the use of restraints and seclusion in mental health care facilities. I look forward to working with Senator FRIST toward the inclusion of this important initiative within SAMHSA's reauthorization.

Mr. President, this bill demonstrates our continuing support for SAMHSA and for sustaining programs which improve the quality and availability of substance abuse and mental health services. I am pleased that Senator FRIST has moved this legislation forward and look forward to working with him to include provisions to address the substance abuse treatment needs of adolescents and to enact standards regarding the use of restraint and seclusion. I again offer my support and cosponsorship of this bill.●

By Mr. WARNER:

S. 978. A bill to specify that the legal public holiday known as Washington's Birthday be called by that name; to the Committee on the Judiciary.

GEORGE WASHINGTON BICENTENNIAL ACT OF 1999

●Mr. WARNER. Mr. President, I rise today to introduce legislation to reestablish the third Monday in February as a national holiday called ''Washington's Birthday.''

Current law provides that the third Monday in February is a legal public holiday designated as ''Washington's Birthday.'' Nonetheless, there is an inaccurate misconception that this federal holiday is called ''President's Day.'' Not only does the use of the phrase ''President's Day'' in reference to the third Monday in February have no force in federal law, the misnomer obscures the true meaning of the holiday.

Simply put, the true meaning of the federal holiday known as ''Washington's Birthday'' is to celebrate the birthday of the father of our country. Washington's role in achieving our Nation's independence, in helping to create our Constitution, and as the first President of the United States of America cannot be overestimated.

As one of Virginia's delegates to the Second Continental Congress assembled in Philadelphia in May 1775, Washington was elected Commander in Chief of the Continental Army. As Commander in Chief of the Army, Washington helped ensure the independence of our Nation when he, with the help of French allies, forced the surrender of British forces at Yorktown. After the war, Washington soon realized the problems associated with the Articles of Confederation, and he became a prime mover in the steps leading to the Constitutional Convention in Philadelphia in 1787. Washington presided over the Constitutional Convention and ultimately yielded to the cries that he serve as our country's first President. After the Constitution was ultimately ratified, the electoral college twice unanimously elected Washington to serve as President of the United States.

As the father of our country, President Washington deserves to be distinguished from other Presidents. Federal law recognizes this deserved distinction in that President Washington's birthday is the only President's birthday recognized as a federal holiday. However, because this holiday is all too often misconceived as ''President's Day,'' this legislation is necessary to reestablish that the federal holiday is in fact ''Washington's Birthday.''

This legislation would achieve this objective by simply requiring all entities and officials of the United States Government, as well as federally funded publications, to refer to this day as ''Washington's Birthday.'' This bill in no way infringes on the right of any State or local government to recognize a ''President's Day'' or any other holiday. In fact, ''President's Day'' is a State holiday in a number of states.

President Buchanan emphasized the importance of Washington's birthday when he stated, ''when the birthday of Washington shall be forgotten, liberty will have perished from the earth.'' I urge my colleagues to support this bill to ensure that President Washington receive the distinction he deserves.●

By Mr. CAMPBELL for himself and Mr. MCCAIN):

S. 979. A bill to amend the Indian Self-Determination and Education Assistance Act to provide for further self-governance by Indian tribes, and for other purposes; to the Committee on Indian Affairs.

TRIBAL SELF-GOVERNANCE AMENDMENTS OF 1999

● Mr. CAMPBELL. Mr. President, today I introduce amendments to the Indian Self-Determination and Education Assistance Act of 1975 (''ISDEA'') to provide for greater tribal self-governance for the programs and services of the Department of Health and Human Services (''HHS'').

Over the years the poor circumstances and conditions of Native Americans have been compounded by vacillating federal policies and federal domination of matters affecting Indian people.

This situation began to change in 1970, when President Nixon delivered his now-famous ''Message to Congress on Indian Affairs'', which laid the foundation for a more enlightened federal Indian policy. This new policy allowed tribes to forge their own destiny and challenged the federal government to find new, innovative ways to administer Indian programs.

Because of the tangible benefits it has brought, this shift away from federal domination and toward Indian self-determination has been supported by every Administration since 1970.

Indian self-determination fosters strong tribal governments and reservation economies. This policy has encouraged tribes to assume more responsibility for their own affairs, caused a reduction in the federal bureaucracy and, most importantly, improved the quality of services to tribal members.

