RxAir360

RxAir360 Inc. | National Research Brief

The National Hyperbaric
Access Gap

A Directional Analysis of Where America's HBOT Infrastructure Sits, Which Patients It Misses, and Why the Hospital Model Alone Cannot Close the Gap

RESEARCH SERIES | PAPER 2 OF 4

This brief is the second in a series examining hyperbaric oxygen therapy access in the United States. Paper 1 documented the access gap in the DMV region. Paper 2 applies the same method to the nation as a whole. Paper 3 will address veterans and TBI/PTSD access, and Paper 4 will make the economic case for amputation prevention.

<1,400	~500,000	~1 in 4	197
HBOT Facilities Serving the Entire United States	Clinically Eligible Patients Per Year Nationally	Estimated Share of Eligible Patients the System Can Treat	Rural Hospitals Closed or Converted Since 2005

Diallo M. Watts, Sr.
Founder & CEO, RxAir360 Inc. | October 2026
www.rxair360inc.com

SECTION I | EXECUTIVE SUMMARY

Executive Summary

Paper 1 in this series found that the hospital-centered hyperbaric system in the Baltimore–Washington corridor can serve roughly 12–15% of the patients who clinically qualify for treatment each year, and that entire counties within a two-hour drive of the nation's capital have no hyperbaric oxygen therapy (HBOT) at all. This brief asks whether that pattern is a regional quirk or a national condition. The evidence points to a national condition.

HBOT is an FDA-cleared, Medicare-reimbursable treatment for 14 serious conditions, including non-healing diabetic wounds, radiation tissue injuries, chronic osteomyelitis, and carbon monoxide poisoning. A standard course runs 20 to 40 sessions, usually five days a week, which makes the distance between a patient's home and the nearest chamber one of the most important factors in whether that patient finishes treatment.

Fewer than 1,400 facilities offer HBOT across the entire United States, and roughly 70% of them are hospital-based programs in metropolitan areas. Meanwhile, the conditions that drive hyperbaric demand are concentrated somewhere else. About 40.1 million Americans have diabetes, and roughly 1.6 million develop a diabetic foot ulcer every year. The heaviest diabetes burden sits in a band of 644 counties across 15 mostly Southern states that the CDC calls the Diabetes Belt, and in rural America, where about 66 million people live and the estimated average one-way trip to an HBOT facility exceeds 67 miles.

Applying the same conservative method used in Paper 1, this brief estimates that roughly 500,000 Americans clinically qualify for HBOT each year, about 440,000 of them for chronic, scheduled indications. The nation's clinical HBOT infrastructure can treat an estimated 90,000 to 160,000 new patients a year, or roughly one in four. Actual use runs lower still. In a CMS evaluation of three states with historically high HBOT utilization, only about 5.5% of Medicare beneficiaries with a qualifying condition received the therapy.

The pressure on the rural system that refers patients into HBOT is building. Since 2005, 197 rural hospitals have closed or converted to outpatient-only care, and 720 more are at risk of closing, 294 of them within the next two to three years. The Congressional Budget Office projects that H.R. 1 will leave about 10 million more Americans uninsured by 2034 and reduce federal Medicaid and CHIP spending by roughly $990 billion over ten years. The $50 billion Rural Health Transformation Program partly offsets those reductions, and how states spend it will shape rural specialty care for the rest of the decade.

KEY NATIONAL FINDING

The United States has fewer than 1,400 HBOT facilities to serve an estimated 500,000 clinically eligible patients a year. Even using conservative assumptions, the current infrastructure can treat roughly one in four of them, and the facilities that do exist are concentrated in metropolitan hospital systems far from the rural counties and Diabetes Belt communities where the need is greatest. The DMV findings in Paper 1 are a local version of a national pattern.

Key Findings at a Glance

- **Fewer than 1,400 facilities** offer HBOT nationwide, roughly 70% of them hospital-based programs in metropolitan areas.
- **About 500,000 Americans** clinically qualify for HBOT each year by this brief's estimate, including about 320,000 with chronic diabetic foot ulcers.
- **Roughly one in four** eligible patients can be treated with current clinical capacity of about 90,000 to 160,000 new patients a year.
- **Only about 5.5%** of Medicare beneficiaries with a qualifying condition received HBOT in a CMS evaluation of three high-utilization states.
- **About 66 million** Americans live in rural areas, where the estimated average one-way trip to an HBOT facility exceeds 67 miles. A 30-session course at that distance means roughly 4,000 round-trip miles.
- **Black patients** with diabetes face up to four times the risk of major amputation compared with non-Hispanic white patients, and the Diabetes Belt has nearly three times the share of Black residents found in the rest of the country.
- **197 rural hospitals** have closed or converted since 2005, and **720** more are at risk of closing.
- **Annual national HBOT demand** is estimated at roughly **$4.5 billion**, of which an estimated **$3.1 to $3.7 billion** goes unmet each year.

SECTION II | THE NATIONAL FACILITY LANDSCAPE

Fewer Than 1,400 Facilities for a Nation of 340 Million

Fewer than 1,400 facilities across the United States offer HBOT. The large majority are hospital-based wound care and hyperbaric programs, and roughly 70% of all facilities sit inside metropolitan areas. A smaller group of independent clinics, many of them wellness-oriented, makes up the rest. Those independent providers serve a different patient population, often outside the FDA-cleared clinical framework and outside Medicare reimbursement for wound care, so they add little capacity for the chronic wound patients who make up most of the clinical demand.

