# State Review Framework
# Round 2 Review Report
# New Mexico

July 2010

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U.S. Environmental Protection Agency
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http://www.epa.gov/compliance/state/srf/index.html

**Final Report**

# State Review Framework

# Review of Region 6

# Direct Implementation

# New Mexico

# CWA NPDES Program

# For FY 2008

**December 28, 2009**

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## I. EXECUTIVE SUMMARY

This is a State Review Framework review of the Region 6 direct implementation of the CWA NPDES program in New Mexico for fiscal year 2008.

The State Review Framework (SRF) is a program designed to ensure EPA conducts oversight of state and EPA direct implementation, compliance and enforcement programs in a nationally consistent and efficient manner. Reviews look at 12 program elements covering: data (completeness, timeliness, and quality); inspections (coverage and quality); identification of violations, enforcement actions (appropriateness and timeliness); and, penalties (calculation, assessment and collection). Reviews are conducted in three phases: analyzing information from the national data systems; reviewing a limited set of state files; and development of findings and recommendations. Considerable consultation is built into the process, to ensure EPA and the state understand the causes of issues, and to seek agreement on identifying the actions needed to address problems. The Reports generated by the reviews are designed to capture the information and agreements developed during the review process in order to facilitate program improvements. The reports are designed to provide factual information and do not make determinations of program adequacy. EPA also uses the information in the reports to draw a "national picture" of enforcement and compliance, and to identify any issues that require a national response. Reports are not used to compare or rank state programs.

### A. SUMMARY OF RESULTS

#### Status of Recommendations from Round 1

#### *CWA Recommendations*

Region 6 implemented 13 of the 13 CWA recommendations from the previous SRF report.

#### Summary of Round 2 Results

The findings represent OECA's conclusions regarding the issue identified. Findings are based on the Initial Findings identified during the data or file review, as well as from follow-up conversations or additional information collected to determine the severity and root causes of the issue.

#### *Results of the CWA NPDES Program*

The Region meets program requirements in the findings for five of the 12 elements. They are Elements 2 (data accuracy), 4 (meets program commitments), 5 (meeting inspection coverage requirements), 6 (completeness of inspection reports) and 9 (enforcement actions resulting in compliance). ,. Element 3 (data timeliness) was not evaluated.

The Region needs to pay attention to issues in the findings for four of the 12 elements. They are Elements 1 (data completeness), , , , 7 (prompt reporting of violations in the national database), 11 (proposed penalty documentation and, 12 ( final penalty documentation).

The Region needs improvement that requires a recommendation for findings in two ofthe 12 elements reviewed. They are Elements 8 (timely entry of SNC data for single event violations) and 10 (timely enforcement response).

#### *Significant Issues Identified in the CWA NPDES Program*

At the time of the review, the Region was not entering single event violations in a timely fashion. Another significant issue identified during the CWA review is the low percentage of timely enforcement against non-SNC violations. Region 6 enforcement responses are appropriate. The Regiongenerally issues

administrative orders for significant non-compliance (SNC) violations and informal warning letters for violations that are not significant, or non-SNC. The main issue is the timeliness of the enforcement responses particularly for non-SNC violations.

The significant findings and recommendations are summarized in the tables below.

**Significant CWA/NPDES Summary of Findings**

| # | Finding | Outcome |
|---|---|---|
| Finding 8.2 | Region 6 CWA compliance program for New Mexico has not been entering SEV data violations in New Mexico in a timely manner. | OECA will review the OTIS metrics at the end of FY 2010 to determine if SEVs are being entered into ICIS in a timely manner. |
| Finding 10.2 | Region 6 CWA compliance program responses to noncompliance at NPDES facilities in New Mexico are often appropriate, but they are not always timely. | Area for Regional Improvement: By March 31, 2010 OECA and Region 6 will develop and agree to an action plan for addressing the timeliness of enforcement responses for both SNC and non-SNC violations. |

## A. GENERAL PROGRAM OVERVIEW

### Agency Structure

The Office of Enforcement and Compliance Assurance (OECA) is responsible for monitoring compliance with environmental statutes administered by EPA and takes enforcement actions when investigations document non-compliance. The OECA at Headquarters is the National Program Manager for compliance and enforcement policies implemented by the ten EPA regional offices. Region 6, located in Dallas Texas, has program oversight for EPA delegated programs in Arkansas, Louisiana, , Oklahoma, and Texas in addition to tribal lands, and the direct implementation of the CWA/NDPES program in New Mexico.

This report will review Region 6's direct implementation of the CWA/NDPES program in New Mexico for FY2008.

### Compliance/Enforcement Program Structure in Region 6

The Region 6 CWA/NPDES compliance and enforcement programs are the responsibility of the *Compliance Assurance and Enforcement Division*, which is divided into four media-based branches.

### Roles and Responsibilities in Region 6

The compliance and enforcement roles and responsibilities are focused in the *Compliance Assurance and Enforcement Division* that serves as the focal point for compliance and enforcement planning, guidance, and resources allocation activities. This division is responsible for coordinating strategic

compliance assurance efforts, measuring progress, coordinating with EPA Headquarters, and assisting in special enforcement or compliance assistance efforts.

The *Water Enforcement Branch* has three sections. They are: *NPDES Compliance Section*, *NPDES Industrial and Municipal Section*, and the *Water Resources Section*. These sections are responsible for interacting with the New Mexico state Department of Environmental Quality, which conducts the majority of NPDES inspections in New Mexico.

The CWA/NPDES compliance monitoring and enforcement program activities are undertaken by the *Water Enforcement Branch of the division. The Water Enforcement Branch performs the administrative, technical and scientific review and evaluation necessary to implement the enforcement provisions of NPDES permits, 40 CFR part 503, and direct enforcement of Section 301 of the CWA to address unauthorized discharges. Two NPDES sections within the Water Enforcement Branch are primarily dedicated to NPDES compliance monitoring and enforcement: the Municipal and Industrial Wastewater Section and the NPDES Compliance Monitoring Section.*

**Other Programs' Support Roles and Responsibilities**

The water program (eg, permitting, assistance programs, etc.) is conducted by the *Water Quality Protection Division,* which has five operating Branches. The *NPDES Permits and TMDL Branch* is responsible for NPDES permitting in New Mexico.

**Local Agencies included/excluded from review**

As noted above, the New Mexico Environmental Department (NMED)has not assumed the NPDES program, but conducts the majority of the coverage inspections in New Mexico. The NMED provides Clean Water Act section 401 certifications and performs surveillance and inspections for EPA as funded by the CWA section 106 grant program.

**Staffing/Training**

For the review period, the NPDES program was fully staffed and trained.

**Data Reporting Systems/Architecture**

Region 6 reports annual commitments and accomplishments in the Annual Commitments System, the EPA accountability system.

Region 6 codes all NPDES compliance and enforcement activities and data is coded into ICIS-NPDES.

Region 6 also uses an internal system to track the status of facilities that are in non-compliance and the actions that the Region is taking to return those facilities to compliance.

**B. MAJOR PROGRAM PRIORITIES AND ACCOMPLISHMENTS**

**Priorities**:
National Priorities: Pollutant discharges during wet whether including storm water runoff from construction sites and concentrated animal feeding operations.

Regional Priorities: Consistent with national priorities, focusing on those pollutant discharges posing the most significant impacts to water quality.

**Accomplishments:** In FY 2008, Region 6's NPDES enforcement program in New Mexico resulted in $1.3 million being spent by violators on pollution control and clean up with commensurate pollutant reductions, as well as over $2 million in penalties.

## C. PROCESS FOR SRF REVIEW

**Review Period**: FY 2008

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**Key Dates and Communications with Region**

Initial state notification: The Kick-Off Letter was sent to the Region on September 19, 2008.

Preliminary Call: The OECA review team conducted a preliminary meeting, by teleconference, with the Region on March 12, 2009

Data: The data for the PDA was generated on September 9, 2008. It was determined that since the on-site review was taking place in April 2009 that FY2008 data would be complete and the PDA was revised to use that data. The revised PDA was shared with the Region on March 23, 2009.

On-Site Review: The On-Site Review was conducted in the Region 6 offices in Dallas, Texas on April 21-23, 2009. During the On-Site Review, the review team conducted an entrance and exit meeting with the Region 6 managers and staff. The review team also conducted a separate exit meeting with the Director of the Enforcement.

**OECA and Regional Lead Contacts for Review**

**EPA Evaluator**

| | | |
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**Regional Contacts**:

| | | |
|---|---|---|
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## II Findings

| [CWA] Element 1 – Data Completeness | | |
|---|---|---|
| **Degree to which the Minimum Data Requirements are complete.** | | |
| Element + Finding Number | Finding 1.1 | Region 6 CWA compliance data for New Mexico is complete. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>**X** Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | The Region 6 CWA data is accurate, with only minor discrepancies in the data metrics identified in the PDA. Those discrepancies included the counts of major and non-majors facilities.<br><br>Region 6 pointed out discrepancies in three metrics in the PDA relating to DMR entry and noncompliance rates. Two metrics point to low DMR entry rates for NPDES non-majors and non-major noncompliance rates. These data are not required of the states, but since the Region is implementing the program, they are expected to be reporting non-major facility data.<br><br>Region 6 explained that the PDA data discrepancies were not due to a lack of data entry by the Region into ICIS. Specifically, the information contained in the PDA for the non-majors count contained facilities that should not have been counted in the FY 2008 pull because they were not issued until FY2009, which was discussed with OECA during the PDA review. The review team has reviewed the data metrics in OTIS and the initial errors have now been corrected. The data for non-major individual permits DMR entry rate based on DMRs expected has improved to 86.7%. Other data errors identified in the PDA were not serious, and they have been corrected.<br><br>Region 6 needs to continue to ensure that the universe of major individual facilities and non-major general permittees are updated and current and to continue to improve the DMR entry rate. |
| | Metric(s) and Quantitative Value | 1A1C – Active facility universe: NPDES major individual permits. (35)<br>1A3C – Active facility universe: NPDES non-major general permits. (93)<br>1C1C – Non-major individual permits: correctly coded limits. (89%)<br>1C2C – Non-major individual permits: DMR entry rate based on DMRs expected (forms). (54%)<br>1C3C – Non-major individual permits: DMR entry rate based on DMRs expected (permits). (55.9%)<br>1D1C – Violations at non-majors: noncompliance rate (1yr). (81.8%) |
| | Action(s) | |
| Element + Finding Number | Finding 1.2 | Region 6 CWA compliance program for New Mexico has a high number of “informal Enforcement Actions” in relation to the number of facilities. Many of these actions are internal deliberations that are given an ICIS code, and which are identified and displayed as enforcement actions in OTIS. This is a reporting procedure that OECA has allowed Region 6 to use since the introduction of ICIS. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | The data metrics indicate that informal enforcement actions were issued in FY 2008 at a rate of more than 2 to 1. Upon review of these “informal enforcement actions” during the on-site review, the review team found that many of them are documentation of internal regional deliberations and are not enforcement actions. Region 6 explained to the review team that they are implementing procedures based on their current EMS, specifically the TRAC (Technical Review Action Criteria) in the Enforcement Response Guide, to identify and route violations for appropriate enforcement response to ensure compliance and promote deterrence. The review team has learned that Region 6 uses the “agency enforcement review” code in ICIS to track these actions and that they are meant to appear on the QNCR to show that those potential violations are under review by the region. The review team has also learned that Region 6 is the only region to use this code in this way, and that this procedure was agreed to by OECA when ICIS was implemented. Since Region 6 is following a data procedure agreed to by OECA, the review team believes that the region meets the SRF program requirements.<br><br>Region 6 and OECA recognize that continuing to report internal reviews in this manner needs a data system enhancement to ensure that those reviews do not continue to appear in the national data as enforcement actions. In July 2009 Region 6 proposed an enhancement to ICIS to allow for a comment field to denote internal review so that the Region would not need to use the agency enforcement review code for this purpose. OECA has received this request and is working on it. |
| | Metric(s) and Quantitative Value | 1E1E – Informal actions: number of major facilities. (20)<br>1E2E – Informal actions: number of actions at major facilities (1 yr). (55)<br>1E3E – Informal actions: number of nom-major facilities (1 FY) (10) |
| | Action(s) | |

| [CWA] Element 2 – Data Accuracy | | |
|---|---|---|
| **Degree to which data reported into the national system is accurately entered and maintained (example, correct codes used, dates are correct, etc.).** | | |
| Element + Finding Number | Finding 2.1 | Region 6 CWA compliance program data for New Mexico are generally, but not always consistent with data in the compliance program files. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>X Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 84% (27 of 32) of the files reviewed were found to contain data that were accurate and consistent with the data in the OTIS Detailed Facility Reports. In the instances where data were not accurate, the problem is usually that data in the files were not reflected in OTIS. Examples of isolated instances of inaccurate data are: missing inspection reports, listing wrong inspection type, listing an expired facility that still receives inspections, and enforcement responses from previous years not listed in OTIS. Each of these problems occur only once or twice in the files and there are no patterns of problems that indicate a particular issue, but they do indicate that the Region needs to pay attention to its approach to file management and data entry.<br><br>The Region 6 CWA EMS, based on the national CWA EMS, serves as a set of Standard Operating Procedures (SOP) to manage the region's data flows and NPDES program in general. The EMS, however, need updating to include the guidelines in recent OECA memos, i.e., memos on reporting single event violations ("Permit Compliance System (PCS) Policy Statement of 1985 and amended in 2000," and the 2007 memo "ICIS Addendum to the Appendix of the PCS Policy Statement.")<br><br>Region 6 explained to the review team that the following EMS procedures are in place:<br><br>▪ Procedures to maintain the accuracy of data entry to ICIS.<br>▪ Procedures for entering Single Event Violations into ICIS.<br>▪ Procedures are in place for ICIS data QA/QC<br>▪ Procedures are in place in the Surveillance Section for inspection performance standards in staff member PARS agreements.<br><br>Region 6 has also explained that they have recently added reporting guidelines to the EMS relating to the Wet Weather Policy statement and memos on single events violations. Region 6 further explained that they will continue to review the EMS to ensure that all updated procedures are included in the manual and procedures can be tracked in the SRF Tracker.<br><br>Area for Regional Attention:<br><br>Region 6 needs to update the EMS to include the specifications for reporting on the Wet Weather Policy and the memo on SEVs, the guidance for tracking internal enforcement discussions and other guidance discussed in other findings of this report. |
| | Metric(s) and Quantitative Value | File Review Metric 2b – Percentage of files reviewed where data is accurately reflected in the national data system. (84%) |
| | Action(s) | |

| [CWA] Element 3 – Timeliness of Data Entry | | |
|---|---|---|
| **Degree to which the Minimum Data Requirements are timely.** | | |
| Element + Finding Number | Finding | This metric was not reviewed due to the lack of frozen data in OTIS. |

| [CWA] Element 4 – Completion of Commitments. | | |
|---|---|---|
| **Degree to which all enforcement/compliance commitments in relevant agreements (i.e., PPAs, PPGs, categorical grants, CMS plans, authorization agreements, etc.) are met and any products or projects are completed.** | | |
| Element + Finding Number | Finding 4.1 | Region 6 and New Mexico Environment Department (NMED) met their major facility inspection commitments and greatly exceed their commitments for general permittees. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | Between Region 6 and the NMED there was a FY 2008 commitment to conduct inspections at 20 major facilities and they completed 20 inspections. These are the only required ACS commitments. Region 6 and NMED targeted 37 non-major individual permitted facilities for inspections and 20 non-major general permitted facilities. They completed a total of 27 inspections at the former and 104 inspections at the latter.<br><br>Region 6 and NMED met and exceeded their FY 2008 inspection commitments for major sources and for major and non-major general permits, yet they did not meet the non-major individual permit inspection commitments.<br><br>Region 6 met their major source inspection commitments for the review year. |
| | Metric(s) and Quantitative Value | File Review Metric – Percentage of planned inspections completed:<br>Major Sources. (100%)<br>Non-Major Individual Permits. (71%)<br>Non-Major General Permits. (Region 6 – 370%, NMDEQ – 670%) |
| | Action(s) | |

| [CWA] Element 5 – Inspection Coverage | | |
|---|---|---|
| **Degree to which state completed the universe of planned inspections/compliance evaluations (addressing core requirements and federal, state and State priorities).** | | |
| Element + Finding Number | Finding 5.1 | Region 6 CWA compliance program in New Mexico meets the annual inspection goal for NPDES major sources. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | Region 6 and NMED met their inspection requirements for major source inspection. They inspected 20 of the 35 major permittees. And they conducted inspections at 205 non-major facilities, both individual and general permittees. The Region exceeds the 2 to 1 minor to major source trade off currently acceptable under OECA's National Program Guidance. |
| | Metric(s) and Quantitative Value | Metric 5A0C – Inspection coverage: NPDES majors (1 FY) Combined. (20)<br>Metric 5B1C – Inspection coverage: NPDES non-major individual permits (1FY) Combined. (23).<br>Metric 5B1C - Inspection coverage: NPDES non-major individual permits (1 FY) (27)<br>Metric 5B2S – Inspection coverage: NPDES non-major general permits (1 FY) (67)<br>Metric 5B2E – Inspection coverage: NPDES non-major general permits (1 FY) (37)<br>Metric 5B2C – Inspection coverage: NPDES non-major general permits (1 FY) (104) |
| | Action(s) | |

| [CWA] Element 6 – Quality of Inspection or Compliance Evaluation Reports | | |
|---|---|---|
| **Degree to which inspection or compliance evaluation reports properly document observations, are completed in a timely manner, and include accurate description of observations.** | | |
| Element + Finding Number | Finding 6.1 | Generally, Region 6 CWA inspection reports for facilities in New Mexico were complete. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 96% (26 of 27) of the Region 6 NPDES inspection reports reviewed were complete. 26 of the inspection reports reviewed were prepared by NMED inspectors. NMDEQ inspection reports were well prepared and followed the requirements of a complete CEI. The NMDE inspection report that was not complete lacked a discussion of possible corrective actions. The Region 6 inspection report that was reviewed lacked the following information: a narrative, facility description, observations, and inspector or supervisor signatures. |
| | Metric(s) and Quantitative Value | File Review Metric 6b – Percentage of inspection reports reviewed that are complete. (96%)<br>File Review Metric 6c – Percentage of inspection reports that provide sufficient dociumentation to lead to an accurate compliance determination. (96%) |
| | Action(s) | |
| Element + Finding Number | Finding 6.2 | Region 6 CWA inspection reports for facilities in New Mexico contain enough information to lead to accurate compliance determinations. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 96% (26 of 27) of the NPDES inspection reports reviewed contained sufficient information to lead to accurate compliance determinations. 21 of the inspection reports reviewed were prepared by NMDEQ inspectors. Region 6 did not achieve 100% because one of the inspection reports was not in the file and could not be reviewed to determine whether the ensuing enforcement action was warranted as a result of the inspection. Nonetheless, even if in the few instances where the inspection reports were not complete, they contained enough information to help inform an accurate compliance determination. |
| | Metric(s) and Quantitative Value | File Review Metric 6c – Percentage of inspection reports reviewed that contains sufficient documentation to lead to an accurate compliance determination. (96%) |
| | Action(s) | |
| Element + Finding Number | Finding 6.3 | Region 6 NPDES inspection reports are generally completed in a timely manner. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 74% (20 of 27) of the NPDES inspection reports reviewed were timely, and were completed within 30 days of the inspection. The average was 36 days. The median time was 18 days. The mode was 14 days. The indication is that Region 6 and NMED generally meet the timeliness requirements for preparing inspection reports. There were, however, two Region 6 inspection reports that took a very long time to complete (104 and 201 days).<br><br>Region 6 acknowledges that there have been delays in completing some inspection reports. One explanation for this is that there were delays in transmitting the reports from Region 6 field offices. Another explanation is that the Region may need additional time to gather enough sampling data to support a potential enforcement action. Region 6 states that they are working to correct these problems. The two inspection reports that took 104 and 201 days to complete do not detract from the reports that are timely, but Region 6 needs to avoid having outliers like these.<br><br>While the percentage of timely reports is relatively low (74%), the average and median time to complete these reports show that the regional inspectors are generally well within the prescribed timelines for completing inspection reports. Moreover, based on the findings above (Finding 6.2), the results of Region 6 CWA NPDES inspections lead to accurate and appropriate compliance decisions. So, the 74% timeliness rate does not tell the whole story. Therefore, the review team has determined that Region 6 meets the requirements for timeliness of completing inspection reports. |

| | | |
|---|---|---|
| | Metric(s) and Quantitative Value | File Review Metric 6d – Percentage of inspection reports reviewed that is timely. (74%) |
| | Action(s) | |

| **[CWA] Element 7 – Identification of Alleged Violations.** | | |
|---|---|---|
| **Degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information (e.g., facility-reported information).** | | |
| Element + Finding Number | Finding 7.1 | Region 6 CWA compliance program for New Mexico is entering Single Event Violations into the national database. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>**X** Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | Region 6 NPDES compliance program enters Single Event Violation data into ICIS; however, there was an indication that Region 6 was not entering all SEVs into the national database in a timely manner. Also, the review team learned that SEVs were not entered into ICIS until a formal enforcement action was issued. The effect of this is that SEVs were either entered late into ICIS, or SEVs were not entered into ICIS until formal action was not taken,. As noted under Element 2, the Region has only recently begun to follow recent OECA guidance on entering SEVs. Thus, while the Region has been entering these data, it has not been on a systematic basis. The NPDES staff assured the review team that they are now beginning to enter these data pursuant to the national guidance. A check of the FY 2009 OTIS data shows an increase in the number of SEVs for majors and non-majors, which indicates that this is the case.<br><br>Region 6 explained to the review team that they have updated their procedures on entering inspection Single Event Violations (SEV's) in ICIS. Enforcement no longer waits until the hard copies of inspections are received from the inspectors to enter a SEV. Instead, upon completion of their written reports, EPA and NMED inspectors electronically route copies of inspection reports to the Enforcement Compliance Section and the enforcement section conducts timely enforcement action. The inspection report is reviewed by the Compliance Section for detection of violations. Upon detection of violations, the inspection reports are routed to the Municipal/Industrial Section for further determinations and formal enforcement actions. The inspections are routed attached to a source document (CRAS's) Critical Review Action Sheets. Single events are then entered into ICIS.<br><br>Region 6 has the practice of entering SEVs into ICIS, but only recently have they begun to follow OECA policy on SEV data entry. They are improving this practice. Region 6 should continue to implement the most recent OECA SEV policies and ensure that it is part of the EMS. |
| | Metric(s) and Quantitative Value | Data Metric 7A1C – Single event violations at majors (1 yr). (2)<br>Data Metric 7A2C – Single event violations at non-majors (1yr). (1) |
| | Action(s) | |
| Element + Finding Number | Finding 7.2 | Region 6 CWA compliance program compliance determinations for facilities in New Mexico are documented are documented in the file. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 93% (25 of 27) of the NPDES inspection reports reviewed led to accurate compliance determinations. The review team could not determine whether accurate compliance determinations were made for two of the files because there was no documentation for the inspection reports. Region 6 explains that the have are implementing the EMS procedures for routing documents to the file room. The process includes screening each single document that is received in the Branch. Upon completion of the screening and appropriate enforcement actions of documents, the documents are routed to the file room. After the document is sent to the region's file room, it is the responsibility of the file room to ensure that the documents are filed in the appropriate files. Region 6 explained to the review team that they are working with the file room to ensure that documents are accurately placed in the files. |
| | Metric(s) and Quantitative Value | File Review Metric 7e – Percentage of inspection reports or facility files reviewed that led to accurate compliance determinations. (93%) |
| | Action(s) | |

| [CWA] Element 8 – Identification of SNC and HPV | | |
|---|---|---|
| **Degree to which the state accurately identifies significant noncompliance/high priority violations and enters information into the national system in a timely manner.** | | |
| Element + Finding Number | Finding 8.1 | Region 6 CWA compliance program for New Mexico is accurately identifying SEV violations in New Mexico as SNC or non-SNC. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 100% (14 of 14) of the inspection reports that documented violations led to an accurate assessment of either SNC or non-SNC determinations. |
| | Metric(s) and Quantitative Value | File Review Metric 8b – Percentage of single event violation(s) that are accurately identified as SNC or Non-SNC. (100%) |
| | Action(s) | |
| | Finding 8.2 | Region 6 CWA compliance program for New Mexico has not been entering SEV data violations in New Mexico in a timely manner. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>**X** Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 25% (3 of 12) of the SEVs in SNC were reported to ICIS in a timely manner. The reason for this is that the Region does not enter SNC determinations until the enforcement action is filed. The Region told the review team that this practice has changed and that SNC are now to be entered when they are determined.<br><br>Area for Regional Improvement (Recommendation Required):<br><br>Region 6 needs to improve the timeliness, based on the SEV guidance, of entering SEV data into ICIS. |
| | Metric(s) and Quantitative Value | Data Metric 8A1C – Major facilities in SNC (1 yr) (10)<br>Data Metric 8A2C – SNC rate. Percentage of majors in SNC (1 yr). (29.4%)<br>File Review Metric 8c – Percentage of single event violation(s) identified as SNC that are reported timely. 25%) |
| | Action(s) | By the end of the second quarter of FY 2010, Region 6 should share EMS with the update to the EMS that will now include the most recent policy memorandum from OECA regarding Single Event Violations. OECA will review the OTIS metrics at the end of FY 2010 to determine if SEVs are being entered into ICIS in a timely manner. |

| [CWA] Element 9 - Enforcement Actions Promote Return to Compliance | | |
|---|---|---|
| **Degree to which state enforcement actions include required corrective action (i.e., injunctive relief or other complying actions) that will return facilities to compliance in a specific time frame.** | | |
| Element + Finding Number | Finding 9.1 | The Region 6 CWA Compliance program files for New Mexico reviewed contain sufficient documentation that either SNC or non-SNC violations have or will return to compliance. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>X Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 100% (5 of 5) of the enforcement responses against SNC violations that were reviewed contained documentation that those facilities have or will return the facilities back to compliance.<br><br>93% (13 of 14)) of the enforcement responses against non-SNC violations that were reviewed contain documentation that those facilities have or will return facilities back to compliance. In 2 files reviewed, AO are being prepared against those facilities<br><br>Regarding the facilities for which there was no documentation, Region 6 explained that they have two procedures to track its actions and deliberations when following up on inspections to ensure appropriate actions are taken. The non-SNC violations are usually for non-reporting and the usual response is an informal warning letter. A number of those were in the files, but a number of them were not. The region shared some of the warning letters that were not in the files with the review team. |

| | | |
|---|---|---|
| | | Region 6 needs to ensure that information on return to compliance is documented in all files, in particular the non-SNC violations. |
| | Metric(s) and Quantitative Value | File Review Metric 9b – Percentage of enforcement responses that have returned or will return a source in SNC to compliance. (100%)<br>File Review Metric 9c – Percentage of enforcement responses that have returned or will return a source with non-SNC violations to compliance. (93%) |
| | Action(s) | |

| **[CWA] Element 10 – Timely and Appropriate Action** | | |
|---|---|---|
| **Degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media.** | | |
| Element + Finding Number | Finding 10.1 | Region 6 CWA compliance program responses to noncompliance at NPDES facilities in New Mexico are often appropriate. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 80% (4 of 5) of the files reviewed for facilities in SNC were addressed with an appropriate enforcement response. Two of the enforcement responses to SNC were addressed with informal enforcement actions, which were not found in the files; therefore, it is difficult to know if the violations were addressed appropriately.<br><br>90% (17 of 19) ) of the enforcement responses reviewed appropriately addressed facilities with non-SNC violations. In several cases, there was no enforcement response to date. In another instance, the violations for chlorine are a chronic problem, but those facilities were only addressed with informal enforcement actions, many of which are not found in the file, so the response to noncompliance for this facility cannot be fully evaluated. This is similar to the issues identified for the SNC violations noted in the findings above. For violations that are non-SNC, some of the informal enforcement actions are appropriate to the violations; however, a number of those actions were not found in the files. Also, some of the informal enforcement actions that were reviewed (either in the files or provided to the review team by the Region's NPDES data steward) describe regional deliberations and are not enforcement actions (see Finding 9.1).<br><br>The review team agrees that the region has a process for managing enforcement response. Region 6 generally addresses SNC with formal enforcement. There was not enough documentation for a number of non-SNC informal enforcement actions to determine if the responses were appropriate.<br><br>Region 6 NPDES program should, to the extent possible, address SNC violations with formal enforcement actions. Informal actions, i.e., LOVs or NOVs, may be appropriate in some instances, but they should include language about return to compliance and the Region should require follow-up actions in order to determine that the facility did return to compliance.<br><br>Internal Reviews are used to decide on the appropriate action for any given NPDES violation. Region 6 should document these Internal Reviews better in order to evaluate whether the action was appropriate. |
| | Metric(s) and Quantitative Value | File Review Metric 10c – Percentage of enforcement responses reviewed that address SNC that are appropriate to the violations. (80%)<br>File Review Metric 10d – Percentage of enforcement responses reviewed that appropriately addresses non-SNC violations. (90%) |
| | Action(s) | |
| | Finding 10.2 | Region 6 CWA compliance program responses to noncompliance at NPDES facilities in New Mexico are often not timely. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>**X** Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 80% (4 of 5) of the files reviewed for facilities in SNC were addressed in a timely manner. Of the two untimely actions: 1) one AO took 9 months to be issued; and 2) the file for one facility lacked the documentation of the form of enforcement actions, thus it was not possible to determine if any of the enforcement response were either timely or appropriate.<br><br>Region 6 explained that while it may take time for some inspection reports to reach the files a copy is prepared in PDF format of all signed inspection reports for the files and transmitted to Region 6 in Dallas via email. The hard copy follows later and the NPDES program signs for receipt of the original inspection report. Therefore, while there is the appearance of a lack of timeliness, the enforcement staff does get the report in a timely manner through informal channels.<br><br>35% (8 of 20) enforcement responses for non-SNC violations were not taken in a timely manner.<br><br>The file review indicates that not all SNC is addressed timely (also supported by data metric 10A) or with formal and informal enforcement. Region 6's main issue is the timeliness of addressing violations, primarily non-SNC. Region 6 NPDES program should improve the timeliness of addressing facilities with SNC or non-SNC violations. |

