

White Paper

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# **The Kohama Theory and CAMP Management Analysis System & CAMP LIFE Application System**

A Theory That Transforms Long-Term Care Management from “Experience” to “Science,” and Our In-House  
Implementation of These Two Pillars

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# Table of Contents

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- 1. Executive Summary**
- 2. Kohama Theory — Transforming Long-Term Care Management from “Experience” to “Science”**
  - 2.1 Definition and Background
  - 2.2 Three Major Management Indicators — The Engine That Generates Revenue
  - 2.3 Synergistic Effects of the Three Major Indicators — The “Multiplication Model”
  - 2.4 Long-Term Care Business Revenue Reform: 10 Indicators and a Three-Tier Structure
- 3. Data Infrastructure — Primary Data: National Health Insurance Association Claims Data**
- 4. CAMP Management Analysis System — Implementation of the Kohama Theory**
  - 4.1 Automatic Calculation of the Three Key Indicators
  - 4.2 Management Dashboard Providing an Overview of the Entire Organization
  - 4.3 AI-Driven Automatic Generation of Management Reports
  - 4.4 Security and Separation of Duties
- 5. What Is the CAMP LIFE Utilization System?**
  - 5.1 Structural Challenges in LIFE Submission Practices
  - 5.2 Data Ingestion Pipeline and Status of 27-IF Compliance
  - 5.3 Visualization of the Barzel Index and Other Metrics, and AI-Generated Comments
  - 5.4 Support for Documenting the PDCA Cycle
  - 5.5 SSO Integration with the CAMP Management Analysis System
- 6. Complementary Relationship Between the Two Pillars — Linkage Between Management Metrics and Quality of Care**
- 7. Data Governance and Risk Management**
- 8. Capability to Address the Reiwa 9 Fiscal Year Revisions**
- 9. Delineation of Responsibility in AI Utilization**
- 10. Conditions for Application and Limitations of the Kohama Theory**
- 11. Practical Implementation Process**
- 12. Summary**

# 1. Executive Summary

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Management improvements in the long-term care industry should be based not on intuition or rules of thumb, but on the data that operators already generate every month. The Kohama Theory is a management theory that systematizes this approach. It narrows down the factors that directly constitute the revenue of long-term care businesses to three key points—utilization rate, additional payment calculation rate, and average care level—and places the synergistic improvement of these three points at the center of management improvement.

The C&MP Management Analysis System and the C&MP LIFE Utilization System are the two pillar systems developed and provided by the C&MP Secretariat to implement the Kohama Theory in practice. The former uses data from claims for long-term care benefits submitted to the National Health Insurance Federation as its primary source, while the latter uses data submitted to LIFE (Scientific Long-Term Care Information System) as its primary source. Although the nature of the target data differs, both systems are built on a common design philosophy: code performs the initial assessment, AI handles the formalization, and humans make the final judgment.

This white paper systematically organizes the theoretical structure of the Kohama Theory, the functional composition of the two-pillar system that implements it, the complementary relationship between the two, data governance, and their practical positioning in the upcoming remuneration revision and the utilization of AI.

## Conclusions of this paper

- Only three factors directly generate revenue: utilization rate, additional payment calculation rate, and average care level (Kohama Theory)
- These three factors are not independent indicators but are interrelated in a “multiplicative” relationship
- Both the C&MP Management Analysis System and the C&MP LIFE Utilization System are in-house developed products and are distinct from the LIFE system operated by the national government
- Both systems are designed to rely on primary data already generated by service providers, thereby minimizing the burden of entering new data
- The Kohama Theory is not a universal theory; it should be applied only after correctly understanding the conditions for its application and its limitations for each service category
- AI does not make judgments; it should be positioned as a tool that reproduces judgment criteria designed by humans on a monthly basis.

## 2. Kohama Theory — Transforming Long-Term Care Management from “Experience” to “Science”

### 2.1 Definition and Background

The Kohama Theory is a management theory that transforms long-term care management from “experience” to “science.” Until now, the management of long-term care businesses has long been supported by experience, intuition, and the efforts of frontline staff. This in itself is not something to be dismissed. However, under the triple pressure of changes in the user demographic due to population decline, a worsening labor shortage, and revisions to long-term care reimbursement rates that occur every few years, management that relies solely on experience and intuition is no longer sustainable.

