Switch

A FIELD GUIDE FOR SNF ADMINISTRATORS & OPERATORS

The Turnover You Didn't Know You Had

How CMS counts your contract clinicians — and the 90-day clock you can still beat.

01 / THE RULE NOBODY EXPLAINED

Your turnover rate counts people, not payrolls

> CMS includes agency and contract clinicians in your nursing home's turnover rate, exactly the same as employees. What decides whether someone counts isn't who signs their paycheck — it's how many hours they worked and whether they came back.

Most administrators assume contract labor sits outside the turnover measures. It's an understandable assumption, and it is wrong in a specific and expensive way.

The CMS Five-Star Technical Users' Guide states it directly: *"both regular employees and agency staff are included in the turnover measure if they work sufficient hours to be eligible for the denominator."* There is no separate treatment for contract labor, no exemption, and no way to file the hours so they land outside the calculation.

Three numbers govern the whole thing.

120

Hours in a 90-day window that put a clinician into your turnover denominator

90

Consecutive days without a shift that records them as a separation

130

Of roughly 380 staffing-rating points that ride on stability, not hours

The rest of this guide is what those three numbers do to a real building — and the one window where you can still act.

02 / WHO ACTUALLY COUNTS

The 120-hour line — and who sits on each side of it

CMS built a threshold to keep occasional coverage out of the measure. Where a clinician falls against it changes everything.

HOURS WORKED IN 90 DAYS	WHAT CMS DOES WITH THEM
Under 120 hours Fewer than ~10 twelve-hour shifts	Never enters the calculation. They can stop coming entirely and your turnover rate does not move.
120 hours or more	Enters the denominator, counted exactly like a staff nurse or aide. A 90-day lapse is recorded as turnover.

CMS is explicit about the intent: the threshold exists to exclude *"individuals who work infrequently (e.g., occasionally covering shifts at a nursing home)."*

> Read that twice, because the consequence runs backwards from intuition: your *best* contract clinicians are the only ones who can hurt your turnover rate.

The traveler who covered three shifts in March and disappeared is invisible to the measure. The per diem CNA who has picked up two shifts a week for four months — who knows your residents by name, who your charge nurse asks for — is squarely in the denominator. If she stops coming and 90 days pass, she costs you precisely what a departing employee costs you.

This is why **"we only use agency for coverage, so it doesn't affect our numbers"** is half true in the worst possible way. Occasional agency use genuinely doesn't touch turnover. Reliable contract coverage does — meaning the staffing arrangement you're most satisfied with is the one carrying rating risk you probably aren't tracking.

The one Five-Star mechanic with a countdown you can see

Almost everything in the rating is backward-looking. This isn't. It's a deadline, and it's the only place in the staffing domain where acting early actually prevents the event.

Day 0 — last shift worked

Day 60 — act now

Day 90 — separation recorded

Days since a denominator-eligible clinician last worked in your building. Nothing is recorded until day 90 — but by day 60 you need a scheduling conversation, not a notification.

1

They return before day 90 — nothing happens.

No gap of 90 consecutive days ever forms, so no turnover event is ever recorded. The measure simply does not fire. This is the entire opportunity.

2

They return after day 90 — it's already counted.

The separation is dated to their last shift before the gap, not to the day you noticed. Bringing them back afterward does not undo it.

3

And the return starts a brand new clock.

CMS treats a clinician who comes back after a 90-day gap as a new employment spell — in its words, "essentially, they are treated as new employees." Because the formula divides spells that ended in turnover by total eligible spells, the same person can register as turnover more than once.

A churning contract pool can charge you for the same person twice. That is not a metaphor — it is how the arithmetic works.

04 / THE TRAP UNDERNEATH

How changing an employee ID can void the measure entirely

CMS never sees termination dates. It tracks human beings by the employee system ID you report in PBJ — which makes that ID the most fragile part of the whole calculation.

If those IDs change — a payroll migration, a new numbering scheme, or a contract-hours process that assigns fresh IDs each quarter — every returning clinician reads as a brand new person, and everyone from the prior period reads as having left.

CMS knows this happens and handles it bluntly. Nursing homes showing **100% daily turnover on any single day** in the six-quarter window (with at least five eligible nurse staff) are **excluded from the total nurse and RN turnover measures entirely.** The guide notes this pattern *"reflects the change in the employee IDs and not actual staff turnover."*

> Being excluded is not a reprieve. It means the measure cannot be calculated for your building — and it points at a reconciliation process that isn't tracking the same human across quarters.

This failure mode punishes good operators hardest — a building can run stable contract coverage for two years and still post numbers that look like a revolving door, purely because of how the hours were filed. If you use contract labor, there is one question worth asking whoever reconciles them:

THE QUESTION

Does the same clinician carry the same ID every quarter?

If the answer is no — or nobody knows — then the continuity you have actually earned is invisible in the only data CMS reads.

A third of your staffing score is not about hours

STABILITY MEASURE	WHO'S COUNTED	MAX POINTS
Total nurse turnover	RNs, LPNs/LVNs, CNAs, aides in training, med aides	50
RN turnover	RN director of nursing, RNs with admin duties, RNs	50
Administrator turnover	Nursing home administrators	30 / 25 / 10

Turnover measures are scored on deciles against the national distribution: the lowest-turnover decile earns the full 50 points, the highest earns 5. Administrator turnover is banded — no departures earns 30, one earns 25, two or more earns 10.

And the staffing star doesn't stop at the staffing star. Under the current CMS methodology, a **one-star staffing rating subtracts a full star from your overall rating**, unconditionally. The bonus, by contrast, only pays at five stars.

THE STAFFING STAR, IN POINTS

155 points separates 1 star from 2

Staffing ratings are assigned on a 380-point scale: under 155 is one star, 155–204 is two, 205–254 is three, 255–319 is four, and 320+ is five. Losing both nurse turnover measures outright is a 90-point swing — on its own, most of the distance between one star and two.