The most definitive expression of the policy change brought about by President Nixon was the ISDEA which authorized tribes to negotiate and enter into agreements with the U.S. to assume control over and operate federal programs which had been previously administered by federal employees.

In the years after enactment of the ISDEA, Congress expanded on the framework by enacting tribal ''self-governance'' laws which created a demonstration project that authorized tribes to enter into ''compacts'' with the U.S., so that they may administer an array of services.

The principles of the ISDEA are similar to those of block granting to the states. Instead of the federal government micro-managing Indian tribes, the federal government is contracting with tribes to perform those functions. Like states, tribes know best which governmental programs best serve their communities and how programs should be delivered. In short, the concept of local administration of federal dollars works.

By continuing to build tribal capacity and expertise in the administration of programs and services previously administered by employees of the Department of the Interior and the HHS, the Act has forged stronger tribal governments and economies and led to a smaller federal presence in Indian affairs.

The current self governance ''demonstration project'' in health care involves approximately 50 tribes. The legislation I introduce today builds on these successes, makes the self governance program permanent and expands an array of eligible functions available for tribal self governance to include the many programs, services and activities of the HHS, such as clinical services, public health nursing, mental health, substance abuse, community health representatives, and dental health.

The bill ensures continued participation by the tribes now participating in the self governance project, and provides for participation by an additional 50 tribes or tribal organizations annually.

This is far from a ''no-strings attached'' approach to federal programs. To participate, tribes must successfully complete legal and accounting requirements, as well as demonstrate financial stability and financial management capability.

This legislation also addresses the issue of which functions may be performed by tribes and which may not. This bill differentiates between those services and activities that are federal, and therefore ineligible for tribal performance through a self-governance compact, and those that are not inherently federal, and therefore eligible for tribal performance through a self-governance compact.

To track the progress made in raising the health status of Indians, the bill requires participating tribes to report health-related data to the Secretary so that an accurate picture of Indian health can be drawn.

I am mindful that there are issues we need to explore further, such as contract support cost funding, and I fully anticipate that interested parties will have full and fair opportunity to raise their concerns during the legislative process.

I am hopeful that after working with the tribes, the Administration and other interested parties, and after careful consideration by the Committee on Indian Affairs, we will be able to enact this important legislation to raise the health status of Native Americans and continue the unparalleled success of the Indian self-determination policies.●

By Mr. BAUCUS (for himself, Mr. DASCHLE, Mr. THOMAS, Mr. HARKIN, Mr. GRASSLEY, Mr. CONRAD, Mr. ROBERTS, Mr. FRIST, Mr. JOHNSON, Mr. ROCKFELLER, Mr. JEFFORDS, Mr. WELLSTONE, and Mr. MURKOWSKI):

S. 980. A bill to promote access to health care services in rural areas; to the Committee on Finance.

PROMOTING HEALTH IN RURAL AREAS ACT OF 1999

Mr. BAUCUS. Mr. President, I rise today to introduce the Promoting Health in Rural Areas Act of 1999.

All Americans deserve access to quality health care. But in rural America health care delivery is often difficult, given the great distances and extreme weather conditions that typically prevail. That's why Senator DASCHLE and I, along with bipartisan group of Senators, are introducing this important legislation. Its provisions are many, but it purpose is singular: to correct the federal government's tendency to view all areas—urban and rural—with a one-size-fits all lens.

Before I begin explaining what this bill does, I want to recognize the tremendous contributions of some of the cosponsors' staff who have worked on the bill.

The Minority Leader is known in the Senate not only for this tremendous leadership, but for the quality of his staff. Elizabeth Hargrave is no exception. On loan from the Department of Health and Human Services, she has worked tirelessly to see this bill through to introduction. With her expertise and attention to the intricate details of health policy, we have come up with a solid, comprehensive bill, much improved from that which was introduced last year.

Tom Walsh on the Senate Aging Committee has also done tremendous work. His knowledge of Medicare law is vast, and his parent demeanor has done wonders toward making negotiations on this bill amicable and fruitful. Heidi Cashman with Senator ROBERTS, Neleen Eisinger with Senator CONRAD, Diane Major and Stephanie Sword with Senator THOMAS, Sabrina and Bryan with Senator HARKIN, The list goes on. The Promoting Health in Rural Areas Act is the product of many long meetings, extensive research, and a great deal of cooperation. Would that we could all work so well together.