In my many years of providing management consulting to long-term care facilities nationwide, I have repeatedly observed a common reality: when faced with complaints such as “the number of clients has decreased,” “we’re not turning a profit,” or “we’re struggling financially even though we’re receiving additional payments,” the managers themselves can only explain the causes based on gut feelings, such as “I feel like we’ve been getting fewer referrals lately” or “I think it’s because the staff are so busy.” Of course, these factors do play a role, but management decisions should be based on numbers, not gut feelings. The Kohama Theory is a systematic framework designed to enable this “numbers-based management” using only existing operational data, without the need for special system investments or surveys.

### 2.2 Three Major Management Indicators — The Engine That Generates Revenue

There are numerous management indicators in the long-term care industry: occupancy rate, bonus acquisition rate, profit margin, average care level, service termination and attrition rates, referral rate, staff retention rate, paid time off utilization rate, overtime hours, labor cost ratio, and value added per person. All of these are indicators that cannot be ignored when assessing the soundness of management. However, only the following three serve as the engines that directly generate revenue.

- Occupancy Rate — The proportion of users admitted relative to capacity
- Rate of Eligibility for Additional Payments — The extent to which all eligible additional charges are being claimed without omission
- Average care level — The composition of service users by care level, i.e., the level of unit rates

#### Structure of the utilization rate

Utilization rates cannot be accurately measured simply by comparing the number of service users to the total capacity. The methodology for calculating this varies by service type, and if the calculation method is incorrect, it can result in the utilization rate being significantly lower than the actual figure.

| Service Type                          | Allocation (Maximum Capacity)                                    | Allocation (Actual)          |
|---------------------------------------|------------------------------------------------------------------|------------------------------|
| Day Services (e.g., day care)         | Unit Capacity × Number of Operating Days (× Turnover Rate)       | Total Number of Service Days |
| Home-Visit Services (Home Care, etc.) | Number of possible visits (upper limit based on staffing levels) | Number of Cases              |

|                                                                |                                                                |                                |
|----------------------------------------------------------------|----------------------------------------------------------------|--------------------------------|
| Home Care Support                                              | Maximum number of cases per care manager ×<br>Number of people | Actual Number of Cases Handled |
| Short-term Residential Care and<br>Residential Care Facilities | Capacity × Operating Days                                      | Total days of use              |

### Structure of the Surcharge Calculation Rate

The additional payment calculation rate is determined by automatically tallying, from the claim details, how many cases for each additional payment registered in the master list for that service type were calculated for the current month and how many were not. In practice, it is crucial to clearly distinguish between add-on categories that require separate generation management—such as the Treatment Improvement Add-on—and other standard add-ons when compiling these figures. If the calculation rate is determined without clearly defining these categories, the status of the Treatment Improvement Add-on may obscure the actual status of standard add-ons, resulting in figures that differ from reality and are used as the basis for management decisions.

### Structure of the Average Care Level

The average care level is calculated as a weighted average based on the number of users by care level category recorded in the claim details. This not only influences unit price levels but also serves as an indicator of the role the facility plays in the community. Facilities with a high average care level function as reception centers for individuals with moderate to severe care needs, which is significant from the perspective of role sharing within the community-based integrated care system.

## 2.3 Synergistic Effects of the Three Major Indicators — The “Multiplication Model”

It is crucial not to attempt to improve the utilization rate, the rate of additional payment calculations, and the average care level independently of one another. Taking day care services as an example, the monthly insurance claim amount is ultimately determined by the product of these three factors. Therefore, these three points

must be understood not as three separate pillars, but as a single system in which they mutually influence one another.

If you pursue only the utilization rate and accept anyone who applies, the average care level will drop, and the basic reimbursement rate will decrease. Conversely, if you try to raise the average care level by accepting only those with severe needs, there is a risk that the utilization rate will actually decline due to limitations in staffing capacity and care quality. If you focus solely on securing additional payments, you will be swamped with paperwork, the frontline staff will become exhausted, and user satisfaction may decline.

Furthermore, there is a synergistic effect in the opposite direction: improving the rate at which additional payments are claimed actually helps to normalize the average care level. If a facility establishes a system to reliably claim additional payments—such as the “Scientific Care Promotion System Surcharge,” which requires data submission to LIFE and the utilization of feedback—the habit of quantitatively monitoring changes in service users’ conditions on a daily basis will take root within the organization. This practice directly leads to improved assessment accuracy and risk management capabilities when accepting users with moderate to severe care needs, and consequently helps build a system capable of smoothly accommodating a user base with a high average care level.