| | | |
|---|---|---|
| | Metric(s) and Quantitative Value | File Review Metric 10b – Percentage of enforcement responses reviewed that address SNC that are taken in a timely manner. (80%)<br>File Review Metric 10e – Percentage of responses for non-SNC violations were a response was taken in a timely manner. (40%) |
| | Action(s) | By July 31, 2010 OECA and Region 6 will develop and agree to an action plan for addressing the enforcement response for both SNC and non-SNC violations. |

| **[CWA] Element 11 – Penalty Calculation Method** | | |
|---|---|---|
| **Degree to which state documents in its files that initial penalty calculation includes both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy.** | | |
| Element + Finding Number | Finding 11.1 | Most Region 6 CWA compliance program files for facilities in New Mexico with formal enforcement actions documented penalty calculations for gravity and economic benefit, but did not calculate economic benefit when it was believed to be de minimus. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>**X** Area for Regional Attention<br>❒ Area for Regional Improvement (Recommendation Required) |
| | Explanation of the Finding | 75% (3 of 4) of the CWA New Mexico program files reviewed with penalty actions contained documentation that gravity and economic benefit were considered. The fourth file reviewed with a penalty documented the gravity calculation and indicated that the economic benefit was zero. However, there was no BEN calculation prepared or other documentation to indicate why the Region believed there was no economic benefit.<br><br>Region 6 explains that economic benefit is considered for all cases except Expedited Settlement Agreements. If the calculated economic benefit is de minimus, a value of zero is used. If the economic benefit value is believed to be de minimus, no BEN calculation is performed. The review team agrees with this process; however, the region needs to have documentation that the economic benefit of noncompliance is de minimus.<br><br>Area for Regional Improvement (Recommendation Required):<br><br>Region 6 NPDES compliance program needs to ensure that economic benefit is calculated in order to demonstrate the value of the economic benefit, especially if the economic benefit is a de minimus amount. The value of economic benefit should not be assumed to be de minimus without justification for that decision. The BEN model would typically be used to document these decisions. |
| | Metric(s) and Quantitative Value | File Review Metric 11a – Percentage of penalty calculations that consider and include where appropriate gravity and economic benefit. (75%) |
| | Action(s) | |

| **[CWA] Element 12 – Final Penalty Assessment and Collection** | | |
|---|---|---|
| **Degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected.** | | |
| Element + Finding Number | Finding 12.1 | Region 6 CWA compliance program files for facilities in New Mexico generally document the initial and final penalties in the files. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>❒ Meets SRF Program Requirements<br>**X** Area for Regional Attention<br>❒ Area for State Improvement (Recommendation Required) |
| | Explanation of the Finding | 75% (3 of 4) of the files reviewed with penalty actions contained documentation for the difference and rationale between the initial and final assessed penalty. One of the files did not contain the penalty documentation and documentation was not available to the review team at the time of the on-site review.<br><br>Area for Regional Attention:<br><br>Region 6 needs to ensure that all enforcement files are properly documented. |
| | Metric(s) and Quantitative Value | File Review Metric 12a – Percentage of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. (75%) |
| | Action(s) | |
| | Finding 12.2 | Region 6 CWA compliance program files for facilities in New Mexico document the collection of penalties. |
| | Is this finding a(n) (select one): | ❒ Good Practice<br>**X** Meets SRF Program Requirements<br>❒ Area for Regional Attention<br>❒ Area for State Improvement (Recommendation Required) |

| | | |
|---|---|---|
| | Explanation of the Finding | 100% (4 of 4) of the files reviewed with penalty actions contained documentation that the penalties were collected. Region 6 routinely sends the penalty collection information to the EPA finance center in Cincinnati, Ohio for collection. |
| | Metric(s) and Quantitative Value | File Review Metric 12a – Percentage of enforcement actions with penalties that document collection of penalty. (100%) |
| | Action(s) | |

# Appendix A

## Status of Recommendations form Previous Review

During the first SRF review of Region's compliance and enforcement programs, OECA identified a number of actions to be taken to address issues found during the review. The table below shows the status of progress toward completing those actions.

| # | CWA NPDES Recommendation | Status | Comments |
|---|---|---|---|
| 1 | The Region should ensure properly managed files by managing the files for unpermitted sources in the regions central filing system. | Completed | The Region is now filing storm water and CAFO facilities in the file room. |
| 2 | The problem of incomplete files is not major, but should still be addressed. The Region does have a process for reviewing and verifying inspection reports. This process should be also be used to ensure the completeness of the files, especially ensuring that the inspection date is clearly on the report so that the time lines can be calculated. | Completed | NM sends us a monthly list of inspections conducted. We review this and ensure that the inspections have been received. If not we track the system to locate the inspections. Also, we need to implement this list requirement from EPA inspectors. . |
| 3 | The first recommendation is that violations found through inspections need to be identified sooner and a determination made if they should be considered SNC. Where these violations constitute repeat patterns of violations, there needs to be an escalated enforcement response. There should be documentation in the files. | Completed | 6EN-WC has procedures in place to route inspection violations for formal action and address repeated patterns of violations upon receipt of inspections. |
| 4 | The second recommendation is that there needs to be an expedited process for the Region to get inspection reports from the NM DEQ inspectors. This could be either to have the Region's file room to have a process for identifying these reports and forwarding them quickly to the water enforcement branch, or formalizing the process of the NM DEQ sending copies simultaneously to the water enforcement branch. | Completed | On average, inspection reports are received in well under 30 days by the Region. |
| 5 | The Region should ensure that inspection reports are actually completed in a timely manner and not just reported timely to the database. | Completed | Inspection Reports are tracked for enforcement action through routing CRAS to Compliance Section and maintaining Violation Summary Logs. |
| 6 | The Region should formalize a process for making an SNC determination for single event violators to ensure that they are properly identified in PCS and so there will be the appropriate enforcement response. There should be escalating enforcement in cases where there are repeat violations and non response to lower level enforcement actions. | Completed | Currently the Region manually enters single events and manually raises flags on violations to ensure that single events show up on QNCR for tracking. |
| 7 | The main recommendation is that the Region needs to ensure that there are better procedures and documentation in the files to indicate that the sources return to compliance, especially for the expedited settlement cases. | Completed | Facility certifies they are compliant when they sign CAFO |
| 8 | Another recommendation is that the enforcement actions need to be clear about the injunctive relief. | Completed | AO language was revised to be specific. |
| 9 | The water program should have a process in place for ensuring that enforcement actions are resolved as soon as possible within the time line. | Completed | Enforcement actions are tracked in our database for progress reports, and achieve compliance schedules. When these schedules are delinquent appropriate escalation is taken in timely manner. Upon compliance, the enforcement action is closed. |
| 10 | The Region needs to improve the documentation of the expedited settlement cases. The Region also needs to improve documentation of economic benefit and may require further training on the BEN model. | Completed | ESO penalty calculations take into account economic benefit as part of the formula. Every effort is made to ensure complete documentation. |
| 11 | Documentation of decisions around penalty assessments and collections should be maintained in the files. | Completed | Penalty assessment documentation is kept in the files, however, collections are handled at Cincinnati and are not forwarded to the Region. |
| 12 | Region should enter enforcement type for all violations into the data system. | Completed | The Region makes every effort to make sure all data elements are entered into ICIS-NPDES in a timely manner. |
| 13 | Region needs to ensure that they meet the national standard of 95% of major sources with permit limits in PCS. | Completed | |

## Appendix B

## Official Data Pull

## FY 2008 Data

| | Metric | Metric Type | Agency | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| 1. Data completeness. degree to which the minimum data requirements are complete. | | | | | | | | | |
| A | Active facility universe: NPDES major individual permits (Current) | Data Quality | Combined | | | 34 | NA | NA | NA |
| | Active facility universe: NPDES major general permits (Current) | Data Quality | Combined | | | 0 | NA | NA | NA |
| | Active facility universe: NPDES non-major individual permits (Current) | Data Quality | Combined | | | 94 | NA | NA | NA |
| | Active facility universe: NPDES non-major general permits (Current) | Data Quality | Combined | | | 0 | NA | NA | NA |
| B | Major individual permits: correctly coded limits (Current) 1 | Goal | Combined | ≥ 95% | 95.30% | 97.20% | 35 | 36 | 1 |
| | Major individual permits: DMR entry rate based on MRs expected (Forms/Forms) (1 Qtr) 2 | Goal | Combined | ≥ 95% | 92.30% | 96.70% | 118 | 122 | 4 |
| | Major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr) 3 | Goal | Combined | ≥ 95% | 91.10% | 94.40% | 34 | 36 | 2 |
| | Major individual permits: manual RNC/SNC override rate (1 FY) | Data Quality | Combined | | | 33.30% | 4 | 12 | 8 |
| C | Non-major individual permits: correctly coded limits (Current) 4 | Informational Only | Combined | | | 90.40% | 94 | 104 | 10 |
| | Non-major individual permits: DMR entry rate based on DMRs expected (Forms/Forms) (1 Qtr) 5 | Informational Only | Combined | | | 52.00% | 78 | 150 | 72 |
| | Non-major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr) 6 | Informational Only | Combined | | | 51.00% | 53 | 104 | 51 |
| D | Violations at non-majors: noncompliance rate (1 FY) | Informational Only | Combined | | | 81.90% | 77 | 94 | 17 |
| | Violations at non-majors: noncompliance rate in the annual noncompliance report (ANCR)(1 CY) 7 | Informational Only | Combined | | | 0 / 0 | 0 | 0 | 0 |
| | Violations at non-majors: DMR non-receipt (3 FY) | Informational Only | Combined | | | 3 | NA | NA | NA |
| E | Informal actions: number of major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 20 | NA | NA | NA |
| | Informal actions: number of actions at major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 55 | NA | NA | NA |
| | Informal actions: number of non-major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | EPA | | | 10 | NA | NA | NA |
| | Informal actions: number of actions at non-major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 17 | NA | NA | NA |
| | Formal actions: number of major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 2 | NA | NA | NA |
| | Formal actions: number of actions at major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 2 | NA | NA | NA |
| | Formal actions: number of non-major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 18 | NA | NA | NA |
| | Formal actions: number of actions at non-major facilities (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| F | | | EPA | | | 18 | NA | NA | NA |
| | Penalties: total number of penalties (1 FY) | Data Quality | State | | | 0 | NA | NA | NA |
| | | | EPA | | | 7 | NA | NA | NA |
| | Penalties: total penalties (1 FY) | Data Quality | State | | | $0 | NA | NA | NA |
| | | | EPA | | | $35,400 | NA | NA | NA |
| | Penalties: total collected pursuant to civil judicial actions (3 FY) | Data Quality | State | | | $0 | NA | NA | NA |
| | | | EPA | | | $0 | NA | NA | NA |
| | Penalties: total collected pursuant to administrative actions (3 FY) | Informational Only | State | | | $0 | NA | NA | NA |
| | | | EPA | | | $188,544 | NA | NA | NA |
| | No activity indicator - total number of penalties (1 FY) | Data Quality | State | | | $0 | NA | NA | NA |
| G | | | EPA | | | $35,400 | NA | NA | NA |
| 2. Data accuracy. degree to which the minimum data requirements are accurate. | | | | | | | | | |
| | Actions linked to violations: major facilities (1 FY) | Data Quality | State | ≥ 80% | | 0 / 0 | 0 | 0 | 0 |
| A | | | EPA | ≥ 80% | | 100.00% | 2 | 2 | 0 |
| 3. Timeliness of data entry. degree to which the minimum data requirements are complete. | | | | | | | | | |
| A | Comparison of Frozen Data Set | Target availability is March 2009 | | | | | | | |
| 5. Inspection coverage. degree to which state completed the universe of planned inspections/compliance evaluations. | | | | | | | | | |
| | Inspection coverage: NPDES majors (1 FY) | Goal | State | 100% | 57.60% | 30.30% | 10 | 33 | 23 |
| | | | EPA | 100% | 5.90% | 18.20% | 6 | 33 | 27 |
| A | | | Combined | 100% | 60.40% | 48.50% | 16 | 33 | 17 |
| | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | State | | | 22.30% | 21 | 94 | 73 |
| | | | EPA | | | 4.30% | 4 | 94 | 90 |
| B | | | Combined | | | 26.60% | 25 | 94 | 69 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | State | | | 0 / 0 | 0 | 0 | 0 |
| | | | EPA | | | 0 / 0 | 0 | 0 | 0 |
| | Inspection coverage: NPDES non-major general permits (1 FY) | Goal | Combined | | | 0 / 0 | 0 | 0 | 0 |
| | | | State | | | 0.00% | 0 | 1 | 1 |
| | | | EPA | | | 0.00% | 0 | 1 | 1 |
| C | Inspection coverage: NPDES other (not 5a or 5b) (1 FY) | Informational Only | Combined | | | 0.00% | 0 | 1 | 1 |
| 7. Identification of alleged violations. degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information. | | | | | | | | | |
| | Single-event violations at majors (1 FY) | Review Indicator | Combined | | | 2 | NA | NA | NA |
| A | Single-event violations at non-majors (1 FY) | Informational Only | Combined | | | 1 | NA | NA | NA |
| B | Facilities with unresolved compliance schedule violations (at end of FY) | Data Quality | Combined | | 37.00% | 33.30% | 2 | 6 | 4 |
| C | Facilities with unresolved permit schedule violations (at end of FY) | Data Quality | Combined | | 28.90% | 30.40% | 7 | 23 | 16 |
| D | Percentage major facilities with DMR violations (1 FY) | Data Quality | Combined | | 55.00% | 67.60% | 23 | 34 | 11 |
| 8. Identification of SNC and HPV. degree to which the state accurately identifies significant noncompliance & high priority violations and enters information into the national system in a timely manner. | | | | | | | | | |
| | Major facilities in SNC (1 FY) | Review Indicator | Combined | | | 10 | NA | NA | NA |
| A | SNC rate: percent majors in SNC (1 FY) | Review Indicator | Combined | | 23.80% | 29.40% | 10 | 34 | 24 |
| B | Wet weather SNC | Metric(s) likely to be developed in the future. | | | | | | | |
| 10. Timely and appropriate action. degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media. | | | | | | | | | |
| A | Major facilities without timely action (1 FY) | Goal | Combined | < 2% | 16.80% | 29.40% | 10 | 34 | 24 |

**Note:** EPA Regions must archive the state official data set (first results screen) used for a state review, as these data cannot be reproduced at a later date. SRF data metrics results may change as data are updated in AFS, ICIS, PCS, and RCRAInfo. The above data set may be saved in Excel or comma delimited text format by clicking on the appropriate Save Results link above. Drilldown tables that are linked from this page also cannot be exactly reproduced after a new data refresh occurs if the state has entered or changed data. OECA does not require regions to save the drilldown facility lists in order to document their review; however, if potential problem areas are identified through regional analysis or via state dialogue, the region may want to save selected drilldown lists.

**General Notes:**

* Blue-shaded rows denote that the metric was pulled manually.

* The results counts of some metrics contain enforcement sensitive (ES) records/actions. When using the drilldowns, enforcement sensitive access may be required to view all records/actions included in the results counts.

* Because of timeout issues, links are not provided to drilldowns that produce more than 1500 records.

**Caveats:**

[0] State Metric column is generally computed from the value in the Count column (x) divided by the value in the Universe column (y).

[1] FY2008 Metric 1B1 ICP data was pulled manually using IDEA data from February 2009.

[2] FY2008 Metric 1B2 data was pulled manually using IDEA data from February 2009.

[3] FY2008 Metric 1B3 data was pulled manually using IDEA data from February 2009.

[4] FY2008 Metric 1C1 ICP data was pulled manually using IDEA data from February 2009.

[5] FY2008 Metric 1C2 data was pulled manually using IDEA data from February 2009.

[6] FY2008 Metric 1C3 data was pulled manually using IDEA data from February 2009.

[7] Metric 1D2 data is pulled manually, and is available only for CY2007. CY2008 data will be posted in March of 2009.

## Appendix B

## Official Data Pull

## FY 2008 Data

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New MexicoMetric | Count | Universe | Not Counted | Discrepancy Explanation | Evaluation (Preliminary) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| P01A1C | Active facility universe: NPDES major individual permits (Current) | Data Quality | Combined | | | 34 | NA | NA | NA | R6 added City of Aztec NM0020168 | Potential Concern |
| P01A2C | Active facility universe: NPDES major general permits (Current) | Data Quality | Combined | | | 0 | NA | NA | NA | | N/A |
| P01A3C | Active facility universe: NPDES non-major individual permits (Current) | Data Quality | Combined | | | 94 | NA | NA | NA | 3 should be added, 4 should be subtracted | Potential Concern |
| P01A4C | Active facility universe: NPDES non-major general permits (Current) | Data Quality | Combined | | | 0 | NA | NA | NA | | N/A |
| P01B1C | Major individual permits: correctly coded limits (Current) | Goal | Combined | >=; 95% | 95.3% | 97.1% | 33 | 34 | 1 | | Appears Acceptable |
| C01B2C | Major individual permits: DMR entry rate based on MRs expected (Forms/Forms) (1 Qtr) | Goal | Combined | >=; 95% | 92.3% | 97.5% | 115 | 118 | 3 | | Appears Acceptable |
| C01B3C | Major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr) | Goal | Combined | >=; 95% | 91.1% | 97.1% | 33 | 34 | 1 | | Appears Acceptable |
| P01B4C | Major individual permits: manual RNC/SNC override rate (1 FY) | Data Quality | Combined | | | 33.3% | 4 | 12 | 8 | | Potential Concern/Supplemental |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| P01C1C | Non-major individual permits: correctly coded limits (Current) | Informational Only | Combined | | | 88.3% | 83 | 94 | 11 | | Minor Issue |
| C01C2C | Non-major individual permits: DMR entry rate based on DMRs expected (Forms/Forms) (1 Qtr) | Informational Only | Combined | | | 54.2% | 77 | 142 | 65 | 1 major should be subtracted then only 5 facilities remaining (6 DMRs) | Potential Concern |
| C01C3C | Non-major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr) | Informational Only | Combined | | | 55.3% | 52 | 94 | 42 | 3 facilities issued in FY09 | Potential Concern |
| P01D1C | Violations at non-majors: noncompliance rate (1 FY) | Informational Only | Combined | | | 81.9% | 77 | 94 | 17 | | Potential Concern/ Supplemental |
| C01D2C | Violations at non-majors: noncompliance rate in the annual noncompliance report (ANCR)(1 CY) | Informational Only | Combined | | | 0 / 0 | 0 | 0 | 0 | | N/A |
| P01D3C | Violations at non-majors: DMR non-receipt (3 FY) | Informational Only | Combined | | | 3 | NA | NA | NA | | Minor Issue |
| P01E1E | Informal actions: number of major facilities (1 FY) | Data Quality | EPA | | | 20 | NA | NA | NA | | Minor Issue |
| P01E2E | Informal actions: number of actions at major facilities (1 FY) | Data Quality | EPA | | | 55 | NA | NA | NA | | Potential Concern/Supplemental |
| P01E3E | Informal actions: number of nom-major facilities (1 FY) | Data Quality | EPA | | | 10 | NA | NA | NA | | Minor Issue |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| P01E4E | Informal actions: number of actions at non-major facilities (1 FY) | Data Quality | EPA | | | 17 | NA | NA | NA | | Potential Concern/Supplemental |
| P01F1E | Formal actions: number of major facilities (1 FY) | Data Quality | EPA | | | 2 | NA | NA | NA | | Appears Acceptable |
| P01F2E | Formal actions: number of actions at major facilities (1 FY) | Data Quality | EPA | | | 2 | NA | NA | NA | | Appears Acceptable |
| P01F3E | Formal actions: number of non-major facilities (1 FY) | Data Quality | EPA | | | 18 | NA | NA | NA | | Appears Acceptable |
| P01F4E | Formal actions: number of actions at non-major facilities (1 FY) | Data Quality | EPA | | | 18 | NA | NA | NA | | Appears Acceptable |
| P01G1E | Penalties: total number of penalties (1 FY) | Data Quality | EPA | | | 7 | NA | NA | NA | | Appears Acceptable |
| P01G2E | Penalties: total penalties (1 FY) | Data Quality | EPA | | | $35,400 | NA | NA | NA | | Potential Concern |
| P01G3E | Penalties: total collected pursuant to civil judicial actions (3 FY) | Data Quality | EPA | | | $0 | NA | NA | NA | | Minor Issue |
| P01G4E | Penalties: total collected pursuant to administrative actions (3 FY) | Informational Only | EPA | | | $188,544 | NA | NA | NA | | Minor Issue |
| P01G5E | No activity indicator - total number of penalties (1 FY) | Data Quality | EPA | | | $35,400 | NA | NA | NA | | Potential Concern |
| P02A0E | Actions linked to violations: major facilities (1 FY) | Data Quality | EPA | >=; 80% | | 100.0% | 2 | 2 | 0 | | Appears Acceptable |
| P05A0S | Inspection coverage: NPDES majors (1 FY) | Goal | State | 100% | 57.6% | 30.3% | 10 | 33 | 23 | | Potential Concern |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| P05A0E | Inspection coverage: NPDES majors (1 FY) | Goal | EPA | 100% | 5.9% | 18.2% | **8** | **35** | 27 | | Potential Concern |
| P05A0C | Inspection coverage: NPDES majors (1 FY) | Goal | Combined | 100% | 60.4% | 48.5% | **18** | **35** | 17 | | Potential Concern |
| P05B1S | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | State | | | 22.3% | **23** | **93** | 73 | | Potential Concern |
| P05B1E | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | EPA | | | 4.3% | 4 | **(93** | 90 | | Potential Concern |
| P05B1C | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | Combined | | | 26.6% | **27** | **93** | 69 | | Potential Concern |
| P05B2S | Inspection coverage: NPDES non-major general permits (1 FY) | Goal | State | | | 0 / 0 | **67** | 0 | 0 | | N/A |
| P05B2E | Inspection coverage: NPDES non-major general permits (1 FY) | Goal | EPA | | | 0 / 0 | **37** | 0 | 0 | | N/A |
| P05B2C | Inspection coverage: NPDES non-major general permits (1 FY) | Goal | Combined | | | 0 / 0 | **104** | 0 | 0 | | N/A |
| P05C0S | Inspection coverage: NPDES other (not 5a or 5b) (1 FY) | Informational Only | State | | | 0.0% | 0 | 1 | 1 | | Appears Acceptable |
| P05C0E | Inspection coverage: NPDES other (not 5a or 5b) (1 FY) | Informational Only | EPA | | | 0.0% | 0 | 1 | 1 | | Appears Acceptable |
| P05C0C | Inspection coverage: NPDES other (not 5a or 5b) (1 FY) | Informational Only | Combined | | | 0.0% | 0 | 1 | 1 | | Appears Acceptable |
| P07A1C | Single-event violations at majors (1 FY) | Review Indicator | Combined | | | 2 | NA | NA | NA | | Appears Acceptable |
| P07A2C | Single-event violations at non-majors (1 FY) | Informational Only | Combined | | | 1 | NA | NA | NA | | Appears Acceptable |
| P07B0C | Facilities with unresolved compliance schedule violations (at end of FY) | Data Quality | Combined | | 37.0% | 33.3% | 2 | 6 | 4 | | Minor Concern |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| P07C0C | Facilities with unresolved permit schedule violations (at end of FY) | Data Quality | Combined | | 28.9% | 30.4% | 7 | 23 | 16 | | Minor Concern |
| P07D0C | Percentage major facilities with DMR violations (1 FY) | Data Quality | Combined | | 55.0% | 67.6% | 23 | 34 | 11 | | Potential Concern |
| P08A1C | Major facilities in SNC (1 FY) | Review Indicator | Combined | | | 10 | NA | NA | NA | | Potential Concern |
| P08A2C | SNC rate: percent majors in SNC (1 FY) | Review Indicator | Combined | | 23.8% | 29.4% | 10 | 34 | 24 | | Potential Concern |
| P10A0C | Major facilities without timely action (1 FY) | Goal | Combined | < 2% | 16.8% | 29.4% | 10 | 34 | 24 | | Potential Concern/Supplemental |

## Appendix D

## Preliminary Data Analysis Chart

This section provides the results of the Preliminary Data Analysis (PDA). The Preliminary Data Analysis forms the initial structure for the SRF report, and helps ensure that the data metrics are adequately analyzed prior to the on-site review. This is a critical component of the SRF process, because it allows the reviewers to be prepared and knowledgeable about potential problem areas before initiating the on-site portion of the review. In addition, it gives the region focus during the file reviews and/or basis for requesting supplemental files based on potential concerns raised by the data metrics results. The full PDA is available in Appendix C of this report.