Most hospital programs operate three to six monoplace chambers. Each chamber treats about four to five patients a day, and because a standard course requires 20 to 40 sessions, each chamber can take on roughly 30 to 40 new patients a year. A hospital program with four chambers can therefore start about 120 to 160 new patients a year, regardless of how many patients in its region qualify.

Emergency Capacity Has Thinned as Programs Shifted to Wound Care

Hyperbaric medicine began as emergency medicine, treating divers, carbon monoxide poisoning, and gas embolism. Two decades ago, according to an open letter published by the Undersea and Hyperbaric Medical Society, the majority of U.S. hyperbaric facilities were available around the clock for emergencies. Today, the Divers Alert Network counts only 67 facilities that treat diving accidents. The reasons cited by clinicians include staffing requirements, liability, and physician payment that does not reflect the length of emergency treatments.

The shift matters for this analysis in two ways. First, it shows that hospital chambers are now organized mainly around scheduled wound care. Second, the acute cases that do arrive still have to go somewhere, and when they come into a hospital program they take chamber time away from scheduled chronic patients. Hospitals are the right setting for those emergencies. They are simply not built to be the only setting for everything else.

COUNTING CHAMBERS IS NOT THE SAME AS COUNTING ACCESS

A national facility count can make the system look larger than it is. A chamber in a downtown hospital adds no practical capacity for a patient who lives 80 miles away and needs to come back 30 times. Access depends on three things at once: whether a clinical facility exists, whether it has open chamber time, and whether the patient can realistically reach it five days a week for six to eight weeks. Most of the country fails at least one of those tests.

SECTION III | WHERE THE NEED LIVES

The Disease Burden Behind Hyperbaric Demand

The CDC estimates that 40.1 million Americans, about 12% of the population, have diabetes, and that another 115.2 million adults have prediabetes. Roughly 1.6 million Americans develop a diabetic foot ulcer each year. About half of those ulcers become infected, and ulcers precede roughly 80% of diabetes-related lower-extremity amputations. The five-year mortality rate is about 30% after a diabetic foot ulcer and above 70% after a major amputation.

Chronic wounds are not a niche problem for Medicare. A 2018 analysis in *Value in Health* found that about 8.2 million Medicare beneficiaries, nearly 15% of the program, had at least one wound or wound-related infection in a single year, with total Medicare spending on wound care estimated between $28.1 billion and $96.8 billion.

The Diabetes Belt

Diabetes is not spread evenly. CDC researchers identified a Diabetes Belt of 644 counties in 15 states, including all of Mississippi and parts of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Every county in the belt has diagnosed diabetes prevalence of 11% or higher. Compared with the rest of the country, belt counties have nearly three times the share of non-Hispanic Black residents, higher rates of obesity and physical inactivity, and fewer college graduates.

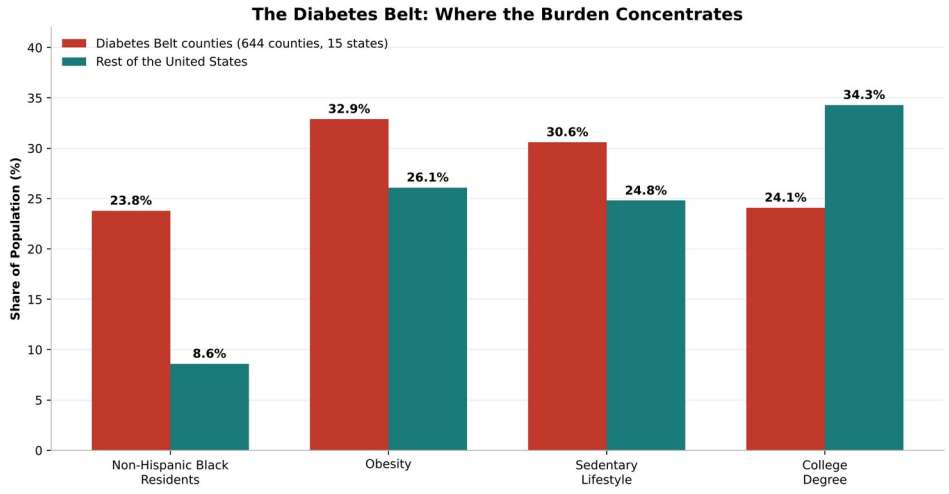

Figure 1: Population profile of Diabetes Belt counties compared with the rest of the United States. Source: Barker et al., American Journal of Preventive Medicine (2011).

Amputation Risk Follows Income, Race, and Geography

The same communities that carry the heaviest diabetes burden also carry the heaviest amputation burden. A 2025 review in *Current Diabetes Reports* found that Black patients face up to four times the risk of major amputation compared with non-Hispanic white patients, even after controlling for age and gender. The same review reported that every $10,000 drop in median household income is associated with a 4.4% increase in amputation rates. These are the patients for whom a completed course of HBOT can mean keeping a limb, and they are disproportionately the patients who live farthest from a chamber or who cannot take six weeks of daily time off to reach one.

THE NATIONAL MISMATCH

America's hyperbaric infrastructure was built where hospitals are. America's hyperbaric demand lives where diabetes is: in rural counties, in the Diabetes Belt, and in lower-income urban neighborhoods. The result is a structural mismatch between where chambers sit and where eligible patients live, and it repeats in state after state.