Let’s consider a concrete example. Suppose there are two day service facilities with the same capacity: one has a 90% occupancy rate but primarily serves users with mild care needs, resulting in minimal additional payments; the other has a 75% occupancy rate but actively accepts users with moderate to severe care needs, reliably claiming additional payments such as the Individual Functional Training Surcharge and the Moderate-to-Severe Care System Surcharge. If we look solely at the utilization rate, the former facility appears to be in a better position; however, in terms of total monthly billing—which includes unit prices and additional fees—the latter facility often exceeds the former. If we focus solely on the superficial indicator of utilization rate, we risk misjudging this structure. Only by examining these three points simultaneously can we identify the areas where our facility should truly focus its growth efforts.

## 2.4 Long-Term Care Business Revenue Reform ④: 10 Indicators and a Three-Tier Structure

To apply the Kohama Theory in practice, it is necessary to organize and understand the 10 indicators into three tiers.

### First Tier — The Engine That Generates Revenue

Utilization Rate, Additional Payment Calculation Rate, and Average Care Level. These form the core of the Kohama Theory and directly determine revenue.

### Second Tier — Profit-Determining Metrics

Labor cost ratio, overtime hours, paid leave utilization rate, and value added per employee. Even if revenue increases, a business cannot sustain itself if no profit remains. The labor cost ratio is the most critical cost management indicator in long-term care management, and overtime hours reflect productivity itself. The paid leave utilization rate is an indicator that reflects the health of the workplace environment, while value added per employee is the most critical differentiation indicator in long-term care management, as it most clearly shows how much value each staff member generates.

Note that while the paid leave utilization rate is placed in this category for convenience, its nature differs somewhat from indicators that directly define costs or productivity, such as overtime hours or value added per employee; rather, it is an indicator that measures the health of the workplace environment, closely related to staff retention rates. However, workplaces with low paid leave utilization rates often reflect chronic staff shortages, and since these shortages manifest as increased overtime hours and worsening labor cost ratios, they ultimately

### **Third Tier — Indicators That Shape the Future**

Referral rate, service completion rate, dropout rate, and staff retention rate. A high referral rate is evidence that a facility is trusted by the community, while a low dropout rate is evidence of high service quality. Facilities with high staff retention rates are able to consistently provide high-quality care. These three metrics are leading indicators that determine business performance not just for today's revenue, but for one year, three years, and five years from now.

### **The Cyclical Structure Between Levels**

These 10 indicators are not listed in isolation. They form a cyclical structure in which the “engine” of the first tier is supported by the leading indicators of the third tier (referral rate, turnover rate, and retention rate), and the results are verified by the “report card” of the second tier (labor cost ratio, overtime hours, paid leave utilization rate, and value added per person). The most efficient practical approach is for management to focus first on the first tier, while using the remaining seven metrics as guidelines to monitor and maintain improvements in that tier.

This three-tier structure functions not only as a one-off health check but also as the framework for the next fiscal year's management plan. Managers should outline in advance, using numerical values, how much they intend to boost the “engine” of the first tier for the next fiscal year, how they will improve the leading indicators of the third tier to achieve that goal, and how the performance metrics of the second tier are expected to change as a result. This transforms the management plan from a vague, motivational statement like “We'll do our best next fiscal year” into a verifiable blueprint.

### 3. Data Infrastructure — Primary Data: National Health Insurance

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#### Association Claims Data

How do we manage these three key management indicators? There is only one answer: the National Health Insurance Federation claims data. Long-term care facilities submit claims every month without fail. In other words, this analysis does not require any new work.

##### Accuracy

Because claims data is directly linked to long-term care reimbursement payments, it is the data that providers themselves manage with the highest precision. Unlike estimates based on surveys or interviews, it is the very basis for the reimbursements that have actually been paid (or should be paid).

##### Comprehensiveness

The utilization rate can be derived from the number of service users and service delivery records; the additional payment calculation rate from the details of the calculated additional payment codes; and the average care level from the care level classifications recorded in the billing details—all of which can be derived from this single data source. There is no need to aggregate data across multiple management ledgers or systems; these three metrics can be understood simultaneously and consistently from a single primary source.

