

New York Health Benefit Exchange

Detailed Blueprint Summary for 9.5.1 Business Rules / Business Requirements October 26, 2012

Item Number	Topic
9.5.1	Business Rules / Business Requirements

Version Number	Modified By	Revision Date	Description of Change
1.1	N Simpson	10/19/2012	Updates as requested by CCIO from CMS Design Review on 10/9/2012 and 10/10/2012 to include sample Scenarios in Section 4 and sample Business Rules in Section 6 of this document



New York State Department of Health

New York Health Exchange Project

CSC

9.5.1 Information Technology Business Rules/Business Requirements

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VERSION HISTORY

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1 INTRODUCTION

The CSC NY-HX project for the New York State Department of Health (DOH) is using an Agile development process. The CSC Agile project management approach is derived from a Scrum-based management approach and focuses on managing the incremental delivery of features and functionality.

1.1 Agile Overview

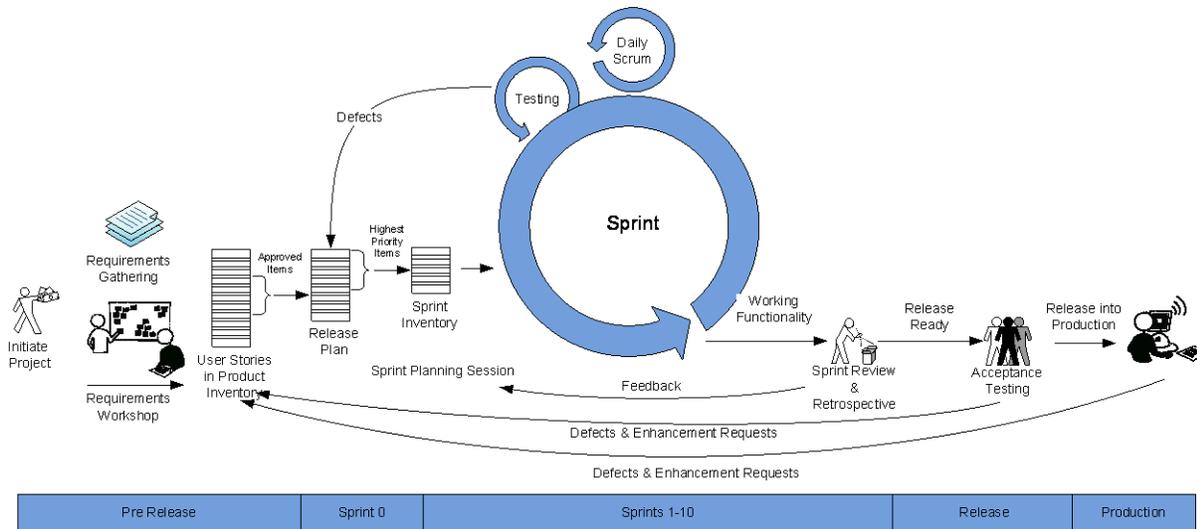


Figure 1: Agile Overview

Figure 1 depicts the Agile process. Leveraging the Agile development method enables faster and earlier completion of NY-HX components, functions, and deliverables. Small teams of Department Subject Matter Experts, product owners, business owners and CSC business analysts, policy analysts, designers, developers, architects, configuration management analysts, infrastructure system analysts, testers, database analysts, tech writers, and quality analysts work closely together to complete NY-HX components, functions, and deliverable documentation in short intervals known as Sprints.

This approach provides measureable progress much sooner than traditional waterfall development methods, but also requires heightened levels of daily commitment and accountability by each CSC and DOH team member. The teams collaboratively work together to complete requirements, design, development, test, review and approval in a concentrated period of time. The resulting products are incrementally constructed NY-HX components, applications, functions, features, or deliverables that may be demonstrated to CMS at key Exchange Lifecycle (“ELC”) milestone dates.

The NY-HX Agile development approach focuses on the execution of Releases comprised of multiple Sprints. The number of Releases per Track varies based on the scope and complexity of the functional Tracks. At the core of the NY-HX Agile development approach are Sprints that enable a small CSC and DOH team to pull a small batch of work from requirements through to a deployable product increment within a pre-specified time. The Sprint team must therefore be lean and support the efficient completion of work.

The organizational structure for NY-HX Agile includes the following levels:

- **Track.** Agile development also focuses on establishing and maintaining the direction of functional Tracks of work comprised of multiple Releases. The NY-HX five functional Tracks include Individual Eligibility & Enrollment (2), Plan Management, Financial Management, and Consumer Assistance & Communications.
- **Release.** The NY-HX Agile development approach focuses on the execution of Releases comprised of multiple Sprints. The number of Releases per Track varies based on the scope and complexity of the functional Tracks.
- **Sprint.** At the core of the NY-HX Agile development approach are Sprints that enable a small CSC and DOH team to pull a small batch of work from requirements through to a deployable product increment within a pre-specified time. The Sprint team must therefore be lean and support the efficient completion.