Two exclusions worth knowing: buildings with fewer than five eligible nurses in the denominator are excluded from the nurse turnover measures, and if you fail to submit staffing data for any quarter used in the calculation, you receive the **lowest possible score** on these measures automatically.

CMS sees less churn than you live with

The 120-hour threshold does not just shape who counts. It hides roughly half of real hiring churn from the published numbers.

PEER-REVIEWED · HEALTH AFFAIRS SCHOLAR

46% of nursing hires never appear in CMS turnover data

In 2022–2023, about 46% of total nursing hires and 41% of RN hires worked fewer than 120 hours in their first 90 days — and were therefore excluded from CMS turnover reporting entirely.

That cuts two ways, and both are worth sitting with.

Your published rate is probably better than your lived experience. If your turnover number looks lower than the building feels, you aren't imagining the gap. Half the churn genuinely isn't in there. That is useful context before you conclude the measure is broken or the data is wrong.

But the measure is tracking exactly the people you can least afford to lose. By design, it only counts clinicians who showed up enough to matter — the ones who learned your building, your residents, and your routines. Losing them is precisely what the measure was built to catch, and it is the loss that actually degrades care.

So the number is narrow, but it is not arbitrary. It is a measure of whether your committed workforce stayed committed — whoever employs them.

Four moves, in order of how fast they pay

Turnover is the slowest lever in the rating — the measures look back twelve months, so nothing you do this quarter shows up this quarter. That argues for starting now, not for deprioritizing it.

1. **Pull your denominator list.**
   Every clinician — employed or contract — who has worked 120+ hours in a 90-day window at your building. Most facilities have never produced this list, and it is fully knowable from your own PBJ data.

2. **Track days since last shift for that group.**
   This is the only Five-Star mechanic with a visible countdown. A clinician at day 60 is a scheduling conversation. At day 91 they are a number on Care Compare for the next twelve months.

3. **Fix ID continuity before it becomes an exclusion.**
   One clinician, one ID, every quarter — including contract hours. Confirm it in writing with whoever supplies and reconciles those hours.

4. **Choose coverage that returns.**
   Whether a shift is filled by the same person or a different one every time makes no difference to your hours measures — and all the difference to your stability measures. This is the structural choice underneath the other three.

The last one compounds: **filling shifts and keeping people are scored separately**, and only one of them is about volume.

08 / SELF-AUDIT

Nine questions that tell you where you stand

If you can't answer four or more of these today, the turnover measures are being decided for you rather than by you.

- [ ] Can you produce a list of every clinician — employed *and* contract — who worked 120+ hours in a 90-day window at your building?
- [ ] Do you know how many of them have not worked a shift in the last 60 days?
- [ ] Does every contract clinician carry the same employee ID across quarters?
- [ ] Has anyone verified that your PBJ file has never shown 100% daily turnover on any day in the last six quarters?
- [ ] Do you know your current total nurse turnover and RN turnover percentages without looking them up on Care Compare?
- [ ] Do you know which decile those percentages put you in nationally?
- [ ] Has your administrator seat turned over in the last twelve months?
- [ ] Do you have five or more eligible nurses in the denominator — i.e. are you even being scored on these measures?
- [ ] When a reliable per diem clinician stops picking up shifts at your building, does anyone find out before day 90?

The last one is the whole guide. Every other question describes a number you already have. That one describes the only moment where the number is still yours to change.

09 / SOURCES

Every number in this guide, sourced

Methodology documents for the Five-Star system are revised regularly, and older copies circulate widely online. Check the cover date on anything you rely on.

1. *CMS, Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide, July 2026.*

   The source for every mechanic described here: the 120-hour denominator threshold and the 90-day separation gap (pp. 13–14); the inclusion of agency staff (p. 14); multiple employment spells for clinicians who return after a gap (p. 14); the 100% daily turnover exclusion arising from changed employee IDs, and the five-eligible-nurse minimum (p. 14); turnover measure weights and decile scoring (p. 15); the 380-point staffing scale and star cut points (p. 16); and the overall rating calculation (p. 24).

   cms.gov → provider-enrollment-and-certification → usersguide.pdf

2. *CMS, July 2024 Five-Star refresh.*

   Raised the separation threshold from 60 to 90 consecutive days, so that employees taking full parental leave under the Family and Medical Leave Act are not counted as turnover.

3. *Health Affairs Scholar (2026). "Invisible staffing churn in nursing homes: CMS turnover metrics miss a growing short-term workforce."*

   Source for the finding that approximately 46% of total nursing hires and 41% of RN hires in 2022–2023 worked fewer than 120 hours in their first 90 days and were excluded from CMS turnover reporting.

   academic.oup.com/healthaffairsscholar

4. *A note on what this guide is not.*

   This is an explanation of a public CMS methodology, not regulatory or legal advice. Your PBJ submissions and their accuracy remain your facility's responsibility. Where this guide describes what a measure does, verify it against the current Technical Users' Guide before acting on it.

Switch

COVERAGE THAT COMES BACK

A clinician who returns never opens a 90-day gap.

Switch is built around clinicians returning to buildings they already know — arriving fully credentialed and current, with shifts worked at a **96% work rate**, because accountability runs both ways under the strictest cancellation policy in the category.

And every Switch provider carries **one persistent provider ID** — the same identifier on every shift, in every building, every quarter. It never changes, so the continuity you earn is the continuity CMS actually sees.

Continuity isn't only better care. It's the difference between a returning clinician and a separation on your public rating.

See how Switch fills shifts →

Run your building's real number with the Switch CNA Turnover Cost Calculator — switchcare.com/cna-turnover-calculator