##### Suitability for Time-Series Analysis

Because claim data is generated monthly, it is easy to track monthly trends. Rather than getting overly excited ; instead, by comparing trends in occupancy rates, additional payment calculation rates, and average care levels over a 12-month period or longer, your facility's structural strengths and weaknesses will become apparent. If the occupancy rate is stable but only the additional payment calculation rate is trending downward, this indicates a problem with the facility's ability to adapt to regulatory changes. If the average care level is rising gradually but the occupancy rate is not keeping pace, this suggests that the facility's intake capacity has reached its limit.

##### A Note on Accuracy

For the sake of accuracy, we must add the following caveat here. We cannot categorically state that “there are absolutely no errors in the National Health Insurance Federation data.” In fact, through our practical experience in system development and maintenance, we have confirmed that if the implementation of CSV import and aggregation processes is inadequate, duplicate entries or missing data can occur. What is important is not to over-rely on the assumption that “there are no errors,” but rather to accurately understand that “this is the most reliable primary source data for operators—claims data reviewed by the government—and that by continuously performing consistency checks during the import and aggregation stages, we can ensure a level of accuracy sufficient to serve as a foundation for management analysis.”

Given its value as a primary source, the essence of the National Health Insurance Federation (Kokuhoren) CSV is no longer merely “claims data.”

It is “management data”; to put it another way, it is the financial statements themselves for long-term care providers. General companies review their income statements every month. Long-term care providers submit the National Health Insurance Federation CSV every month. However, in most cases, they simply save the CSV the moment it is submitted and that is the end of it; it is never reviewed again as a financial statement.

## 4. CAMP Management Analysis System — Implementation of the

### Kohama Theory

The CΔMP Management Analysis System uses the long-term care benefit claim data that providers submit to the National Health Insurance Federation every month as its sole primary source of information to automatically calculate the three key indicators of the Kohama Theory. Developed and provided by the CΔMP Secretariat, this product is a tool designed to support the day-to-day operations of service providers, distinct from the government-administered system itself.

#### 4.1 Automatic Calculation of the Three Major Indicators

The utilization rate is calculated by applying the correct calculation model for each service type, as shown in Table 1 of the previous chapter. The calculation formula varies by service type: for day-care services, it is “capacity per unit × number of business days”; for home-visit services, it is “number of possible visits”; and for in-home care support, it is “maximum number of cases per care manager × number of care managers.” The system strictly implements this principle—that a single calculation formula cannot be applied to all services—by using distinct calculation models for each service type.

The additional charge calculation rate is determined by automatically aggregating data from the National Health Insurance Federation’s claim details to identify how many cases of each additional charge registered in the master data for that service type were billed that month and how many were not. The system clearly distinguishes between additional charge categories—such as the Working Conditions Improvement Surcharge—that require separate generation management, and other standard additional charges. It is designed so that the status of the Working Conditions Improvement Surcharge does not obscure the actual status of standard additional charges.

The average care level is calculated as a weighted average based on the number of users recorded in the claim details for each care level category.

#### 4.2 A Management Dashboard Providing an Overview of the Entire Organization

For organizations operating multiple facilities, the value of CΔMP lies in its management dashboard, which provides an overview of the entire organization. It displays utilization rates, additional payment calculation rates, and average care levels on a single screen—not only at the individual facility level but also as aggregated and recalculated figures for the organization as a whole.

It is important to note that ratios should not be calculated as simple averages. If you take a simple average of the occupancy rates for facilities with different capacity sizes, the impact of smaller facilities will be disproportionately large. The correct approach is to first aggregate the numerators (actual figures) and denominators (capacity × number of operating days) for each facility, and then recalculate the ratios for the organization as a whole. The CΔMP Management Analysis System follows this principle, aggregating and recalculating data across all facilities within the organization before presenting the indicators.

For organizations operating multiple facilities, comparing the utilization rate, additional payment calculation rate, and average care level for each facility side-by-side makes it immediately clear which facilities within the organization are growing and where support from headquarters is needed. It also serves as a basis for rolling out the strategies for calculating additional fees and operational methods for accepting clients—which are employed by high-performing facilities—to other facilities. Another practical strength of this claims-data-based analysis is that it allows the efforts of individual facilities to be accumulated as management assets for the entire organization, rather than remaining limited to individual experience.

