The Hyperbaric Access Gap in the Nation's Capital Region

A directional infrastructure analysis · RxAir360 Inc. · 2026

12–15%
of eligible patients the system can currently reach

9,500+
clinically eligible DMV patients/year unreached

4,200 mi
travel burden, one 30-session course in Kent County

0
HBOT facilities on MD Eastern Shore

THE INFRASTRUCTURE GAP

HBOT is FDA-cleared for 14 serious conditions, including non-healing diabetic wounds, osteomyelitis, radiation tissue injuries, and carbon monoxide poisoning. Medicare covers it. The clinical evidence is established. The problem is not medical. The problem is structural.

The DMV's hospital-centered HBOT infrastructure serves only approximately 12–15% of clinically eligible patients each year. Virtually every facility is concentrated within a 25-mile radius of the I-95 corridor between Baltimore and Woodbridge, VA.

"A diabetic patient on Maryland's Eastern Shore has the same functional HBOT access as a patient in rural Mississippi, which is to say, effectively none."

HBOT is not a one-time procedure. Standard protocols require 20–40 daily sessions over 4–8 weeks. Distance manageable for a single specialist visit becomes clinically prohibitive across 40 sessions, making HBOT access more analogous to dialysis than to a typical specialty referral.

THE CARE DESERTS

Step outside the I-95 corridor and HBOT access drops to zero. These communities carry the highest chronic disease burden in the region and the lowest access to the therapy that treats it.

MD Eastern Shore ~450,000 residents · 9 counties · 0 facilities · 70–110 mi to nearest care	**Southern Maryland** ~375,000 residents · Charles, Calvert, St. Mary's · 0 facilities
Rural Virginia SW VA diabetes prevalence 13.4% vs. NoVA 7.7% · 0 facilities	**The DMV Paradox** NIH, FDA, and CMS are headquartered here. The gap is visible from their offices.

Maryland is among only 7 states where the rural–urban diabetes disparity remains statistically significant after adjusting for age, sex, race, and ethnicity (CDC, 2025).

H.R. 1 accelerates the gap. Three rural Virginia clinics have already closed citing the law. Eight of nine at-risk Virginia hospitals face immediate closure risk, threatening the referral networks through which rural patients reach HBOT.

Full 27-page brief with facility maps, demand modeling, and legislative analysis available upon request.

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

$85M+

Annual unmet DMV HBOT demand

THE ARCHITECTURAL SHIFT

The hospital-centric HBOT system cannot close this gap through incremental expansion. It was designed for acute institutional care, not for 40-session outpatient protocols serving patients 70 miles away. A fundamental architectural shift is required: from centralized hospital deployment to decentralized, community-based delivery.

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. This is not a device sale model. It is an asset-backed infrastructure model.

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.

195 closed nationally since 2005. 338 more at risk, including six in Virginia. The referral pipeline to HBOT is disappearing at the moment demand is rising.

→ H.R. 1 suppresses hospital capacity expansion.

$4.7B in projected annual Virginia hospital revenue losses makes new hospital-based HBOT programs unlikely at exactly the moment chronic disease burden is growing.

→ 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.

Preventing 200 major amputations a year in the DMV would avoid ~$14–20M in acute hospital costs annually. HBOT infrastructure is cost-containment infrastructure.

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
10 deployed units	300–600 patients/year	~$3.6M–$7.2M
50 deployed units	1,500–3,000 patients/year	~$18M–$36M
100 deployed units	3,000–6,000 patients/year	~$36M–$72M

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, beginning with the DMV region. 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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