The National Hyperbaric Access Gap

A directional infrastructure analysis · RxAir360 Inc. · October 2026

<1,400
HBOT facilities serving the entire United States

~500,000
clinically eligible patients nationwide each year

~1 in 4
eligible patients current capacity can treat

4,000 mi
travel for one 30-session course at the rural average distance

THE INFRASTRUCTURE GAP

HBOT is FDA-cleared for 14 serious conditions, including non-healing diabetic wounds, osteomyelitis, radiation tissue injuries, and carbon monoxide poisoning, and Medicare covers it. What holds it back is where the chambers are.

Fewer than 1,400 facilities offer HBOT nationwide, roughly 70% of them hospital programs in metropolitan areas. Even using conservative assumptions, that infrastructure can treat about 90,000 to 160,000 new patients a year, roughly one in four of the estimated 500,000 Americans who qualify.

> *"The patient in the Mississippi Delta is not an outlier. He is one of an estimated 500,000 Americans each year who qualify for a covered, FDA-cleared therapy that the current system can reach about one in four times."*

Standard protocols require 20–40 sessions over 4–8 weeks. At the estimated rural average of 67 miles each way, a single 30-session course means roughly 4,000 miles of driving, which puts HBOT access closer to dialysis than to a typical specialty referral.

WHERE THE NEED LIVES

America's chambers were built where hospitals are. Hyperbaric demand lives where diabetes is: in rural counties, the Diabetes Belt, and lower-income communities with the highest amputation rates.

Rural America ~66 million residents · est. 67+ mi average one-way trip to HBOT	**The Diabetes Belt** 644 counties · 15 states · diabetes prevalence 11% or higher
Amputation Risk Black patients face up to 4× the risk of major amputation	**Utilization** Only ~5.5% of qualifying Medicare patients treated, even in high-use states

The referral network is shrinking. 197 rural hospitals have closed or converted since 2005, and 720 more are at risk of closing, 294 of them within two to three years.

Policy is pulling both ways. CBO projects about 10 million more uninsured by 2034 under H.R. 1, while the new $50 billion Rural Health Transformation Program puts funding in states' hands now.

Full 18-page brief with national demand modeling, capacity analysis, and policy recommendations available at rxair360inc.com.

The RxAir360 device has not yet received FDA clearance.
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The Deployment Model That Closes the Gap

From infrastructure crisis to investable infrastructure asset

$3.1–3.7B

Estimated annual unmet U.S. HBOT demand

THE ARCHITECTURAL SHIFT

Hospital programs were designed for acute institutional care, and incremental expansion will not reach patients who live 67 miles away and need 30 visits. Closing the gap calls for a shift toward community-based capacity in physician offices and outpatient settings, with hospitals continuing to handle the emergencies that belong there.

RxAir360 Inc. is developing a compact, physician-office-deployable HBOT system engineered for exactly this deployment model and purpose-built for the outpatient practice setting, subject to FDA clearance.

RXAIR CAPITAL SOLUTIONS: THE FINANCIAL ENGINE

RxAir Capital Solutions, the planned leasing subsidiary, is the primary mechanism for deployment, recurring revenue, and scale, built as an asset-backed infrastructure model rather than a device sale.

Each deployed unit is placed inside a credentialed physician practice with little to no upfront capital required from the physician. RxAir360 captures recurring lease revenue backed by the Medicare reimbursement stream already flowing for HBOT under National Coverage Determination 20.29, a structure closer to dialysis center deployment than to a conventional device transaction.

WHY NOW

→ Rural hospital closures are eliminating referral networks.

197 rural hospitals closed or converted since 2005 and 720 at risk, removing the local entry points that connect patients to HBOT.

→ States are deciding how to spend rural transformation funds.

First-year Rural Health Transformation Program awards averaging about $200M per state are flowing now, and state plans will shape rural specialty care through 2030.

→ Medicare reimbursement is already in place.

Medicare covers HBOT today under NCD 20.29. The only missing piece is delivery infrastructure within reach of the covered population.

→ Cost avoidance reframes the ROI.

Every 10,000 major amputations avoided represents roughly $700M–$1B in avoided acute hospital costs.

COMPANY STATUS

One issued U.S. patent. Device development complete. Third-party EMC and electrical safety testing completed. FDA 510(k) submission in final preparation.

$3.65M+ raised

Medical Advisory Board co-chaired by Dr. Jeffrey Niezgoda (Past President, American College of Hyperbaric Medicine) and Dr. Tyler Sexton (President, ACHM).

UNIT ECONOMICS

Deployment Scale	Est. New Patients/Year	Est. Gross Reimbursement
1 deployed unit	30–60 patients/year	~$360K–$720K
100 deployed units	3,000–6,000 patients/year	~$36M–$72M
500 deployed units	15,000–30,000 patients/year	~$180M–$360M
1,000 deployed units	30,000–60,000 patients/year	~$360M–$720M

Gross Medicare reimbursement to treating physicians at ~$400/session × 30 sessions. Not RxAir360 revenue. Varies by payer mix & indication.

RxAir360 is actively convening a working group

of infrastructure investors, clinical leaders, and policy advisors focused on the states and communities where the national gap is widest. If you recognize this gap and want to be part of closing it, we invite you into that conversation.

MEDIA & POLICY BRIEFINGS

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