CMS is producing a series of topic-specific data quality (DQ) briefs that assess the usability of each state’s data in the T-MSIS Analytic Files (TAF). TAF DQ assessments are expressed in terms of levels of concern—referred to as DQ concerns—that represent the reliability, accuracy, and usability of a state’s TAF data for analyzing policy-relevant Medicaid and CHIP topics.

This document shows the DQ concerns for Michigan as documented in the DQ briefs based on the 2016 TAF. Click on any topic to access the TAF DQ brief that describes the criteria used to assign the DQ concerns for that topic.

Users are encouraged to review the TAF DQ briefs to identify the data elements and to supplement the assessment in each brief with their own reviews of the TAF data to determine the extent to which the assessments apply to their analyses.

### A. Enrollment Benchmarking

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicaid and CHIP beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>Medicaid beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>M-CHIP and S-CHIP beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>Dually eligible beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>Comprehensive managed care (CMC)</td>
<td>Medium</td>
</tr>
<tr>
<td>Primary care case management</td>
<td>Unclassified</td>
</tr>
<tr>
<td>Behavioral health organizations</td>
<td>Low</td>
</tr>
<tr>
<td>Adult expansion beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>Newly eligible beneficiaries</td>
<td>Low</td>
</tr>
<tr>
<td>1915(c) participants</td>
<td>Low</td>
</tr>
</tbody>
</table>

### B. Eligibility Information

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment spans</td>
<td>Low</td>
</tr>
<tr>
<td>Enrollment gaps</td>
<td>Low</td>
</tr>
<tr>
<td>Overlapping enrollment spans</td>
<td>Low</td>
</tr>
<tr>
<td>Beneficiary age</td>
<td>Low</td>
</tr>
<tr>
<td>Beneficiary gender</td>
<td>Low</td>
</tr>
<tr>
<td>Beneficiary ZIP code</td>
<td>Low</td>
</tr>
<tr>
<td>Beneficiary race/ethnicity</td>
<td>Low</td>
</tr>
<tr>
<td>Beneficiary income</td>
<td>Low</td>
</tr>
<tr>
<td>Dual eligibility code</td>
<td>Unusable</td>
</tr>
<tr>
<td>CHIP code</td>
<td>Low</td>
</tr>
<tr>
<td>Eligibility group code</td>
<td>Medium</td>
</tr>
<tr>
<td>Restricted benefits code</td>
<td>Low</td>
</tr>
</tbody>
</table>

### C. Claims Completeness

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims volume - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Claims volume - LT</td>
<td>Unclassified</td>
</tr>
<tr>
<td>Claims volume - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Claims volume - RX</td>
<td>Low</td>
</tr>
<tr>
<td>Service users - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Service users - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Service users - RX</td>
<td>Low</td>
</tr>
</tbody>
</table>

### D. Encounter Data Usability

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC encounter volume - IP</td>
<td>Low</td>
</tr>
<tr>
<td>CMC encounter volume - LT</td>
<td>Low</td>
</tr>
<tr>
<td>CMC encounter volume - OT</td>
<td>Low</td>
</tr>
<tr>
<td>CMC encounter volume - RX</td>
<td>Low</td>
</tr>
</tbody>
</table>

### E. Expenditures

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS expenditures</td>
<td>High</td>
</tr>
<tr>
<td>Monthly beneficiary payments</td>
<td>Medium</td>
</tr>
<tr>
<td>Payment consistency - IP</td>
<td>High</td>
</tr>
<tr>
<td>Payment consistency - LT</td>
<td>Medium</td>
</tr>
<tr>
<td>Payment consistency - OT</td>
<td>Medium</td>
</tr>
<tr>
<td>Payment consistency - RX</td>
<td>Low</td>
</tr>
<tr>
<td>Payment data - FFS</td>
<td>Low</td>
</tr>
</tbody>
</table>

### F. Service Use Benchmarking

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient stays</td>
<td>Medium</td>
</tr>
</tbody>
</table>

### G. Service Use Information

<table>
<thead>
<tr>
<th>DQ Concern</th>
<th>DQ Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis code - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Diagnosis code - LT</td>
<td>Low</td>
</tr>
<tr>
<td>Diagnosis code - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Procedure codes - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Procedure codes - OT professional</td>
<td>Low</td>
</tr>
<tr>
<td>Procedure codes - OT institutional</td>
<td>Low</td>
</tr>
<tr>
<td>Type of service - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Type of service - LT</td>
<td>Low</td>
</tr>
<tr>
<td>Type of service - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Type of service - RX</td>
<td>Low</td>
</tr>
<tr>
<td>Place of service</td>
<td>High</td>
</tr>
<tr>
<td>Admission date - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Admission date - LT</td>
<td>Low</td>
</tr>
<tr>
<td>Discharge date - IP</td>
<td>Low</td>
</tr>
<tr>
<td>Discharge date - LT</td>
<td>Unusable</td>
</tr>
<tr>
<td>Discharge date - RX</td>
<td>Low</td>
</tr>
<tr>
<td>Type of bill - IP</td>
<td>Medium</td>
</tr>
<tr>
<td>Type of bill - LT</td>
<td>Low</td>
</tr>
<tr>
<td>Type of bill - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Generic indicator - RX</td>
<td>Low</td>
</tr>
<tr>
<td>Billing provider NPI</td>
<td>Low</td>
</tr>
<tr>
<td>Servicing provider NPI</td>
<td>Low</td>
</tr>
<tr>
<td>Prescribing provider NPI</td>
<td>Low</td>
</tr>
<tr>
<td>Dispensing provider NPI</td>
<td>Unusable</td>
</tr>
<tr>
<td>Billing provider type - IP</td>
<td>Medium</td>
</tr>
<tr>
<td>Billing provider type - LT</td>
<td>Low</td>
</tr>
<tr>
<td>Billing provider type - OT</td>
<td>Low</td>
</tr>
<tr>
<td>Hospital type - IP</td>
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</tr>
<tr>
<td>Supplemental payment records</td>
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</tbody>
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