In addition, the system includes facility-by-facility rankings, 12-month trend graphs for key indicators, and trends in referral performance by home care support facility. This provides an analytical pathway that allows users to gain a bird’s-eye view of the organization’s overall situation while delving into the details of individual facilities.

## 4.3 AI-Driven Automatic Generation of Management Reports

Another core feature of C&MP is the automated generation of management analysis reports using AI. The code (program logic) handles all calculations, evaluation grading, and quantification of room for improvement. The AI's sole role is to organize these confirmed figures and supporting evidence into text that is easy for management to understand. "Eligible for Billing"

By designing the system to strictly present only the facts derived from billing data—and avoiding assertions such as "calculable" or "can be calculated if requirements are met"—the system prevents the risk of refunds resulting from inaccurate conclusions made by AI at the system design stage.

## 4.4 Security and Separation of Duties

Since the system handles sensitive information such as management data, security design is a critical element that cannot be overlooked. To prevent corporate administrators from directly specifying and accessing business office numbers belonging to entities other than their own, an affiliation verification check has been incorporated into the business office switching process. Furthermore, the management screen dedicated to the C&MP Secretariat (Contract and Corporate Master Data Management) is intentionally protected by a separate authentication system from the general login system for corporations and business locations. The design philosophy adopted here is to maintain this separation while establishing a separate SSO connection point.

## 5. What Is the CAMP LIFE Utilization System?

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The CAMP LIFE Utilization System is a system independently developed by the CAMP Secretariat to support the actual process of submitting data to LIFE (Scientific Long-Term Care Information System). It is a separate system from the main LIFE system operated by the national government and is responsible for importing, standardizing, analyzing, and generating feedback reports for the data that service providers submit to LIFE.

### 5.1 Structural Challenges in LIFE Submission Practices

Although LIFE defines 27 types of interfaces (27-IF) as official specifications, few service providers have actually established a recording and submission system that supports all of these interfaces. Furthermore, there is a time lag of several months between the submission and the official feedback provided by the LIFE system itself, creating a structural limitation that makes it difficult to immediately apply this feedback to the daily review of care. The CAMP LIFE Utilization System aims to address these two challenges—namely, the “large number of IFs to support” and the “time lag in feedback”—through a proprietary system developed in-house.

### 5.2 Data Import Pipeline and 27-IF Support Status

The CAMP LIFE Utilization System imports CSV data submitted to LIFE and centrally manages it using a normalized table as the master record. It supports bulk imports of ZIP files and entire folders and automates the monthly import process. User identification is performed based on a combination of the insured person’s ID number and the insurer’s ID number. Errors in historical data are handled via logical deletion (discard) rather than physical deletion, allowing corrections to be made while retaining the history.

Of the 27 official IFs, implementation is currently complete for 12 IFs, and for the 11 high-priority IFs (related to day care services and special nursing homes for the elderly), field dependency analysis has been completed. The very act of transparently disclosing this implementation status demonstrates the integrity of the CAMP LIFE application system’s design. Rather than exaggerating that all IFs are supported, the development policy is to prioritize them and expand the scope of support in stages.

### 5.3 Visualization of the Barthel Index and AI-Generated Comments

The CAMP LIFE application system implements radar charts and trend graphs for the Barthel Index (an assessment of independence in activities of daily living), allowing users to visually track changes in their condition. In addition, the system features an AI-powered comment generation pipeline that automatically generates draft observations based on recorded assessment data, whether during the user’s initial intake or at the end of each month. Here, too, the design principle is consistently applied: the system mechanically calculates the numerical assessments, while the AI is responsible only for converting them into text.

Furthermore, a decision engine capable of handling complex assessment logic—such as determining the level of independence in dementia patients—has been implemented, and continuous verification and correction are performed down to the finest details, such as whether assessment criteria are handled as numeric or string types. This attention to detail ultimately has a direct impact on both the quality of care management and the reduction of the risk of having to repay LIFE-related surcharges.

## 5.4 PDCA Documentation Support

The eligibility requirements for LIFE-related surcharges go beyond mere data submission; they require documentation of the ongoing review of plans based on feedback

(PDC cycle). The CAMP LIFE Utilization System is equipped with a function to document this series of PDC processes, allowing it to be used during operational guidance not only as proof of submission but also as a record demonstrating actual utilization.