SECTION IV | THE DISTANCE PROBLEM AT NATIONAL SCALE

Why Distance Decides Who Finishes Treatment

About 66 million Americans, roughly one in five, live in rural areas according to the 2020 Census. For rural patients, the estimated average one-way trip to the nearest HBOT facility is more than 67 miles. At that distance, a 30-session course adds up to about 4,000 round-trip miles, and a 40-session course to more than 5,300. Each treatment takes 90 to 120 minutes in the chamber, so a single day of care can easily consume five hours or more.

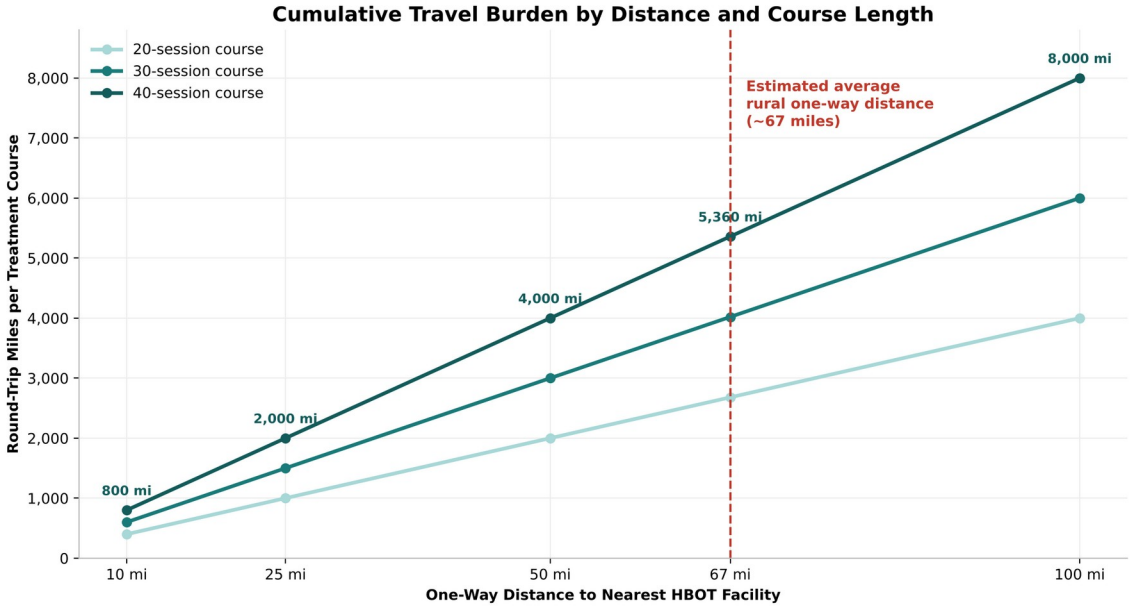

Figure 2: Round-trip miles required to complete a course of HBOT at different one-way distances. At the estimated rural average of about 67 miles, a 30-session course requires roughly 4,000 miles of travel.

One-Way Distance	20 Sessions	30 Sessions	40 Sessions
10 miles	400 mi	600 mi	800 mi
25 miles	1,000 mi	1,500 mi	2,000 mi
50 miles	2,000 mi	3,000 mi	4,000 mi
67 miles (est. rural average)	2,680 mi	4,020 mi	5,360 mi
100 miles	4,000 mi	6,000 mi	8,000 mi

Registry data point in the same direction. An analysis of 262,055 hyperbaric sessions recorded across 53 centers in 34 states between 2013 and 2022 found that patients averaged about 26 treatments, short of the 40-treatment series the authors used as the standard reference. Many factors affect how many sessions a patient completes, but for a therapy delivered five days a week, the time and cost of getting there are hard to separate from the outcome.

WHY HYPERBARIC ACCESS IS DIFFERENT FROM OTHER SPECIALTIES

A patient can manage one long drive to see a cardiologist or an orthopedic surgeon. HBOT requires 20 to 40 visits over four to eight weeks, which puts it closer to dialysis or radiation oncology than to a typical specialty referral. Proximity standards built for one-time specialty visits understate the problem. For HBOT, the right question is whether a patient can get to the chamber every weekday for six weeks.

AN ILLUSTRATIVE WEEK: A RURAL DIABETES BELT PATIENT

Composite example. Patient with a Wagner Grade III diabetic foot ulcer in a rural Mississippi Delta county. Nearest clinical HBOT program: about 75 miles away.

Each treatment day: roughly 150 miles of driving plus a two-hour session, about five and a half hours in total.

Each week: about 750 miles and 27 hours, often requiring a family member to drive and miss work.

Full 30-session course: about 4,500 miles and more than 160 hours. The treatment is clinically indicated and covered by Medicare. Completing it is a different question.

SECTION V | NATIONAL TREATMENT CAPACITY ANALYSIS

Estimating National Demand

This brief applies the method used in Paper 1 to national data. Starting with the 29.1 million Americans with diagnosed diabetes, it uses the published estimate of about 1.6 million diabetic foot ulcers per year and assumes that about 20% become chronic, non-healing wounds that meet HBOT criteria. That yields about 320,000 eligible diabetic foot ulcer patients a year. Other chronic indications, including refractory osteomyelitis, radiation injury, and compromised grafts and flaps, add roughly 120,000. Acute indications such as carbon monoxide poisoning, crush injury, and decompression illness add about 60,000 more.