So why is this bill important? As you know, Mr. President, a couple of years ago Congress passed the Balanced Budget Act. In it we extended the life of Medicare for several years and passed some important rural health provisions, including Medicare reimbursement for telemedicine and the Medicare Rural Hospital Flexibility Program to establish Critical Access Hospitals (CAHs).

Under the new CAH law, rural hospitals can convert to limited-service hospital status and received flexibility with Medicare regulations designed for full-size, full-service facilities. They are reimbursed by Medicare based on actual costs, not fixed or limited payments; in exchange, CAHs agree to a limit of 15 hospitals beds and patients stays of limited duration. The model for the new program was based largely on Montana's Medical Assistance Facility Program. CAHs show well the progress we can make if rural areas are afforded the flexibility to develop solutions to the problems they know best. They also illustrate a creative means by which we can use the Medicare program to keep rural hospitals open—and rural communities alive.

But not all of the Balanced Budget Act was positive for rural areas. Far from it. Montana health care facilities, including hospitals, home health agencies and nursing homes, are suffering.

In 1997, even before the BBA cuts, small rural hospitals in Montana lost 6.5% treating Medicare patients. And although we do not yet have complete data on the impact of the BBA changes, anecdotal evidence tells me that the situation in rural Montana has gotten even worse. In rural areas where many, usually most, patients are of Medicare age, we cannot expect these facilities to stay open without paying them enough to break even. We must do something to ensure the integrity of our rural health care systems.

This bill is a good first step. Among other things, the bill provides rural communities with assistance in recruiting health care providers; expands the range of services that can be provided with telemedicine; increases payments to hospitals in rural areas; expands access to mental health services in rural areas; changes the formula by which managed care payments are calculated to attract more managed care health plans to rural areas; and increase rural representation on the Medicare Payment Advisory Commission.

As Dennis Farney, a reporter from Kansas once wrote: ''A prairie is not any old piece of flat land in the Midwest. No a prairie is wine-colored grass, dancing in the wind. A prairie is a sun-splashed hillside, bright with wild flowers. A prairie is a fleeting cloud shadow, the song of the meadowlark. It is the wild land that has never felt the slash of the plow.'' For me, this conjures up images of an idyllic rural setting, far removed from the commotion of city life. And certainly that is in the minds of many who live in these sparsely-populated areas—that they are inhabiting a part of the world that is in many ways pristine and untouched.

Of course there is a price to pay for that. Rural folks should not expect to have all the amenities of city life: opera houses and professional sports teams are just a couple of things that rural areas must simply do without. Rural Montanans can't expect to have a subway system—or even a Subway sandwich shop for that matter—because economies of scale dictate as much.

And even in the area of health care, rural Americans realize they give up something. Full-service hospitals and dental clinics are the stuff of populated areas, and will probably remain so. But although you won't find a full-service acute-care hospital in Choteau, Montana, you can find a CAH. And though you don't find a full-service dental clinic in Eureka, you can find a rural health clinic. Rural residents cannot expect to have the most extensive health care facilities or access to the array of specialists typical of urban settings, but they should expect a minimum standard of quality care. This bill is a step in the right direction towards raising that standard.

Whether it's helping rural areas with highway dollars, preventing small post offices from moving to towns' outskirts, or keeping hospitals open, I think most of us agree that saving rural areas is something that ought to be done. Regardless of how hard we try, however, we cannot do so without ensuring the integrity of these communities' health care systems. I urge my colleagues to join the Minority Leader and I in doing just that.

Mr. DASCHLE. Mr. President, today I introduce a bill intended to improve health care for Americans living in rural areas. The Promoting Health in Rural Areas Act of 1999 would improve the viability of rural hospitals and clinics, help rural communities attract and retain health care providers and health plans, and make optimal use of the extraordinary medical and telecommunications technology available today.

One-fifth of Americans live in rural areas. They experience the same health care access problems that Americans in cities and suburbs face—plus some problems that are uniquely rural. Issues of geography and transportation, which rural Americans face all the time, can make it difficult to visit the doctor or get to a hospital. These problems are made worse by the short supply of health care professionals in rural areas.

Rural communities are striving to improve access through telehealth and the recruitment of health care professionals. At the same time, they must also struggle to maintain what they have, to ensure that providers who leave their area are replaced, and to keep their hospitals' doors open. This