The PDA reviews each data metric and evaluates state performance against the national goal or average, if appropriate. The PDA Chart in this section of the SRF report only includes metrics where potential concerns are identified or potential areas of exemplary performance. The full PDA contains every metric: positive, neutral or negative. Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the file review results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | Discrepancy Explanation | Evaluation (Preliminary) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P01A1C | Active facility universe: NPDES major individual permits (Current) | Data Quality | Combined | | | 34 | NA | NA | NA | R6 added City of Aztec NM0020168 | Potential Concern | Region 6 has identified a discrepancy in the universe of major permittees. The universe is off by one permittee because one source is actually a major and not minor facility. If this is the case, the system needs to be updated to change the major/minor status of the facility. |
| P01A2C | Active facility universe: NPDES major general permits (Current) | Data Quality | Combined | | | 0 | NA | NA | NA | | N/A | |
| P01A3C | Active facility universe: NPDES non-major individual permits (Current) | Data Quality | Combined | | | 94 | NA | NA | NA | 3 should be added, 4 should be subtracted | Potential Concern | Region 6 has identified a discrepancy in the universe of major and non-major permittees. If this is the case, the system needs to be updated to change the major/minor status of the facility |
| P01B4C | Major individual permits: manual RNC/SNC override rate (1 FY) | Data Quality | Combined | | | 33.3% | 4 | 12 | 8 | | Potential Concern/ Supplemental | The percentage of manual overrides appears high and needs to evaluated further to assess whether these overrides are accurate. |
| P01C1C | Non-major individual permits: correctly coded limits (Current) | Informational Only | Combined | | | 88.3% | 83 | 94 | 11 | | Minor Issue | The percentage is good, but since New Mexico is a direct implementation state, OECA would expect this percentage to be a little higher. |
| C01C2C | Non-major individual permits: DMR entry rate based on DMRs expected (Forms/Forms) (1 Qtr) | Informational Only | Combined | | | 54.2% | 77 | 142 | 65 | 1 major should be subtracted then only 5 facilities remaining (6 DMRs) | Potential Concern | While considering a revision to the universe based on previous metrics, there still appears to be a discrepancy between what is in the database and what the region has counted. |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C01C3C | Non-major individual permits: DMR entry rate based on DMRs expected (Permits/Permits ) (1 Qtr) | Informational Only | Combined | | | 55.3% | 52 | 94 | 42 | 3 facilities issued in FY09 | Potential Concern | While considering a revision to the universe based on previous metrics, there still appears to be a discrepancy between what is in the database and what the region has counted. |
| P01D1C | Violations at non-majors: noncompliance rate (1 FY) | Informational Only | Combined | | | 81.9% | 77 | 94 | 17 | | Potential Concern/ Supplemental | Given the number of facilities that make up the universe for this metric and the correction provided by Region 6, there appears to be a discrepancy between what is in the database and what the region has counted. |
| P01E2E | Informal actions: number of actions at major facilities (1 FY) | Data Quality | EPA | | | 55 | NA | NA | NA | | Potential Concern/ Supplemental | On average there are 2 informal enforcement actions to every major facility with violations. The review team is concerned about why multiple informal actions are being taken at the same permits in a short time period. |
| P01E3E | Informal actions: number of nom-major facilities (1 FY) | Data Quality | EPA | | | 10 | NA | NA | NA | | Minor Issue | |
| P01E4E | Informal actions: number of actions at non-major facilities (1 FY) | Data Quality | EPA | | | 17 | NA | NA | NA | | Potential Concern/ Supplemental | On average there are just less than 2 informal enforcement actions to every non-major facility with violations. The review team is concerned about why multiple informal actions are being taken at the same permits in a short time period. |
| P01G2E | Penalties: total penalties (1 FY) | Data Quality | EPA | | | $35,400 | NA | NA | NA | | Potential Concern | The review team will want to assess the penalty orders and penalties for some of these enforcement responses. The total penalties for FY2008 is well below the previous 3 year average. |
| P01G3E | Penalties: total collected pursuant to civil judicial actions (3 FY) | Data Quality | EPA | | | $0 | NA | NA | NA | | Minor Issue | It appears that Region 6 took no civil judicial actions in New Mexico. |
| P01G4E | Penalties: total collected pursuant to administrative actions (3 FY) | Informational Only | EPA | | | $188,544 | NA | NA | NA | | Minor Issue | This metric will be evaluated under element 12. |
| P01G5E | No activity indicator - total number of penalties (1 FY) | Data Quality | EPA | | | $35,400 | NA | NA | NA | | Potential Concern | The review team will want to assess the penalty orders and penalties for some of these enforcement responses. The total penalties for FY2008 is well below the previous 3 year average. |
| P05A0S | Inspection coverage: NPDES majors (1 FY) | Goal | State | 100% | 57.6% | 30.3% | 10 | 33 | 23 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |
| P05A0E | Inspection coverage: NPDES majors (1 FY) | Goal | EPA | 100% | 5.9% | 18.2% | **8** | **35** | 27 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P05A0C | Inspection coverage: NPDES majors (1 FY) | Goal | Combined | 100% | 60.4% | 48.5% | **18** | **35** | 17 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |
| P05B1S | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | State | | | 22.3% | **23** | **93** | 73 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |
| P05B1E | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | EPA | | | 4.3% | 4 | **(93** | 90 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |
| P05B1C | Inspection coverage: NPDES non-major individual permits (1 FY) | Goal | Combined | | | 26.6% | **27** | **93** | 69 | | Potential Concern | This metric does not meet the program Goal. The review team will discuss this with Region 6. |
| P07D0C | Percentage major facilities with DMR violations (1 FY) | Data Quality | Combined | | 55.0% | 67.6% | 23 | 34 | 11 | | Potential Concern | This metric is above the national average. This wll need to be assessed further by the review team. |
| P08A1C | Major facilities in SNC (1 FY) | Review Indicator | Combined | | | 10 | NA | NA | NA | | Potential Concern | 10 of 34 major facilities are in SNC and need to be addressed. The review team will want to discuss with Region 6 their strategy for addressing these 10 instances of SNC. |
| P08A2C | SNC rate: percent majors in SNC (1 FY) | Review Indicator | Combined | | 23.8% | 29.4% | 10 | 34 | 24 | | Potential Concern | 10 of 34 major facilities are in SNC and not addressed in a timely manner. The review team will want to discuss with Region 6 their strategy for managing the timeliness of addressing SNC. |
| P10A0C | Major facilities without timely action (1 FY) | Goal | Combined | < 2% | 16.8% | 29.4% | 10 | 34 | 24 | | Potential Concern/ Supplemental | 10 of 34 major facilities are in SNC and not addressed in a timely manner. The review team will want to discuss with Region 6 their strategy for managing the timeliness of addressing these facilities in SNC. |

## Appendix E

## File Selection

The files were selected randomly from using the OTIS File Selection Tool. The total number of files in the selection universe was under 300, so the review team needed to select between 15 and 25 files. Files were selected to have a representative sample of majors, minors, municipalities, mines, and facilities with inspections, enforcement actions, SNC violations, minor violations, and Single Event Violations. Several files were selected as supplemental files in order to review specific issues from the PDA. This brought the total number of files requested to 34.

| | Program ID | city | state | zip | Permit Component | Inspection | Violation | Single Event Violation | SNC | Informal Action | Formal Action | Penalty | Universe | Select |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | NM0022250 | ALBUQUERQUE | NM | 87105 | POT PRE | 0 | 16 | 0 | 0 | 3 | 0 | 0 | Major | accepted_representative |
| 2 | NMU001535 | ALTO | NM | 88312 | SWC | 1 | 1 | 1 | 0 | 0 | 1 | 1 | Minor | added to the list. |
| 3 | NM0028762 | AZTEC | NM | 87410 | | 1 | 20 | 0 | 2 | 0 | 0 | 0 | Minor | accepted_representative |
| 4 | NM0020168 | AZTEC | NM | 87410 | | 1 | 21 | 0 | 0 | 0 | 0 | 0 | Minor | accepted_representative |
| 5 | NMU001576 | BERNALILLO | NM | | SWC | 2 | 0 | 0 | 0 | 0 | 0 | 0 | Minor | accepted_representative |
| 6 | NM0022306 | QUESTA | NM | 87556 | | 1 | 2 | 0 | 0 | 0 | 0 | 0 | Major | accepted_representative |
| 7 | NM0020150 | BELEN | NM | 87002 | POT | 1 | 5 | 0 | 0 | 1 | 0 | 0 | Major | accepted_representative |
| 8 | NM0026395 | CARLSBAD | NM | 88220 | POT | 0 | 8 | 0 | 0 | 0 | 1 | 0 | Major | accepted_representative |
| 9 | NM0020583 | FARMINGTON | NM | 87401 | POT PRE | 1 | 16 | 0 | 3 | 3 | 0 | 0 | Major | accepted_representative |
| 10 | NM0020681 | TRUTH OR CONSEQUENCES | NM | 87901 | POT | 0 | 15 | 0 | 2 | 5 | 0 | 0 | Major | accepted_representative |
| 11 | NM0020672 | GALLUP | NM | 87301 | | 1 | 20 | 2 | 0 | 3 | 0 | 0 | Major | accepted_representative |
| 12 | NM0029971 | HOLLOMAN AFB | NM | 88330 | | 1 | 3 | 0 | 3 | 0 | 0 | 0 | Major | accepted_representative |
| 13 | NMR15FN69 | ALBUQUERQUE | NM | 87110 | SWC | 5 | 0 | 0 | 0 | 0 | 0 | 0 | Minor | accepted_representative |
| 14 | NM0020141 | LOS ALAMOS | NM | 87544 | | 1 | 22 | 0 | 0 | 1 | 0 | 0 | Major | accepted_representative |
| 15 | NM0028851 | LOS LUNAS | NM | 87031 | | 1 | 1 | 0 | 0 | 0 | 0 | 0 | Minor | accepted_representative |
| 16 | NMR15F545 | ALBUQUERQUE | NM | 87113 | SWC | 2 | 0 | 0 | 0 | 0 | 1 | 0 | Minor | accepted_representative |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | NM0020532 | MCKINLEY COUNTY | NM | 87020 | | 0 | 3 | 0 | 1 | 2 | 0 | 0 | Major | accepted_representative |
| 18 | NM0027987 | RIO RANCHO | NM | 87124 | POT | 2 | 18 | 1 | 4 | 4 | 1 | 0 | Major | accepted_representative |
| 19 | NM0020311 | ROSWELL | NM | 88201 | POT PRE | 0 | 13 | 0 | 0 | 4 | 0 | 0 | Major | accepted_representative |
| 20 | NM0029165 | RUIDOSO | NM | 88345 | POT | 1 | 16 | 0 | 4 | 11 | 0 | 0 | Major | accepted_representative |
| 21 | NM0028533 | RUIDOSO | NM | 88312 | | 0 | 13 | 0 | 3 | 0 | 0 | 0 | Minor | accepted_representative |
| 22 | NM0029505 | SAN JUAN | NM | 87418 | | 1 | 16 | 0 | 0 | 0 | 0 | 0 | Minor | accepted_representative |
| 23 | NMG010031 | CLOVIS | NM | 88101 | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | Minor | accepted_representative |
| 24 | NMR15E720 | RUIDOSO | NM | | SWC | 0 | 4 | 0 | 4 | 0 | 0 | 0 | Minor | accepted_representative |
| 25 | NMU000719 | LOS CRUCES | NM | 88011 | SWC | 1 | 1 | 1 | 0 | 0 | 1 | 1 | Minor | added to the list. |
| 26 | NM0030503 | ANGEL FIRE | NM | 87710 | POT | 1 | 5 | 0 | 4 | 0 | 0 | 0 | Minor | accepted_representative |
| 27 | NM0023485 | BERNALILLO | NM | 87004 | | 0 | 42 | 2 | 4 | 3 | 0 | 0 | Minor | accepted_representative |
| 28 | NM0024066 | RANCHO DE TAOS | NM | 87557 | POT | 1 | 9 | 0 | 1 | 2 | 0 | 0 | Major | accepted_representative |
| 29 | NM0028614 | SANTA FE COUNTY | NM | 87504 | | 1 | 14 | 0 | 4 | 1 | 0 | 0 | Minor | accepted_representative |
| 30 | NM0027731 | CHAMA | NM | 87520 | POT | 0 | 53 | 0 | 3 | 5 | 1 | 0 | Minor | accepted_representative |
| 31 | NM0029149 | MAXWELL | NM | 87728 | POT | 1 | 4 | 0 | 4 | 0 | 0 | 0 | Minor | accepted_representative |
| 32 | NM0030392 | RUIDOSO | NM | 88345 | | 0 | 23 | 0 | 0 | 1 | 0 | 0 | Minor | accepted_representative |

## Appendix F

## File Review Metrics Analysis Form

This section presents the initial observations of the Region regarding program performance against file metrics. Initial Findings are developed by the region at the conclusion of the File Review process. The Initial Finding is a statement of fact about the observed performance, and should indicated whether the performance indicates a practice to be highlighted or a potential issue, along with some explanation about the nature of good practice or the potential issue. The File Review Metrics Analysis Form in the report only includes metrics where potential concerns are identified, or potential areas of exemplary performance.

Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the PDA results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section VI of this report.

The quantitative metrics developed from the file reviews are initial indicators of performance based on available information and are used by the reviewers to identify areas for further investigation. Because of the limited sample size, statistical comparisons among programs or across states cannot be made.

**Name of State: New Mexico** **Review Period: FY 2008**

| CWA Metric # | CWA File Review Metric: | Metric Value | Assessment | Initial Findings and Conclusions |
|---|---|---|---|---|
| **Metric 2b** | % of files reviewed where data is accurately reflected in the national data system. | 93% | Potential Concern | The information in 25 of the 27 files reviewed were found to be adequate and consistent with the data in the OTIS Detailed Facility Reports. Either information was not in the files to support the OTIS data, or there was information in the files that was not reflected in OTIS. Examples of inaccurate data include: missing inspection reports, listing wrong inspection type, listing an expired facility that still receives inspections, and enforcement responses from previous years not listed in OTIS. Each of these types of problems occur only once or twice. They do not represent any pattern of problems that roll up to a particular issue, but they do indicate the Region would benefit from exercising a higher level of care in its approach to file management and data entry. One pattern of potentially inaccurate data that the review team identified concerns the inaccurate use of the "informal enforcement" designation for internal, regional enforcement activities. It turns out that this is based on a reporting procedure that OECA allowed Region 6 to use. |
| **Metric 4a** | % of planned inspections completed. Summarize using the Inspection Commitment Summary Table in the CWA PLG. | 100% | Minor Issues/Appears Acceptable | Between Region 6 and the New Mexico DEQ there was a FY 2008 commitment to conduct inspections as 20 major facilities and they completed 20 inspections. These are the only required ACS commitments. However, Region 6 and NMDEQ also committed to conducting 37 inspections at non-majors individual permitted facilities and 20 inspections at non-major general permitted facilities. They completed a total of 27 inspections at the former and 104 inspections at the latter. |
| **Metric 4b** | Other Commitments. Delineate the commitments for the FY under review and describe what was accomplished. This should include commitments in PPAs, PPGs, grant agreements, MOAs, or other relevant agreements. The commitments should be broken out and ident | | | It appears that there are no other regional commitments for the CWA/NPDES program. |

| | | | | |
|---|---|---|---|---|
| **Metric 6a** | # of inspection reports reviewed. | | | |
| **Metric 6b** | % of inspection reports reviewed that are complete. | 82% | Minor Issues/Appears Acceptable | 22 of the 27 inspection reports reviewed were complete. 21 of the inspection reports reviewed were prepared by New Mexico DEQ inspection. Only 3 of those reports were not complete. The main problem was that those reports were missing from the files. Generally, though, the state inspection reports were well prepared and followed the requirements of a complete CEI. There was one regional inspection report that lacked a narrative, facility description, observations, and inspector/supervisor signatures. This was clearly an exception, but the state inspection reports were generally of better quality than the EPA inspection reports. |
| **Metric 6c** | % of inspection reports reviewed that provide sufficient documentation to lead to an accurate compliance determination. | 96% | Minor Issues/Appears Acceptable | 26 of the 27 inspection reports reviewed contained sufficient information to lead to accurate compliance determinations. 21 of the inspection reports reviewed were prepared by New Mexico DEQ inspectors. This metric is not 100% because one report was not in the file and could not be reviewed to determine whether the ensuing enforcement action was warranted as a result of the inspection. Nonetheless, even if in the few instances where the inspection reports were not complete, they generally contained enough information to help inform an accurate compliance determination. Also, in most instances, the inspection reports led to some type of enforcement response. |
| **Metric 6d** | % of inspection reports reviewed that are timely. | 74% | Potential Concern | 20 of the 27 inspection reports reviewed were timely, within 30 days of the inspection. The average was about 36 days. The median time was 18 days. The mode was 14 days. There were only two EPA reports that took a very long time to complete (104 and 201 days). One explanation for this is that the inspections were conducted by another division in Region 6 in the region and it took them time to transmit the reports to the enforcement division. The region is working to correct this problem. |
| **Metric 7e** | % of inspection reports or facility files reviewed that led to accurate compliance determinations. | 96% | Minor Issues/Appears Acceptable | 26 of the 27 inspection reports reviewed led to accurate compliance determinations. The review team could not determine whether accurate compliance determinations were made for two of the files because there was no documentation for the inspection reports. |
| **Metric 8b** | % of single event violation(s) that are accurately identified as SNC or Non-SNC. | 100% | Minor Issues/Appears Acceptable | 13 of the 13 of the inspection reports that documented violations led to an accurate assessment of either SNC or non-SNC determinations. |
| **Metric 8c** | % of single event violation(s) identified as SNC that are reported timely. | 25% | Significant Issue | 3 of the 12 SEVs were reported to ICIS in a timely manner. The reason for this is that the Region does not enter SNC determinations until the enforcement action is filed. The Region told the review team that this practice has changed and that SNC are now to be entered when they are determined. All of the SEVs not entered timely into ICIS were non-SNC violations. |
| **Metric 9a** | # of enforcement files reviewed | | | |
| **Metric 9b** | % of enforcement responses that have returned or will return a source in SNC to compliance. | 75% | Potential Concern | 9 of the 12 enforcement responses against SNC violations have or will return the facilities back to compliance. Most of the enforcement response documented in the files and in OTIS are informal enforcement actions. Many of these actions are not documented in the files, so there is nothing to help document the steps for return to compliance or to know if that was achieved. Also, many of the informal actions that were found in the files are letters requiring a facility to submit DMRs. Finally, many of the informal actions that are documented in the files are not really enforcement actions. Instead they represent documentation in ICIS that internal regional discussions or actions were taken. These should not be listed in ICIS in this manner because they are not enforcement actions against the facilities and they distort the record. It is allowable to issue informal enforcement responses for violations that are SNC, but it formal enforcement that return the facilities to compliance are the appropriate response. |
| **Metric 9c** | % of enforcement responses that have returned or will returned a source with non-SNC violations to compliance. | 59% | Significant Issue | 10 of the 17 enforcement responses against non-SNC violations have or will return facilities back to compliance. In 2 files reviewed, AO are being prepared against those facilities. Otherwise, the finding is the same as for Metric 9b. |

| | | | | |
|---|---|---|---|---|
| **Metric 10b** | % of enforcement responses reviewed that address SNC that are taken in a taken in a timely manner. | 71% | Potential Concern | 5 of the 7 enforcement responses against SNC for major facilities were addressed in a timely manner. Examples of addressed SNC that was not timely include: 1) one file contained an inspection report that was completed in a timely manner, but that did not reach Region 6 for 3 months thus exceeding the 90 day standard for taking and enforcement action; 2) one AO took 9 months to be issued; and 3) for one facility, there were only informal actions that were not documented in the file so it is not possible to determine if they were timely. |
| **Metric 10c** | % of enforcement responses reviewed that address SNC that are appropriate to the violations. | 83% | Potential Concern | 5 of the 6 enforcement responses that address SNC appear to be appropriate to the violations. Since so few of the facilities actually are returned to compliance, it appears that the enforcement response is not appropriate. Several of the enforcement responses to SNC were done informally and the enforcement actions were not documented in the files, therefore, it is difficult to know if the violations were addressed appropriately. |
| **Metric 10d** | % of enforcement responses reviewed that appropriately address non-SNC violations. | 63% | Significant Issue | 12 of the 19 enforcement responses reviewed appropriately addressed non-SNC violations. In a couple of cases, there has been no response to date. In another case, the chlorine has been a chronic problem, but there have only been informal actions, which are not documented in the file, so it cannot be evaluated. This similar to the problem identified in 10b & 10c. Since this metric measures non-SNC, the informal actions are appropriate to the violations; however, a number of those actions are not documented in the files. Also, some of the informal actions that were reviewed are documentation of internal Region 6 communications, and not enforcement actions directed to the facilities. Those actions are also not appropriate to the violations. |
| **Metric 10e** | % enforcement responses for non-SNC violations where a response was taken in a timely manner. | 40% | Significant Issue | 7 of the 20 enforcement responses for non-SNC violations were not taken in a timely manner. This is similar to the issues in metric 10b. The lack of documentation of informal enforcement actions prevents a determination of the timeliness of the actions to be made by the review team. |
| **Metric 11a** | % of penalty calculations that consider and include where appropriate gravity and economic benefit. | 75% | Minor Issues/Appears Acceptable | 3 of the 4 files reviewed with penalty actions contained documentation that gravity and economic benefit were considered. The documentation for these penalties were not in the program files, but were in the files of the engineer and the attorneys. For one penalty, the documentation showed the gravity and indicated that the economic benefit was zero. There was no indication that this was calculated to show this was the case. |
| **Metric 12a** | % of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. | 75% | Minor Issues/Appears Acceptable | 3 of the 4 files reviewed with penalty actions contained documentation for the difference and rationale between the initial and final assessed penalty. |
| **Metric 12b** | % of enforcement actions with penalties that document collection of penalty. | 75% | Minor Issues/Appears Acceptable | 3 of the 4 files reviewed with penalty actions contained documentation that the penalties were collected. |

| **Findings Criteria** |
|---|
| **Minor Issues/Appears Acceptable** -- No EPA recommendation required. |
| **Potential Concern** -- Not a significant issue. Issues that the state may be able to correct without specific recommendation. May require additional analysis. |
| **Significant Issue** -- File review shows a pattern that indicates a significant problem. Will require an EPA Recommendation. |

New Mexico Environmental Department Enforcement Program Review
State Review Framework
Fiscal Year 2007

**November 23, 2009**

## I. EXECUTIVE SUMMARY

The State Review Framework (SRF) is a program designed to ensure that EPA conducts oversight of state compliance and enforcement programs in a nationally consistent and efficient manner. Reviews look at 12 program elements covering: data (completeness, timeliness, and quality); inspections (coverage and quality); identification of violations, enforcement actions (appropriateness and timeliness); and penalties (calculation, assessment and collection). Reviews are conducted in three phases: analyzing information from the national data systems; reviewing a limited set of state files; and development of findings and recommendations. Considerable consultation is built into the process to ensure EPA and the state understand the causes of issues, and to seek agreement on identifying the actions needed to address problems. The Reports generated by the reviews are designed to capture the information and agreements developed during the review process in order to facilitate program improvements. The reports are designed to provide factual information and do not make determinations of program adequacy. EPA also uses the information in the reports to draw a "national picture" of enforcement and compliance, and to identify any issues that require a national response. Reports are not used to compare or rank state programs.

This report covers the New Mexico Environmental Department's (NMED) administration of the compliance and enforcement programs for Clean Air Act stationary sources and Resource Conservation Act hazardous waste. NMED has not assumed the Clean Water Act NPDES program.

### A. Major Priorities and Accomplishments

- General
  The State developed an Environmental Notification Tracking System which allows the public to enter a complaint via a website. The complaint is accessible to all environment department staff and allows the ability to track the status of the complaint, documents what action was taken as well as when the complaint was closed.
- Clean Air Act (CAA)
  The Air Quality Bureau completed initiatives in 3 major areas since the last Framework review to improve data quality and timeliness, regulatory enhancements, and work quality improvements.

    - The State developed a Data Tracking System (DTS) database for monitoring the status of all section activities and is used for management tracking and to ensure data quality for uploading to AFS.

    - In 2008, the State repealed and replaced its Excess Emission regulation to conform it to Federal Guidance. The new regulation allows for an affirmative defense for emissions from malfunctions, but only under narrowly defined criteria and, it specifically requires scheduled maintenance emissions to be permitted. The new rule complies with all Federal Guidance

regarding excess emissions. The state also promulgated a new regulation for the issuance of Field Citations to provide an additional tool for enforcement of minor violations. The regulation allows for violations and penalties to be issued at the time of an inspection and follows an expedited schedule for hearing and resolution.

- In 2008, the Air Quality Bureau completed a major process improvement project to streamline the compliance report review process thereby improving efficiency, consistency and timeliness in reviewing the hundreds of reports that the bureau receives. Coupled with this effort, the section was reorganized, creating a Compliance Reporting Group that centralized data reporting.

- Resource Conservation and Recovery Act (RCRA)
  The NMED RCRA program began an enforcement initiative in 2005 that in recent years has not only resulted in a significant increase in the number of formal and informal enforcement actions but also significantly improved timeliness of these actions. The NMED is also committed to reducing the number of RCRA notifiers that have never been inspected. Over the last several years, about 70% of Compliance Evaluation Inspections and Compliance Assistance Visits have fallen into this category. Both of these initiatives continue to be priorities.

**B. Summary of Results**

- Recommendations from Round 1
  - CAA

    Recommendations or suggestions were made regarding the quality of CAA data in the national data base (AFS), the identification of high priority violators (HPV) and penalty documentation. NMED completed all recommended actions. The results from the current review indicate significant progress and improvement and underscore the effectiveness of the actions taken by NMED.
  - RCRA

    No Recommendations from the previous review.
- Overall Round 2 Accomplishments and Best Practices
  - CAA

    The review indicates that NMED's CAA compliance monitoring and enforcement programs are strengths. Inspection coverage levels meet commitments and national program goals. Inspection reports are timely and of a high quality. Violations are pursued with timely and appropriate enforcement.

    The Air Quality Bureau has made significant progress in addressing HPV identification concerns raised in the previous SRF review. The Bureau's Air Compliance and Enforcement Section is to be commended for its success thus far in addressing these concerns (see details in Section II below).
  - RCRA

    The review indicates that NMED's Hazardous Waste Bureau is meeting or exceeding compliance and enforcement program expectations in most review elements. Data management, inspection coverage and quality as well as the Bureau's enforcement program continue to be NMED strengths.

- Round 2 Findings and Recommendations
  - *Areas meeting program requirements* –
    - CAA
      - Meets compliance related grant commitments

        - Inspection levels consistent with program commitments and national goals; inspection reports of high quality
        - Enforcement actions are timely and appropriate
        - Penalty calculations and documentation
    - RCRA
        - Data quality
        - Meets compliance/enforcement related grant commitments
        - Inspection levels consistent with program commitments and national goals; inspection reports of high quality
        - Enforcement actions are appropriate
        - Penalty calculations and documentation
- *Areas for State attention* -
    - CAA
        - Compliance monitoring and enforcement related data quality and timeliness
    - RCRA
        - Some delay in violation data entry; some enforcement actions did not meet EPA timeliness guidelines.
- *Areas for State Improvement Requiring Recommendations* -
    - CAA
        - Some data issues with HPV identification, however, significant progress made in addressing HPV identification issues.
    - RCRA
        - None

## II. BACKGROUND INFORMATION ON STATE PROGRAM AND REVIEW PROCESS

### A. General Program Overview

- Agency Structure:

  The New Mexico Environmental Department is a cabinet level secretariat, divided functionally into several divisions and offices. Within the Environmental Protection Division, the Air Quality Bureau is responsible for, among other things, CAA enforcement and permitting. The RCRA hazardous waste permitting and enforcement programs are within the Hazardous Waste Bureau under the Water and Waste Management Division. Legal counsel is centralized under the Office of General Counsel. While the Department has 22 field offices, the CAA and RCRA hazardous waste compliance and enforcement programs are managed from NMED's central office.

  Compliance/Enforcement Program Structure:

  - CAA

    NMED's air inspection and enforcement functions are carried out by the Air Compliance and Enforcement Section. The Section reorganized in 2008, centralizing its compliance monitoring and enforcement data reporting functions into Compliance Reporting unit. The Section also has an Enforcement unit and a Compliance Inspections unit. The Air Quality Bureau has 4 Compliance Inspectors in Field Offices in Farmington, Grants, Las Cruces and Roswell.
  - RCRA

    The RCRA Inspection and Enforcement responsibilities are located organizationally in the Hazardous Waste Bureau, Compliance & Technical Assistance Program. There are 3 groups located under the Compliance & Technical Assistance Program: the Santa Fe Group (located in Santa Fe), the Albuquerque Group (located in Albuquerque) and Incident Coordination and Spill Response.
- Roles and Responsibilities:
  - CAA

    The Air Quality Bureau's Compliance and Enforcement Section is responsible for CAA inspections, compliance monitoring, enforcement and associated data entry functions. A significant component of the overall workload of the Section is the review of required compliance reports from the regulated community. The Section conducts investigations and enforcement throughout New Mexico except for Bernalillo County and on Tribal lands. The process for violation determinations, including the identification of high priority violations, and timely and appropriate enforcement response is guided by the Section's standard operating procedures. The Section also investigates and responds to citizen's complaints.
  - RCRA

    The Compliance and Technical Assistance Program is responsible for conducting inspections and technical assistance site visits at all facilities that generate or may generate hazardous waste, as well as treatment, storage, or disposal facilities throughout New Mexico, exclusive of Indian country. Data collected during the field activities are analyzed by program staff to determine whether violations of the hazardous waste regulations have occurred. Violation evaluations, including identification of significant non-compliance and development of timely and appropriate enforcement responses are guided by Hazardous Waste Bureau's Enforcement Response Protocol. The Compliance and Technical Assistance Program initiates and provides technical support for enforcement actions. Compliance monitoring and enforcement data entry

functions also reside within the program. The program is also responsible for responding to complaints and requests for information from the public.

- Office of General Counsel
  Formal civil enforcement actions are supported by the Office of General Counsel. Attorneys are assigned based upon requests from the program offices. Typically, where the violations are straight forward and litigation risk is perceived to be minimal, the program offices will proceed with the enforcement process including settlement discussions. All formal enforcement actions undergo General Counsel approval prior to issuance.

- Local Agencies Included/Excluded from Review: NMED does not administer the CAA program in Bernalillo County. The city of Albuquerque's Air Quality Division administers the program and has undergone a separate review.
- Resources:
  - CAA
    The Air Quality Bureau has a Bureau Chief and 4 Section Managers. The Compliance and Enforcement Section is lead by a Section Chief, Senior Environmental Compliance Specialist, and 3 program managers. The Enforcement unit has one manager and 4 staff positions. The Compliance Inspections unit has 9 positions, including one front-line supervisor position, and the Compliance Reporting unit has 5 positions.
  - RCRA
    Under the Hazardous Waste Bureau Organization Structure there is one Bureau Chief and 3 Program Managers. The Compliance & Technical Assistance Program has one Program Manager and 1 Secretary. Three Groups report directly Program Manager position. The Groups are organized as follows: Santa Fe Group has a 1 team leader and 5 Inspector positions; the Albuquerque Group has 1 team leader and 4 Inspector positions and the Incident Coordination and Spill Response Group has 1 position assigned for overall lead supported by the Program's inspectors.
- Staffing/Training:
  - Staffing – NMED is currently under a state-wide hiring freeze and is suffering from an 11% vacancy rate. The freeze is expected to continue until the 2011 fiscal year. The vacancies in the Air Quality Bureau create a challenge for the agency to fulfill its commitments for compliance monitoring and data timeliness.
    The Hazardous Waste Bureau Compliance & Technical Assistance Program is currently adequately staffed to meet its EPA grant commitments.
  - Training – The State ensures that all new staff and current staff attend classes presenting the program core curriculum, health and safety and review of rules and regulations, etc. to ensure that Inspectors are compliant with EPA Order 3500.1 as well as State requirements. Training courses can be provided via on-the-job training, classroom and via computer by in-house contractors, EPA and the Western States Project, a regional environmental enforcement association.
- Data Reporting Systems/Architecture:
  - CAA – NMED inputs CAA compliance and enforcement information directly into the State's data base TEMPO which provides updates to AFS.
  - RCRA - The State reports the minimum data requirements (MDRs) directly into RCRAInfo, the EPA national data system.