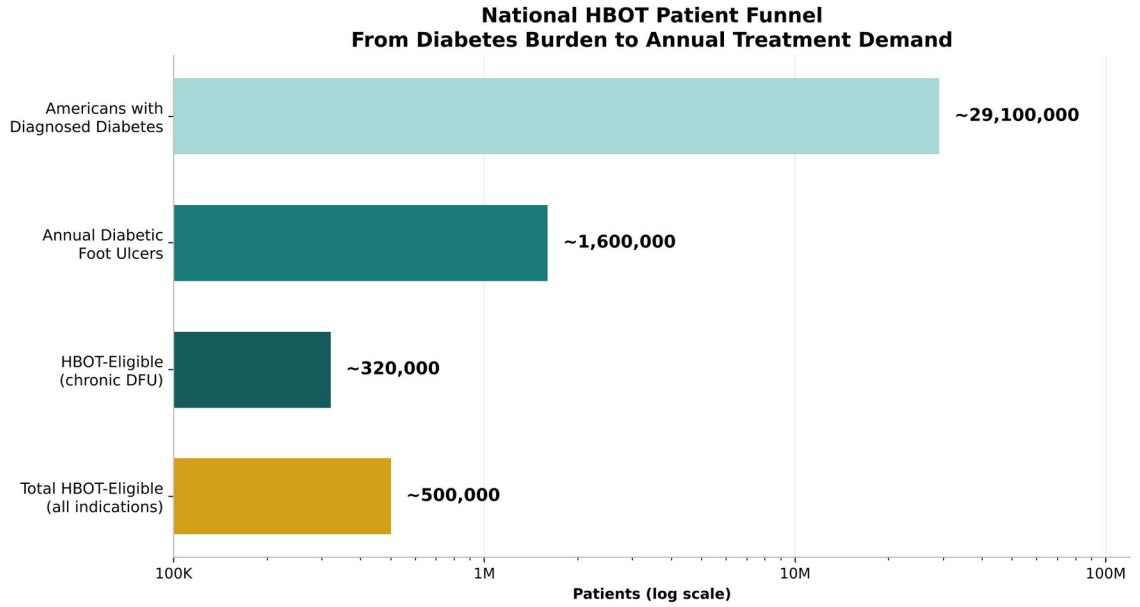

Figure 3: National HBOT patient funnel. Diabetes and diabetic foot ulcer figures from CDC (2026) and Armstrong et al., JAMA (2023); eligibility and additional indications estimated using the Paper 1 method.

Modeling Step	Assumption / Source	National Estimate
U.S. adults and children with diagnosed diabetes	CDC National Diabetes Statistics Report (2026)	~29.1 million
Annual diabetic foot ulcers	Armstrong et al., JAMA (2023)	~1.6 million
HBOT-eligible chronic DFU	~20% of DFUs become chronic (mid-range of 15–25%)	~320,000 patients/year
Other chronic indications	Osteomyelitis, radiation injury, grafts/flaps; Paper 1 ratios	~120,000 patients/year
Acute indications	CO poisoning, crush injury, DCI, gas gangrene; Paper 1 ratios	~60,000 patients/year
Total HBOT-eligible		**~500,000 patients/year**
Average reimbursement per course	Conservative estimate, consistent with Paper 1	$9,000 per patient
Total annual demand		**~$4.5 billion**
Unmet annual demand	Eligible patients beyond estimated capacity	~$3.1–$3.7 billion

Estimating National Capacity

Of the fewer than 1,400 facilities, this brief treats about 1,000 as clinical programs that can serve Medicare wound patients. At three to four monoplace chambers per program and 30 to 40 new patients per chamber per year, national clinical capacity comes to roughly 90,000 to 160,000 new patients a year, with a midpoint near 125,000. Measured against about 500,000 eligible patients, the system can treat roughly one in four.