The Tracks for NY-HX are:

- Individual Eligibility and Enrollment
- Small Business Health Options Program (SHOP)
- Plan Management
- Financial Management (Funds and Risk)
- Consumer Assistance (included user facing capabilities and pathways for assisters (Broker & Navigators))
- Oversight & Persistent Features

1.2 User Stories Define Requirements

User stories are an agile requirements approach that helps shift the focus from writing about requirements to talking about them. All agile user stories include a written sentence or two. User stories are short, simple description of a feature told from the perspective of the person who desires the new capability, usually a user or customer of the system. They typically follow a simple template:

As a <type of user>, I want <some goal> so that <some reason>.

User stories are often written on index cards or sticky notes, stored in a shoe box, and arranged on walls or tables to facilitate planning and discussion.

Very high level stories, called Epics, are captured before the first Sprint of a Release. In that first sprint, (Sprint 0) the team elaborates the stories and determines the work to be done in the Release.

Stories and scenarios are similar, but there are distinct differences which will not be described here. In the following sections Stories will be used to address the scenario questions.

1.3 Rational Suite

To manage development, NY-HX is using Rational tools in IBM's Jazz Suite as shown in the figure below.

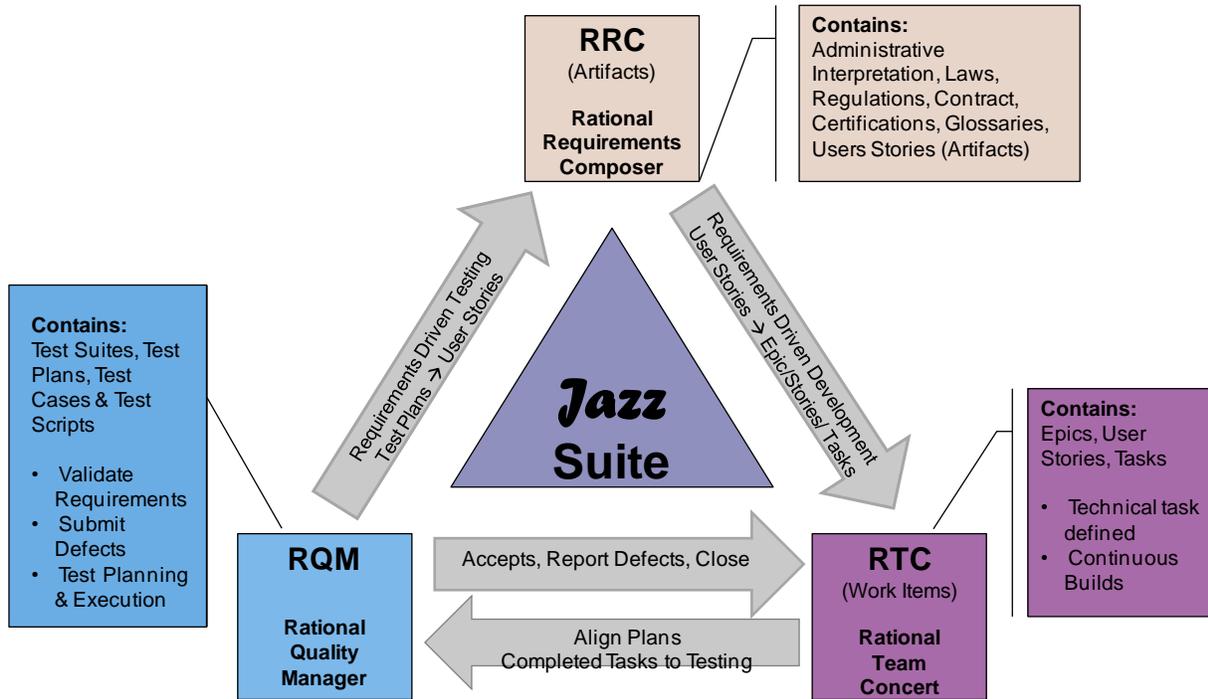


Figure 2: Jazz Rational Suite

Rational Requirements Composer (RRC) is used by NY-HX to store requirements documents from the Act itself to guidance and white papers. Stories (epics) are linked to these source requirements to establish traceability and assure conformity to the Act and regulations. Many of the sections in this document and in the report on 9.6 have data drawn from RRC.

2 Stakeholders Interest in the System

See Section 2.0.

3 Constraints Imposed by Agreements or Interfaces with Legacy Systems have been identified

NY-HX has reviewed and identified numerous systems for interface consideration. Figure 3 depicts these system to system data exchanges.

