Durham County facilities.

These inmigration assumptions are also unreasonable based on UNC's assumption that it will experience a comparable inmigration of patients to existing facilities with a very different scope of services and in a different location in the county. The existing inmigration patterns include patients referred to DUH's highly specialized quaternary care, and are not necessarily those seeking "community" hospital services. It is not reasonable to expect that patients from Person, Granville, Caswell, and Warren Counties will bypass closer Duke and UNC facilities to access care at UNC-Cary.

Finally, UNC projects an identical "inmigration" for all acute care services, without any explanation or support. Patient origin data in hospital license renewal applications, including those for Durham County facilities, do not support the assumption that outpatient and emergency department services will have the same patient origin patterns as inpatient services.

UNC's application is accordingly not conforming with the requirements in Criterion 3 regarding identifying the patient population to be served.

UNC's Utilization Projections are Unsupported and Unreasonable

UNC's utilization projections are not reasonably supported, and as a result the Application is not conforming with Criteria 3, 4, 5, 6, and 18a, as well as the regulatory performance standards.

Throughout its application, UNC tries to distinguish itself from the existing facilities in Durham County by stating that it will have a narrower scope of services. However, in order to meet the performance standards, UNC-Cary's utilization projections reflect a much broader scope of services that it proposes to offer. UNC does adjust the projected days of care it will provide by excluding certain types of services such as transplant. It does not, however, make any further adjustment for the appropriate case mix index for the facility described by UNC-Cary by limited volume projections by DRG or other acuity level. Therefore, UNC necessarily projects that it will attract and serve the full scope and complexity of patients in all of the "included" service categories currently treated at the existing tertiary hospital providers, regardless of ICU needs, co-morbidities, or other complications that would drive patients to an academic medical center or other specialty setting. This overstates the number of patients who would be likely to seek care at UNC.

The unreasonableness of perpetuating these aggressive assumptions is demonstrated in the application's average length of stay (ALOS). UNC-Cary's projected average length of stay across all service lines is 5.84 days (38146 days/6535 discharges). By contrast, the ALOS at UNC-Rex Hospital, a much larger tertiary hospital approximately 15 miles away from UNC-Cary's location was 4.26 days in its 2025 license renewal application. Similarly, the ALOS of Duke Regional Hospital, the tertiary hospital in Durham County that UNC repeatedly contrasts to its proposal, was 4.98 days. Because average length of stay is directly related to the total bed days that UNC-Cary relies on to demonstrate the need for the project, the application's total bed days are similarly unreasonable. It is notable that nowhere does UNC state its ALOS at its Hillsborough campus, a comparable facility in terms of size and scope, nor any other data more reflective of UNC's proposed facility scope.

Furthermore, as discussed above, UNC's inmigration assumptions also overstated projected utilization. For all these reasons, UNC's projections and resulting financial pro formas are unreasonable and its application is unapprovable.

UNC's Payor Mix Assumptions are Unsupported and Unreasonable

UNC's Application also provides inadequate and unsupported assumptions regarding its projected payor mix and therefore does not meet the requirements of Criterion 13(c).

Despite having access to its own payor mix information for patients from Durham County seeking care at UNC and Rex facilities, UNC assumes that its inpatients will have a payor mix equivalent to patients "receiving inpatient services" in Durham County generally. This does not accurately reflect the scope of services UNC actually proposes to provide. For example, UNC does not

document any intention to provide pediatric services, which are typically provided in separate units within a hospital. Such services have a dramatically different payor mix than adult inpatient services. Other "excluded" services included in the baseline data used to projected payor mix may reflect a very different patient population than the one UNC proposes to serve. Similarly, UNC assumes that its emergency department patients will have the same payor mix as all county residents reported in HIDI for such services, despite the fact that the UNC emergency department will not be a trauma center.

Finally, and fundamentally, this payor mix assumption reflects the same unsupported assumption that "Durham County" patients from across the county – with the same demographics and payor profile – will come to this facility at the edge of the county in lieu of the 3 existing facilities in the county as well as UNC facilities in Orange County that are closer to most of the service area.

UNC's Application Is Not The Most Effective Proposal In This Review.

Even if it were approvable, UNC's Application would not be comparatively superior to the other application in this review filed by DUH for 82 beds, for the following reasons:

Addressing the SMFP Need Determination

DUH proposes to meet the entire need established in the 2025 SMFP. In addition, that need is based solely on the growing utilization at DUH. For the reasons described above, UNC is not positioned to effectively meet that need for additional capacity for DUH's specialized services.

Scope of Services and Access by Service Area Residents

Generally, the application proposing to provide the broadest scope of services is the most effective alternative regarding this comparative factor. DUH is an existing acute care provider to include a Level I trauma center and a tertiary and quaternary care academic medical center providing a wide array of advanced medical services. UNC-Cary is a proposed community hospital that will offer a smaller range of services to patients of lower acuity.