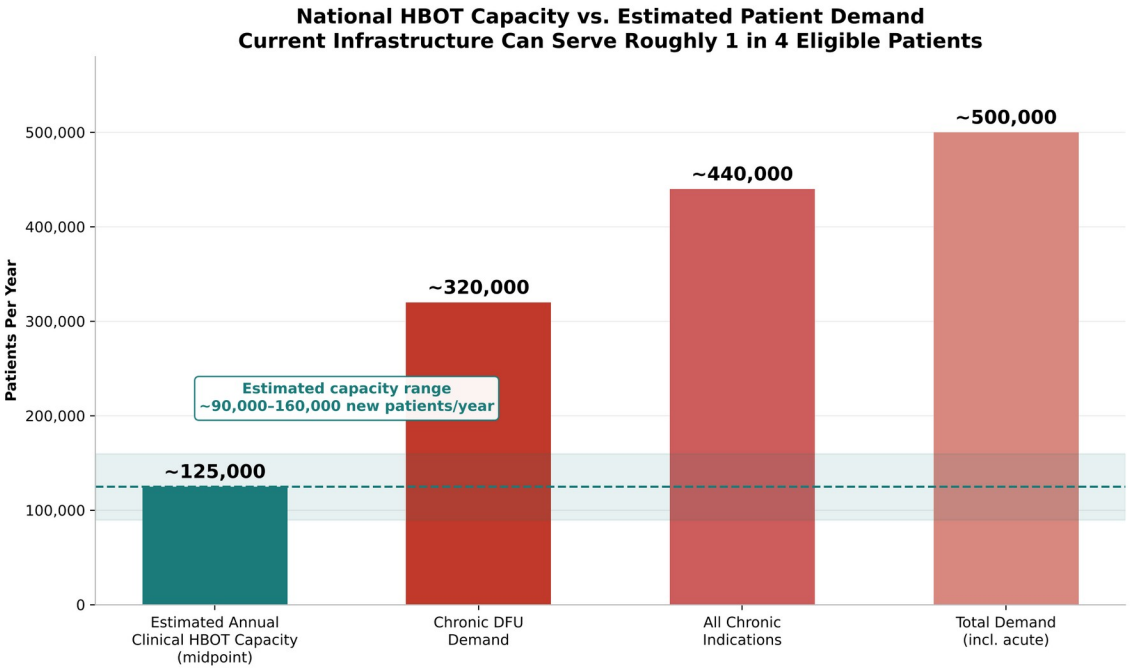

Figure 4: National HBOT capacity compared with estimated patient demand. Even at the top of the capacity range, most eligible patients cannot be treated within the current infrastructure.

Real-world utilization is lower than capacity would suggest. In its evaluation of the Medicare Prior Authorization Model for non-emergent HBOT in Illinois, Michigan, and New Jersey, three states chosen because they had the highest historical utilization, CMS found that about 5.5% of beneficiaries with a qualifying condition received HBOT. Not every one of those beneficiaries would meet full clinical criteria, but the gap between the number who qualify on paper and the number who are treated is large even in the parts of the country that use the therapy most.

Two Different Infrastructure Needs

National demand separates into two groups with different infrastructure needs. Chronic, scheduled indications make up about 88% of eligible patients and depend on proximity to the patient’s home. Acute indications belong in hospitals with emergency capability, and they also draw on the same hospital chambers that chronic patients need.

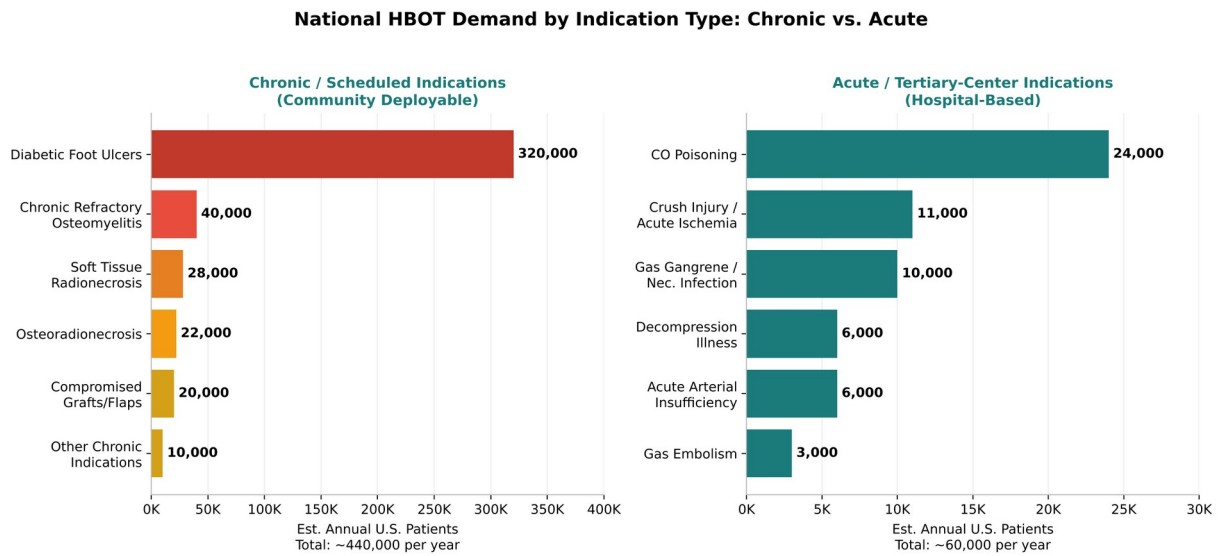

Figure 5: National HBOT demand by indication type. Chronic scheduled indications (left) make up an estimated 440,000 patients a year; acute hospital indications (right) an estimated 60,000. Estimates are directional.

THE CAPACITY FINDING

Even using conservative assumptions, the nation's hospital-centered HBOT infrastructure can serve roughly one in four clinically eligible patients each year, and the patients it does reach are concentrated near metropolitan hospitals. The national estimate runs somewhat higher than the DMV figure of 12–15% in Paper 1 because it applies an average chamber count across all clinical programs, but both point to the same conclusion: most eligible patients cannot be treated within the current system. The national gap is a capacity problem and a distribution problem at the same time.

SECTION VI | RURAL INFRASTRUCTURE UNDER PRESSURE

The Referral Network Is Shrinking

For most rural patients, the road to HBOT runs through a local hospital or clinic, where a wound is identified and a referral is made. That network is getting thinner. The Cecil G. Sheps Center for Health Services Research at UNC counts 197 rural hospital closures and conversions since January 2005, including 109 complete closures and 88 conversions to facilities that no longer provide inpatient care. In May 2026, the Center for Healthcare Quality and Payment Reform identified 720 rural hospitals, about one-third of the national total, at risk of closing, including 294 at immediate risk within the next two to three years. Texas, Kansas, and Oklahoma have the most hospitals at risk.