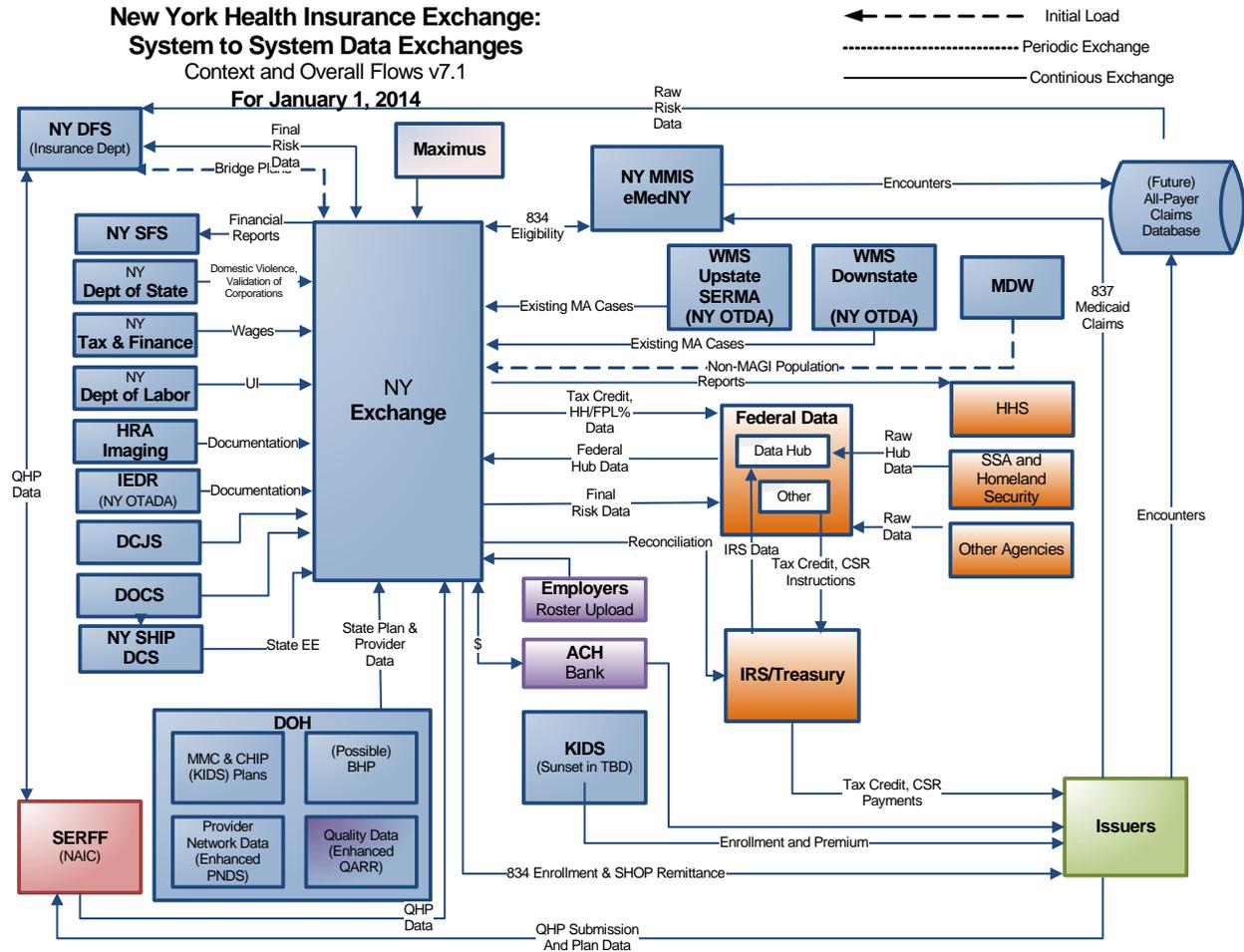


Figure 3: System To System Data Exchanges

4 Scenarios Have Been Identified

The following scenarios have been identified for Individual E & E:

Scenario ID	Scenario Title	Business Owner	User Role Targeted	Scenario Short Description (Target less than 80 characters)
1	Unsub - Family of 4 no twists	Beth Osithmer	Individual	This scenario will allow a user to purchase unsubsidized health insurance through the exchange. The user will be a US Citizen submitting their SSN.
1a	Unsub - Family of 4, persistent features	Beth Osithmer	Individual	This scenario builds onto scenario 1, adding additional questions/field that are required/needed by all scenarios.
2	Sub-non Medicaid APTC Family of 4	Beth Osithmer	Individual	This scenario will allow a user to purchase subsidized health insurance through the exchange, specifically being eligible for the advanced premium tax credit.
3	Sub - Medicaid family of 4 w/Uncle Henry	Beth Osithmer	Individual	This scenario will allow a Medicaid eligible user to purchase health insurance through the exchange.
4	Account Maintenance/Management	Beth Osithmer	Individual	This scenario will allow a user to manage their account, allowing them to change their preferred language, etc.
5	Renewals/Appeals/Exceptions	Beth Osithmer	Individual	This scenario will allow a user to file an appeal if their eligibility was denied or file for an exception from purchasing insurance.

Each scenario has description document. Scenario 1 description is included here as an example:

Scenario #1 Basic facts: Family of four, Parents file taxes jointly, children are two college students living at home. Total family magi is \$64,000. This puts them at a 275%FPL. They want to purchase family coverage through the exchange.