Scope of services is particularly relevant given that DUH's high utilization generated the need for the additional acute care beds identified in the 2025 SMFP. The demand for acute care beds is being generated by the highly specialized services offered only at DUH and DUH's patient origin, and UNC-Cary does not propose to offer such services to that population.

Therefore, only DUH projects the range of high acuity services driving the SMFP need for acute care beds in the service area, making it the most effective alternative with respect to scope of services.

This significant difference in scope of services means that utilization by service area residents is not a meaningful comparative factor. In the 2024 Wake County bed review, the Agency expressly found that access by service area residents is not a useful factor where the scope of services varies greatly among the applicants:

> In addition, differences in the acuity level of patients at each facility, the level of care (community hospital, tertiary care hospital, quaternary) at each facility, and the number and types of surgical services vs. all patient services proposed by each of the facilities may impact the numbers shown in the table above. Furthermore, the SMFP need methodology for acute care beds does not consider patient origin. Considering the discussion above, the Agency believes that in this instance attempting to compare the applicants based on the projected acute care bed access of residents of the Wake County service area would be ineffective. Therefore, the result of this analysis is inconclusive.

See Findings p. 392.
(https://info.ncdhhs.gov/dhsr/coneed/decisions/2025/jan/findings/2024%20Wake%20Acute%20Care%20Bed%20and%20OR%20Review%20Findings.pdf).

This same conclusion is similarly true here, where the need was driven solely by the utilization at Duke University Hospital, including over 71% of patients from outside of Durham County.

Geographic Accessibility

Neither UNC-Cary's change of scope nor DUH's proposed project will change the location of existing or approved acute care hospitals in Durham County. UNC-Cary is specifically proposing a "change in scope" to a facility previously approved, not a new facility. There will be no meaningful change in geographic access to hospital services. In the 2024 Wake County bed review, the Agency specifically concluded:

> If an applicant proposes to locate the health service/asset in a facility or location where there is already that health service/asset, then the proposal offers no greater geographic accessibility. If an applicant proposes to locate the health service/asset in a facility or location where there is not currently any of those health services/assets, then, generally, it is a more effective alternative. If all applicants are proposing to locate their health service/asset in facilities or locations that already operate those services, then they are equally effective because residents have the same geographic access they had previously.

See Findings p. 289.
(https://info.ncdhhs.gov/dhsr/coneed/decisions/2025/jan/findings/2024%20Wake%20Acute%20Care%20Bed%20and%20OR%20Review%20Findings.pdf).

The Agency specifically applied this analysis to approved as well as existing facilities, concluding that "[t]he applications of WakeMed North, WakeMed Cary, WakeMed Raleigh, UNC Rex Raleigh, Duke Raleigh and Duke Cary applications all propose to locate acute care beds in a facility at a location which either currently offers acute care beds **or is approved to offer acute care beds**, therefore they are all least effective alternatives."

In addition, the UNC-Cary facility is located almost on the Durham-Wake border and is less accessible to patients from most of the service area, including but not limited to Caswell and Warren Counties. UNC-Cary's project will not meet this high acuity need and will not increase geographic access for those needed services, as patients are traveling from throughout the state for DUH's tertiary and quaternary care. DUH's project will expand access to a broad range of patients throughout the region and state.

DUH's proposal is therefore equally or more effective than UNC in terms of geographic access.

Historical Utilization

DUH is the most effective alternative regarding historical utilization. DUH has a utilization rate that routinely exceeds 90%, well in excess of UNC's projected utilization even at full ramp-up. In the 2024 Wake County bed review, the Agency used relative utilization rates and bed deficits as a differentiating factor in awarding beds among applicants. The facilities with the higher utilization rates and greater deficits demonstrated a greater need. In this review, DUH has a higher historical and projected utilization rate, and has demonstrated an ongoing and unaddressed bed deficit. UNC will not even begin services until 2032 and will have a lower utilization rate.

DUH is the more effective alternative for this factor.

Access to Underserved and Revenues/Costs per Encounter

Other factors commonly used in CON reviews, including percentage of Medicare and Medicaid patients, operating costs, and net revenues, have been found to be inconclusive in acute care bed reviews. This reflects the different scope of services and the differences in how applicants present their financial pro formas.

CONCLUSION

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of acute care beds that the Healthcare Planning and Certificate can approve. Approval of all applications submitted during the review would result in an acute care bed excess of the need determination for the Durham/Caswell/Warren County service area. Only DUH's project can be approved as it is the only application that conforms to all project review criteria and applicable

performance standards. DUH's project is also the most effective alternative to meet the need if all applicants were approvable, based on the summary above.