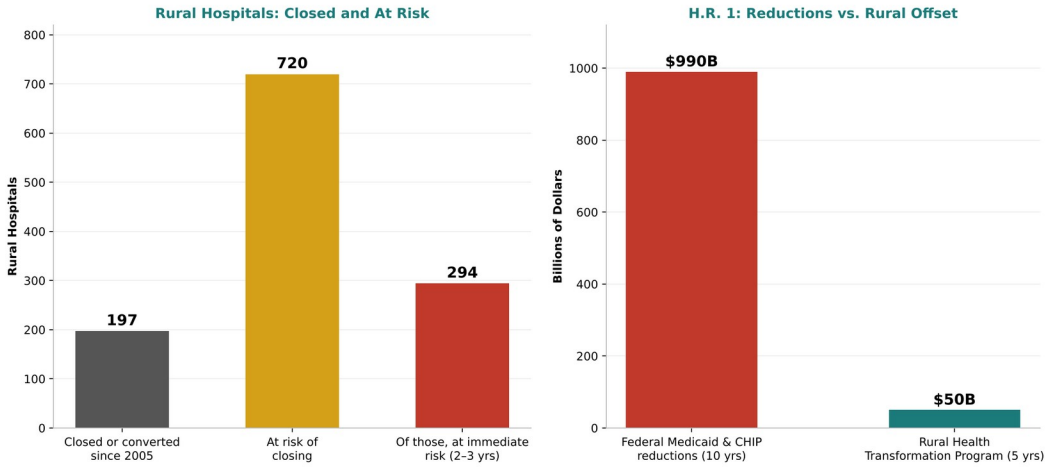

Figure 6: Left, rural hospital closures since 2005 (Sheps Center) and hospitals currently at risk (CHQPR, May 2026). Right, projected ten-year federal Medicaid and CHIP reductions under H.R. 1 (CBO) compared with the five-year Rural Health Transformation Program.

H.R. 1 and the Rural Health Transformation Program

The One Big Beautiful Bill Act, signed July 4, 2025, is the largest change to federal health financing in more than a decade. CBO estimates that the law will increase the number of uninsured Americans by about 10 million in 2034 and reduce federal Medicaid and CHIP spending by about $990 billion over ten years. Patients with chronic conditions who need ongoing specialty care are among the most exposed to coverage losses, and hospitals that depend on Medicaid revenue are among the most exposed to financial strain.

The same law created the $50 billion Rural Health Transformation Program. On December 29, 2025, CMS announced first-year awards to all 50 states, averaging about $200 million per state and ranging from about $147 million for New Jersey to about $281 million for Texas. State plans emphasize primary and preventive care, workforce, facility and equipment modernization, telehealth, and hub-and-spoke care models. Hyperbaric medicine is not named in those priorities, but community-based HBOT fits several of them directly.

WHAT THIS MEANS FOR HBOT ACCESS

The policy environment is pulling in two directions. Coverage losses and hospital strain threaten the rural referral network that connects patients to HBOT, while the Rural Health Transformation Program puts new money in the hands of states that are deciding right now what rural care should look like for the next five years. States that count hyperbaric access as part of rural specialty care can use that funding to place capacity closer to patients instead of watching the referral network erode.

SECTION VII | THE ECONOMIC CASE

The Cost of Untreated Chronic Wounds

HBOT is already a covered Medicare benefit under the National Coverage Determination for Hyperbaric Oxygen Therapy (NCD 20.29) for diabetic wounds of the lower extremities and the other conditions modeled here. This market does not need a new coverage policy. It needs delivery infrastructure that patients can reach.

The cost of not treating is high. Major lower-extremity amputations carry acute care costs of roughly $70,000 to $100,000 per case, before rehabilitation, prosthetics, lost work, and long-term care. The 2018 *Value in Health* analysis estimated Medicare spending on diabetic foot ulcers alone at $6.2 billion to $18.7 billion a year, including infection costs. Per-patient Medicare costs for a full course of HBOT for a diabetic foot ulcer were estimated at roughly $17,900 to $35,800 in 2022, which means the $9,000 per-course figure used in this brief's demand model is conservative.

COST AVOIDANCE: NATIONAL CONTEXT

Every 10,000 major amputations avoided represents roughly $700 million to $1 billion in avoided acute hospital costs. With an estimated 300,000 or more chronic HBOT-eligible patients going untreated each year, even a modest improvement in completed treatment would produce savings measured in the billions over the life of the patient population. HBOT infrastructure is better understood as cost-containment infrastructure than as a new cost center.

Who Carries the Cost

For payers. Medicare, Medicare Advantage plans, and commercial insurers already cover HBOT for these indications. The downstream costs of untreated wounds, including amputation, extended hospitalization, and long-term disability, land on the same payers. Expanding practical access is one of the few ways to lower those costs without changing a coverage rule.

For the safety net. As Medicaid coverage contracts, the costs of untreated diabetic wounds do not disappear. They move to emergency departments, uncompensated care pools, and long-term safety net programs.

For families. A wound that could have healed with a completed course of treatment instead progresses to amputation. The patient loses mobility, work, and independence, and family members take on caregiving. These outcomes are well documented, and they follow distance to care more closely than any measure of a patient's willingness to be treated.

SECTION VIII | RECOMMENDATIONS

A National Path Forward

For Federal Policymakers

- CMS should add HBOT access to the specialty care measures it uses to evaluate rural health demonstrations and Rural Health Transformation Program outcomes.
- HRSA should make community-based HBOT an eligible use in rural health and community health center grant programs.
- Federal agencies that track specialty care shortages should include hyperbaric medicine, so the access gap becomes visible in the data that drives planning.