## 5.5 SSO Integration with the CAMP Management Analysis System

The CAMP Management Analysis System and the CAMP LIFE Utilization System are connected via SSO (Single Sign-On) using a one-time URL signed with HMAC-SHA256. Users can access the functions of the LIFE Utilization System using the same authentication credentials they use for the Management Analysis System. This integration is subject to security audits, including risks related to bidirectional privilege escalation; corrective measures have been implemented, such as externalizing hard-coded signature keys and adding CSRF countermeasures.

It should be noted that this SSO integration is strictly limited to the sharing of authentication credentials; it is not a mechanism for automatically synchronizing the databases of the two systems. As described in the next chapter, cross-checking the additional payment calculation rates in the management analysis system against the PDC records and care quality status in the LIFE application system is achieved only through periodic manual verification by the service provider.

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## 6. The Complementary Relationship Between the Two Pillars —

### Linkage Between Management Figures and Care Quality

The C&MP Management Analysis System and the C&MP LIFE Utilization System handle different types of data. C&MP LIFE handles assessment data—such as  $\Delta$ DL, cognitive function, and nutritional status—used to evaluate the quality of care for individual users. On the other hand, the C&MP Management Analysis System handles actual performance data—claims submitted to the National Health Insurance Federation and reimbursements received—which directly reflect the facility’s revenue structure.

| Perspective                     | C&MP LIFE Utilization System                                                                      | C&MP Management Analysis System                                                                                     |
|---------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| Target Data                     | Assessments of $\Delta$ DL, cognitive function, nutritional status, etc. (for submission to LIFE) | National Health Insurance Federation Long-Term Care Benefit Claim Data                                              |
| Main Purpose                    | Streamlining the LIFE submission process and visualizing care quality                             | Visualization of revenue structure and support for management decision-making (implementation of the Kohama Theory) |
| Data Import                     | Bulk CSV/ZIP Import, Monthly Import                                                               | National Health Insurance Federation CSV Import                                                                     |
| Role of $\Delta$ I              | Generation of Draft Findings Based on Evaluation Data                                             | Generation of report text based on management indicators                                                            |
| Relationship to Additional Fees | Support for the calculation requirements of LIFE-related surcharges themselves                    | A component of the management indicator known as the “add-on calculation rate”                                      |

Given this distinction, the two are not separate products but rather exist in a complementary relationship that constitutes a single management foundation. However, the two systems merely share authentication information via SSO and do not have a mechanism for automatic synchronization between their databases. Since whether the eligibility criteria for LIFE-related surcharges are met is ultimately reflected in the surcharge calculation status in the National Health Insurance Federation’s claims data, quality-of-care initiatives in the C&MP LIFE Utilization System can indirectly be reflected in the level of the “surcharge calculation rate” metric in the C&MP Management Analysis System. However, this is not an automatic linkage; rather, it is a relationship that is established only through operational practices, whereby providers periodically cross-check the records in the C&MP LIFE Utilization System against the indicators in the C&MP Management Analysis System.

Therefore, if efforts within the C&MP LIFE Utilization System remain insufficient and are left unaddressed, this may eventually manifest as a decline in the additional payment calculation rate within the C&MP Management Analysis System. Conversely, if the C&MP LIFE Utilization System is used thoroughly and the calculation requirements are continuously met, the additional payment calculation rate in the Management Analysis System can be maintained at a consistently high level. Rather than operating the two systems separately, the key to maximizing the benefits of the Kohama Theory and the C&MP product line lies in regularly cross-checking how initiatives in LIFE are reflected in management figures.

## 7. Data Governance and Risk Management

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### 7.1 Continuous Verification of Data Consistency

Both the National Health Insurance Federation data and the data submitted to LIFE are primary sources based on systems established by the government; however, it cannot be categorically stated that they are “completely free of errors.” Our system development and maintenance teams have confirmed that data duplication or omissions can occur due to duplicate entries on the system side during CSV import or flaws in the implementation of aggregation logic. What is important is not to overconfidently assume that “no errors exist,” but rather to adopt an operational approach that ensures the accuracy of both management analysis and LIFE analysis by continuously performing consistency checks during the import and aggregation stages.