- What we need to know: SL CSP that covers this family. MVP silver: premium \$1000 per month or \$12,000 per year. The plan must be open to enrollment to one or more members of the tax household when they register and it must be in their rating area. If there is one plan that covers all members, that will be the applicable benchmark even if they choose some individual policies.
- Compare with chart for maximum contribution:



FPL	Minimum	Maximum
<133%	2.0%	2.0%
133% > 150%	3.0%	4.0%
150% > 200%	4.0%	6.3%
200% > 250%	6.3%	8.05%
250% > 300%	8.05%	9.5%
300% > 400%	9.5%	9.5%

- 275% is halfway between 250% and 300%. Halfway between 8.05 and 9.5 is 8.78.
- Multiply 8.78 % by 64,000.= \$5619.20. This is the maximum amount of premium this family should pay.
- To determine the maximum APTC for this family, subtract \$5619.20 from \$12,000 which is the SLCSB that would cover this family. Maximum APTC is \$6381.00 per year or 531.75 per month. They can apply that amount to any plan they choose but if they choose a plan that costs less than \$531.75 their premium tax credit will be reduced—you cannot make money off a tax credit.
- maximum APTC will be \$ 8381 per year. (Some rules still forthcoming on members of family residing in different locations)
- If have children and the QHP does not have pediatric dental coverage, a standalone dental plan could be added to determine the SLCSB benchmark.

5 Scenarios Have Been Developed To Define the Conceptual System Including the Range of Anticipated Uses of the System, the Intended Operational Environment; and Interfacing Systems, Platforms, or Products

Stories addressing front end users (Individuals, Employers and Employees), back end users (Call Center, Customer Service, DOH, etc) and assisters (Brokers, Navigators) are detailed in 9.6.

6 Critical and Desired Performance Requirements Have Been Established

Attached are a number of Sprint products. Mostly describing business rules

6.1 Example 1 - Plan Management

Business Requirements

Business Processes

The following sections describe the key Exchange business processes and the associated business requirements for NY-HX Plan Management. The business processes and requirements are organized by plan type – QHP and IAP (Medicaid and CHIP). For each plan type area, we define associated processes and the business requirements within each process. We also provide any associated event diagrams for the plan type.

QHP

Initiation of Certification Process for QHP

1. The Department of Health creates a Notice of Intent form for Issuers to complete. This is a public notice that will be published, available on the website, and sent to plan associations in early January 2013. The Exchange issues this Notice of Intent to participate in the Health Insurance Exchange. Initiating this communication allows DOH to gauge what plans will want to participate and the types of products they will offer. The Department of Financial Services (DFS) creates the New York Template for New York with New York specific rate information.
2. The Notice of Intent will provide Issuers with material and instructions on how to begin the NY-HX QHP certification process. The Notice of Intent will include:
 - Information on how to submit plan data (plans, rates, benefits) to SERFF to initiate the QHP certification process
 - Identification of all required documentation
 - The Exchange Participation Contract template that must be signed
 - A summary of regulatory requirements
 - The data required for the New York Template
3. Issuers respond to the Notice of Intent – this is a non-binding agreement. This will indicate the type of market they want to offer plans in – SHOP or Individual, the metal level and the geographic location of the plan. There is no requirement for a QHP to offer a plan in each metal level – they must have a Silver and a Gold plan. The Notice of Intent will be issued in January of 2013.
4. The expected turnaround time on the Notice of Intent is approximately 30 days. When the Notice of Intent is received from the plan, DOH Exchange Plan Management will notify DFS. April 1st is the submission deadline for the plan.
5. Data Use Agreement – CSC will not need a data use agreement. There is a Memorandum of Understanding (MOU) in place between the Exchange and NAIC that details data sharing. There is also an existing MOU between DFS and DOH that is being expanded to define the responsibilities of each business area. There is a Service



Level Agreement (SLA) between the Exchange and NAIC to describe the expectations of web services to share data.

Receipt of Plan Data via SERFF

Plan data for QHPs is received via SERFF.

1. Issuer must have submission access to SERFF.
2. Issuer logs onto SERFF and create a binder to submit their data via SERFF. There will be one binder for Individual plans and one for SHOP plans.
 - They complete the standard SERFF screens to identify the general QHP data. The process followed for QHP certification builds upon legacy SERFF functionality currently in place to support existing SERFF filings. Standard data validations, such as field size and format, will be performed.
 - They complete the standard SERFF template to indicate the benefits. This is submitted as an attachment.
 - The New York template is completed, indicating the rates. This is submitted as an attachment.
 - When a binder fails a validation and the Issuer needs to resubmit it in SERFF, all validations are done on the resubmission as well.
3. The required data elements for rates are identified in the New York Template. Please see Appendix B for the New York Template.
4. A calculator for actuarial values will also be available to calculate the actuarial value of the plan and assign the metal level.

SERFF will pass the Plan ID with all data exchanges to the NY-HX. They will use a modified version of the HIOS ID as the Plan ID passed to the Exchange. The HIOS ID is an ID that is assigned by HIOS to each user. The state abbreviation is added as a prefix and a Provider ID assigned by the Issuer is used as the suffix. The SERFF data dictionary currently contains a State Plan ID, an Issuer Plan ID and Exchange Plan ID field. This new HIOS ID will be in passed to the Exchange in the Issuer Plan ID field. This ID is at the Plan/Product level. This ID drives the Plan Management data model.