**B. Major Priorities and Accomplishments**

- **CAA**

  The Air Quality Bureau accomplished a major data improvement initiative following the last Framework review. The Compliance and Enforcement Section developed a database which allows the section to track the status of Compliance Monitoring Strategy (CMS) and other inspections, complaint investigations, asbestos notices of intent, test protocols and reports, correspondence received, reports received and reviewed, HPV determinations, and all enforcement activities. The database is used by management and staff to monitor the activities and status of the section and to assure data accuracy for AFS.

  Two major regulatory enhancements were accomplished in 2008. The existing state Excess Emission regulation was repealed and replaced and now conforms to Federal Guidance regarding emissions generated during upset conditions and scheduled maintenance. The regulation contains strict criteria for claiming an affirmative defense for malfunction emissions and requires sources to perform root cause analyses of a malfunction event upon request of the state. Few states if any have such a rigorous provision for malfunction analysis. A new Field Citation regulation was also promulgated in 2008. The regulation allows for the immediate issuance of citations and penalties while an inspector is on-site. The violations must be minor in nature and easily correctible and will allow the Bureau to obtain more efficient resolution of minor violations, particularly state regulations such as Open Burning. The expected outcome is a reduction of time spent by inspectors and enforcement staff on these minor violations.

  The Compliance and Enforcement section hired a contractor to facilitate a process improvement project called a Kaizen event which used a combination of Six Sigma and Lean Manufacturing principles to analyze the Report Submittal Review Process. The section receives hundreds of reports which include Annual Compliance Certifications, Semi-annual monitoring reports, NSPS reports and other compliance reports required by permits. The main objective of the Kaizen event was to streamline the review process, standardize the data received and improve the quality of report reviews.

  The section was reorganized to better match staff strengths with duties and a new group to process the reports was created. To standardize the data received, the group created pre-populated Annual Compliance and Semi-Annual Monitoring Certification forms, customized for each permit holder. This was a monumental task and the result has been a dramatic improvement in the time for staff review of reports and greater awareness from permit holders about the reporting requirements.

- **RCRA**

  The State compliance and enforcement priorities for Fiscal Year 2007 were established from the State Legislature, EPA national priorities, tips/complaints and resource prioritization focusing on facilities with greater risk potential. The priorities included conducting 57 hazardous waste inspections including RCRA Compliance Evaluation Inspections at 10 Federal Facilities, 4 TSDF's, 7 Large Quantity Generators, 21 Small Quantity Generators, 14 Non-notifiers and 1 Comprehensive Ground-Water Monitoring Evaluation.

  The State's enforcement priority was to maintain a high rate of compliance in accordance with the US EPA Enforcement Memorandum of Understanding by making timely, visible and appropriate enforcement. The State focused on the most environmentally significant handlers, promoting pollution prevention and encouraging a holistic view of compliance through support of multimedia enforcement.

The State incorporated waste minimization activities in support of their RCRA enforcement program by assisting in educating the regulated communities about pollution prevention, incorporating waste minimization outreach into inspections, determining compliance with waste minimization requirements and incorporating waste minimization projects into enforcement settlement agreements.

The State developed the Environmental Notification Tracking System (ENTS) which allows the Department's staff and the public to enter a complaint via a website. The complaint is accessible to all environment department staff and allows the ability to track the status of the complaint, documents what action was taken as well as when the complaint was closed. ENTS is used by the State as a way of capturing data on things such as complaints and spill reports that don't get tracked wholly in RCRAInfo or other federal data bases and ensuring that complaints are acted upon in a timely manner.

The State has also focused some of their inspection resources on conducting inspections and Compliance Assistance Visits at facilities that have "never been inspected" to ensure that they are correctly identified in the appropriate universe, with the overall goal of this priority reducing the "never inspected" count by 4% annually to achieve a target of less than 5% of all active RCRA notifiers that have never been inspected by 2019.

**C. Process for SRF Review**

- Review Period: Fiscal Year 2007
- Key Dates:
  - Kick-off letter, data transmittal – September 8, 2008
  - Data corrections received – N/A
  - Preliminary Data Analysis, file selection list provided – November 10, 2008
  - On-site file review – (CAA) December 3-5, 2008; (RCRA) December 2-4, 2008
- Communication with NMED - began with a policy level meeting for Region 6 State Directors on May 29, 2008, to help the Region develop its plan for the second round of SRF reviews. Throughout the ensuing SRF process, NMED and Region 6 have communicated primarily via the telephone and e-mail. The on-site file review included orientation and exit review discussions.
- NMED and Region 6 Contacts:
  - NMED:
    - (CAA) Mary Uhl, mary.uhl@state.nm.us, (505) 476-4301
    - (CAA) Debra McElroy, debra.mcelroy@state.nm.us, (505) 476-4302
    - (CAA) Donald Flores, donald.flores@state.nm.us, (505) 476-4359
    - (RCRA) Art Vollmer, art.vollmer@state.nm.us, (505) 476-6004
    - (RCRA) Sandra Martin, sandra.martin@state.nm.us, (505) 222-9457
  - Region 6
    - (CAA) Toni Allen, allen.toni@epa.gov, (214) 665-7271
    - (CAA) Janet Adams adams.janet@epa.gov, (214) 665-3157
    - (CAA) Esteban Herrera, herrera.esteban@epa.gov, (214) 665-7348
    - (RCRA) Eva Steele, steele.eva@epa.gov, (214) 665-7211
    - (RCRA) Patricia Weatherly, weatherly.patricia@epa.gov, (214) 665-2165
    - Mark Potts, potts.mark@epa.gov, (214) 665-2723

## III. STATUS OF RECOMMENDATIONS FROM PREVIOUS REVIEWS

During the first SRF review of NMED's compliance and enforcement programs. NMED and Region 6 identified a number of actions to be taken to address issues found during the review. The table below shows the status of progress toward completing those actions.

| State | Status | Due Date | Media | Element | Title | Finding |
|---|---|---|---|---|---|---|
| NM | Complete | 9/28/06 | CAA | 11 | Convert to TEMPO, update majors universe. | Nominal inspection coverage shortfall attributed to data accuracy and changes to facility status. |
| NM | Complete | 9/28/06 | CAA | 11 | Verify SM80 universe. | NMED issues several types of General Construction Permits to address groups of sources that have similar operations. Need to verify actual classification. |
| NM | Complete | 9/28/06 | CAA | 11 | Include Title V ACC results in AFS | AFS does not reflect that NMED reported compliance results due to data uploading difficulties. |
| NM | Complete | 9/28/06 | CAA | 11 | Verify effectiveness of TEMPO conversion, inspect remaining facilities. | The number of sources in New Mexico with unknown compliance status was 89. NMED attributes this to a combination of factors including uploading difficulties, inappropriate source classifications, and inspection scheduling issues (e.g., inspector vacancy). |
| NM | Complete | 9/28/06 | CAA | 2 | Include enforcement history in inspection reports. | None of the inspection reports reviewed contained an enforcement history. |
| NM | Complete | 11/03/07 | CAA | 4 | Establish HPV identification procedures. EPA schedule State HPV training. | Of the seven (7) enforcement files reviewed, 0% of the violations that should have been identified as HPVs were identified as such in AIRS. |
| NM | Complete | 9/28.06 | CAA | 7 | Include justification for 0 economic benefit. | Of the seven (7) enforcement files reviewed, none included an assessment for economic benefit. |
| NM | Complete | 9/28/06 | CAA | 12 | Complete conversion to TEMPO. Include missing data in AFS. | Not all of the Minimum Data Requirements are reflected in AFS/AIRS due to data upload issues. |

## IV PRELIMINARY DATA ANALYSIS CHART

This section provides the results of the Preliminary Data Analysis (PDA). The Preliminary Data Analysis forms the initial structure for the SRF report, and helps ensure that the data metrics are adequately analyzed prior to the on-site review. This is a critical component of the SRF process, because it allows the reviewers to be prepared and knowledgeable about potential problem areas before initiating the on-site portion of the review. In addition, it gives the region focus during the file reviews and/or basis for requesting supplemental files based on potential concerns raised by the data metrics results. The PDA reviews each data metric and evaluates state performance against the national goal or average, if appropriate.

The PDA Chart in this section of the SRF report only includes metrics where potential concerns are identified or potential areas of exemplary performance. However, the full PDA, which is available as a document separate from this report, contains every metric - positive, neutral or negative. Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the file review results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report.

### CAA

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | NMED-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 1C3 | CAA Subprogram Designations: MACT (Current) | Data Quality | | | 35 | | Appears low, need to verify. |
| 1C4 | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 73.3% | 58.7% | | Appears low; need to verify if subject & applicable subparts verify that the inspectors are determining applicable subparts/determining compliance during inspection. |
| 1C5 | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 31.5% | 28.6% | | Same as 1C4 |

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | NMED-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 1C6 | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 89.3% | 71.4% | | Same as 1C4 |
| 1D3 | Compliance Monitoring: Number of PCEs (1yr) | Information | | | 19 | | See if counting review of semi-annual reports, settlement deliverables, etc. |
| 1G1 | HPV: Number of New Pathways (1yr) | Data Quality | | | 7 | | Maybe low, need to verify |
| 1G2 | HPV: Number of new sources (1yr) | Data Quality | | | 7 | | Same as 1G1 |
| 1H1 | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | 100% | 45.3% | 0 | | Minimum data requirement with 2005 ICR. Should track for all HPVs identified |
| 1H2 | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | 100% | 67.0% | 0 | | Same as 1H1 |
| 1H3 | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | 100% | 57.7 | 0 | | Same as 1H1 |
| 2A0 | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | <= 50% | 71.0% | 233.3% | | Look behind violations identified in informal/formal enforcement actions to verify NC status in AFS |
| 2B2 | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | | | 0 | | 0 appears low. Look at stack tests to see if any failed. Include supplemental files. |
| 3A0 | Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY) | Goal | 100% | 24.6% | 0 | | Looks for HPV entry from DZ. Process discussion indicated. |

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | NMED-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 3B1 | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | 100% | 52.6% | 20% | | % appears low, discuss data entry/upload. |
| 3B2 | Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | 100% | 67.3% | 22% | | Same as 3B1 |
| 5E0 | Number of Sources with Unknown Compliance Status (Current) | Review Indicator | | | 21 | | Discuss CMS frequencies in AFS |
| 5G0 | Review of Self-Certifications Completed (1 FY) | Goal | 100% | 91.0% | 73.5% | | Discuss status of the 36 (ACC reviews) |
| 7C2 | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | >1/2 Nat Avg | 34.3% | 0 | | Examine stack tests, discuss NC status |
| 8A0 | High Priority Violation Discovery Rate – Per Major Source (1FY) | Review Indicator | .1/2 Nat Avg | 9.2% | 4.1% | | Shows improvement over previous SRF review, however, appears low. Review formal and informal enforcement actions. Supplemental files selected. |
| 8B0 | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | .1/2 Nat Avg | 1.5% | 0.2% | | Appears low, review SM informal/formal enforcement actions |
| 8C0 | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | >1/2 Nat Avg | 73.1% | 33.3% | | Same as 8A |

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | NMED-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 8D0 | Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY) | Review Indicator | <1/2 Nat Avg | 39.6% | 63.6% | | Appears high, review violation classification in informal enforcement actions. |
| 8E0 | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | >1/2 Nat Avg | 42.4% | 0 | | Appears low. Review stack tests for pass/fail designations |
| 12B0 | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | >=80% | 86.1% | 60.0% | | Assumes penalty assessments for HPVs. Look at enforcement actions |

## RCRA

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | NMED-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 5C | Inspection coverage for LQGs (5 FYs) | Goal | 100% | 64.7% | 85.0% | | above national average but below national goal. (According to NMED -This is a difficult metric to derive accurately because OTIS uses the current number of LQGs, which doesn't accurately reflect the number of LQGs over the previous 5 years. In New Mexico many facilities in this universe are one-time or episodic generators so the number is in constant flux.) |
| 8A | SNC identification rate at sites with inspections (1 FY) | Review Indicator | >1/2 Nat Avg | 3.8% | 3.0% | | % slightly less than national average (NMED noted that it was above the national goal.) |

## V. FILE SELECTION

Files that were reviewed were selected according to a standard protocol and using a web-based file selection tool (available to EPA and state users here: http://www.epa-otis.gov/cgi-bin/test/srf/srf_fileselection.cgi ). The protocol and tool are designed to provide consistency and transparency in the process. Based on the description of the file selection process in section A, states should be able to recreate the results in the table in section B.

### A. File Selection Process

Below is a description of how Region 6 selected files for review:

**Clean Air Act**

Region 6 used the file selection tool in OTIS, which follows the SRF File Selection Protocol. The universe of files was 130. According to the Protocol, the range of files for a universe that size is 15-30. Region 6 selected 28 files (23 FCEs and 5 enforcement actions), representing 23 facilities, at random by selecting every sixth FCE for majors and SM80s. In addition to those files selected at random, the Region augmented its file selection list with 9 supplemental files (1 FCE, 4 enforcement and 4 stack tests) to more closely examine HPV identification and stack test failures.

**RCRA**

Using the file selection tool in OTIS, there were 121 facilities on the data pull which indicates a sample size of 15-30. We decided to select 20% of the total for review. Of those, there were 3 SNC's identified and all of those were selected for review. In the review of the total facilities we noted that there were some facilities (20) listed as not having an evaluation conducted, some of these had violations identified with some type of enforcement action, to better understand the circumstances behind these actions we randomly selected 4 of these facilities to review with one of those having a violation and enforcement action reflected. The remaining selections of files were made by selecting all facilities where penalties were issued (6 total); randomly selecting a percentage of informal enforcement only, formal enforcement only and 2 facilities where both informal and formal enforcement was issued, or where no enforcement was issued. These selections were made by using random sorts of the facilities listed using Lotus Notes.

### B. File Selection Table

**CAA**

| Program ID | FCE | PCE | Violation | Stack Test Failure | Title V Deviation | HPV | Informal Action | Formal Action | Penalty | Universe | Select |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **3500500004** | **yes** | **no** | **no** | **no** | **no** | **no** | **no** | **no** | **no** | **MAJR** | **accepted_representative** |
| **3501300002** | **yes** | **no** | **no** | **no** | **no** | **no** | **no** | **no** | **no** | **MAJR** | **accepted_representative** |

| Program ID | FCE | PCE | Violation | Stack Test Failure | Title V Deviation | HPV | Informal Action | Formal Action | Penalty | Universe | Select |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3501300025 | yes | no | no | no | no | no | no | no | no | MAJR | supplemental-stk test |
| 3501500005 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3501500021 | yes | no | no | no | yes | yes | yes | yes | no | MAJR | accepted_representative |
| 3501500044 | yes | no | no | no | no | no | no | yes | yes | MAJR | supplemental-enf action |
| 3501700001 | yes | no | no | no | no | no | yes | no | no | MAJR | accepted_representative |
| 3502300002 | yes | no | no | no | no | no | no | no | no | MAJR | supplemental-stk test |
| 3502500034 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3502500048 | no | no | no | no | no | no | yes | yes | no | MAJR | supplemental-enf action |
| 3502500052 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3502500075 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3502900002 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3503100008 | no | no | yes | no | yes | no | yes | yes | no | MAJR | supplemental-enf action |
| 3503100026 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3503900032 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3503900042 | no | no | no | no | yes | yes | no | no | no | MAJR | supplemental-stk test |
| 3503900075 | yes | no | no | no | yes | no | no | no | no | MAJR | accepted_representative |
| 3503900160 | no | yes | no | no | no | no | yes | yes | no | MAJR | supplemental-enf action |
| 3504300031 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3504500062 | no | no | no | no | yes | no | no | no | no | MAJR | supplemental-stk test |
| 3504500069 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3504500274 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3504500375 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3506100005 | yes | no | no | no | no | no | no | no | no | MAJR | accepted_representative |
| 3500500016 | yes | no | no | no | no | no | no | no | no | SM80 | accepted_representative |
| 3501500103 | yes | no | no | no | no | no | no | no | no | SM80 | accepted_representative |
| 3501700026 | no | no | no | no | no | no | no | yes | no | SM80 | accepted_representative |
| 3502500047 | yes | no | no | no | no | no | no | no | no | SM80 | supplemental-stk test |
| 3504300051 | no | no | no | no | no | no | yes | no | no | SM80 | accepted_representative |
| 3577700263 | no | no | no | no | no | no | no | yes | no | SM80 | accepted_representative |
| 3577700866 | yes | no | yes | no | no | no | yes | yes | no | SM80 | accepted_representative |

## RCRA

| Program ID | f_state | Evaluation | Violation | SNC | Informal Action | Formal Action | Penalty | Universe | Select |
|---|---|---|---|---|---|---|---|---|---|
| NMD046290797 | NM | yes | yes | no | no | no | no | LQG | accepted_representative |
| NMD000761627 | NM | yes | no | no | no | no | no | LQG | accepted_representative |
| NMR000012872 | NM | yes | no | no | no | no | no | OTH | accepted_representative |
| NMR000010058 | NM | yes | yes | no | yes | no | no | SQG | accepted_representative |
| NMD982553448 | NM | yes | no | no | no | no | no | SQG | accepted_representative |
| NM0000590240 | NM | no | no | no | yes | no | no | CES | accepted_representative |
| NMR000003640 | NM | yes | yes | no | yes | no | no | SQG | accepted_representative |
| NMR000006551 | NM | yes | no | no | no | no | no | NON | accepted_representative |
| NM6572124422 | NM | yes | yes | no | yes | no | no | LDF | accepted_representative |
| NMD360010029 | NM | no | yes | no | yes | no | no | SQG | accepted_representative |
| NMD000609339 | NM | no | no | no | yes | no | no | LQG | accepted_representative |
| NM9570024423 | NM | yes | yes | yes | no | yes | yes | LDF | accepted_representative |
| NMR000007088 | NM | yes | yes | no | yes | no | no | CES | accepted_representative |
| NM8800019434 | NM | yes | no | no | no | yes | yes | LDF | accepted_representative |
| NMD048918817 | NM | yes | yes | yes | yes | no | no | LDF | accepted_representative |
| NMD075088252 | NM | yes | yes | no | yes | no | no | LQG | accepted_representative |
| NMD981611247 | NM | yes | yes | no | yes | no | no | CES | accepted_representative |
| NMR000010942 | NM | yes | yes | no | yes | no | no | TRA | accepted_representative |
| NMD000804294 | NM | no | no | no | yes | yes | yes | TSF | accepted_representative |
| NMD980698849 | NM | yes | yes | no | no | no | no | TSF | accepted_representative |
| NM5890110518 | NM | yes | yes | yes | yes | yes | yes | LDF | accepted_representative |
| NMR000012534 | NM | yes | yes | no | yes | no | no | CES | accepted_representative |
| NM0890010515 | NM | yes | yes | no | yes | yes | yes | LDF | accepted_representative |
| NMD980621197 | NM | yes | no | no | yes | no | no | LQG | accepted_representative |
| NM2750211235 | NM | yes | yes | no | no | yes | yes | LDF | accepted_representative |

## VI. FILE REVIEW ANALYSIS CHART

This section presents the initial observations of the Region regarding program performance against file metrics. Initial Findings are developed by the region at the conclusion of the File Review process. The Initial Finding is a statement of fact about the observed performance, and should indicate whether the performance indicates a practice to be highlighted or a potential issue, along with some explanation about the nature of good practice or the potential issue. The File Review Analysis Chart in the report only includes metrics where potential concerns are identified, or potential areas of exemplary performance. Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the PDA results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report. The quantitative metrics developed from the file reviews are initial indicators of performance based on available information and are used by the reviewers to identify areas for further investigation. Because of the limited sample size, statistical comparisons among programs or across states cannot be made.

### CAA

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| **1** | **Metric 2c** | % of files reviewed where MDR data are accurately reflected in AFS. | 54% | 37 files reviewed (32 facilities): 24 FCEs, 9 enforcement, 4 stack tests. 13 of 24 FCEs , 4 of 9 enforcement actions, and 3 of 4 stack tests all MDR data accurately reflected in AFS |
| | **Metric 4a** | Confirm whether all commitments pursuant to a traditional CMS plan (FCE every 2 yrs at Title V majors; 3 yrs at mega-sites; 5 yrs at SM80s) or an alternative CMS plan were completed. Did the state/local agency complete all planned evaluations negotiated in a CMS plan? Yes or no? If a state/local agency implemented CMS by following a traditional CMS plan, details concerning evaluation coverage are to be discussed pursuant to the metrics under Element 5. If a state/local agency had negotiated and received approval for conducting its compliance monitoring program pursuant to an alternative plan, details concerning the alternative plan and the S/L agency's implementation (including evaluation coverage) are to be discussed under this Metric. | 100% | NMED's 2007 compliance monitoring plan called for: 2 yr frequency (2007-2008) for FECs at Title V majors (151) except 10 compressor stations and mega sources; total of 75 FCEs in FY2007. 4 yr frequency for 10 compressor stations and 2 mega sources. 5 yr frequency (2007-2011) for SM80s; 18 in 2007. The Region approved a modification of the compliance monitoring plan in June 2007 calling for 27 on-site FCEs and 48 off-site FCEs in 2007. (All 75 received on-site FCEs in 2005) |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| | **Metric 4b** | Delineate the air compliance and enforcement commitments for the FY under review. This should include commitments in PPAs, PPGs, grant agreements, MOAs, or other relevant agreements. The compliance and enforcement commitments should be delineated. | N/A | o Submit a Compliance Monitoring Strategy or an update to the strategy, including the number of Major and 80% SM sources.<br>o Complete the universe of planned inspections consistent with the compliance monitoring strategy (CMS). Include:<br>Identify universe of Majors and 80% SM<br>o Complete other compliance monitoring inspections (e.g. PCEs)<br>o Compliance Monitoring Reports (CMRs) document FCE/PCE findings, include accurate identification of violations:<br>Include in the CMRs, at a minimum, the basic elements identified in the CMS (Attachment A)<br>o High priority violations are reported to EPA in a timely manner consistent with HPV Policy (Attachment B)<br>o State enforcement actions include required injunctive relief that will return facilities to compliance in a specific time frame.<br>o Enforcement actions taken in a timely manner consistent with HPV Policy.<br>o Gravity and economic benefit calculations are addressed for all penalties.<br>o Final Enforcement actions issued/collected appropriate economic benefit and gravity portions of a penalty:<br>Review Database to ensure penalties are being collected<br>o Enter all required and accurate data (minimum data requirements) into AIRS consistent with the October 5, 2001 Source Compliance and State Action Reporting (SFB83 Supporting Statement) (Attachment C):<br>Review Database to ensure minimum data requirements are being entered into AFS<br>o Review CMRs to ensure accurate minimum data requirements are being offered into AFS<br>o Enter all required TV annual compliance certification information, including date due, date received, whether deviations were reported, date reviewed, and compliance status into AIRS. |
| **4** | **Metric 6a** | # of files reviewed with FCEs. | 24 | |
| **5** | **Metric 6b** | % of FCEs that meet the definition of an FCE per the CMS policy. | 100% | All 24 FCEs reviewed reflected all the required components. In general, the reports were high quality. One report was identified as a quality benchmark. Initially EPA identified 2 FCEs reviewed that did not appear to include ACC reviews. However from follow up discussions with NMED, the review team was able to confirm that the ACC review was reported in the inspection field |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| | | | | notes and identified on the inspection checklist for one. The ACC review was identified on the checklist for the second, although supporting field notes were not included. |
| **6** | **Metric 6c** | % of CMRs or facility files reviewed that provide sufficent documentation to determine compliance at the facility. | 100% | All of 24 of the FCEs reviewed included all necessary documentation. As mentioned above, quality of inspection reports is high. One off-site FCE did not include the date of evaluation. |
| **7** | **Metric 7a** | % of CMRs or facility files reviewed that led to accurate compliance determinations. | 100% | |
| **8** | **Metric 7b** | % of non-HPVs reviewed where the compliance determination was timely reported to AFS. | 60% | 5 non-HPV violations identified from FCEs. Three were timely in AFS (i.e., compliance status changed to reflect violations) |
| **29** | **Metric 8f** | % of violations in files reviewed that were accurately determined to be HPV. | 100% | 1 correctly identified HPV reviewed. EPA and NMED discussed another potential HPV, however, facility major status for NOx , violation unrelated to NOx therefore, not an HPV. |
| **10** | **Metric 9a** | # of formal enforcement responses reviewed. | 9 | |
| **11** | **Metric 9b** | % of formal enforcement responses that include required corrective action (i.e., injunctive relief or other complying actions) that will return the facility to compliance in a specified time frame. | 100% | All 9 actions included complying actions with specified timeframes |
| **12** | **Metric 10b** | % of formal enforcement responses for HPVs reviewed that are addressed in a timely manner (i.e., within 270 days). | 100% | One HPV action reviewed – issued within 270 days. |
| **13** | **Metric 10c** | % of enforcement responses for HPVs appropriately addressed. | 100% | One HPV action reviewed – was appropriate |
| **14** | **Metric 11a** | % of reviewed penalty calculations that consider and include where appropriate gravity and economic benefit. | 100% | 9 proposed penalty actions reviewed. All documented gravity and economic benefit components. |
| **15** | **Metric 12c** | % of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. | 100% | 6 final penalties reviewed, where proposed and final penalties differed, file contained documentation. (Of the 9 proposed penalties reviewed, 2 were not finalized within the review period and 1 other was ultimately withdrawn) |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| **16** | **Metric 12d** | % of files that document collection of penalty. | 100% | 6 final penalties reviewed, all included a copy of check in files. |

## RCRA

| | RCRA Metric # | RCRA File Review Metric: | Metric Value | Initial Findings and Conclusions |
|---|---|---|---|---|
| **1** | **Metric 2c** | % of files reviewed where mandatory data are accurately reflected in the national data system. | 100% | Of the files reviewed 100% of the mandatory data was accurately reflected in RCRAInfo. The NMED does have one area relative to linking SNC violations in RCRAInfo where in some cases, because NMED considers a facility to be a chronic violator of the New Mexico RCRA regulations, which can include compliance issues associated with the Corrective Action Consent Order that is in place. Hence the SNC determination is not linked to any specific violations. |
| **2** | **Metric 4a** | Planned inspections completed | 100% | The State committed to conducting 57 hazardous waste inspections including RCRA Compliance Evaluation Inspections at 10 Federal Facilities, 4 TSDF's, 7 Large Quantity Generators, 21 Small Quantity Generators, 14 Non-notifiers and 1 Comprehensive Ground-Water Monitoring Evaluation. The State met and in some cases exceeded these commitments. |
| **3** | **Metric 4b** | Planned commitments completed | N/A | NMED's 2007 RCRA grant commitments are listed in metric 4a above. The State met and in some cases exceeded these commitments |
| **4** | **Metric 6a** | # of inspection reports reviewed. | 21 | |

| | RCRA Metric # | RCRA File Review Metric: | Metric Value | Initial Findings and Conclusions |
|---|---|---|---|---|
| **5** | **Metric 6b** | % of inspection reports reviewed that are complete and provide sufficient documentation to determine compliance at the facility. | 100% | All 21 inspection reports reviewed were very well written accurately describing the events and findings of the inspection, the inspection files contained photos, inspector notes, copies of pertinent facility records, checklists and best management practices that were shared with the facility personnel. All inspection reports and files reviewed were complete and provided excellent documentation to determine compliance of the facility being inspected. |
| **6** | **Metric 6c** | Inspection reports completed within a determined time frame. | 100% | The State files reviewed for inspections were all completed in a timely manner including timely identification of violations. Reports are usually completed the same day or within a week of the actual inspection. |
| **7** | **Metric 7a** | % of accurate compliance determinations based on inspection reports. | 100% | For the 21 inspections and associated documentation reviewed, all compliance determinations were consistent with State and EPA Enforcement Response Policy and Guidance. |
| **8** | **Metric 7b** | % of violation determinations in the files reviewed that are reported timely to the national database (within 150 days). | 67% | According to the Hazardous Waste Bureau's Hazardous Waste Act Enforcement Response Protocol, the date of violation determination, and violation data entry into RCRAInfo, is not later than the date the enforcement action is issued. Of the 15 inspections reviewed that identified violations, 10 were entered into RCRAInfo within 150 days. According to NMED, those that exceeded the timeframes outlined in the ERP were due to the difficult nature of the regulatory issues involved. In these cases, repeated site visits or information requests are needed to fully understand the nature of the violations. |
| **9** | **Metric 8d** | % of violations in files reviewed that were accurately determined to be SNC. | 100% | All violations in the 22 enforcement actions reviewed were accurately determined to either be SNC's or SV's, based on State and EPA Enforcement Response Policy and Guidance. 2 of the 3 SNCs reviewed were entered into RCRAInfo within 150 days. |

| | RCRA Metric # | RCRA File Review Metric: | Metric Value | Initial Findings and Conclusions |
|---|---|---|---|---|
| **10** | **Metric 9a** | # of enforcement responses reviewed. | 22 | 22 enforcement actions were reviewed with a mix of both informal and formal enforcement (3 actions were reviewed that addressed SNC violations). |
| **11** | **Metric 9b** | % of enforcement responses that have returned or will return a source in SNC to compliance. | 100% | All three SNC actions reviewed included some type of corrective or complying action to return the facility to compliance within a prescribed time frame |
| **12** | **Metric 9c** | % of enforcement responses that have returned or will return Secondary Violators (SV's) to compliance. | 100% | All 19 SV actions reviewed included complying actions to return the facilities to compliance within specified time periods. |
| **13** | **Metric 10c** | % of enforcement responses reviewed that are taken in a timely manner. | 59% | Of the 22 actions reviewed 13 were taken in a timely manner.<br>Those that exceeded the timeframes outlined in the ERP were typically due to the difficult nature of specific cases. In these cases, repeated site visits or information requests are needed to fully understand the nature of the violations. |
| **14** | **Metric 10d** | % of enforcement responses reviewed that are appropriate to the violations. | 100% | Of the 22 actions reviewed all were appropriate to the violations identified. |

| | RCRA Metric # | RCRA File Review Metric: | Metric Value | Initial Findings and Conclusions |
|---|---|---|---|---|
| **15** | **Metric 11a** | % of reviewed penalty calculations that consider and include where appropriate gravity and economic benefit. | 100% | All 6 of the penalty actions reviewed included gravity and economic benefits and contained documentation in the files. |
| **16** | **Metric 12a** | % of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. | 100% | There was no difference in the initial and final assessed penalty for the 6 final penalty actions reviewed. |
| **17** | **Metric 12b** | % of files that document collection of penalty. | 100% | All 6 final penalties included documentation in the files that penalties were collected. |