For State Policymakers

- States should consider physician-supervised HBOT capacity as an eligible use of Rural Health Transformation Program funds, particularly in counties at risk of hospital closure and in Diabetes Belt counties.
- State health departments should measure HBOT access at the county level alongside other specialty care metrics.
- States should coordinate HBOT capacity planning with hub-and-spoke models so that hospitals remain the hub for acute cases while community sites carry scheduled chronic care.

For Health Systems, Providers, and Payers

- Health systems should evaluate satellite or affiliated physician-office HBOT sites in communities beyond their main campuses, freeing hospital chamber time for acute cases.
- Federally Qualified Health Centers and wound care practices should assess local HBOT demand using diabetes prevalence and wound referral data.
- Medicare Advantage plans and commercial insurers should treat HBOT access in underserved areas as a cost-avoidance strategy for amputation and hospitalization.

SECTION IX | THE INFRASTRUCTURE SOLUTION MODEL

Complementing the Hospital System

The national access gap is not a knowledge problem. HBOT is clinically established, covered by Medicare, and prescribed by physicians. The barrier is structural: the therapy sits inside institutions that many eligible patients cannot reach or cannot return to five days a week for six weeks.

The right response is a complement to the hospital system rather than a replacement for it: compact, code-compliant HBOT capacity placed inside physician practices, community health centers, and outpatient settings close to where patients live, with hospitals continuing to handle the acute emergencies that belong there. Wound care specialists, primary care practices, and community health centers already treat the patients who need HBOT, which makes them the natural network for this kind of deployment.

PROXIMITY IS BUILT IN

A system placed in a community physician's office sits where the patient already has a care relationship. For a patient who lives 67 miles from the nearest hospital program, the difference between a 10-minute drive and a 67-mile drive is often the difference between completing treatment and stopping early.

CAPACITY IS DEDICATED, NOT COMPETED AWAY

Hospital chambers have to divide time between scheduled chronic patients and acute emergencies. A physician-office system serves scheduled chronic indications, so every treatment slot goes to the patient population this analysis identifies as most underserved, and hospital chambers stay available for the emergencies that need them.

The National Deployment Math

A single monoplace system operating at standard wound care utilization, four to five patients a day, five days a week, can support roughly 1,000 to 1,200 sessions a year, or 30 to 60 new patients depending on course length.

Deployment Scale	Est. New Patients/Year	Share of National Unmet Need	Est. Gross Reimbursement
100 deployed units	3,000–6,000	~1–2%	~$36M–$72M
500 deployed units	15,000–30,000	~4–8%	~$180M–$360M
1,000 deployed units	30,000–60,000	~8–16%	~$360M–$720M
2,500 deployed units	75,000–150,000	~20–40%	~$900M–$1.8B

Note: Reimbursement modeled at ~$400/session × 30 sessions per course, consistent with Paper 1. Share of unmet need calculated against an estimated 375,000 eligible patients beyond current capacity. Figures represent gross reimbursement to treating physicians, not RxAir360 revenue, and vary by payer mix, indication, and local rates.

Even 1,000 community-based units, roughly the number of clinical HBOT programs operating today, would expand national clinical capacity by roughly a third without taking a single hour of chamber time away from hospital emergencies.

Removing the Capital Barrier

Physician adoption of new technology is constrained by capital. A practice that sees the clinical need may still lack the upfront investment to acquire and install a compliant system. RxAir Capital Solutions, the planned leasing subsidiary of RxAir360 Inc., is designed to let practices add HBOT capacity without that upfront expense, structured against the Medicare reimbursement stream the therapy already generates.

Why Now

→ **The rural referral network is under strain.** With 197 rural hospitals already closed or converted and 720 at risk, the local entry points that connect patients to HBOT are disappearing.

→ **States are deciding how to spend rural transformation funds.** First-year Rural Health Transformation Program awards are flowing now, and the plans states adopt will shape rural specialty care through 2030.

→ **Medicare coverage is already in place.** HBOT is covered today under NCD 20.29 for the conditions that drive most demand. The missing piece is delivery infrastructure within reach of covered patients.

→ **The physician network already exists.** Wound care specialists, primary care practices, and community health centers are treating these patients today and referring them out to distant chambers.

THE BOTTOM LINE

Across the United States, HBOT is limited less by clinical evidence or coverage than by where the chambers are. Fewer than 1,400 facilities, concentrated in metropolitan hospitals, cannot reach an estimated 500,000 eligible patients a year, most of whom need care close to home.

RxAir360 Inc. is developing a compact, physician-office HBOT system designed for the community-based model described in this analysis, with the footprint, safety architecture, and clinical workflow integration that outpatient practices require, subject to FDA clearance.

SECTION X | DATA SOURCES AND METHODOLOGY

Data Sources

This brief draws on publicly available data from peer-reviewed literature, federal agencies, and health policy research organizations. Primary statistics are cited to specific sources to allow independent verification.