### 7.2 Preparation for Operational Guidance

The PDC implementation history recorded by the C&MP LIFE Utilization System and the trends in additional payment calculation rates displayed by the C&MP Management Analysis System are both directly linked to the items subject to verification during operational guidance. Analyzing and recording this data on a regular basis also serves as preparation for fulfilling accountability requirements during on-site and operational guidance. Given the  
tend to require strict record-keeping from providers, this preparation is, in essence, a form of business risk management.

## 8. Readiness for the Reiwa 9

### Fiscal Year Revisions

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With revisions to long-term care reimbursement rates, reimbursement units change, eligibility requirements for additional payments change, and calculation methods also change. If National Health Insurance Federation (Kokuhoren) data is analyzed on a regular basis, you can simply apply the new reimbursement units directly to your current billing records to simulate how revenue and profits will change, and determine which additional payments to prioritize. With your facility's actual billing data accumulated in the C&MP Management Analysis System, you can perform these calculations immediately.

This responsiveness is also significant in relation to the revision issues currently under deliberation. Benefit containment measures—such as increasing user fees for individuals with incomes above a certain threshold and revising room charges for multi-bed rooms—are all still being debated in advisory councils and other forums; whether they are implemented and their specific details may change depending on the course of future discussions. By maintaining a daily, time-series track record of occupancy rates, additional payment calculation rates, and average care levels, facilities can promptly verify—after the revisions take effect—exactly which of their indicators were affected by these system changes and to what extent. Operators lacking this foundation can only gauge the impact of the revisions intuitively, and delays in responding could lead to a structural decline in profitability.

There is also speculation, both within and outside the council, that the track record of LIFE utilization may be incorporated into the eligibility requirements for basic reimbursement in the future. While this point should be understood as merely a topic under discussion and consideration at this stage, managing the usage records from the C&MP LIFE system and the management figures from the C&MP Management Analysis System as an integrated whole—in preparation for the possibility that the system might change in that direction—serves as a proactive measure to anticipate system changes.

## 9. Lines of Responsibility in AI

### Utilization

In recent years, we have seen numerous advertisements claiming that “AI performs management analysis,” but AI has no understanding of business management, nor does it understand the long-term care system or the realities of the care setting. What AI excels at is combining learned patterns; the criteria for determining “what to look for” must be designed by humans, as AI cannot discern them on its own. That is precisely why we must not allow AI to make these judgments. The decisions are made by the Kohama Theory, and AI merely mechanically reproduces that theory every month.

This design philosophy is implemented in practice by clearly defining the scope of AI’s responsibilities.

| Tier   | How AI Is Involved                              | Specific Examples                                                                                                                                |
|--------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| Tier A | AI may take the lead                            | Drafting records, performing initial analysis of monthly data, and generating draft findings                                                     |
| Tier B | AI provides support; a human must always verify | Draft revisions to care plans; checking eligibility for additional payment criteria                                                              |
| Tier C | AI is not allowed to make direct decisions      | Final decisions on response policies for on-site inspections and operational guidance; determinations on the eligibility of reimbursement claims |

If AI is introduced while this boundary remains ambiguous, far from improving operational efficiency, it could create new risks of having to repay funds. The system performs the assessment, AI generates the documentation, the supporting evidence is retained, and the final decision is made by a human. This is the consistent design philosophy shared by the CAMP Management Analysis System and the CAMP LIFE Utilization System.

## 10. Conditions for Application

### and Limitations of the Kohama

**Theory**  
The Kohama Theory is not a universal theory. When applying it, it is necessary to accurately understand the following conditions and limitations.

- Differences in cost allocation by service type — The methods for calculating utilization rates differ among day care, home visit, in-home care support, and residential care services; a single formula cannot be applied to all services
- Limitations in quantifying institutional adaptability and human resources strategies — While utilization rates, additional payment calculation rates, and average care levels can be accurately calculated from billing data, personnel and attendance data—such as staff retention rates and the effectiveness of staff development—cannot be determined from billing data alone. Attempting to forcefully infer these factors from billing data risks using inaccurate figures as the basis for management decisions.
- The Operational Burden of Maintaining Data Consistency — The value of billing data as a primary source is guaranteed only when duplicate entries are eliminated and consistency checks are continuously performed during the data import and aggregation stages. Neglecting these operational steps risks leading to erroneous management decisions based on inaccurate figures
- The constraint of time lag — As with LIFE-related feedback, data provided by regulatory bodies may have a time lag of several months, so it must be used in conjunction with monthly monitoring conducted at the facility itself.
- Limitations of Inter-System Integration — The C&MP Management Analysis System and the C&MP LIFE Utilization System are linked via SSO authentication; the data itself is not automatically synchronized. Operators must periodically reconcile the figures between the two systems themselves.