## VII. FINDINGS

Findings represent the Region's conclusions regarding the issue identified. Findings are based on the Initial Findings identified during the data or file review, as well as from follow-up conversations or additional information collected to determine the severity an root causes of the issue. There are four types of findings, which are described below:

| Finding | Description |
|---|---|
| Good Practices | This describes activities, processes, or policies that the SRF data metrics and/or the file reviews show are being implemented exceptionally well and which the State is expected to maintain at a high level of performance. Additionally, the report may single out specific innovative and noteworthy activities, process, or policies that have the potential to be replicated by other States and that can be highlighted as a practice for other states to emulate. No further action is required by either EPA or the State. |
| Meets SRF Program Requirements | This indicates that no issues were identified under this Element. |
| Areas for State* Attention<br><br>*Or, EPA Region's Attention where program is directly implemented. | This describes activities, processes, or policies that the SRF data metrics and/or the file reviews show are being implemented with minor deficiencies that the State needs to pay attention to strengthen its performance, but are not significant enough to require the region to identify and track state actions to correct. This can describe a situation where the State is implementing either EPA or State policy in a manner that requires self-correction to resolve concerns identified during the review. These are single or infrequent instances that do not constitute a pattern of deficiencies or a significant problem. These are minor issues that the State should self-correct without additional EPA oversight. However, the State is expected to improve and maintain a high level of performance. |
| Areas for State* Improvement – Recommendations Required<br><br>* Or, EPA Region's attention where program is directly implemented. | This describes activities, processes, or policies that the metrics and/or the file reviews show are being implemented by the State that have significant problems that need to be addressed and that require follow-up EPA oversight. This can describe a situation where the State is implementing either EPA or State policy in a manner requiring EPA attention. For example, these would be areas where the metrics indicate that the State is not meeting its commitments, there is a pattern of incorrect implementation in updating compliance data in the data systems, there are incomplete or incorrect inspection reports, and/or there is ineffective enforcement response. These would be significant issues and not merely random occurrences. Recommendations are required for these problems that will have well defined timelines and milestones for completion. Recommendations will be monitored in the SRF Tracker. |

## CAA

| CAA | | |
|---|---|---|
| **Element 1. Data Completeness** | | |
| | | |
| 1-1 | Finding | NSPS, NESHAP, MACT subpart designations appear low in AFS |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If | Data Metrics 1C3, 1C4, 1C5, 1C6 show facilities with program subpart designations. They |

| | | |
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| | area for attention, describe why action not required; if area for improvement, provide recommended action.) | appeared low. During the file review NMED confirmed that they were low and provided updated numbers.<br>Of the 32 facilities reviewed, 12 were missing subpart designations. According to NMED, there is a problem getting the subparts into the State's TEMPO data base and uploaded into AFS. NMED is working on the problem (see additional details in State response below) and believes that this will be fixed in FY 2009. Until then NMED will manually enter applicable subparts to keep AFS updated. Corrections were made in AFS July 1, 2009. As NMED indicates in their comments below, the current data reflects significant improvements (current values are included below*). Therefore no additional recommended actions. |
| | Metric(s) and Quantitative Values | Metric: 1C3 facilities with MACT subparts in AFS<br>Value: NMED – 35,<br>Metric: 1C4 facilities with FCEs having NSPS subparts in AFS<br>Value: Nat. Avg. 73.3%, NMED 58.7% (*current 78.8%)<br>Metric: 1C5 facilities with FCEs having NESHAP subparts in AFS<br>Value: Nat. Avg. 31.5%, NMED 28.6% (*current 66.7%)<br>Metric: 1C6 facilities with FCEs having MACT subparts in AFS<br>Value: Nat. Avg. 89.3%, NMED 71.4% (*current 100%) |
| | State Response | The root cause for the deficient subpart designations is data recording omissions and inconsistencies by the Bureau's permitting section. A permanent solution to this problem on a going forward basis has been devised. To correct the old existing data, Compliance/Enforcement has initiated a procedure to review the NSPS, NESHAP and MACT subpart designations data and make the corrections necessary to ensure that the Air Programs all have subpart designations associated. In late January, over a 3 week period, section staff examined the air programs without a subpart designation for applicability to the programs/subpart. The resulting changes that were made in AFS now indicate that NMED percentages are above the National Average percentages as indicated in the FY 2009 OTIS Framework Results. NMED's goal is to achieve 100% subpart designation in AFS so the corrections and changes will continue until the goal is achieved this fiscal year. In the future, NMED will continue to monitor the data by quarterly reviews of the OTIS Framework results and correcting any new deficiencies at that time. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |
| | | |
| 1.2 | Finding | HPV Day Zero Pathway – discovery dates, violating pollutants, and violation type codes appear low in AFS. |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>□Area for State Attention |

| | | |
|---|---|---|
| | | X Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Data metrics 1H1, 1H2 and 1H3 provide day zero, the violating pollutants and violation type codes for HPVs identified. While NMED identified HPVs it did not include these HPV related data in AFS. For the 1 HPV reviewed, the violating pollutant and violation type code were not in AFS. During the file review NMED attributed these data deficiencies to its HPV data sheets and indicated that it would make the necessary modifications to collect the data which has to be entered manually into AFS (see additional details in State response below).<br>Recommended Action:<br>NMED modified its HPV data sheets on April 1, 2009. The current data for 2009 shows significant improvement (current values provided below *). |
| | Metric(s) and Quantitative Values | Metric: 1H1 – HPV day zero pathway discovery date<br>Value: Nat. Avg. 45.3%, NMED – 0 (*current 85.7%)<br>Metric: 1H2 – HPV day zero pathway violating pollutant<br>Value: Nar Avg. 67%, NMED – 0 (*current 100%)<br>Metric: 1H3 day zero pathway violation type code<br>Value: Nat. Avg. 57/7%, NMED 0 (* current 95.2%) |
| | State Response | NMED modified the HPV data sheet in April 2009 to ensure that the reportable elements are captured. To improve the accuracy and timeliness of this measure, NMED used the Kaizen process to examine the issue and streamline the process. The SOP has been revised to clarify the procedure and responsibilities for data capture and forwarding to the data steward for processing. At this time, the data entry into AFS must be manually done and automation of this function is not anticipated soon due to staffing restrictions currently in place. Since the new process has been in place for several months now, the latest SFR FY 2009 report from OTIS indicates that NM data now exceeds the national average for percentage of HPV day zero pathway discovery date, violating pollutant and violation type code. NMED will continue to use the new process to maintain this high rate of timely data entry. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NMED made the correction to the data sheets April 1, 2009.<br>The Region will track day zero pathway data with NMED through FY2010 to determine the effectiveness of actions taken and the need for additional actions by 9/30/10. |

| **CAA** | | |
|---|---|---|
| **Element 2. Data Accuracy** | | |
| | | |
| 2-1 | Finding | HPVs exceed number of non-compliant sources identified |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action | Metric 2A indicates that non-compliance status is not being updated in AFS. Some non-compliance status is reported into AFS. Of the 10 files reviewed with violations, 6 had corresponding correct non-compliance designations in AFS. Of the 4 that did not, 2 were FCEs |

| | | |
|---|---|---|
| | not required; if area for improvement, provide recommended action.) | and 2 were enforcement.<br>At the file review, NMED indicated that TEMPO does not update AFS compliance status. Hence non-compliance status must be updated manually and this has been incorporated into standard operating procedures. EPA will support NMED in updating TEMPO to automatically update the compliance status in AFS in the future, however, no date has been established for this to occur. Until automated, NMED will manually update compliance status. 2009 data reflects improvement for this data metric. No additional recommended actions.<br><br>AFS reports that in 2007 NMED conducted 75 FCEs at major facilities. However, at the outset of the review, AFS incorrectly reported 71 FCEs as on-site and 4 as off-site (corrections have been made). NMED actually conducted 42 off-site and 33 on-site FCEs at majors. The State's TEMPO data base reflects the correct numbers. FY08 data had the same problem (AFS shows 12 off-site FCEs, actual should be 7 – corrections have been made). This particular data accuracy issue was identified fairly late in the SRF review. NMED manually corrected the data in AFS. NMED will investigate the cause of the problem to address it systematically and will manually update on-site/off-site status in AFS as needed. |
| | Metric(s) and Quantitative Values | Metric: 2A – number of HPVs per number of non-compliant sources<br>Value: Nat. Avg. 71%; NMED 233% |
| | State Response | The new process and modified data sheet described in element 1.2 will ensure that the Violating Pollutant with Air Program data is identified for sources in non-compliance. The data steward manually processes the elements on the data sheet to include updating the compliance status of the source directly in AFS. NMED has updated the incorrect designations in AFS and will continue to do this manually until such time as TEMPO can be programmed to do so. The SFR FY 2009 report from OTIS indicates NMED results for this measure are now 75%. The state will continue to monitor this element via the OTIS report to maintain a high percentage of data accuracy. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| **CAA** | | |
|---|---|---|
| **Element 3. Data Timeliness** | | |
| | | |
| 3-1 | Finding | HPVs, monitoring data, and enforcement data not in AFS within 60 days |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area | Metric 3A indicates 0 of the 7 HPVs identified by NMED were entered into AFS timely. |

| | | |
|---|---|---|
| | for attention, describe why action not required; if area for improvement, provide recommended action.) | During the file review, NMED noted that AFS should reflect 9 HPV pathways (at 8 sources) rather than 7. NMED updated this HPV pathway data on November 30, 2008. NMED attributed delayed HPV entry primarily to the process in use before revising procedures in January 2008 (requires HPV designation within 45 days of discovery). Metric 3B1indicates a relatively low percentage of timely monitoring data entries into AFS. Metric 5G indicates a relatively low percentage of ACCs reviewed. At the file review conference NMED explained that the monitoring data issues fall into 3 categories: 1. due date and receipt date for Annual Compliance Certifications (ACCs) were not mapped (TEMPO to AFS upload) – until mapped, these data will be updated manually. 2. Inspection date – inspectors waited to enter inspection date until inspection report completed. New procedures are now in place to get inspection dates into AFS timely. 3. ACC review dates were not all being entered in a timely manner. According to NMED all expected ACCs were reviewed, 36 were reviewed late (Metric 5G shows 36) and as with the due and receipt dates these ACC data are being entered into AFS manually.<br>Metric 3B2 indicates a relatively low percentage of enforcement data getting into AFS in a timely manner. NMED attributed this late data entry into TEMPO to a single company that self reported violations at 22 facilities. The data for 21 (approximately 90 entries) were late.<br>NMED reported several major steps taken to improve timeliness of monitoring and enforcement data. In 2008 NMED's Compliance and Enforcement Section reorganized, centralizing its compliance reporting functions under one manager. This in conjunction with the recommendations from the Section's Kaizen analysis (discussed in detail under Section II above) are addressing the process side of the timeliness issues. The Section also developed a new data base and procedures to better track corrective actions.<br>Data for 2009 indicates significant improvement in the metrics discussed above (current values provided below*), and while the Region is not including additional recommended actions, it will work with NMED to address the data mapping issues and eliminating as much manual data entry as possible**.** |
| | Metric(s) and Quantitative Values | Metric: 3A – HPVs entered within 60 days<br>Value: Nat. Avg. 24.6%; NMED 0 (*current 71.4%)<br>Metric: 3B1 – monitoring data entered within 60 days<br>Value: Nat. Avg 52.6%; NMED 20% (*current 80.8%)<br>Metric 3B2 – enforcement data entered within 60 days<br>Value: Nat. Avg. 67.3; NMED 22% (*current 94.4%) |
| | State Response | The state has revised its procedures for managers and staff to improve timely reporting of data to AFS. Several new tracking mechanisms were added to DTS reports so that managers can ensure that data has been entered in TEMPO within required timeframes. QA and QC checks of data are routinely completed monthly prior to batching of data to AFS and more time has been allotted to the review of AFS data Staff have been given refresher training on HPV requirements and all violations are given timely management review immediately following the discovery action. NMED will continue to work on the mapping issues with the goal of eliminating as much manual entry as possible. SFR FY 2009 report from OTIS indicates that 83.7% of the 233 compliance monitoring data was reported within 60 days, 89.2% of enforcement actions were reported within 60 days, and 62.5% of HPV actions were timely. The state will continue to monitor these elements through the OTIS report to improve and maintain data quality. |

| | | |
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| | | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| **CAA** | | |
|---|---|---|
| **Element 4 Completion of Commitments** | | |
| | | |
| 4-1 | Finding | NMED met its compliance and enforcement commitments |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | NMED met its compliance monitoring evaluation commitments. Those commitments are listed in the file review analysis chart (metrics 4a and 4b) in Section VI above. NMED submitted a timely State CMS. For 2007, NMED committed to 75 FCEs at majors (27 on-site and 48 off-site)and 18 FCEs at SMs. The Region reviewed the list of facilities NMED proposed for off-site FCEs. Since each facility had received an on-site FCE within the previous 5 years and the facilities were logical candidates for which an off-site FCE could be completed under the CMS Policy, the Region approved NMED's 2007 CMS plan. As discussed in more detail below, NMED actually conducted off-site FCEs at 43 of the 48 proposed.<br>AFS reports that in 2007 NMED met the projection for majors (75 FCEs completed) and exceeded the SM projection with 21 FCEs. Initially, AFS incorrectly reported 71 on-site and 4 off-site FCEs at majors. NMED actually conducted a total of 34 on-site FCEs and 41 off-site FCEs at majors. AFS on-site/off-site designations have been corrected. NMED also conducted 19 on-site and 2 off-site FCEs at SMs. This data inaccuracy is also discussed in finding 2-1 above. |
| | Metric(s) and Quantitative Values | File metric 4a and b: Compliance/Enforcement commitments met<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **CAA** | | |
|---|---|---|
| **Element 5 Inspection Coverage** | | |
| | | |
| 5-1 | Finding | NMED completed the universe of planned inspections |

| | | |
|---|---|---|
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | The Region approved NMED's 2007-2008 compliance monitoring plan. For 2007 it projected 75 FCEs at major facilities (27 on-site and 48 off-site). The plan also called for 18 FCEs at SM80s in 2007. NMED's compliance monitoring plan met the criteria of the national compliance monitoring strategy (i.e., FCEs at 100% of the majors universe every 2 years and 100% coverage of the SM80 universe every 5 years). NMED met its FCE projections with 75 FCEs at major facilities (34 on-site and 41 off-site) and 21 FCEs at SM80s.<br>Data metric 5e shows 21 facilities with unknown compliance status. AFS shows that all the facilities have been inspected. Most of the unknown compliance status designations resulted from delays in data entry. NMED believes that the data enhancements described in Section II and in finding 3-1 have improved data timeliness. Current data supports this (current value for metric 5e provided below*).<br>Data metric 5g indicates that 36 of 136 ACCs were not reviewed. According to NMED, the 36 certifications were reviewed, however, the data was not entered timely. Resolution of data timeliness issues is covered in element 3 above. |
| | Metric(s) and Quantitative Values | Metric: 5a1 CMS majors coverage<br>Value: Goal 100%, Net.Avg. 91%, NMED 93.6%<br>Metric: 5b1 CMS SM80 coverage<br>Value: Goal 20%-100%, Nat. Avg. 50.2%, NMED 23.3%<br>Metric: 5e Number of facilities with unknown compliance status<br>Value: 21 (*current 2)<br>Metric: 5g Review of self certifications completed<br>Value: Goal 100%, Nat. Avg. 91.1%, NMED 73.5% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **CAA** | | |
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| **Element 6 Quality of Inspection or Compliance Evaluation Reports** | | |
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| 6-1 | Finding | Compliance Evaluation Reports properly document observations and are timely |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area | Overall, NMED compliance evaluation reports are of a high quality and are timely. |

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| | for attention, describe why action not required; if area for improvement, provide recommended action.) | All 24 FCE reports reviewed contained all the information to document an FCE per the criteria in national CMS Policy. For 2 of the reports reviewed, the review team did not initially see documentation in the FCE reports that ACC reviews were included. In comments to the draft SRF report NMED identified the documentation overlooked in the file review (i.e., the FCEs included ACC reviews)<br>Twenty-three of 24 FCE reports reviewed contained all the necessary information per the CMS Policy. One report did not include the date of the compliance evaluation. |
| | Metric(s) and Quantitative Values | File Metric 6b: meets criteria for FCE under the CMS Policy<br>Value: NMED 92%<br>File Metric 6c: contains all necessary information<br>Value: NMED 96% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **CAA** | | |
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| **Element 7. Identification of alleged violations** | | |
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| 7-1 | Finding | Relatively low rate of non-compliance status designations in AFS |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Metrics 2B2 and 7C2 indicate 0 stack test failures. The Region supplemented its file selection to include 4 additional stack tests. All stack tests reviewed had correct pass/fail status in AFS – all passed. In the first draft of this report, the review team flagged stack test observations as a potential area of concern. However, from NMED comments and subsequent discussions, records substantiate NMED's stack test observation program. NMED records indicate that 9 stack tests were observed in calendar year 2007. NMED also provided a copy of a 2007 stack test observation document. It documented the test protocol, test observation checklist, equipment calibration information, applicable experience of the stack tester, EPA method used, test report, and analytical information.<br>NMED and the Region agreed to work toward enhancing capacity to observe stack tests through training and the Region offers to help on critical facilities as warranted.<br>Metric 7C2 also indicates a relatively low number of non-compliance designations (non-compliance status designations discussed under finding 2-1 above). Three of 5 FCEs reviewed with violations had corresponding non-compliance designations in AFS. |
| | Metric(s) and Quantitative Values | Metric: 7C2 stack test failures per non-compliance status designations<br>Value: Nat. Avg. 34.3%; NMED 0 |

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| | | File Metric: 7B % FCEs identifying violations with corresponding non-compliance designations<br>Value: NMED 60% |
| | State Response | The state strongly objects to the inclusion of this element as an area of concern. During file review, the region confirmed data accuracy for this measure. The state has historically had a low percentage of stack test failures and does not believe that zero failures in the FY2007 time period represent any concerns. There have been reportable stack tests in time periods preceeding and subsequent to FY 2007. As to any correlation between the number of tests observed and the number of test failures, NMED has no historical data that indicates a direct correlation. NMED will continue to observe as many stack tests as resources allow, and will continue to utilize the spreadsheet that we developed in order to verify the testers results side by side. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| **CAA** | | |
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| **Element 8. Identification of HPVs** | | |
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| 8-1 | Finding | Delayed entry of HPVs into AFS |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Mectics 8a and 8c indicate a marginally low HPV rate. The Region supplemented its file selections to help evaluate this. Of the 10 files reviewed with violations, 9 were correctly identified as non-HPVs in AFS. The one HPV reviewed was correctly identified in AFS in a timely manner, however the corresponding change to the compliance status was delayed (compliance status reporting is discussed in finding 2-1 above). Metric 8A shows 6 majors with HPV status. During the file review, NMED indicated that the number should be 7. Delayed HPV entry is addressed in finding 3-1 above.<br>There has been significant improvement in HPV identification from the previous SRF review. (Current values for metrics 8a and 8c are provided below*) Based upon this trend and the organizational and procedural changes described in finding 3-1 above, the Region is not including additional recommended actions for this element. |
| | Metric(s) and Quantitative Values | Metric: 8A HPV identification rate<br>Value: Nat. Avg. 9.2%; NMED 4.9% (*current 11.7%)<br>Metric: 8C Formal actions with pervious HPVs<br>Value: Nat. Avg. 73.1%; NMED 33.3% (*current 80%)<br>File Metric: 8F % violations accurately determined to be HPV<br>Value: 50% |
| | State Response | The state has made significant improvement in HPV identification since this data pull from |

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| | | 2007. Based on the latest OTIS report, metric 8A is now at 8.9% for the state while the national average is 4.3%. Metric 8C is now 80%, exceeding the national average of 73.5%. It is important to note that the state places a high priority on all violations, not just those designated as HPV's, and has policies in place to address all violations by day 270. While the state recognizes and appreciates the purpose of a national HPV initiative, we feel that our policy of addressing all violations on the HPV timeline, focusing on returning sources to immediate compliance, and assessing significant penalties appropriate to the gravity of a violation is a most effective method of protecting human health and the environment. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| **CAA** | | |
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| **Element 9 Enforcement Actions Promote Return to Compliance** | | |
| | | |
| 9-1 | Finding | Enforcement actions included corrective actions necessary and time frames. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | All 9 formal enforcement actions reviewed included required corrective measures and specified time frames for compliance. |
| | Metric(s) and Quantitative Values | File Metric: 9a – formal enforcement files reviewed<br>Value: 9<br>File Metric: 9b - % with complying action required and specified time frame<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **CAA** |
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| **Element 10 Timely and Appropriate Action** | | |
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| 10-1 | Finding | HPV enforcement is timely and appropriate |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Of the 9 formal enforcement actions reviewed, 1 addressed HPVs. It met the timely and appropriate criteria under the HPV Policy. |
| | Metric(s) and Quantitative Values | Metric: 10a - % HPV actions not meeting 270 days<br>Value: Nat. Avg. 40.8%, NMED 38%<br>File Metric: 10b - % HPV actions reviewed meeting 270 days<br>Value: 100%<br>File Metric: 10c - % HPV actions reviewed that were appropriate<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **CAA** | | |
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| **Element 11 Penalty Calculation Method** | | |
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| 11-1 | Finding | penalty calculations included both gravity and economic benefit |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide | 9 proposed penalty actions reviewed. All documented gravity and economic benefit components. |

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| | recommended action.) | |
| | Metric(s) and Quantitative Values | File Metric: 11a - % penalty calculations reviewed that included gravity and economic benefit<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

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| **CAA** | | |
| **Element 12 Final Penalty Assessment and Collection** | | |
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| 12-1 | Finding | files documented differences between initial and final penalties were documented and penalty collection |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | 6 final penalties reviewed, where proposed and final penalties differed, file contained documentation. (Of the 9 proposed penalties reviewed, 2 were not finalized within the review period and 1 other was ultimately withdrawn). All 6 final penalty files contained a copy of the penalty payment check.<br>Data Metric 12b indicated 3 of 5 HPV actions with penalties. According to NMED all 5 received penalty actions. AFS now reflects all 5 with penalty actions. |
| | Metric(s) and Quantitative Values | Metric: 12b: % HPV actions with penalties<br>Value: Goal >=80%, Nat. Avg. 86.1%, NMED 100%<br>Metric 12c: % penalties reviewed that documented difference between initial and final penalties<br>Value: 100%<br>Metric 12d: % penalty files reviewed that documented penalty collection<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

## RCRA

| RCRA | | |
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| **Element 1. Data Completeness** | | |
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| 1-1 | Finding | Minimum Data Requirements were complete |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Twenty-one inspection files and 22 enforcement files were reviewed. Minimum data requirements were complete for all files reviewed. |
| | Metric(s) and Quantitative Values | File Metric: 2a - % of files reviewed where mandatory data are accurately reflected in the national data system.<br>Value: NMED 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| RCRA | | |
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| **Element 2. Data Accuracy** | | |
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| 2-1 | Finding | Minimum Data Requirements were accurate |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended | Minimum data requirements were accurate for the 21 inspection and 22 enforcement files reviewed.<br><br>Metric 2b indicated that 6 facilities had been in violation for greater than 240 days. According to NMED, enforcement actions that exceeded the timeframes outlined in the ERP were typically due to the difficult nature of the regulatory issues involved with specific cases. In the context of RCRA corrective action (i.e., site investigation/clean-up), NMED may consider a facility to |

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| | action.) | be a chronic violator of the New Mexico RCRA regulations, and will identify a facility as an SNC in RCRAInfo and may not link the SNC designation to a specific violation(s) this can sometimes include compliance issues associated with a Corrective Action Consent Order that may be in place for the facility. For the 6 facilities listed: 2 were addressed (action delayed due to regulatory issues involved) and received return to compliance designations; 1 is considered by NMED as a chronic violator in the context of RCRA corrective action; and 3 will have their status updated (e.g, enter return to compliance dates) by 11/30/09. |
| | Metric(s) and Quantitative Values | File Metric: 2a - % of files reviewed where mandatory data are accurately reflected in the national data system.<br>Value: NMED 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **RCRA** | | |
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| **Element 3. Timeliness of Data Entry** | | |
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| 3-1 | Finding | Minimum Data Requirements were timely |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Minimum data requirements for the 21 inspections and 22 enforcement actions were entered in a timely fashion with one exception dealing with the timeliness of entering violations into RCRAInfo. There were 5 inspection reports where violations were not entered into RCRAInfo within 150 days. According to NMED the delays were due to the time necessary to substantiate the violations before identifying them in RCRAInfo. This is discussed in more detail in finding 7-1 below. |
| | Metric(s) and Quantitative Values | Metric: 3a - % SNC entered >= 60 days after designation<br>Value: NMED 0<br>Data metric: 8b - % SNC determinations made within 150 days<br>Value: Nat. Avg. 82%, NMED 66.7% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| RCRA | | |
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| **Element 4 Completion of Commitments** | | |
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| 4-1 | Finding | Compliance and enforcement commitments were met |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | NMED's 2007 RCRA grant commitments are listed in the File Review Analysis Chart (metric 4a) in Section VI above.<br>NMED projected 57 inspections for FY2007. According to RCRAInfo, in 2007 NMED did 107 inspections as follows:<br>18 TSDs; 7 LQGs; 27 SQGs; 48 CESQGs; 6 Non-notifer and 7 other.<br>Included in the TSD and SQG categories were 14 federal facilities.<br>NMED projected 7 LQGs and inspected 7. It projected 14 non-notifiers and inspected 6 (there is no requirement to inspect a specific percentage of non-notifiers, this was a projected goal by the State). The State also began an initiative to focus some of their inspection resources on conducting inspections and Compliance Assistance Visits at facilities that have "never been inspected" to ensure that they are correctly identified in the appropriate universe, with the overall goal of this priority reducing the "never inspected" count by 4% annually to achieve a target of less than 5% of all active RCRA notifiers that have never been inspected by 2019. |
| | Metric(s) and Quantitative Values | File Metric: 4a – completion of planned inspections<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| RCRA | | |
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| **Element 5 Inspection Coverage** | | |
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| 5-1 | Finding | The universe of planned inspections was completed |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action | NMED TSD inspection coverage met the national program goal (100% coverage every 2 years). Data metric 5c indicated that NMED had covered 85% of its LQG universe over the five year period culminating in FY2007. According to NMED -This is a difficult metric to derive |