The SERFF PM module will be separate and distinct from other parts of SERFF. In SERFF, the creation and submission of a Rate and Form filing is a separate workflow and approval process than that of a plan (QHP). The traditional rate and form filing will be conducted in addition to the QHP filing. The QHP is designed only for the Exchange.

1. During filing preparation, QHP filers will have a tool to look up forms from existing SERFF filings and indicate they are related to the QHP. DFS and the Exchange can also use this tool to monitor similar products being offered in and out of the Exchange. SERFF is creating a new user role.
2. The creation and submission of a QHP may occur in conjunction with a filing submission, or may happen separately. This allows DFS and or the Exchange to conduct simultaneous reviews of the respective data.
3. The QHP submission will include indication of market type (individual or small group) and metal level.
4. The filer will satisfy any additional requirements for a Plan submission. This will be similar fashion to the way in which the Rate and Form filer currently completes the

Supporting Documentation section. This includes the specific Exchange requirements such as separate submission of the Provider Network and Quality data.

5. Per federal regulation, the rate of the product offered in the Exchange must be the same as the rate for the same product being offered outside of the Exchange. The DOH Exchange needs a way to identify what plans are being offered in the Exchange as well as outside of the Exchange. The SERFF Binder does have an indicator where the Issuer can identify a plan as being offered inside or outside of the Exchange. If a plan does offer both, then requests to change the rate of only one plan, DOH must be aware of this request so they can monitor compliance with this rule. DFS must notify DOH for review.
6. Exchange validations will be performed on the plan data entered in SERFF via the New York rate data template. Validation rules are sourced from DFS guidelines. Data goes to a temporary table within the Exchange to have the validation step done. When it is passed, it gets moved to the staging table. If validation fails, the Exchange will notify the plan.
7. Final Exchange approval and certification is at the binder level. The average time for DFS to approve a filing for the rates and forms is 90 days. The average time for the Exchange to provide final approval is 120 days.
8. Once the forms and rates have been approved by DFS, the plan is then moved to the Exchange. The Provider Network and Quality data are merged to the plan data using the Plan ID as the identifier. The plans are then ready for validation. Once the plan has been validated and final approval has been received, the plan is moved to production and will be available to support plan selection for enrollment in the Exchange.

Main Event Diagram for Quality Health Plans

SERFF will provide QHP data to the Exchange. The below figure represents the path of a Quality Health Plan being certified in SERFF, routed to NY-HX, and then is validated by the Insurer and Exchange to be available in the Exchange.