Source	Data Used
CDC, National Diabetes Statistics Report (updated September 2026)	40.1 million with diabetes; 29.1 million diagnosed; 115.2 million adults with prediabetes
Armstrong DG et al., “Diabetic Foot Ulcers: A Review,” JAMA (2023)	~1.6 million U.S. DFUs per year; infection, amputation, and five-year mortality rates
Barker LE et al., Am J Prev Med (2011)	Diabetes Belt: 644 counties in 15 states; demographic comparison
Humphries MD, Current Diabetes Reports (2025)	Racial and income disparities in diabetes-related amputation
Nussbaum SR et al., Value in Health (2018)	8.2 million Medicare beneficiaries with wounds; $28.1–$96.8 billion in wound care spending; DFU costs
Gelly H et al., Undersea Hyperb Med (2024)	HBOT registry: 262,055 sessions, 53 centers, 34 states; ~26 treatments per patient; 2022 Medicare cost estimates
CMS, Evaluation of the Medicare Prior Authorization Model for Non-Emergent HBOT (2019)	~5.5% of beneficiaries with a qualifying condition received HBOT in model states
Divers Alert Network, via InDEPTH (2023); Butler & Moon, UHMS (2020)	67 facilities treating diving accidents; decline in 24/7 emergency availability
UNC Cecil G. Sheps Center (2026)	197 rural hospital closures and conversions since 2005
Center for Healthcare Quality and Payment Reform (May 2026)	720 rural hospitals at risk of closing; 294 at immediate risk
Congressional Budget Office, via Georgetown CCF (August 2025)	~10 million more uninsured in 2034; ~$990 billion in federal Medicaid and CHIP reductions
HHS/CMS press release (December 29, 2025)	Rural Health Transformation Program first-year state awards
U.S. Census Bureau, 2020 Census	Rural population of about 66 million
CMS, NCD 20.29	Medicare coverage of HBOT

Methodology Note

Facility counts reflect the public figure of fewer than 1,400 HBOT facilities nationwide. The national demand model applies the Paper 1 method: published diabetic foot ulcer incidence, a 20% chronic-wound eligibility rate (mid-range of the 15–25% found in clinical literature), and the Paper 1 ratios of other chronic and acute indications to diabetic foot ulcer demand, scaled to the U.S. population. Capacity assumes about 1,000 clinical programs averaging three to four monoplace chambers, with 30 to 40 new patients per chamber per year. Travel figures assume round trips for each session.

NOTE ON ESTIMATES AND DIRECTIONAL MODELING

The capacity and demand estimates in this brief are directional planning figures, not precise market forecasts. They are designed to show the size of the gap between clinical need and treatment availability. The underlying patterns, including facility concentration, rural distance, capacity limits, rural hospital strain, and disease burden, are supported across multiple independent data sources.

RxAir360 DISCLOSURE

RxAir360 Inc. has completed device development. Third-party electromagnetic compatibility (EMC) and electrical safety testing has been completed, and the company is finalizing its FDA 510(k) submission. The RxAir360 device has not yet received FDA clearance. This report documents a structural infrastructure gap and the community-based delivery model designed to address it, and does not constitute promotional claims for a cleared device.

MEDICAL ADVISORY BOARD

This research was developed in consultation with the RxAir360 Medical Advisory Board, co-chaired by Jeffrey A. Niezgoda, M.D., FACHM, MAPWCA, CHWS (President, American Professional Wound Care Association; Past President, American College of Hyperbaric Medicine; Founder & President Emeritus, AZH Wound & Hyperbaric Center) and Tyler Sexton, M.D., MAPWCA, CHWS (President, American College of Hyperbaric Medicine). The Medical Advisory Board provides clinical guidance on HBOT access, deployment models, and patient care standards.

A Note on Safety

Hyperbaric oxygen therapy takes place in an oxygen-rich environment and requires strict attention to fire prevention, grounding, staff training, and manufacturer instructions. In August 2025, the FDA reminded providers and facilities of these requirements. Serious incidents in non-hospital settings, including the January 2025 death of a 5-year-old child at a Michigan clinic, have heightened public concern. The lesson is that safe HBOT depends on code-compliant equipment, trained operators, and physician-supervised care within recognized safety frameworks, and any community-based deployment model has to be built on those foundations.

Forward-Looking Statements. This brief contains forward-looking statements, including estimates of market demand, treatment capacity, deployment scenarios, and the company's regulatory pathway. These statements reflect management's current expectations and are subject to risks and uncertainties that could cause actual results to differ materially. RxAir360 Inc. undertakes no obligation to update forward-looking statements except as required by law.

CONCLUSION

Paper 1 showed that a diabetic patient on Maryland's Eastern Shore, less than 90 miles from the NIH campus, has about the same practical access to HBOT as a patient in the Mississippi Delta. This brief shows why that comparison holds. The patient in the 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 infrastructure can reach only about one in four times.

The gap has a shape. Chambers sit in metropolitan hospitals, while the need concentrates in rural counties, the Diabetes Belt, and lower-income communities where amputation rates are highest. The rural hospitals that connect those patients to care are closing or at risk, coverage is contracting, and the hospital programs that remain are organized around scheduled wound care with less room for emergencies.

Closing the gap will take a more balanced infrastructure mix: hospital capacity for acute emergencies, and physician-supervised community capacity for the chronic, repeated-course care that makes up nearly nine in ten eligible patients. States now have new rural transformation dollars and a short window to decide how to use them.

RxAir360 Inc. is developing technology intended to support that community-based model, subject to FDA clearance. Paper 3 in this series will look at the patients for whom access may matter most of all: America's veterans, including those living with traumatic brain injury and post-traumatic stress.

<1,400 U.S. HBOT Facilities	**~500K** Eligible Patients Per Year	**$3.1–3.7B** Unmet Annual National HBOT Demand	**Now** A Window for Policy & Infrastructure Action

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