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| | not required; if area for improvement, provide recommended action.) | accurately because OTIS uses the current number of LQGs, which doesn't accurately reflect the number of LQGs over the previous 5 years. In New Mexico many facilities in this universe are one-time or episodic generators so the number is in constant flux.<br>Considering a 5+_% shift each year, NMED believes it covers its core LQG universe (i.e., facilities that are routinely LQGs rather than one-time or episodic LQGs) every 5 yrs while also emphasizing less-inspected SQGs, CESQGs and "never inspected" facilities. |
| | Metric(s) and Quantitative Values | Metric: 5a - % TSD coverage<br>Value: Goal 100%, Nat. Avg. 89.00%, NMED 100%<br>Metric: 5b - % LQG coverage (1yr)<br>Value: Goal 20%, Nat. Avg. 23.8%, NMED 42.5%<br>Metric: 5c - % LQG coverage (5 yr)<br>Value: Goal 100%, Nat. Avg. 64.7%, NMED 85% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **RCRA** | | |
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| **Element 6 Quality of Inspection or Compliance Evaluation Reports** | | |
| | | |
| 6-1 | Finding | Compliance Evaluation Reports properly document observations and are timely |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Twenty-one inspection reports were reviewed. All were of a high quality. Observations were well documented and the reports were completed timely. |
| | Metric(s) and Quantitative Values | File Metric: 6b – % of inspection reports reviewed that are complete and provide sufficient documentation to determine compliance at the facility.<br>Value: 100%<br>File Metric: 6c – Inspection reports completed within a determined time frame.<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted | NA |

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| | actions from Round 1 that address this issue.) | |

| **RCRA** | | |
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| **Element 7. Identification of Alleged Violations** | | |
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| 7-1 | Finding | File review indicated delays in entering violations into RCRAInfo |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Fifteen inspection reports were reviewed that identified violations. Violations in 5 of the reports (including 1 SNC) were not entered into RCRAInfo within 150 days of discovery. According to the Hazardous Waste Bureau's Hazardous Waste Act Enforcement Response Protocol (2007), a violation is not entered into RCRAInfo until the violation determination date. Depending upon the complexity of the issues involved, the violation determination date may not coincide with day 150 under EPA's RCRA enforcement response policy. According to NMED, the regulatory/applicability issues surrounding the violations discovered in those 5 reports were complex, delaying the violation determination date and violation data entry.<br>The Region will explore options with the Hazardous Waste Bureau to improve the timeliness of violation data entry while meeting the Bureau's policy goals. There are no additional recommendations. |
| | Metric(s) and Quantitative Values | File metric: 7b - % violation determinations reported within 150 days<br>Value: NMED 67% |
| | State Response | While the State concedes that improvements can be made in timeliness of enforcement actions, there is also a disconnect in RCRAInfo between Day of Evaluation and actual date a determination is made whether a violation exists. The default, which apparently cannot be overridden, has the Day Zero for assessing compliance, the ERP always equals the day the evaluation begins. In complex evaluations there may be an extended period of information exchange between the facility and the agency regarding areas of concern. As a result the agency may not have the "complete picture" to be able to definitively say whether there is a violation for many months after the evaluation began. There should be a way for Day Zero to be reset in RCRAInfo to reflect the day that the agency has all the information its needs to make an accurate determination that a violation has occurred.<br>NMED would consider entering preliminary violations into RCRAInfo within 150 days if this information was not available on public databases that pull data from RCRAInfo. In the meantime NMED continues to improve its performance in this area. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| RCRA | | |
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| **Element 8. Identification of SNC** | | |
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| 8-1 | Finding | Delays in entering SNCs into RCRAInfo |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Metric 8b indicates 2 of 3 SNCs entered into RCRAInfo within 150 days of discovery. This was confirmed in the file review with 2 of 3 SNCs entered timely. Late SNC data entry is discussed under finding 7-1.<br>All violations in the 22 enforcement actions reviewed were accurately determined to either be SNC's (3) or SV's (19), based on State and EPA Enforcement Response Policy and Guidance. |
| | Metric(s) and Quantitative Values | Data metric: 8b - % SNC determinations made within 150 days<br>Value: Nat. Avg. 82%, NMED 66.7%<br>File Metric: 8d - % of violations in files reviewed that were accurately determined to be SNC.<br>Value: 100% |
| | State Response | See discussion under finding 7-1. NMED policy dictates that SNC designations will not be made until an enforcement action is issued.<br>Furthermore, because of the small number of SNCs (3), it is not fair to state in the Explanation that NMED had a "relatively low % of SNCs" identified in a timely manner. The small sample size does not allow such a statement to accurately reflect performance for this metric. Simply stating that 1 of 3 was late is sufficient. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| RCRA | | |
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| **Element 9 Enforcement Actions Promote Return to Compliance** | | |
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| 9-1 | Finding | Enforcement actions included corrective actions necessary and time frames. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area | 22 enforcement actions were reviewed with a mix of both informal and formal enforcement (3 |

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| | for attention, describe why action not required; if area for improvement, provide recommended action.) | actions were reviewed that addressed SNC violations).<br>All three SNC actions reviewed included corrective or complying action requirements to return the facility to compliance within a prescribed time frame.<br>All 19 SV actions reviewed included complying actions to return the facilities to compliance within specified time periods. |
| | Metric(s) and Quantitative Values | File Metric: 9b – % of enforcement responses that have returned or will return a source in SNC to compliance.<br>Value: 100%<br>File Metric: 9c – % of enforcement responses that have returned or will return Secondary Violators (SV's) to compliance.<br>Value: 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **RCRA** | | |
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| **Element 10 Timely and Appropriate Action** | | |
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| 10-1 | Finding | Enforcement is appropriate but not always timely. |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Of the 22 actions (which includes 3 SNCs) reviewed all were appropriate to the violations and 13 met the time requirements of the EPA's RCRAenforcement response policy (ERP).<br>Metric 10a indicates a low percentage of formal enforcement actions (SNCs) issued within 360 days. None of the 3 formal actions reviewed that addressed SNCs met the timeliness criteria of EPA's RCRA ERP. On average they were addressed within 1050 days of the inspection**.** The Hazardous Waste Bureau's Enforcement Response Policy requires formal action for SNCs within 240 days of the date that a violation is determined. This policy differs from EPA's ERP which requires a formal action within 240 days of the the first day of the inspection. In practice, it appears that Hazardous Waste Bureau violation determinations are usually timely (even by EPA's RCRA ERP), but formal enforcement for SNC at times exceeds even the Bureau's ERP time frame. NMED indicated that the complex nature of the regulatory issues involved with the SNCs required more time than allowed under EPA's ERP. |
| | Metric(s) and Quantitative Values | File Metric: 10c - % of enforcement responses reviewed that are taken in a timely manner.<br>Value: 59%<br>File Metric: 10d - % of enforcement responses reviewed that are appropriate to the violations |

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| | | Value: 100%<br>Metric: 10a - % formal enforcement actions taken within 360 days<br>Value: Goal 80%, Nat. Avg. 24.2%, NMED 0 |
| | State Response | While the State concedes that improvements can be made in timeliness of enforcement actions, those that exceeded the timeframes outlined in the ERP were typically due to the difficult nature of specific cases. There is also a disconnect in RCRAInfo between Day of Evaluation and actual date a determination is made whether a violation exists. The default, which apparently cannot be overridden, has the Day Zero for assessing compliance, the ERP always equals the day the evaluation begins. In complex evaluations there may be an extended period of information exchange between the facility and the agency regarding areas of concern. As a result the agency may not have the "complete picture" to be able to definitively say whether there is a violation for many months after the evaluation began. There should be a way for Day Zero to be reset in RCRAInfo to reflect the day that the agency has all the information its needs to make an accurate determination that a violation has occurred. The State also began an enforcement initiative in 2005 that in recent years has not only resulted in a significant increase in the number of formal and informal enforcement actions but also significantly improved timeliness of these actions. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **RCRA** | | |
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| **Element 11 Penalty Calculation Method** | | |
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| 11-1 | Finding | penalty calculations included both gravity and economic benefit |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | All 6 of the penalty actions reviewed included gravity and economic benefits and contained documentation in files. |
| | Metric(s) and Quantitative Values | File Metric: 11a - % of reviewed penalty calculations that consider and include where appropriate gravity and economic benefit.<br>Value: 100% |
| | State Response | |

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| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **RCRA** | | |
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| **Element 12 Final Penalty Assessment and Collection** | | |
| | | |
| 12-1 | Finding | files documented differences between initial and final penalties were documented and penalty collection |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for State Attention<br>□ Area for State Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | There was no difference in the initial and final assessed penalty for the 6 final penalty actions reviewed.<br>All 6 final penalties included documentation in the files that penalties were collected. |
| | Metric(s) and Quantitative Values | File Metric: 12a - % of penalties reviewed that document the difference and rationale between the initial and final assessed penalty.<br>Value: 100%<br>File Metric: 12b - % of files that document collection of penalty.<br>Value: 100%<br>Data metric: 12b - % final formal actions with penalties<br>Value: Goal >= half Nat. Avg., Nat. Avg. 85.5%, NMED 100% |
| | State Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

## APPENDIX A: Corrected Data Pull

### CAA

NMED did not provide corrected data prior to the file review. Below is the original data set.

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A01A1S | Title V Universe: AFS Operating Majors (Current) | Data Quality | State | | | 146 | NA | NA | NA | None Identified |
| A01A2S | Title V Universe: AFS Operating Majors with Air Program Code = V (Current) | Data Quality | State | | | 146 | NA | NA | NA | None Identified |
| A01B1S | Source Count: Synthetic Minors (Current) | Data Quality | State | | | 403 | NA | NA | NA | None Identified |
| A01B2S | Source Count: NESHAP Minors (Current) | Data Quality | State | | | 14 | NA | NA | NA | None Identified |
| A01B3S | Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current) | Informational Only | State | | | 131 | NA | NA | NA | None Identified |
| A01C1S | CAA Subprogram Designations: NSPS (Current) | Data Quality | State | | | 252 | NA | NA | NA | None Identified |
| A01C2S | CAA Subprogram Designations: NESHAP (Current) | Data Quality | State | | | 39 | NA | NA | NA | None Identified |
| A01C3S | CAA Subprogram Designations: MACT (Current) | Data Quality | State | | | 35 | NA | NA | NA | None Identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A01C4S | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 73.1% | 57.6% | 38 | 66 | 28 | None Identified |
| A01C5S | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 31.3% | 31.2% | 5 | 16 | 11 | None Identified |
| A01C6S | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 89.0% | 66.7% | 10 | 15 | 5 | None Identified |
| A01D1S | Compliance Monitoring: Sources with FCEs (1 FY) | Data Quality | State | | | 96 | NA | NA | NA | None Identified |
| A01D2S | Compliance Monitoring: Number of FCEs (1 FY) | Data Quality | State | | | 99 | NA | NA | NA | None Identified |
| A01D3S | Compliance Monitoring: Number of PCEs (1 FY) | Informational Only | State | | | 19 | NA | NA | NA | None Identified |
| A01E0S | Historical Non-Compliance Counts (1 FY) | Data Quality | State | | | 54 | NA | NA | NA | None Identified |
| A01F1S | Informal Enforcement Actions: Number Issued (1 FY) | Data Quality | State | | | 51 | NA | NA | NA | None Identified |
| A01F2S | Informal Enforcement Actions: Number of Sources (1 FY) | Data Quality | State | | | 50 | NA | NA | NA | None Identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A01G1S | HPV: Number of New Pathways (1 FY) | Data Quality | State | | | 7 | NA | NA | NA | None Identified |
| A01G2S | HPV: Number of New Sources (1 FY) | Data Quality | State | | | 7 | NA | NA | NA | None Identified |
| A01H1S | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | State | 100% | 44.3% | 0.0% | 0 | 7 | 7 | None Identified |
| A01H2S | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | State | 100% | 66.0% | 0.0% | 0 | 7 | 7 | None Identified |
| A01H3S | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | State | 100% | 56.9% | 0.0% | 0 | 7 | 7 | None Identified |
| A01I1S | Formal Action: Number Issued (1 FY) | Data Quality | State | | | 66 | NA | NA | NA | None Identified |
| A01I2S | Formal Action: Number of Sources (1 FY) | Data Quality | State | | | 61 | NA | NA | NA | None Identified |
| A01J0S | Assessed Penalties: Total Dollar Amount (1 FY) | Data Quality | State | | | $1,147,568 | NA | NA | NA | None Identified |
| A01K0S | Major Sources Missing CMS Policy Applicability (Current) | Review Indicator | State | 0 | | 0 | NA | NA | NA | None Identified |
| A02A0S | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | State | <= 50% | 71.5% | 233.3% | 7 | 3 | NA | None Identified |
| A02B1S | Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY) | Goal | State | 0% | 5.6% | 0.0% | 0 | 55 | 55 | None Identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A02B2S | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | State | | | 0 | NA | NA | NA | None Identified |
| A03A0S | Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 24.0% | 0.0% | 0 | 7 | 7 | None Identified |
| A03B1S | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 52.6% | 20% | 82 | 409 | 327 | None Identified |
| A03B2S | Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 67.3% | 22% | 25 | 115 | 90 | None Identified |
| A05A1S | CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle) | Goal | State | 100% | 90.7% | 92.8% | 129 | 139 | 10 | None Identified |
| A05A2S | CAA Major Full Compliance Evaluation (FCE) Coverage(most recent 2 FY) | Review Indicator | State | 100% | 84.7% | 87.8% | 129 | 147 | 18 | None Identified |
| A05B1S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle) | Review Indicator | State | 20% - 100% | 48.6% | 22.5% | 20 | 89 | 69 | None Identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A05B2S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY) | Informational Only | State | 100% | 88.0% | 82.1% | 78 | 95 | 17 | None Identified |
| A05C0S | CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY) | Informational Only | State | | 79.4% | 55.3% | 223 | 403 | 180 | None Identified |
| A05D0S | CAA Minor FCE and Reported PCE Coverage (last 5 FY) | Informational Only | State | | 31.8% | 5.3% | 107 | 2,032 | 1,925 | None Identified |
| A05E0S | Number of Sources with Unknown Compliance Status (Current) | Review Indicator | State | | | 21 | NA | NA | NA | None Identified |
| A05F0S | CAA Stationary Source Investigations (last 5 FY) | Informational Only | State | | | 2 | NA | NA | NA | None Identified |
| A05G0S | Review of Self-Certifications Completed (1 FY) | Goal | State | 100% | 91.1% | 73.5% | 100 | 136 | 36 | None Identified |
| A07C1S | Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY) | Review Indicator | State | > 1/2 National Avg | 18.9% | 20.9% | 27 | 129 | 102 | None Identified |
| A07C2S | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | State | > 1/2 National Avg | 33.9% | 0.0% | 0 | 1 | 1 | None Identified |
| A08A0S | High Priority Violation Discovery Rate - Per Major Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 9.2% | 4.1% | 6 | 146 | 140 | None Identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| A08B0S | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 1.5% | 0.2% | 1 | 403 | 402 | None Identified |
| A08C0S | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | State | > 1/2 National Avg | 73.2% | 33.3% | 3 | 9 | 6 | None Identified |
| A08D0S | Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY) | Review Indicator | State | < 1/2 National Avg | 39.2% | 63.6% | 7 | 11 | 4 | None Identified |
| A08E0S | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | State | > 1/2 National Avg | 42.4% | 0 / 0 | 0 | 2 | 2 | None Identified |
| A10A0S | Percent HPVs not meeting timeliness goals (2 FY) | Review Indicator | State | | 40.8% | 38% | 3 | 8 | 5 | None Identified |
| A12A0S | No Activity Indicator - Actions with Penalties (1 FY) | Review Indicator | State | | | 66 | NA | NA | NA | None Identified |
| A12B0S | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | State | >= 80% | 86.2% | 100.0% | 5 | 5 | 0 | None Identified |

## RCRA

NMED did not provide corrected data prior to the file review. Below is the original data set.

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| 1. Data completeness. degree to which the minimum data requirements are complete. | | | | | | | | | |
| | Number of operating TSDFs in RCRAInfo | Data Quality | State | | | 12 | NA | NA | NA |
| | Number of active LQGs in RCRAInfo | Data Quality | State | | | 52 | NA | NA | NA |
| | Number of active SQGs in RCRAInfo | Data Quality | State | | | 462 | NA | NA | NA |
| | Number of all other active sites in RCRAInfo | Data Quality | State | | | 1,274 | NA | NA | NA |
| A | Number of LQGs per latest official biennial report | Data Quality | State | | | 40 | NA | NA | NA |
| | Compliance monitoring: number of inspections (1 FY) | Data Quality | State | | | 103 | NA | NA | NA |
| | | | EPA | | | 9 | NA | NA | NA |
| | Compliance monitoring: sites inspected (1 FY) | Data Quality | State | | | 101 | NA | NA | NA |
| B | | | EPA | | | 8 | NA | NA | NA |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| | Number of sites with violations determined at any time (1 FY) | | State | | | 96 | NA | NA | NA |
| | | Data Quality | EPA | | | 8 | NA | NA | NA |
| | Number of sites with violations determined during the FY | | State | | | 54 | NA | NA | NA |
| C | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | Informal Actions: number of sites (1 FY) | | State | | | 53 | NA | NA | NA |
| | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | Informal Actions: number of actions (1 FY) | | State | | | 59 | NA | NA | NA |
| D | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | SNC: number of sites with new SNC (1 FY) | | State | | | 3 | NA | NA | NA |
| | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | SNC: Number of sites in SNC (1 FY) | | State | | | 6 | NA | NA | NA |
| E | | Data Quality | EPA | | | 2 | NA | NA | NA |
| | Formal action: number of sites (1 FY) | | State | | | 6 | NA | NA | NA |
| | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | Formal action: number taken (1 FY) | | State | | | 24 | NA | NA | NA |
| F | | Data Quality | EPA | | | 0 | NA | NA | NA |
| | Total amount of assessed penalties (1 FY) | | State | | | $1,567,941 | NA | NA | NA |
| G | | Data Quality | EPA | | | $0 | NA | NA | NA |
| 2. Data accuracy. degree to which the minimum data requirements are accurate. | | | | | | | | | |
| | Number of sites SNC-determined on day of formal action (1 FY) 1 | | | | | | | | |
| A | | Data Quality | State | | | 0 | NA | NA | NA |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| | Number of sites SNC-determined within one week of formal action (1 FY) 2 | Data Quality | State | | | 0 | NA | NA | NA |
| | Number of sites in violation for greater than 240 days 3 | Data Quality | State | | | 6 | NA | NA | NA |
| B | | | EPA | | | 3 | NA | NA | NA |
| 3. Timeliness of data entry. degree to which the minimum data requirements are complete. | | | | | | | | | |
| | Percent SNCs entered ≥ 60 days after designation (1 FY) 4 | Review Indicator | State | | | 0.00% | 0 | 2 | 2 |
| A | | | EPA | | | not prg | not prg | not prg | not prg |
| B | Comparison of Frozen Data Set | Available after December 2008 | | | | | | | |
| 5. Inspection coverage. degree to which state completed the universe of planned inspections/compliance evaluations. | | | | | | | | | |
| | Inspection coverage for operating TSDFs (2 FYs) | Goal | State | 100% | 89.00% | 100.00% | 12 | 12 | 0 |
| A | | | Combined | 100% | 93.60% | 100.00% | 12 | 12 | 0 |
| | Inspection coverage for LQGs (1 FY) | Goal | State | 20% | 23.80% | 42.50% | 17 | 40 | 23 |
| B | | | Combined | 20% | 25.90% | 42.50% | 17 | 40 | 23 |
| | Inspection coverage for LQGs (5 FYs) | Goal | State | 100% | 64.70% | 85.00% | 34 | 40 | 6 |
| C | | | Combined | 100% | 69.90% | 85.00% | 34 | 40 | 6 |
| | Inspection coverage for active SQGs (5 FYs) | Informational Only | State | | | 17.70% | 82 | 462 | 380 |
| D | | | Combined | | | 17.70% | 82 | 462 | 380 |
| E | Inspections at active CESQGs (5 FYs) | Informational Only | State | | | 220 | NA | NA | NA |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| | | | Combined | | | 224 | NA | NA | NA |
| | | Informational Only | State | | | 21 | NA | NA | NA |
| | | | Combined | | | 22 | NA | NA | NA |
| | | Informational Only | State | | | 13 | NA | NA | NA |
| | | | Combined | | | 13 | NA | NA | NA |
| | Inspections at active sites other than those listed in 5a-d and 5e1-5e3 (5 FYs) | Informational Only | State | | | 6 | NA | NA | NA |
| | | | Combined | | | 7 | NA | NA | NA |
| 7. Identification of alleged violations. degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information. | | | | | | | | | |
| C | Violation identification rate at sites with inspections (1 FY) | Review Indicator | State | | | 53.50% | 54 | 101 | 47 |
| | | | EPA | | | 0.00% | 0 | 8 | 8 |
| 8. Identification of SNC and HPV. degree to which the state accurately identifies significant noncompliance & high priority violations and enters information into the national system in a timely manner. | | | | | | | | | |
| A | SNC identification rate at sites with inspections (1 FY) | Review Indicator | State | 1/2 National Avg | 3.80% | 3.00% | 3 | 101 | 98 |
| | | | Combined | 1/2 National Avg | 4.20% | 2.90% | 3 | 104 | 101 |
| B | Percent of SNC determinations made within 150 days (1 FY) | Goal | State | 100% | 82.00% | 66.70% | 2 | 3 | 1 |
| C | Percent of formal actions taken that received a prior | Review Indicator | State | 1/2 National Avg | 53.80% | 95.00% | 19 | 20 | 1 |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) |
|---|---|---|---|---|---|---|---|---|---|
| | SNC listing (1 FY) | | EPA | 1/2 National Avg | 73.20% | 0 / 0 | 0 | 0 | 0 |
| 10. Timely and appropriate action. degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media. | | | | | | | | | |
| A | Percent of enforcement actions/referrals taken within 360 days (1 FY) 5 | Review Indicator | State | 80% | 24.20% | 0.00% | 0 | 3 | 3 |
| | | | Combined | 80% | 22.10% | 0.00% | 0 | 3 | 3 |
| B | No activity indicator - number of formal actions (1 FY) | Review Indicator | State | | | 20 | NA | NA | NA |
| 12. Final penalty assessment and collection. degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected. | | | | | | | | | |
| A | No activity indicator - penalties (1 FY) | Review Indicator | State | | | $1,567,941 | NA | NA | NA |
| B | Percent of final formal actions with penalty (1 FY) | Review Indicator | State | 1/2 National Avg | 85.50% | 100.00% | 6 | 6 | 0 |
| | | | Combined | 1/2 National Avg | 83.30% | 100.00% | 6 | 6 | 0 |

## APPENDIX B: Preliminary Data Analysis

### CAA

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A01A1S | Title V Universe: AFS Operating Majors (Current) | Data Quality | State | | | 146 | NA | NA | NA | None Identified | |
| A01A2S | Title V Universe: AFS Operating Majors with Air Program Code = V (Current) | Data Quality | State | | | 146 | NA | NA | NA | None Identified | |
| A01B1S | Source Count: Synthetic Minors (Current) | Data Quality | State | | | 403 | NA | NA | NA | None Identified | |
| A01B2S | Source Count: NESHAP Minors (Current) | Data Quality | State | | | 14 | NA | NA | NA | None Identified | |
| A01B3S | Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current) | Informational Only | State | | | 131 | NA | NA | NA | None Identified | |
| A01C1S | CAA Subprogram Designations: NSPS (Current) | Data Quality | State | | | 252 | NA | NA | NA | None Identified | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A01C2S | CAA Subprogram Designations: NESHAP (Current) | Data Quality | State | | | 39 | NA | NA | NA | None Identified | Appears low, need to verify |
| A01C3S | CAA Subprogram Designations: MACT (Current) | Data Quality | State | | | 35 | NA | NA | NA | None Identified | Appears low, need to verfiy |
| A01C4S | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 73.1% | 57.6% | 38 | 66 | 28 | None Identified | Appears low, verify if subject & applicable subparts. Verify that inspectors identifying applicable subparts and determining compliance |
| A01C5S | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 31.3% | 31.2% | 5 | 16 | 11 | None Identified | Same as 1C4 |
| A01C6S | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 89.0% | 66.7% | 10 | 15 | 5 | None Identified | Same as 1C4 |
| A01D1S | Compliance Monitoring: Sources with FCEs (1 FY) | Data Quality | State | | | 96 | NA | NA | NA | None Identified | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A01D2S | Compliance Monitoring: Number of FCEs (1 FY) | Data Quality | State | | | 99 | NA | NA | NA | None Identified | |
| A01D3S | Compliance Monitoring: Number of PCEs (1 FY) | Informational Only | State | | | 19 | NA | NA | NA | None Identified | See if counting report reviews |
| A01E0S | Historical Non-Compliance Counts (1 FY) | Data Quality | State | | | 54 | NA | NA | NA | None Identified | |
| A01F1S | Informal Enforcement Actions: Number Issued (1 FY) | Data Quality | State | | | 51 | NA | NA | NA | None Identified | |
| A01F2S | Informal Enforcement Actions: Number of Sources (1 FY) | Data Quality | State | | | 50 | NA | NA | NA | None Identified | |
| A01G1S | HPV: Number of New Pathways (1 FY) | Data Quality | State | | | 7 | NA | NA | NA | None Identified | May be low, need to verify |
| A01G2S | HPV: Number of New Sources (1 FY) | Data Quality | State | | | 7 | NA | NA | NA | None Identified | Same as 1G1 |
| A01H1S | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | State | 100% | 44.3% | 0.0% | 0 | 7 | 7 | None Identified | MDR - Should track all HPVs identified |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A01H2S | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | State | 100% | 66.0% | 0.0% | 0 | 7 | 7 | None Identified | Same as 1H1 |
| A01H3S | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | State | 100% | 56.9% | 0.0% | 0 | 7 | 7 | None Identified | Same as 1H1 |
| A01I1S | Formal Action: Number Issued (1 FY) | Data Quality | State | | | 66 | NA | NA | NA | None Identified | |
| A01I2S | Formal Action: Number of Sources (1 FY) | Data Quality | State | | | 61 | NA | NA | NA | None Identified | |
| A01J0S | Assessed Penalties: Total Dollar Amount (1 FY) | Data Quality | State | | | $1,147,568 | NA | NA | NA | None Identified | |
| A01K0S | Major Sources Missing CMS Policy Applicability (Current) | Review Indicator | State | 0 | | 0 | NA | NA | NA | None Identified | |
| A02A0S | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | State | <= 50% | 71.5% | 233.3% | 7 | 3 | NA | None Identified | Look behind violations identified in informal/formal enforcement actions to verify NC status in AFS |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A02B1S | Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY) | Goal | State | 0% | 5.6% | 0.0% | 0 | 55 | 55 | None Identified | |
| A02B2S | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | State | | | 0 | NA | NA | NA | None Identified | 0 appears low. Look at stack test to see if any failed. Include supplemental files. |
| A03A0S | Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 24.0% | 0.0% | 0 | 7 | 7 | None Identified | Looks for HPV entry from DZ. Process discussion indicated |
| A03B1S | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 52.6% | 20% | 82 | 409 | 327 | None Identified | % appears low. Discuss data entry/upload |
| A03B2S | Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 | Goal | State | 100% | 67.3% | 22% | 25 | 115 | 90 | None Identified | Same as 3B1 |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY) | | | | | | | | | | |
| A05A1S | CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle) | Goal | State | 100% | 90.7% | 92.8% | 129 | 139 | 10 | None Identified | |
| A05A2S | CAA Major Full Compliance Evaluation (FCE) Coverage(most recent 2 FY) | Review Indicator | State | 100% | 84.7% | 87.8% | 129 | 147 | 18 | None Identified | |
| A05B1S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle) | Review Indicator | State | 20% - 100% | 48.6% | 22.5% | 20 | 89 | 69 | None Identified | |
| A05B2S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY) | Informational Only | State | 100% | 88.0% | 82.1% | 78 | 95 | 17 | None Identified | |
| A05C0S | CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY) | Informational Only | State | | 79.4% | 55.3% | 223 | 403 | 180 | None Identified | |
| A05D0S | CAA Minor FCE and Reported PCE Coverage (last 5 FY) | Informational Only | State | | 31.8% | 5.3% | 107 | 2,032 | 1,925 | None Identified | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A05E0S | Number of Sources with Unknown Compliance Status (Current) | Review Indicator | State | | | 21 | NA | NA | NA | None Identified | Discuss CMS frequencies |
| A05F0S | CAA Stationary Source Investigations (last 5 FY) | Informational Only | State | | | 2 | NA | NA | NA | None Identified | |
| A05G0S | Review of Self-Certifications Completed (1 FY) | Goal | State | 100% | 91.1% | 73.5% | 100 | 136 | 36 | None Identified | Discuss status of the 36 |
| A07C1S | Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY) | Review Indicator | State | > 1/2 National Avg | 18.9% | 20.9% | 27 | 129 | 102 | None Identified | |
| A07C2S | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | State | > 1/2 National Avg | 33.9% | 0.0% | 0 | 1 | 1 | None Identified | Examine stack test, discuss NC status |
| A08A0S | High Priority Violation Discovery Rate - Per Major Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 9.2% | 4.1% | 6 | 146 | 140 | None Identified | Shows improvement over previous SRF review, however, appears low. Review formal and informal enforcement actions. Supplemental files selected. |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | New Mexico Metric | Count | Universe | Not Counted | State Discrepancy (Yes/No) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A08B0S | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 1.5% | 0.2% | 1 | 403 | 402 | None Identified | Appears low, review SM informal/formal enforcement actions |
| A08C0S | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | State | > 1/2 National Avg | 73.2% | 33.3% | 3 | 9 | 6 | None Identified | Same as 8A |
| A08D0S | Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY) | Review Indicator | State | < 1/2 National Avg | 39.2% | 63.6% | 7 | 11 | 4 | None Identified | Appears high, review violation classification in informal enforcement actions |
| A08E0S | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | State | > 1/2 National Avg | 42.4% | 0 / 0 | 0 | 2 | 2 | None Identified | Appears low. Review stack tests for pass/fail designations |
| A10A0S | Percent HPVs not meeting timeliness goals (2 FY) | Review Indicator | State | | 40.8% | 38% | 3 | 8 | 5 | None Identified | |
| A12A0S | No Activity Indicator - Actions with Penalties (1 FY) | Review Indicator | State | | | 66 | NA | NA | NA | None Identified | |
| A12B0S | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | State | >= 80% | 86.2% | 100.0% | 5 | 5 | 0 | None Identified | Assumes penalty assessments for HPVs. Look at enforcement actions |