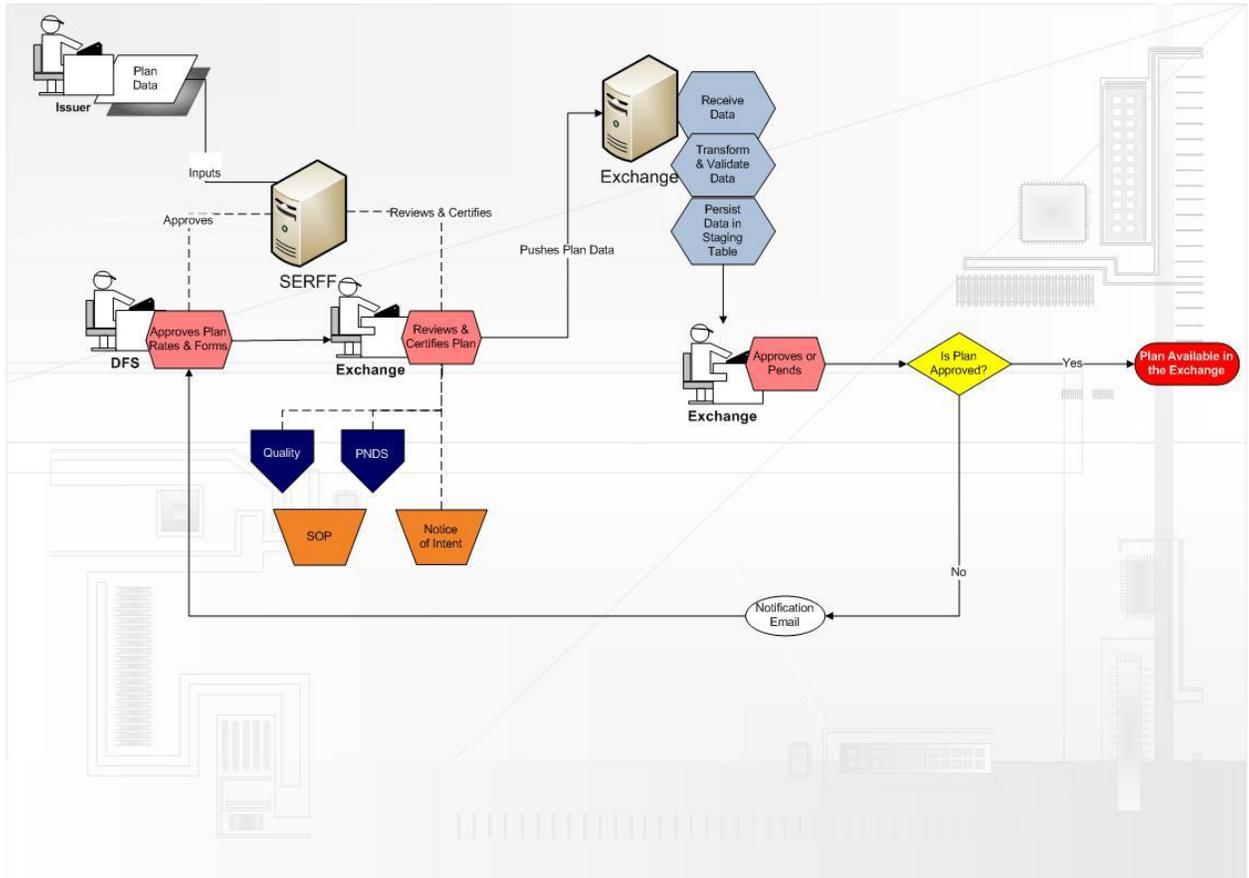


Figure 4: SERFF Flow

QHP Decertification

In the event that a state regulator must de-certify a QHP, appropriate measures are taken on the state side. The plan is then removed from the NY-HX system per state regulator instructions.

In some cases a QHP may be suspended, allowing the QHP to take corrective measures. This could occur when the provider's network fails to meet the adequacy requirements. A process will be in place to suspend new enrollment into a plan while the network adequacy issue is being resolved. When the suspension is revoked, a process will be in place to remove the restriction and once again allow new enrollments into the plan.

Decertification of a plan can be a voluntary (at the Issuer's request) or involuntary (at the Exchange request) action. The Criteria used to determine an involuntary decertification action includes but is not limited to the following:

- Failure to maintain satisfactory quality and enrollment satisfaction scores
- Lack of enrollment into a product for a finite period of time
- Agency enforcement
- Issuer (or Product) does not continue to meet Exchange participation parameters
- Issuer is sanctioned by Medicare, Medicaid, CHIP, etc...

Voluntary requests for decertification of a plan will be submitted by the Issuer via SERFF. Involuntary Decertification actions will be initiated by DFS or DOH Exchange Regulators. A process will be in place to alert existing members of the decertified so that they can enroll in new plans.

Event Diagram for QHP Decertification

<<Diagram Placeholder>>

Figure 5: QHP De-Certification Flow

QHP Recertify – Tentative process

Plans certified in 2014 will be in place until plan year 2016 if they recertify. There will be a recertification process for plans that exist in plan year 2014 to recertify for plan year 2015 but new plans will not be allowed into the Exchange for plan year 2015. The rates and benefit data may still be updated. The existing window for entry into the Exchange is for plan year 2014. The next window will be for plan year 2016.

Except with respect to multi-state plans and CO-OP QHPs, a process will be in place for recertification of QHPs that, at a minimum, includes a review of the general certification criteria. Upon determining the recertification status of the QHP, the Exchange will notify the QHP issuer. QHP recertification process will be completed on or before September 15 of the applicable calendar year.

QHP Decertification Appeals

QHPs will have the ability to appeal a decertification ruling. There could be an appeals process iterative between DFS and the Issuer as they are striving to certify the plan.



6.2 Example 2 - Incarceration

Introduction

The purpose of this document is to describe the business rules for determining if a person seeking health care coverage or a family member being covered is incarcerated.

Preconditions

The primary subscriber must have completed all eligibility information required by the exchange.

Functional Description

P1) Data Elements

Field Name	Field Description	Required	Comment
First Name		Yes	
Middle Name		No	
Last Name		Yes	
Date of Birth		Yes	
Social Security Number		No	

P2) Business Rules

- (1) In the Household Information section, the user is asked to give the following information on each household member: First Name, Middle Name, Last Name, Date of Birth, Social Security Number, and check Male or Female. We also need to obtain the preferred method of contact for notices—mail or e-mail--so the notices can be sent by the user's preferred method.
- (2) The system pings the State Hub (state residents) or the Federal Hub (out of state residents) with identifying information on **all** household members to determine if any of the household members are incarcerated.
- (3) If there is **no** match in #2, the application proceeds.
- (4) If there is a match in #2 and the user agrees that he is incarcerated and is Medicaid eligible, application will be processed and Medicaid-Inpatient Only coverage will be authorized. If s/he went into jail with Medicaid, then Medicaid Outpatient coverage is suspended. Appropriate notification will be issued.
- (5) If the user agrees that he is incarcerated but will be released in 30 days and is APTC/ QHP or CHIP eligible, the application will be pended for 30 days (beginning the first of the following month) and user will be “flagged” for match against subsequent incarceration files. The next step in the process will follow (6) (a) and (b). If the user continues to appear on the incarceration files, the application will be denied and appropriate notification issued.
- (6) If there is a match in #2, and the user disputes the informational match, the system must allow the individual to resolve the discrepancy online and proceed with the application process and enroll the individual in coverage. The case will be flagged by the system. The user resolves the discrepancy online by choosing from a “drop-down” box of options to resolve the information discrepancy. The drop down box will have two reasons for the discrepancy (see below) for the user to choose from. If the user was recently released, the user will be able to include the date of release along with the reason to resolve the information discrepancy.
 - a. The flagged case will be re-run against the incarceration database when the database has been updated the following month.
 - b. If the flagged individual does not reappear in the database, then the application and enrollment proceed as per current procedure.
 - c. If the flagged individual re-appears in the updated database, a 90-day clock will start for the flagged case, beginning on the day that the case was re-run against the database. A Notification letter will be issued requesting documentation to resolve the discrepancy, and documentation must be received by the Exchange within 90 days of the notification. At the end of the 90 days and the incarceration database has been pinged again, another notice will be sent to the individual indicating that he/she has been disenrolled.
 - (i) If the individual is Medicaid eligible and continues to appear on the incarceration files, Medicaid-Inpatient Only coverage will be authorized. Appropriate notification will be issued.