Operating the system with a clear understanding of these limitations is a prerequisite for ensuring that the Kohama Theory functions not as a “universal magic formula,” but as a “management methodology with practical consistency.”

## 11. Practical Application

### Process

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#### 11.1 The Process of Preparing Materials for Management Meetings

At management meetings, discussions focus on sales, profits, changes in the number of users, referral status, the status of additional payment acquisitions, and staff turnover. All of this information can be gleaned from the National Health Insurance Federation (Kokuhoren) data. In traditional management meetings, discussions begin with the facility directors sharing their impressions, and a great deal of time is spent identifying the causes. On the other hand, if there are materials analyzing National Health Insurance Federation data, discussions can begin right at the start of the meeting with specific facts, such as: “The occupancy rate dropped by 3 percentage points compared to the previous month, and the main cause was a 40% decrease in referrals from a specific home care support agency compared to the previous month.” The time previously spent investigating causes can then be redirected toward considering countermeasures.

In terms of the practical process, the following five steps serve as the foundation.

- ① Import the current month’s National Health Insurance Federation (Kokuhoren) CSV file
- ② Automatically calculate the utilization rate, additional payment calculation rate, and average care level
- ③ Check the differences compared to the previous month, the same month of the previous year, and the national average
- ④ Determine which of the three major indicators is responsible for each discrepancy
- ⑤ Organize improvement actions according to the identified factors, prioritizing them

#### 11.2 Steps from Implementation to Operation

- ① Establish a system to import National Health Insurance Federation (Kokuhoren) CSV files, enabling automatic monthly aggregation via the C&A MP Management Analysis System
- ② Import data for LIFE submissions into the C&A MP LIFE Utilization System, and expand the scope of coverage starting with high-priority IFs (such as the 11 IFs for day care services and special nursing homes)
- ③ Calculate the three indicators—utilization rate, additional payment calculation rate, and average care level—using the correct calculation models for each service type
- ④ Periodically reconcile PDC records in the C&A MP LIFE Utilization System with the additional payment calculation rates in the C&A MP Management Analysis System
- ⑤ When introducing AI-based report and observation note generation, clearly separate the roles of numerical evaluation and text generation, and ensure the design strictly prevents AI judgments from being introduced into Tier C areas
- ⑥ Codify data consistency verification as an operational rule and establish in advance the corrective procedures to be followed in the event of duplicate entries or aggregation errors

## 12.

### Summary

Discussions on management improvement in the long-term care industry tend to focus solely on theoretical concepts or general industry trends. However, the primary data for management improvement already exists within the practical process of submitting claims to the National Health Insurance Federation—a task that all providers, without exception, carry out. Adopt a perspective that focuses on raising the three indicators—utilization rate, additional payment calculation rate, and average care level—synergistically rather than individually, and analyze your facility's claim data chronologically as a basis for achieving this. This is the foundation of the Kohama Theory.

The CΔMP Management Analysis System and the CΔMP LIFE Utilization System are in-house developed systems that embody this theory and the practical implementation of the LIFE system, respectively. Rather than treating them as separate tools, care providers themselves should continuously verify how their efforts to improve care quality through CΔMP LIFE are reflected in the management figures within the CΔMP Management Analysis System. This is the concrete and practical starting point for transforming long-term care management from a process based on experience and intuition into a scientific one.

The system will continue to change. The operational framework of the LIFE system itself is also evolving, and discussions are currently underway regarding the remuneration revisions for Reiwa 9. Amid these changes, what is required of business owners is not to respond to each change in the system on a case-by-case basis, but to establish a system for continuously analyzing daily operational data through the two pillars of their organization: the Kohama Theory as a decision-making framework and the CΔMP system.

This is no longer an era where ΔI manages the business.

This is an era in which the Kobayashi Theory is reproduced by ΔI every month.