## RCRA

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Data completeness. degree to which the minimum data requirements are complete. | | | | | | | | | | |
| | Number of operating TSDFs in RCRAInfo | Data Quality | State | | | 12 | NA | NA | NA | |
| | Number of active LQGs in RCRAInfo | Data Quality | State | | | 52 | NA | NA | NA | |
| | Number of active SQGs in RCRAInfo | Data Quality | State | | | 462 | NA | NA | NA | |
| | Number of all other active sites in RCRAInfo | Data Quality | State | | | 1,274 | NA | NA | NA | |
| A | Number of LQGs per latest official biennial report | Data Quality | State | | | 40 | NA | NA | NA | |
| | Compliance monitoring: number of inspections (1 FY) | Data Quality | State | | | 103 | NA | NA | NA | |
| B | Compliance monitoring: sites inspected (1 FY) | Data Quality | State | | | 101 | NA | NA | NA | |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number of sites with violations determined at any time (1 FY) | Data Quality | State | | | 96 | NA | NA | NA | |
| C | Number of sites with violations determined during the FY | Data Quality | State | | | 54 | NA | NA | NA | |
| | Informal Actions: number of sites (1 FY) | Data Quality | State | | | 53 | NA | NA | NA | |
| D | Informal Actions: number of actions (1 FY) | Data Quality | State | | | 59 | NA | NA | NA | |
| | SNC: number of sites with new SNC (1 FY) | Data Quality | State | | | 3 | NA | NA | NA | |
| E | SNC: Number of sites in SNC (1 FY) | Data Quality | State | | | 6 | NA | NA | NA | |
| | Formal action: number of sites (1 FY) | Data Quality | State | | | 6 | NA | NA | NA | |
| F | Formal action: number taken (1 FY) | Data Quality | State | | | 24 | NA | NA | NA | |
| G | Total amount of assessed penalties (1 FY) | Data Quality | State | | | $1,567,941 | NA | NA | NA | |
| 2. Data accuracy. degree to which the minimum data requirements are accurate. | | | | | | | | | | |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number of sites SNC-determined on day of formal action (1 FY) 1 | Data Quality | State | | | 0 | NA | NA | NA | |
| A | Number of sites SNC-determined within one week of formal action (1 FY) 2 | Data Quality | State | | | 0 | NA | NA | NA | |
| B | Number of sites in violation for greater than 240 days 3 | Data Quality | State | | | 6 | NA | NA | NA | number of secondary violations > 240 days without return to compliance or redesignation to SNC |
| 3. Timeliness of data entry. degree to which the minimum data requirements are complete. | | | | | | | | | | |
| A | Percent SNCs entered ≥ 60 days after designation (1 FY) 4 | Review Indicator | State | | | 0.00% | 0 | 2 | 2 | |
| B | Comparison of Frozen Data Set | Available after December 2008 | | | | | | | | |
| 5. Inspection coverage. degree to which state completed the universe of planned inspections/compliance evaluations. | | | | | | | | | | |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A | Inspection coverage for operating TSDFs (2 FYs) | Goal | State | 100% | 89.00% | 100.00% | 12 | 12 | 0 | |
| B | Inspection coverage for LQGs (1 FY) | Goal | State | 20% | 23.80% | 42.50% | 17 | 40 | 23 | |
| C | Inspection coverage for LQGs (5 FYs) | Goal | State | 100% | 64.70% | 85.00% | 34 | 40 | 6 | above national average but below national goal. |
| D | Inspection coverage for active SQGs (5 FYs) | Informational Only | State | | | 17.70% | 82 | 462 | 380 | |
| E | Inspections at active CESQGs (5 FYs) | Informational Only | State | | | 220 | NA | NA | NA | |
| | Inspections at active transporters (5 FYs) | Informational Only | State | | | 21 | NA | NA | NA | |
| | Inspections at non-notifiers (5 FYs) | Informational Only | State | | | 13 | NA | NA | NA | |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| | Inspections at active sites other than those listed in 5a-d and 5e1-5e3 (5 FYs) | Informational Only | State | | | 6 | NA | NA | NA | |
| 7. Identification of alleged violations. degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information. | | | | | | | | | | |
| C | Violation identification rate at sites with inspections (1 FY) | Review Indicator | State | | | 53.50% | 54 | 101 | 47 | |
| 8. Identification of SNC and HPV. degree to which the state accurately identifies significant noncompliance & high priority violations and enters information into the national system in a timely manner. | | | | | | | | | | |
| A | SNC identification rate at sites with inspections (1 FY) | Review Indicator | State | 1/2 National Avg | 3.80% | 3.00% | 3 | 101 | 98 | % slightly less than national average |
| B | Percent of SNC determinations made within 150 days (1 FY) | Goal | State | 100% | 82.00% | 66.70% | 2 | 3 | 1 | |

| | | Measure Type | Metric Type | National Goal | National Average | New Mexico (Metric=x/y) [0] | Count (x) | Universe (y) | Not Counted (y-x) | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| C | Percent of formal actions taken that received a prior SNC listing (1 FY) | Review Indicator | State | 1/2 National Avg | 53.80% | 95.00% | 19 | 20 | 1 | |
| 10. Timely and appropriate action. degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media. | | | | | | | | | | |
| A | Percent of enforcement actions/referrals taken within 360 days (1 FY) 5 | Review Indicator | State | 80% | 24.20% | 0.00% | 0 | 3 | 3 | |
| B | No activity indicator - number of formal actions (1 FY) | Review Indicator | State | | | 20 | NA | NA | NA | |
| 12. Final penalty assessment and collection. degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected. | | | | | | | | | | |
| A | No activity indicator - penalties (1 FY) | Review Indicator | State | | | $1,567,941 | NA | NA | NA | |
| B | Percent of final formal actions with penalty (1 FY) | Review Indicator | State | 1/2 National Avg | 85.50% | 100.00% | 6 | 6 | 0 | |

Albuquerque Air Quality Division Enforcement Program Review
State Review Framework
Fiscal Year 2007

November 23, 2009

## I. EXECUTIVE SUMMARY

The State Review Framework (SRF) is a program designed to ensure that EPA conducts oversight of state compliance and enforcement programs in a nationally consistent and efficient manner. Reviews look at 12 program elements covering: data (completeness, timeliness, and quality); inspections (coverage and quality); identification of violations, enforcement actions (appropriateness and timeliness); and penalties (calculation, assessment and collection). Reviews are conducted in three phases: analyzing information from the national data systems; reviewing a limited set of state files; and development of findings and recommendations. Considerable consultation is built into the process to ensure EPA and the state understand the causes of issues, and to seek agreement on identifying the actions needed to address problems. The Reports generated by the reviews are designed to capture the information and agreements developed during the review process in order to facilitate program improvements. The reports are designed to provide factual information and do not make determinations of program adequacy. EPA also uses the information in the reports to draw a "national picture" of enforcement and compliance, and to identify any issues that require a national response. Reports are not used to compare or rank state programs.

### A. Major Priorities and Accomplishments

The AQD has ramped up its compliance and enforcement presence. It has established a 311 call system to rapidly process tips and complaints and respond with appropriate field investigations. In addition AQD is exceeding minimum inspection coverage requirements for synthetic minor sources. Additional details are provided in Section II.B. below.

### B. Summary of Results

- Recommendations from Round 1
  Recommendations or suggestions were made regarding the identification of high priority violators (HPV) and penalty documentation. While the Air Quality Division (AQD) completed the recommended activities, the current review indicates that AQD is not identifying HPVs as prescribed by EPA's HPV Policy.

- Overall Round 2 Accomplishments and Best Practices
  The review indicates that AQD's compliance monitoring and enforcement programs are strengths. Inspection coverage levels meet commitments and national program goals. Inspection reports are timely and of a high quality. Violations are pursued with timely and appropriate enforcement.

- Round 2 Findings and Recommendations
  - *Areas meeting program requirements* –
    - Meets compliance/enforcement related grant commitments

- Inspection levels consistent with program commitments and national goals; inspection reports of high quality
- Enforcement actions are timely and appropriate

- *Areas for AQD attention –*
  - Data – While the majority of data requirements are met, some key data were missing, inaccurate or untimely (see Section VII, findings 2-2 and 3-1)
  - Penalty documentation – generally good, could be enhanced by including rationale for difference between initial and final amounts (see Section VII, finding 12-1).
- *Areas for AQD Improvement Requiring Recommendations* -
  - Element 1: Data completeness
    - Applicable program subpart designations missing in AFS (see Section VII, finding 1-1)
    - Recommendation: AQD, with support from Region 6 as needed, will complete updating subpart designations from Title V majors and SM80s, for those that are part of their program authorization, by December 1, 2009
  - Elements 2 and 7: Data accuracy and Identification of alleged violations
    - Non-compliance status for violations identified was not reported in AFS (see Section VII, findings 2-1 and 7-1).
    - Recommendation: AQD updated its compliance monitoring data entry procedures to update compliance status in AFS. The Region will track compliance status with AQD through FY2010 to determine the effectiveness of actions taken or the need for additional actions by 9/30/10.
  - Element 8: Identification of high priority violations (HPVs)
    - AQD did not designate any HPVs in AFS (see Section VII, findings 2-1 and 8-1)
    - Recommendation: The agenda for the monthly HPV calls should include ACC submittals, stack test results and investigation findings. AQD should ensure that HPVs are timely identified in AFS. ADQ and EPA will determine the need for additional HPV training by 9/30/10.

## II. BACKGROUND INFORMATION ON STATE PROGRAM AND REVIEW PROCESS

### A. General Program Overview

- Agency Structure: AQD is within the city of Albuquerque Environmental Health Department. The AQD programs include ambient monitoring, stationary source permitting and compliance and enforcement.
- Compliance/Enforcement Program Structure: The compliance monitoring and enforcement functions of AQD are performed by the Air Quality Enforcement/Inspection Section and the Air Quality Compliance Section. The Enforcement Section performs inspections, drafts enforcement actions and forwards them to the Compliance Section. The Compliance Section manages the enforcement process. Most enforcement is handled administratively. Legal counsel is provided from the City Attorney's office as needed.
- Roles and Responsibilities: The AQD has the authority to investigate compliance and take administrative enforcement actions and assess penalties for violations of regulations adopted by the Albuquerque–Bernalillo County Air Quality Board. The Board was formed under the New Mexico Air Quality Control Act to implement provisions of the Clean Air Act for the city of Albuquerque and Bernalillo County, New Mexico.
- Local Agencies Included/Excluded from Review: None
- Resources:
    - The AQD has 6 FTE on paper assigned to compliance monitoring and enforcement. AQD also has 3 FTE in its fugitive dust program that are currently being cross trained in stationary source inspections so as to provide an additional resource that can be drawn upon as needed for compliance monitoring..
        - Resources Constraints – Under the current hiring freeze, AQD is carrying a vacancy in its enforcement program.
- Staffing/Training:
    - Staffing – AQD provided the following information:
      Additional enforcement staff is always beneficial, however, 4 filled FTE positions with support from the 3 fugitive dust FTE would appear to be sufficient.
    - Training – AQD provided the following information:
      Direction to available training on inspection report writing and documentation. The stationary sources operating within Bernalillo County are relatively smaller and less complicated. Because of this, the types of sources within Bernalillo County are typically left off the agenda for the annual inspector's workshop. It would be welcomed if these types of smaller sources could be added to the workshop's basic lectures.

- Data Reporting Systems/Architecture:
    - AQD enters compliance and enforcement data directly into AFS.

### B. Major Priorities and Accomplishments

The Albuquerque – Bernalillo County Air Quality Division (AQD) provided the following information on its priorities and accomplishments:

The Albuquerque – Bernalillo County Air Quality Division (Division) continues to make the protection of human health and the environment its top priority. One of the major accomplishments, has been the frequent presence of our enforcement staff at the stationary sources in Bernalillo County.

This has been accomplished in two ways. First, the City of Albuquerque employs a 311 call system that the public uses to phone in air quality concerns in the county. Those concerns having to do with stationary sources are directed immediately to enforcement staff, via email, who respond and inspect appropriately. This ability to incorporate the public as an additional awareness mechanism has resulted in a high number of facilities being maintained in compliance with air regulations in our county.

Second, the Division continues to exceed the EPA recommended compliance evaluation frequency for SM80 sources. The Division also continues to inspect all SM sources in the county, not just SM80's. The recommended evaluation frequency of SM80 sources is once every 5 years. The Division performs FCE's on all SM sources within Bernalillo County on a biennial frequency, which exceeds EPA's recommended rate.

**C. Process for SRF Review**

- Review Period: Fiscal Year 2007
- Key Dates:
  - Kick-off letter, data transmittal – September 8, 2008
  - Data corrections received – N/A
  - Preliminary Data Analysis, file selection list provided – November 10, 2008
  - On-site file review – December 1-2, 2008
- Communication with AQD: Throughout the SRF process, AQD and Region 6 have communicated primarily via the telephone and e-mail. The on-site file review included orientation and exit review discussions.

- AQD and Region 6 Contacts:
  - AQD:
    - Isreal Tavarez, itavarez@cabq.gov, 505.768.1965
    - Damon Reyes, dreyes@cabq.gov, 505.768.1958
    - Matt Stebleton, mstebleton@cabq.gov, 505.768.1972
  - Region 6
    - Toni Allen, allen.toni@epa.gov, 214.665.7271
    - Esteban Herrera, herrera.esteban@epa.gov, 214.665.7348
    - Mark Potts, potts.mark@epa.gov, 214.665.2723

## III. STATUS OF RECOMMENDATIONS FROM PREVIOUS REVIEWS

During the first SRF review of AQD's compliance and enforcement programs. AQD and Region 6 identified a number of actions to be taken to address issues found during the review. The table below shows the status of progress toward completing those actions.

| State | Status | Due Date | Media | Element | | |
|---|---|---|---|---|---|---|
| NM | Complete | 9/28/06 | CAA | 1 | Inspection reports now include enforcement history | Not all AQD inspection reports reviewed included enforcement history. |
| NM | Complete | 3/14/07 | CAA | 4 | EPA will provide HPV training<br>**Title** | No HPVs identified in AFS. One of 4 inspection files reviewed identified significant violations of ACC requirements, however, it was not identified as an HPV.<br>**Finding** |
| NM | Complete | 9/28/06 | CAA | 8 | Document economic benefit consideration in files | Files reviewed did not document economic benefit consideration where it was determined to be insignificant or inappropriate. |

## IV PRELIMINARY DATA ANALYSIS CHART

This section provides the results of the Preliminary Data Analysis (PDA). The Preliminary Data Analysis forms the initial structure for the SRF report, and helps ensure that the data metrics are adequately analyzed prior to the on-site review. This is a critical component of the SRF process, because it allows the reviewers to be prepared and knowledgeable about potential problem areas before initiating the on-site portion of the review. In addition, it gives the region focus during the file reviews and/or basis for requesting supplemental files based on potential concerns raised by the data metrics results. The PDA reviews each data metric and evaluates state performance against the national goal or average, if appropriate.

The PDA Chart in this section of the SRF report only includes metrics where potential concerns are identified or potential areas of exemplary performance. However, the full PDA, which is available as a document separate from this report, contains every metric - positive, neutral or negative. Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the file review results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report.

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | AQD-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 1C4 | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 73.1% | 0/0 | | Appears low; need to verify if subject & applicable subparts verify that the inspectors are determining applicable subparts/determining compliance during inspection. |
| 1C5 | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 31.3% | 0/0 | | Same as 1C4 |
| 1C6 | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | 100% | 89.0% | 0/0 | | Same as 1C4 |

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | AQD-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 1E0 | Historical Non-Compliance Counts (1 FY) | Data Quality | | | 12 | | Correlate drill downs for 1E, 1F2, 1I1, verify compliance status behind violations cited in informal/formal enforcement actions |
| 1G1 | HPV: Number of New Pathways (1 FY) | Data Quality | | | 0 | | Appears low |
| 1G2 | HPV: Number of New Sources (1 FY) | Data Quality | | | 0 | | Appears low |
| 1H1 | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | | | 0 | | Appears low |
| 1H2 | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | | | 0 | | Appears low |
| 1H3 | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | | | 0 | | Appears low |
| 2A0 | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | | | 0 | | Appears low |
| 2B2 | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | | | 0 | | Verify NC/HPV status behind violations cited in informal and formal enforcement actions |
| 3B1 | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | 100% | 52.6% | 39% | | Appears low, discuss data entry |
| 5G0 | Review of Self-Certifications Completed (1 FY) | Goal | 100% | 91.1% | 100% | | Verify number of expected ACCs |

| Metric | Metric Description | Metric Type | National Goal | National Average | OTIS Metric | AQD-Provided Correction | Initial Findings |
|---|---|---|---|---|---|---|---|
| 7C1 | Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY) | Review Indicator | >1/2 national average | 18.9% | 0% | | verify compliance status data entry for violations identified in inspections and enforcement actions |
| 7C2 | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | >1/2 national average | 33.9% | 0% | | Appears low |
| 8A0 | High Priority Violation Discovery Rate - Per Major Source (1 FY) | Review Indicator | >1/2 national average | 9.2% | 0% | | 0 HPVs appears low |
| 8B0 | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | >1/2 national average | 1.5% | 0% | | Same as 8A |
| 8C0 | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | >1/2 national average | 73.2% | 0% | | Review NC and HPV status behind violations cited in formal enforcement actions |
| 8E0 | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | >1/2 national average | 42.4% | 0% | | Appears low |
| 12B0 | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | >= 80% | 86.2% | 0% | | Appears low |

## V. FILE SELECTION

Files that were reviewed were selected according to a standard protocol and using a web-based file selection tool (available to EPA and state users here: http://www.epa-otis.gov/cgi-bin/test/srf/srf_fileselection.cgi ). The protocol and tool are designed to provide consistency and transparency in the process. Based on the description of the file selection process in section A, states should be able to recreate the results in the table in section B.

### A. File Selection Process

Below is a description of how Region 6 selected files for review:

Region 6 used the file selection tool in OTIS, which follows the SRF File Selection Protocol. The universe of files (i.e., facilities that had any of the following: PCE, FCE, stack test failure, violation, Title V deviation, HPV, informal enforcement, formal enforcement, or penalty during the review period) was 40. According to the Protocol, the range of files for a universe that size is 15-30. Region 6 selected a total of 16 files (9 facilities) consisting of 7 FCEs, 4 stack tests, 3 informal enforcement actions and 2 formal enforcement actions). Thirteen files (7 facilities) were selected randomly (7 FCEs, 1 stack test, 5 enforcement). In addition, 3 supplemental files (2 facilities) were selected in order to more closely examine HPV identification and stack test failures.

### B File Selection Table

| Program ID | FCE | PCE | Violation | Stack Test Failure | Title V Deviation | HPV | Informal Action | Formal Action | Penalty | Universe | Select |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3500100005 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 15,000 | MAJR | accepted_representative |
| 3500100026 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | MAJR | accepted_representative |
| 3500100141 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | MAJR | supplemental |
| 3500100145 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 20,000 | MAJR | accepted_representative |
| 3500100402 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | MAJR | accepted_representative |
| 3500100031 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | SM80 | accepted_representative |
| 3500100041 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | SM80 | accepted_representative |
| 3500100101 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1,400 | SM80 | supplemental |
| 3500100156 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 5,000 | SM80 | accepted_representative |

## VI. FILE REVIEW ANALYSIS CHART

This section presents the initial observations of the Region regarding program performance against file metrics. Initial Findings are developed by the region at the conclusion of the File Review process. The Initial Finding is a statement of fact about the observed performance, and should indicate whether the performance indicates a practice to be highlighted or a potential issue, along with some explanation about the nature of good practice or the potential issue. The File Review Analysis Chart in the report only includes metrics where potential concerns are identified, or potential areas of exemplary performance. Initial Findings indicate the observed results. Initial Findings are preliminary observations and are used as a basis for further investigation. Findings are developed only after evaluating them against the PDA results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report. The quantitative metrics developed from the file reviews are initial indicators of performance based on available information and are used by the reviewers to identify areas for further investigation. Because of the limited sample size, statistical comparisons among programs or across states cannot be made.

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| **1** | **Metric 2c** | % of files reviewed where MDR data are accurately reflected in AFS. | 50% | 4 stack tests, 7 FCEs , 2 formal enforcement actions and 3 informal enforcement actions were reviewed. 1 of the 4 stack tests had complete data, 4 of the 7 FCEs had complete data. All enforcement actions had complete data. |
| | **Metric 4a** | Confirm whether all commitments pursuant to a traditional CMS plan (FCE every 2 yrs at Title V majors; 3 yrs at mega-sites; 5 yrs at SM80s) or an alternative CMS plan were completed. Did the state/local agency complete all planned evaluations negotiated in a CMS plan? Yes or no? If a state/local agency implemented CMS by following a traditional CMS plan, details concerning evaluation coverage are to be discussed pursuant to the metrics under Element 5. If a state/local agency had negotiated and received approval for conducting its compliance monitoring program pursuant to an alternative plan, details concerning the alternative plan and the S/L agency's | 100% | AQD committed to conducting a traditional CMS plan. AQD's CMS spanned 2007-2008. For 2007 AQD committed to 8 majors and 7 SMs. Inspection targets met. |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| | | implementation (including evaluation coverage) are to be discussed under this Metric. | | |
| | **Metric 4b** | Delineate the air compliance and enforcement commitments for the FY under review. This should include commitments in PPAs, PPGs, grant agreements, MOAs, or other relevant agreements. The compliance and enforcement commitments should be delineated. | NA | o Submit a Compliance Monitoring Strategy or an update to the strategy, including the number of Major and 80% SM sources.<br>o Complete the universe of planned inspections consistent with the compliance monitoring strategy (CMS). Include:<br>Identify universe of Majors and 80% SM<br>o Complete other compliance monitoring inspections (e.g. PCEs)<br>o Compliance Monitoring Reports (CMRs) document FCE/PCE findings, include accurate identification of violations:<br>Include in the CMRs, at a minimum, the basic elements identified in the CMS (Attachment A)<br>o High priority violations are reported to EPA in a timely manner consistent with HPV Policy (Attachment B)<br>o State enforcement actions include required injunctive relief that will return facilities to compliance in a specific time frame.<br>o Enforcement actions taken in a timely manner consistent with HPV Policy.<br>o Gravity and economic benefit calculations are addressed for all penalties.<br>o Final Enforcement actions issued/collected appropriate economic benefit and gravity portions of a penalty:<br>Review Database to ensure penalties are being collected<br>o Enter all required and accurate data (minimum data requirements) into AIRS consistent with the October 5, 2001 Source Compliance and State Action Reporting (SFB83 Supporting Statement) (Attachment C):<br>Review Database to ensure minimum data |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| | | | | requirements are being entered into AFS<br>o Review CMRs to ensure accurate minimum data requirements are being offered into AFS<br>o Enter all required TV annual compliance certification information, including date due, date received, whether deviations were reported, date reviewed, and compliance status into AIRS. |
| **4** | **Metric 6a** | # of files reviewed with FCEs. | | 7 FCEs were reviewed |
| **5** | **Metric 6b** | % of FCEs that meet the definition of an FCE per the CMS policy. | 100% | |
| **6** | **Metric 6c** | % of CMRs or facility files reviewed that provide sufficent documentation to determine compliance at the facility. | 100% | |
| **7** | **Metric 7a** | % of CMRs or facility files reviewed that led to accurate compliance determinations. | 100% | |
| **8** | **Metric 7b** | % of non-HPVs reviewed where the compliance determination was timely reported to AFS. | 0% | 2 non-HPVs reviewed - compliance status not changed in AFS to reflect violations identified |
| **9** | **Metric 8f** | % of violations in files reviewed that were accurately determined to be HPV. | 0% | No HPVs identified, 1 file reviewed indicate violations should have been designated as HPV for late ACC. |
| **10** | **Metric 9a** | # of formal enforcement responses reviewed. | | 2 formal actions reviewed |
| **11** | **Metric 9b** | % of formal enforcement responses that include required corrective action (i.e., injunctive relief or other complying actions) that will return the facility to compliance in a specified time frame. | 100% | |
| **12** | **Metric 10b** | % of formal enforcement responses for HPVs reviewed that are addressed in a timely manner (i.e., within 270 days). | 100%* | *The 2 files that in EPA's opinion should have been designated as HPVs, received formal actions within 270 days.<br>Upon further discussion with AQD, one of the possible HPVs – violations related to production parameters documented during a stack test, not emission rates – therefore not HPV. |
| **13** | **Metric 10c** | % of enforcement responses for HPVs appropriately addressed. | 100%* | *The 2 files that in EPA's opinion should have been designated as HPVs, were appropriately addressed.<br>See note under initial findings for metric 10b – not an HPV. |
| **14** | **Metric 11a** | % of reviewed penalty calculations that consider and include where appropriate gravity and economic benefit. | 100% | Two formal actions reviewed, both penalty actions. One file did not include the penalty calculations, however, penalty calculations for this file were later provided. Gravity and economic benefit components were documented. |

| | CAA Metric # | CAA File Review Metric Description: | Metric Value | Initial Findings |
|---|---|---|---|---|
| **15** | **Metric 12c** | % of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. | 0% | Neither of the 2 penalty actions reviewed included a rationale. |
| **16** | **Metric 12d** | % of files that document collection of penalty. | 100% | |

## VII. FINDINGS

Findings represent the Region's conclusions regarding the issue identified. Findings are based on the Initial Findings identified during the data or file review, as well as from follow-up conversations or additional information collected to determine the severity an root causes of the issue. There are four types of findings, which are described below:

| Finding | Description |
|---|---|
| Good Practices | This describes activities, processes, or policies that the SRF data metrics and/or the file reviews show are being implemented exceptionally well and which AQD is expected to maintain at a high level of performance. Additionally, the report may single out specific innovative and noteworthy activities, process, or policies that have the potential to be replicated by other States and that can be highlighted as a practice for other states to emulate. No further action is required by either EPA or AQD. |
| Meets SRF Program Requirements | This indicates that no issues were identified under this Element. |
| Areas for AQD* Attention<br><br>*Or, EPA Region's Attention where program is directly implemented. | This describes activities, processes, or policies that the SRF data metrics and/or the file reviews show are being implemented with minor deficiencies that AQD needs to pay attention to strengthen its performance, but are not significant enough to require the region to identify and track state actions to correct. This can describe a situation where AQD is implementing either EPA or AQD policy in a manner that requires self-correction to resolve concerns identified during the review. These are single or infrequent instances that do not constitute a pattern of deficiencies or a significant problem. These are minor issues that AQD should self-correct without additional EPA oversight. However, AQD is expected to improve and maintain a high level of performance. |
| Areas for AQD* Improvement – Recommendations Required<br><br>* Or, EPA Region's attention where program is directly implemented. | This describes activities, processes, or policies that the metrics and/or the file reviews show are being implemented by AQD that have significant problems that need to be addressed and that require follow-up EPA oversight. This can describe a situation where AQD is implementing either EPA or AQD policy in a manner requiring EPA attention. For example, these would be areas where the metrics indicate that AQD is not meeting its commitments, there is a pattern of incorrect implementation in updating compliance data in the data systems, there are incomplete or incorrect inspection reports, and/or there is ineffective enforcement response. These would be significant issues and not merely random occurrences. Recommendations are required for these problems that will have well defined timelines and milestones for completion. Recommendations will be monitored in the SRF Tracker. |

| **Clean Air Act** | | |
|---|---|---|
| **Element 1. Data Completeness** | | |
| | | |
| 1-1 | Finding | NSPS, NESHAP, MACT subpart designations appear low in AFS |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>□Area for AQD Attention<br>X Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Data metrics 1C4, 1C5 and 1C6 indicate 0 subpart designations for facilities with FCEs conducted. For 6 of the 7 FCEs reviewed, the sources are not subject to NSPS, NESHAP, or MACT subparts. One of the 7 FCEs reviewed, the applicable facility NSPS subpart was missing in AFS. From discussions with AQD, data entry for subpart designations is a function of its permitting group. As permits are renewed, AFS will be updated to reflect subpart applicability. In addition, as facilities are investigated, applicable subparts will be identified in AFS. The Region will provide support on this as needed. |