- (ii) If the member is ATPC/QHP or CHIP eligible, the individual will be disenrolled following the 90-day clock down period. Disenrollment will occur on the 91st day if the user does not provide documentation. Notification of negative action will be issued when the individual is disenrolled.
- (7) If there is a match in #2, and the user is out-of-state with the intent to move to New York, and disputes the informational match, the 90-day clock for incarceration begins from the date of the rerun of the case (item c above). The residency 90-day clock will be a slightly different time period because that clock starts on the first day of the following month. The user can settle both clocks with proof of non-incarceration residency within the incarceration time period which expires before the residency clock.

Drop Down Box Options for #6:

- (1) Household member was never in jail or prison.
- (2) Household member was released from jail or prison.
If #2, Date of Release

6.3 Example 3 - Citizenship

Draft Business Rules for Citizenship

After SSN rules are applied on Household Information pages, follow these Citizenship Rules...

Ask the question: **Is this person a U.S. citizen? YES* NO***

- (1) If applicant says NO, meaning s/he is NOT a U.S. Citizen, then s/he is asked a series of immigration questions, which will be discussed in the immigration rules.
- (2) If applicant says YES, meaning s/he is a U.S. Citizen: Ping Federal Hub for verification. The data elements sent to the Federal Hub are: First Name, Middle Name, Last Name, Date of Birth, Social Security Number, Gender, Citizenship Attestation Flag (Yes).
- (3) If person says YES, meaning s/he is a U.S. Citizen AND the Federal Hub confirms citizenship, store verification in the database and application proceeds.
- (4) If the person says YES, meaning s/he is a U.S. Citizen, BUT the Hub does NOT confirm citizenship, the screen shows a message to the user: **We were not able to confirm citizenship for this person. Do you want to change this information? YES* NO***
- (5) If the answer to #4 is NO, meaning the applicant attests to being a U.S. Citizen, AND they do NOT want to change the information, AND if the applicant's age is up to the final day of the month of his 19th birthday, AND if the applicant meets the CHIP income eligibility guidelines, then the applicant is enrolled in Child Health Insurance Program (CHIP) for 60 days. Begin clock for 60 days.
 - A. If citizenship proof is not provided within 60 days, applicant is disenrolled on day 61.
 - B. If citizenship proof is provided within 60 days, applicant's CHIP is continued.
- (6) If the answer to #4 is NO, meaning the applicant is an U.S. Citizen, AND they don't want to change the information, then allow user to check one of these: **I would like to provide citizenship proof now * I would like to provide citizenship proof later. ***
 - A. If the answer is NOW, then the user is given these choices: (i) upload a document, (ii) fax a document (click sends them to a fax coversheet with scan), (iii) mail a document (clicking sends them to a mailing cover sheet with scan) or (iv) have third party verify original documents (sends them to screen that finds an assistor/navigator in the applicant's zipcode). For options i, ii, and iii, a customer service representative will need to confirm whether the document is acceptable, unless document verification software takes care of it. From the back end, the customer service representative and the assistor/navigator will need the ability to approve the document.
 - B. If the answer is LATER, then the applicant receives this message: **You have 90 days to provide documentation to prove citizenship. (The 90 clock starts when this message screen is displayed, but is actually 95 days.) A list of acceptable documents to prove citizenship is available when you click here. [Link to Q&A page with citizenship questions.] You will be enrolled in any program for which you qualify. However, you will be disenrolled on day 91 if the acceptable documents have not been provided. (Which is actually day 96**

according to federal rule.) Indicate on the screen that citizenship verification is pending. The applicant can continue the application.

- If proof is not provided within the 90-day window, the application is no longer active on the 91st day. This will be stored in the database, but the consumer will not be able to access it. A NOTICE is provided to the applicant that insurance for this person or applicant is no longer pending.
- If the proof is provided within the 90-day window, the applicant follows the document submission choices given in #6A and the eligible health program (CHIP, QHP, Medicaid) is no longer shown as temporary.