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| | | Recommended action: As facilities come up for investigation or permit renewal, their subpart designations should be updated in AFS. AQD projected having outstanding subpart designations for Title V majors and SM80s complete by 12/1/09. |
| | Metric(s) and Quantitative Values | Metric: 1C4 facilities with FCEs having NSPS subparts in AFS<br>Value: Nat. Avg. 73.1%, AQD 0<br>Metric: 1C5 facilities with FCEs having NESHAP subparts in AFS<br>Value: Nat. Avg. 31.3%, AQD 0<br>Metric: 1C6 facilities with FCEs having MACT subparts in AFS<br>Value: Nat. Avg. 89.0%, AQD 0 |
| | AQD Response | The Division's permitting section currently has a standard operating procedure that ensures NSPS and NESHAP subparts are entered. The facilities that were found to be currently missing these subpart entries are older permitting actions created prior to this procedure being put in place. As stated above, new permitting actions, new permits and modifications, will update all sources, and for the relevance of this report, the outstanding Title V and SM80 sources will be updated by December 1, 2009. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | AQD, with support from Region 6 as needed, will complete updating subpart designations from Title V majors and SM80s, for those that are part of their program authorization, by December 1, 2009. |
| | | |
| 1-2 | Finding | FCE not entered into AFS |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Initially, one of the 7 FCEs reviewed did not appear to be entered into AFS. Based upon further discussions with AQD, however, this was not the case.<br>The FCE was comprised of 4 PCEs spanning February through April 2007. The report designated in the file as the FCE was actually the February PCE. The completion data of of the FCE was entered correctly in AFS as April 2007. |
| | Metric(s) and Quantitative Values | Metric 2C – % files where MDRs are accurately reflected in AFS<br>Value: AQD 86% |
| | AQD Response | This was an anomaly where there were several partial inspections on several days and not all were entered. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| | | |
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| **Clean Air Act** | | |
| **Element 2. Data Accuracy** | | |
| | | |
| 2-1 | Finding | No HPVs and no sources with non-compliance status in AFS |

| | | |
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| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>□ Area for AQD Attention<br>X Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Data metric 2.A. indicates that there were no sources with non-compliance status designations in AFS during the review period. Non-compliance should be identified in AFS on a pollutant and program specific basis within 60 days of violation identification. Although all AQD compliance monitoring reports reviewed were thorough, 2 of the 7 FCEs reviewed identified violations, however, the compliance status in AFS was not changed in either instance.<br><br>AQD modified its compliance monitoring data entry procedures to update compliance status in AFS on an ongoing basis. This was in place as of 9/1/09 |
| | Metric(s) and Quantitative Values | Metric: 2A – number of HPVs per number of non-compliant sources. The number of HPVs should be less than the number of non-compliant sources.<br>Value: Nat Avg. 75.5%, AQD 0/0 |
| | AQD Response | This compliance status entry procedure has now been implemented and will be implemented and will be utilized going forward in compliance with the 6/1/09 AFS User Guide for Federally Reportable Violations (FRV's). The Bernalillo/City of Albuquerque AQD would like to have this element changed to an Area of Concern because as the above document issued by EPA noted that this was a common area that States/Locals had a deficiency of accurate entries. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | AQD updated its compliance monitoring data entry procedures to update compliance status in AFS.<br>The Region will track compliance status with AQD through FY2010 to determine the effectiveness of actions taken or the need for additional actions by 9/30/10. |
| | | |
| 2.2 | Finding | Inaccurate facility status |
| | This finding is a(n) | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | For 1 of the 7 (14%) FCEs reviewed, the facility status in AFS is incorrect in AFS. The facility is actually a synthetic minor however at the time of the file review it was in AFS as a major. AQD corrected the facility status in AFS. This appears to be an anomaly and, therefore, there are no additional recommended actions. |
| | Metric(s) and Quantitative Values | File metric: 2C – % files where MDRs are accurately reflected in AFS<br>Value: 63% |
| | AQD Response | This facility status has been changed. |
| | Action(s) (include any uncompleted actions from Round | N/A |

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| | 1 that address this issue.) | |

| **Clean Air Act** | | |
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| **Element 3. Data Timeliness** | | |
| | | |
| 3-1 | Finding | Compliance monitoring related MDRs not in AFS within 60 days |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | Data metric 3B1 indicates a relatively low percentage of compliance monitoring MDRs entered into AFS within 60 days. One of 7 FCEs reviewed was not entered into AFS timely.<br>AQD is taking additional measures per their response below. Data for 2008 and 2009 show improvement in the timeliness of compliance monitoring data (66% compared to the national average of 60%). Based upon the actions described by AQD in its response below and the improvement in data timeliness, no additional recommendations are made. |
| | Metric(s) and Quantitative Values | Metric 3B1 – % compliance monitoring MDRs entered within 60 days.<br>Value: Nat. Avg. 52.6%, AQD 39% |
| | AQD Response | In an attempt to streamline the process, the Enforcement Section has/will implement the following: reduced the number reviews done by the Enforcement and Compliance Section Supervisors, is working on a single Inspection Report Template and updating our Inspection SOP. We will continue to review and evaluate other options that will increase the efficiency of report writing while not compromising the quality of compliance review of each facility. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

| **Clean Air Act** | | |
|---|---|---|
| **Element 4 Completion of Commitments** | | |
| | | |
| 4-1 | Finding | AQD met its compliance and enforcement commitments. Some MDRs missing in AFS. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended | Compliance and enforcement provisions in AQD's 2007 CAA grant are listed in the file review analysis chart (metric 4b) in Section VI above.<br>AQD met grant commitments, however, as described in Findings under Elements 1-3 and 7 of this Section, some MDRs are missing in AFS. For the rationale for including or not including recommendations, see the findings under each of those elements. |

| | | |
|---|---|---|
| | action.) | |
| | Metric(s) and Quantitative Values | File Metric 4b. |
| | AQD Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 5 Inspection Coverage** | | |
| | | |
| 5-1 | Finding | AQD completed the universe of planned inspections |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | For FY 2007 AQD projected 8 FCEs at majors and 7 SMs. AQD met its inspection targets. |
| | Metric(s) and Quantitative Values | Metric: 5a1 – CMS major FCE coverage (2 yr)<br>Value: Goal 100%, Nat. Avg. 90.7%, AQD 100%<br>Metric: 5b1 – CMS SM80 coverage (5 yr)<br>Value: Goal 20-100%, Nat. Avg. 48.6%, AQD 42.1%<br>Metric: 5e – facilities with unknown compliance status<br>Value: 0 |
| | AQD Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 6 Quality of Compliance Evaluation Reports** | | |
| | | |
| 6-1 | Finding | Compliance Evaluation reports properly documented observations, were completed in a timely manner and included accurate descriptions of observations. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action | 7 FCE reports were reviewed. All documented thorough evaluations in terms of scope. Observations were thoroughly documented. Reports were completed in a timely manner. |

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| | not required; if area for improvement, provide recommended action.) | |
| | Metric(s) and Quantitative Values | File Metric: 6b - % of FCEs that meet the definition of an FCE per the CMS policy.<br>Value: 100%<br>File Metric: 6c - % of CMRs or facility files reviewed that provide sufficient documentation to determine compliance at the facility. |
| | AQD Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 7. Identification of Alleged Violations** | | |
| | | |
| 7-1 | Finding | Violations identified in compliance monitoring reports, however, compliance status not changed in AFS. |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>□ Area for AQD Attention<br>X Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | As stated in Finding 2-1 above, 2 of 7 FCEs reviewed identified violations, however, the compliance status was not changed in AFS to reflect violations identified. Additionally, metric 7C1indicates 0 facilities with FCEs, stack tests, or enforcement actions during the review period received non-compliance status in AFS.<br>Recommended action: same as finding 2-1 |
| | Metric(s) and Quantitative Values | Metric: 7C1 - % of facilities with FCEs, stack tests or enforcement actions with non-compliance status<br>Value: Nat. Avg. 18.9%, AQD 0<br>File metric 7B - % of files reviewed where compliance status was timely changed in AFS to reflect violations identified.<br>Value: AQD – 0 |
| | AQD Response | This Compliance Status entry procedure has now been implemented and will be utilized going forward in compliance with the 6/1/09 AFS User Guide for Federally Reportable Violations (FRV's). As in Element 2-1 we would request that this element be changed to Area of Concern. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | Same as finding 2-1 |

| Clean Air Act | | |
|---|---|---|
| **Element 8. Identification of HPVs** | | |
| | | |
| 8-1 | Finding | No HPVs identified in AFS |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>□ Area AQD Attention<br>X Area for AQD Improvement – Recommendation Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | EPA reviewed 2 formal enforcement actions, one of which addressed a late ACC submittal (over 2 months late). AQD did not designate this violation as an HPV although EPA believes it would qualify for an HPV under the HPV Policy.<br>AQD notes that although it was not identified as an HPV in AFS, it was addressed as such with a timely and appropriate enforcement action.<br>Recommended Action: Beginning 10/1/09 the agenda for the monthly HPV call should included ACC submittals, stack test results and investigation findings for the proceeding month. Beginning 10/1/09 AQD should ensure that HPVs are timely identified in AFS. |
| | Metric(s) and Quantitative Values | Metric 8A – rate of HPVs per major source<br>Value: Nat. Avg. 9.2%, AQD 0<br>Metric 8C – percent formal enforcement actions with prior HPV designations; national average 73.2%<br>Value: Nat. Avg. 73.2%, AQD 0<br>File metric 8F - % files EPA agrees with HPV determination.<br>Value: 0 |
| | AQD Response | Although this ACC late submittal was not entered in AIRS, it was addressed in a timely fashion and corrected through our enforcement procedures. This AFS submittal procedure has been addressed and will be done correctly going forward. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | Beginning 10/1/09 the agenda for the monthly HPV call should included ACC submittals, stack test results and investigation findings for the proceeding month. Beginning 10/1/09 AQD should ensure that HPVs are timely identified in AFS. By September 30, 2010, EPA and AQD will determine the need for additional HPV training. |

| Clean Air Act | | |
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| **Element 9 Enforcement Actions Promote Return to Compliance** | | |
| | | |
| 9-1 | Finding | Enforcement actions included the required corrective action to return facilities to compliance in a specific time frame. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | 2 formal enforcement actions were reviewed. Both required corrective actions to be taken and specified time frames. |
| | Metric(s) and Quantitative Values | File Metric: 9b - 100% of formal enforcement responses that include required corrective action (i.e., injunctive relief or other complying |

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| | | actions) that will return the facility to compliance in a specified time frame.<br>Value: 100% |
| | AQD Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 10 Timely and Appropriate Action** | | |
| | | |
| 10-1 | Finding | AQD took timely and appropriate enforcement action. |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | AQD did not designate any HPVs in 2007. EPA reviewed 2 formal enforcement actions. One addressed a late ACC that should have been designated as an HPV. The other action addressed non-HPV violations. Both actions were issued within 270 days and were appropriate. |
| | Metric(s) and Quantitative Values | File Metrci: 10b - % of formal enforcement responses for HPVs reviewed that are addressed in a timely manner (i.e., within 270 days).<br>Value: 100%<br>File Metric: 10c - % of enforcement responses for HPVs appropriately addressed.<br>Value: 100% |
| | AQD Response | |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 11. Penalty calculation method** | | |
| | | |
| 11-1 | Finding | Penalty calculation documentation not available for review |
| | This finding is a(n): | □ Good Practice<br>X Meets SRF Program Requirements<br>□ Area for AQD Attention<br>□ Area for AQD Improvement – Recommendation Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide | Two penalty actions were reviewed. One penalty action was for a stack test failure. The penalty calculation was not immediately available during the file review, however, it was provided later. Both gravity and economic benefit components were considered and documented. For the other penalty reviewed, the file included the penalty calculations which included both gravity and economic |

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| | recommended action.) | benefit components. |
| | Metric(s) and Quantitative Values | File metric 11A – % files reviewed with penalty calculations reflecting gravity and economic benefit components considered.<br>Value: AQD 100% |
| | AQD Response | AQD respectfully requests this Element, 11-1, and Element 12-1 be changed from an Area of Concern because the penalty calculations and rational were provided once it was discovered that they were not in the respective permit files. These documents had been removed, just before SRF Audit, from the permit files due to a public information request, and had not been re-filed back to the permit file by administrative staff. We assert that this was an anomaly. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | NA |

| **Clean Air Act** | | |
|---|---|---|
| **Element 12. Final penalty assessment and collection** | | |
| | | |
| 12-1 | Finding | Penalty collection was documented in the files. Penalty documentation did not include rationale for the difference between proposed and final penalty amounts. |
| | This finding is a(n): | □ Good Practice<br>□ Meets SRF Program Requirements<br>X Area for AQD Attention<br>□ Area for AQD Improvement – Recommendations Required |
| | Explanation: (If area for attention, describe why action not required; if area for improvement, provide recommended action.) | As mentioned in finding 11-1, penalty calculations were not immediately available for one of the 2 penalties reviewed, but were provided later. For the penalty calculations reviewed, the files included documentation for the proposed and final penalty amounts, however, they did not include rationales for the differences between proposed and final amounts.<br>At the Region's request, AQD provided the rationales for the differences in penalty amounts. They appeared to be justified. The Region recommends that AQD include the rationale in the penalty documentation.<br>The files included copies of checks showing that penalties were collected.<br>Final penalty documentation is generally good and collection is documented. Therefore no additional recommendations. |
| | Metric(s) and Quantitative Values | File metric 12 - % files containing documentation for the difference between proposed and final penalty amounts.<br>Value: AQD 0 |
| | State Response | Same as Element 11-1. |
| | Action(s) (include any uncompleted actions from Round 1 that address this issue.) | N/A |

## APPENDIX A: Corrected Data Pull

AQD did not provide corrected data prior to the file review. Below is the original data set.

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A01A1S | Title V Universe: AFS Operating Majors (Current) | Data Quality | Local | | | 10 | NA | NA | NA |
| A01A2S | Title V Universe: AFS Operating Majors with Air Program Code = V (Current) | Data Quality | Local | | | 10 | NA | NA | NA |
| A01B1S | Source Count: Synthetic Minors (Current) | Data Quality | Local | | | 19 | NA | NA | NA |
| A01B2S | Source Count: NESHAP Minors (Current) | Data Quality | Local | | | 2 | NA | NA | NA |
| A01B3S | Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current) | Informational Only | Local | | | 46 | NA | NA | NA |
| A01C1S | CAA Subprogram Designations: NSPS (Current) | Data Quality | Local | | | 10 | NA | NA | NA |
| A01C2S | CAA Subprogram Designations: NESHAP (Current) | Data Quality | Local | | | 4 | NA | NA | NA |
| A01C3S | CAA Subprogram Designations: MACT (Current) | Data Quality | Local | | | 6 | NA | NA | NA |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A01C4S | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | Local | 100% | 73.1% | 0 / 0 | 0 | 0 | 0 |
| A01C5S | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | Local | 100% | 31.3% | 0 / 0 | 0 | 0 | 0 |
| A01C6S | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | Local | 100% | 89.0% | 0 / 0 | 0 | 0 | 0 |
| A01D1S | Compliance Monitoring: Sources with FCEs (1 FY) | Data Quality | Local | | | 16 | NA | NA | NA |
| A01D2S | Compliance Monitoring: Number of FCEs (1 FY) | Data Quality | Local | | | 16 | NA | NA | NA |
| A01D3S | Compliance Monitoring: Number of PCEs (1 FY) | Informational Only | Local | | | 5 | NA | NA | NA |
| A01E0S | Historical Non-Compliance Counts (1 FY) | Data Quality | Local | | | 12 | NA | NA | NA |
| A01F1S | Informal Enforcement Actions: Number Issued (1 FY) | Data Quality | Local | | | 13 | NA | NA | NA |
| A01F2S | Informal Enforcement Actions: Number of Sources (1 FY) | Data Quality | Local | | | 13 | NA | NA | NA |
| A01G1S | HPV: Number of New Pathways (1 FY) | Data Quality | Local | | | 0 | NA | NA | NA |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A01G2S | HPV: Number of New Sources (1 FY) | Data Quality | Local | | | 0 | NA | NA | NA |
| A01H1S | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | Local | 100% | 44.3% | 0 / 0 | 0 | 0 | 0 |
| A01H2S | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | Local | 100% | 66.0% | 0 / 0 | 0 | 0 | 0 |
| A01H3S | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | Local | 100% | 56.9% | 0 / 0 | 0 | 0 | 0 |
| A01I1S | Formal Action: Number Issued (1 FY) | Data Quality | Local | | | 12 | NA | NA | NA |
| A01I2S | Formal Action: Number of Sources (1 FY) | Data Quality | Local | | | 12 | NA | NA | NA |
| A01J0S | Assessed Penalties: Total Dollar Amount (1 FY) | Data Quality | Local | | | $70,890 | NA | NA | NA |
| A01K0S | Major Sources Missing CMS Policy Applicability (Current) | Review Indicator | Local | 0 | | 0 | NA | NA | NA |
| A02A0S | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | Local | <= 50% | 71.5% | 0 / 0 | 0 | 0 | 0 |
| A02B1S | Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY) | Goal | Local | 0% | 5.6% | 0.0% | 0 | 24 | 24 |
| A02B2S | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | Local | | | 0 | NA | NA | NA |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A03A0S | Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY) | Goal | Local | 100% | 24.0% | 0 / 0 | 0 | 0 | 0 |
| A03B1S | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | Local | 100% | 52.6% | 0 / 0 | 0 | 0 | 0 |
| A03B2S | Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | Local | 100% | 67.3% | 0 / 0 | 0 | 0 | 0 |
| A05A1S | CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle) | Goal | Local | 100% | 90.7% | 100.0% | 10 | 10 | 0 |
| A05A2S | CAA Major Full Compliance Evaluation (FCE) Coverage(most recent 2 FY) | Review Indicator | Local | 100% | 84.7% | 100.0% | 10 | 10 | 0 |
| A05B1S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle) | Review Indicator | Local | 20% - 100% | 48.6% | 42.1% | 8 | 19 | 11 |
| A05B2S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY) | Informational Only | Local | 100% | 88.0% | 90.9% | 20 | 22 | 2 |
| A05C0S | CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY) | Informational Only | Local | | 79.4% | 90.9% | 20 | 22 | 2 |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A05D0S | CAA Minor FCE and Reported PCE Coverage (last 5 FY) | Informational Only | Local | | 31.8% | 3.8% | 30 | 798 | 768 |
| A05E0S | Number of Sources with Unknown Compliance Status (Current) | Review Indicator | Local | | | 0 | NA | NA | NA |
| A05F0S | CAA Stationary Source Investigations (last 5 FY) | Informational Only | Local | | | 0 | NA | NA | NA |
| A05G0S | Review of Self-Certifications Completed (1 FY) | Goal | Local | 100% | 91.1% | 100.0% | 5 | 5 | 0 |
| A07C1S | Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY) | Review Indicator | Local | > 1/2 National Avg | 18.9% | 0.0% | 0 | 20 | 20 |
| A07C2S | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | Local | > 1/2 National Avg | 33.9% | 0 / 0 | 0 | 0 | 0 |
| A08A0S | High Priority Violation Discovery Rate - Per Major Source (1 FY) | Review Indicator | Local | > 1/2 National Avg | 9.2% | 0.0% | 0 | 10 | 10 |
| A08B0S | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | Local | > 1/2 National Avg | 1.5% | 0.0% | 0 | 19 | 19 |
| A08C0S | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | Local | > 1/2 National Avg | 73.2% | 0.0% | 0 | 2 | 2 |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque | Count | Universe | Not Counted |
|---|---|---|---|---|---|---|---|---|---|
| A08D0S | Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY) | Review Indicator | Local | < 1/2 National Avg | 39.2% | 100.0% | 2 | 2 | 0 |
| A08E0S | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | Local | > 1/2 National Avg | 42.4% | 0 / 0 | 0 | 0 | 0 |
| A10A0S | Percent HPVs not meeting timeliness goals (2 FY) | Review Indicator | Local | | 40.8% | 0 / 0 | 0 | 0 | 0 |
| A12A0S | No Activity Indicator - Actions with Penalties (1 FY) | Review Indicator | Local | | | 12 | NA | NA | NA |
| A12B0S | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | Local | >= 80% | 86.2% | 0 / 0 | 0 | 0 | 0 |

## APPENDIX B: Preliminary Data Analysis

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A01A1S | Title V Universe: AFS Operating Majors (Current) | Data Quality | State | | | 10 | NA | NA | NA | |
| A01A2S | Title V Universe: AFS Operating Majors with Air Program Code = V (Current) | Data Quality | State | | | 10 | NA | NA | NA | |
| A01B1S | Source Count: Synthetic Minors (Current) | Data Quality | State | | | 19 | NA | NA | NA | |
| A01B2S | Source Count: NESHAP Minors (Current) | Data Quality | State | | | 2 | NA | NA | NA | |
| A01B3S | Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current) | Informational Only | State | | | 46 | NA | NA | NA | |
| A01C1S | CAA Subprogram Designations: NSPS (Current) | Data Quality | State | | | 10 | NA | NA | NA | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A01C2S | CAA Subprogram Designations: NESHAP (Current) | Data Quality | State | | | 4 | NA | NA | NA | |
| A01C3S | CAA Subprogram Designations: MACT (Current) | Data Quality | State | | | 6 | NA | NA | NA | |
| A01C4S | CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 73.1% | 0 / 0 | 0 | 0 | 0 | Appears low; need to verify if subject & applicable subparts verify that the inspectors are determining applicable subparts/determining compliance during inspection. |
| A01C5S | CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 31.3% | 0 / 0 | 0 | 0 | 0 | Same as AO1C4S |
| A01C6S | CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005 | Data Quality | State | 100% | 89.0% | 0 / 0 | 0 | 0 | 0 | Same as AO1C4S |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A01D1S | Compliance Monitoring: Sources with FCEs (1 FY) | Data Quality | State | | | 16 | NA | NA | NA | |
| A01D2S | Compliance Monitoring: Number of FCEs (1 FY) | Data Quality | State | | | 16 | NA | NA | NA | |
| A01D3S | Compliance Monitoring: Number of PCEs (1 FY) | Informational Only | State | | | 5 | NA | NA | NA | |
| A01E0S | Historical Non-Compliance Counts (1 FY) | Data Quality | State | | | 12 | NA | NA | NA | correlate drill downs for 1E, 1F2, 1I1, verify compliance status behind violations cited in informal/formal enforcement actions |
| A01F1S | Informal Enforcement Actions: Number Issued (1 FY) | Data Quality | State | | | 13 | NA | NA | NA | |
| A01F2S | Informal Enforcement Actions: Number of Sources (1 FY) | Data Quality | State | | | 13 | NA | NA | NA | |
| A01G1S | HPV: Number of New Pathways (1 FY) | Data Quality | State | | | 0 | NA | NA | NA | appears low |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A01G2S | HPV: Number of New Sources (1 FY) | Data Quality | State | | | 0 | NA | NA | NA | appears low |
| A01H1S | HPV Day Zero Pathway Discovery date: Percent DZs with discovery | Data Quality | State | 100% | 44.3% | 0 / 0 | 0 | 0 | 0 | appears low |
| A01H2S | HPV Day Zero Pathway Violating Pollutants: Percent DZs | Data Quality | State | 100% | 66.0% | 0 / 0 | 0 | 0 | 0 | appears low |
| A01H3S | HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s) | Data Quality | State | 100% | 56.9% | 0 / 0 | 0 | 0 | 0 | appears low |
| A01I1S | Formal Action: Number Issued (1 FY) | Data Quality | State | | | 12 | NA | NA | NA | |
| A01I2S | Formal Action: Number of Sources (1 FY) | Data Quality | State | | | 12 | NA | NA | NA | |
| A01J0S | Assessed Penalties: Total Dollar Amount (1 FY) | Data Quality | State | | | $70,890 | NA | NA | NA | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A01K0S | Major Sources Missing CMS Policy Applicability (Current) | Review Indicator | State | 0 | | 0 | NA | NA | NA | |
| A02A0S | Number of HPVs/Number of NC Sources (1 FY) | Data Quality | State | <= 50% | 71.5% | 0 / 0 | 0 | 0 | 0 | verify NC/HPV status behind violations cited in informal and formal enforcement actions |
| A02B1S | Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY) | Goal | State | 0% | 5.6% | 0.0% | 0 | 24 | 24 | |
| A02B2S | Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY) | Data Quality | State | | | 0 | NA | NA | NA | appears low |
| A03A0S | Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 24.0% | 0 / 0 | 0 | 0 | 0 | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A03B1S | Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 52.6% | 39% | 24 | 62 | 38 | appears low, discuss data entry |
| A03B2S | Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY) | Goal | State | 100% | 67.3% | 72% | 18 | 25 | 7 | |
| A05A1S | CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle) | Goal | State | 100% | 90.7% | 100.0% | 10 | 10 | 0 | |
| A05A2S | CAA Major Full Compliance Evaluation (FCE) Coverage(most recent 2 FY) | Review Indicator | State | 100% | 84.7% | 100.0% | 10 | 10 | 0 | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A05B1S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle) | Review Indicator | State | 20% - 100% | 48.6% | 42.1% | 8 | 19 | 11 | |
| A05B2S | CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY) | Informational Only | State | 100% | 88.0% | 90.9% | 20 | 22 | 2 | |
| A05C0S | CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY) | Informational Only | State | | 79.4% | 90.9% | 20 | 22 | 2 | |
| A05D0S | CAA Minor FCE and Reported PCE Coverage (last 5 FY) | Informational Only | State | | 31.8% | 3.8% | 30 | 798 | 768 | |
| A05E0S | Number of Sources with Unknown Compliance Status (Current) | Review Indicator | State | | | 1 | NA | NA | NA | |
| A05F0S | CAA Stationary Source Investigations (last 5 FY) | Informational Only | State | | | 0 | NA | NA | NA | |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A05G0S | Review of Self-Certifications Completed (1 FY) | Goal | State | 100% | 91.1% | 100.0% | 5 | 5 | 0 | verify number of expected ACCs |
| A07C1S | Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY) | Review Indicator | State | > 1/2 National Avg | 18.9% | 0.0% | 0 | 20 | 20 | verify compliance status data entry for violations identified in inspections and enforcement actions |
| A07C2S | Percent facilities that have had a failed stack test and have noncompliance status (1 FY) | Review Indicator | State | > 1/2 National Avg | 33.9% | 0 / 0 | 0 | 0 | 0 | |
| A08A0S | High Priority Violation Discovery Rate - Per Major Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 9.2% | 0.0% | 0 | 10 | 10 | 0 HPVs appears low |
| A08B0S | High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY) | Review Indicator | State | > 1/2 National Avg | 1.5% | 0.0% | 0 | 19 | 19 | same as 8B |
| A08C0S | Percent Formal Actions With Prior HPV - Majors (1 FY) | Review Indicator | State | > 1/2 National Avg | 73.2% | 0.0% | 0 | 2 | 2 | review NC and HPV status behind violations cited in formal enforcement actions |

| Metric | Metric Description | Metric Type | Agency | National Goal | National Average | Albuquerque Metric | Count | Universe | Not Counted | Initial Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| A08D0S | Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY) | Review Indicator | State | < 1/2 National Avg | 39.2% | 100.0% | 2 | 2 | 0 | |
| A08E0S | Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY) | Review Indicator | State | > 1/2 National Avg | 42.4% | 0 / 0 | 0 | 0 | 0 | |
| A10A0S | Percent HPVs not meeting timeliness goals (2 FY) | Review Indicator | State | | 40.8% | 0 / 0 | 0 | 0 | 0 | |
| A12A0S | No Activity Indicator - Actions with Penalties (1 FY) | Review Indicator | State | | | 12 | NA | NA | NA | |
| A12B0S | Percent Actions at HPVs With Penalty (1 FY) | Review Indicator | State | >= 80% | 86.2% | 0 / 0 | 0 | 0 | 0 | |