- (7) If the answer to #4 is YES, meaning s/he attests to being a U.S. Citizen, BUT the Hub does not confirm citizenship, AND the applicant wants to change the information, allow user to change information and ping Federal Hub again.
- A. If Federal Hub confirms citizenship, store verification in database and application proceeds.
 - B. If Federal Hub does NOT confirm citizenship, then say: **We were not able to confirm citizenship for this person. Would you like to provide a document that shows citizenship?** Allow the user to select: **I would like to provide citizenship proof now. OR I would like to provide citizenship proof later.** Follow steps 6A and 6B above.

STOP HERE PENDING IMMIGRATION RULES

7 Requirements Have Been Analyzed For Clarity, Completeness, and Consistency

With final responsibility on the Product Owner, the Sprint Teams have developed and performed quality assurance on the stories.

8 A Requirements Traceability Matrix (RTM) has been created to document how the Formal Requirements are intended to meet the Stakeholder Objectives and Achieve Stakeholder Agreement

Links in RRC are depicted in Figure 4.

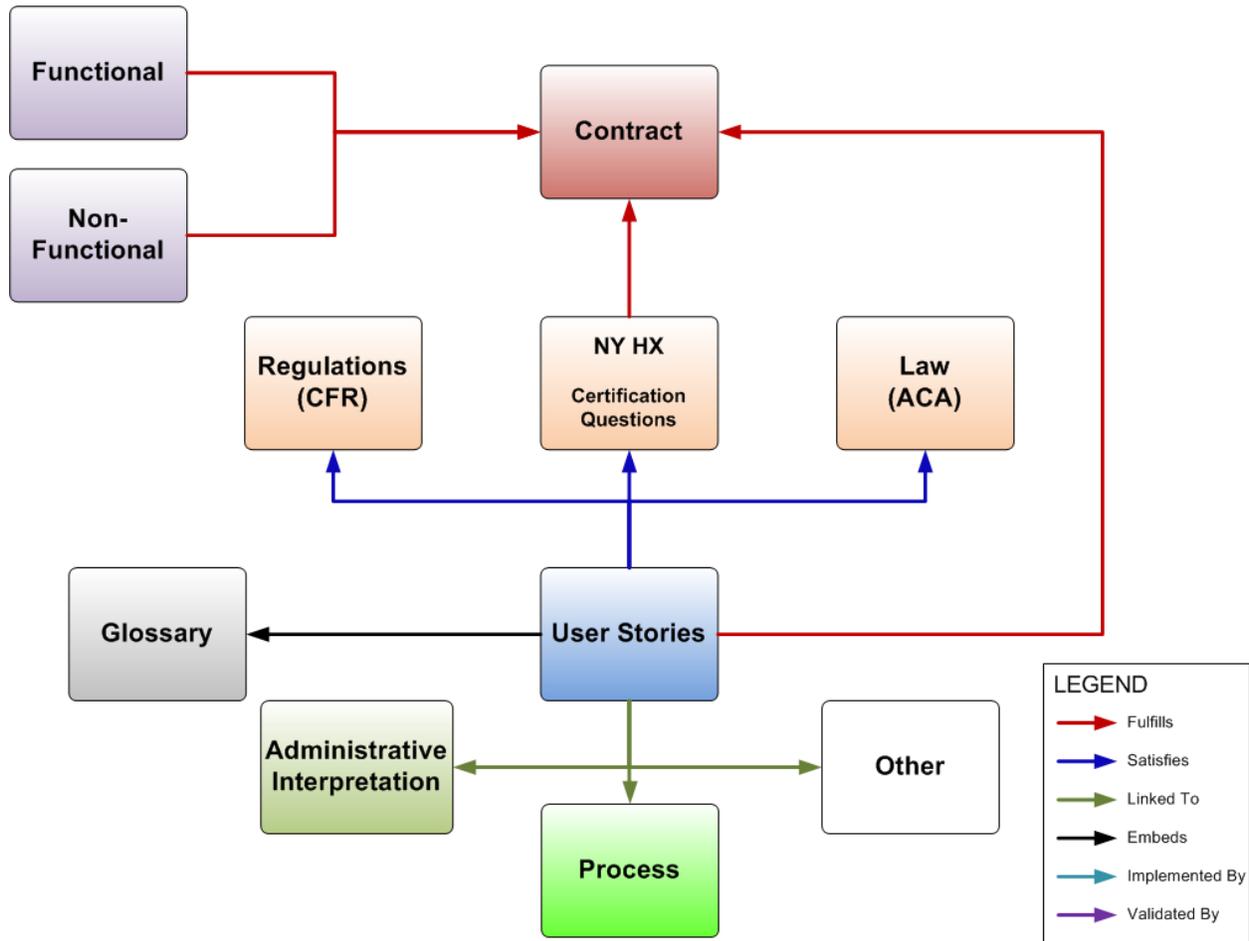


Figure 6: Linking in RRC

These two-way links tie stories to various requirements and supporting documentation. Using the RRC capability to filter and sort, multiple traces can be created. For example: Show stories *not* linked to a regulation (CFRs) **or** Show, for a given requirement set, Sections without stories.

Document 9.6 contains some examples of trace reports.