FOR PUBLICATION

In the United States Court of Appeals
For the Eleventh Circuit

No. 26-10419

CHIANNE D. *et al.*,

Plaintiffs-Appellees,

versus

SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION *et al.*,

Defendants-Appellants.

Appeal from the United States District Court
for the Middle District of Florida
D.C. Docket No. 3:23-cv-00985-MMH

Before JORDAN, ROSENBAUM, and LAGOA, Circuit Judges.

LAGOA, Circuit Judge:

Florida provides Medicaid coverage to qualifying low-income residents. When the Florida Department of Children and

Families ("DCF") determines that an enrollee is no longer financially eligible, it sends the enrollee a written Notice of Case Action stating that his Medicaid benefits will end.

Plaintiffs here are Medicaid enrollees who received notices after the State determined that their household income was too high to qualify. On behalf of a certified class, they challenged the notices under the Due Process Clause, arguing that the notices failed to adequately communicate Florida's termination decision and the reasons behind it. After a bench trial, the district court agreed and entered a declaratory judgment in favor of Plaintiffs, along with a permanent injunction requiring Florida to provide that information before terminating a class member's Medicaid benefits. After careful review, and with the benefit of oral argument, we affirm.

I. BACKGROUND[1]

A. Florida's Medicaid Eligibility Process

Florida participates in Medicaid. The Florida Agency for Health Care Administration ("AHCA") is the State's Medicaid payor, while DCF determines Medicaid eligibility. Fla. Stat. § 409.902(1). During the COVID-19 pandemic, federal law required participating States receiving enhanced Medicaid funding to suspend eligibility reviews and maintain most existing Medicaid enrollment. Congress ended that requirement on March 31, 2023,

[1] The following facts are drawn from the evidence and testimony admitted at the July and August 2024 bench trial.

and Florida resumed regular eligibility reviews in what became known as the Medicaid "unwinding." Between April 2023 and March 2024, DCF redetermined the eligibility of more than four million people.

This case concerns the Family-Related Medicaid program, which covers groups including parents and caretakers, pregnant women, infants, and children. For those groups, DCF first determines whether a person satisfies the program's nonfinancial requirements and then determines financial eligibility. Financial eligibility generally turns on modified adjusted gross income. *See* 42 U.S.C. § 1396a(e)(14)(A); 42 C.F.R. § 435.603(c)–(f). DCF determines whose income counts through what it calls a Standard Filing Unit ("SFU") and compares the resulting income calculation against an income limit that varies with the person's eligibility category and SFU size.

A person who satisfies the nonfinancial requirements for Family-Related Medicaid but exceeds the applicable income limit may instead qualify for the Medically Needy Program. Unlike full Medicaid, Medically Needy coverage generally begins only after the recipient incurs a specified "share of cost" during each month.

DCF uses a mainframe computer system called FLORIDA to make these eligibility determinations. If the FLORIDA system determines a recipient is ineligible to receive Medicaid, DCF generates a written notice. The notice is the only written communication DCF affirmatively sends to a recipient to explain its final eligibility decision.

A single notice may contain decisions concerning several public benefit programs, household members, and time periods. It may also contain multiple sections with the same "Medicaid" or "Medically Needy" heading. Although those sections can reflect different Medicaid eligibility categories, the notices generally do not identify which category a particular section addresses.

For an income-based Medicaid termination, the notice contains a section stating that Medicaid benefits for the listed person or persons will end on a specified date. Other portions of the notice may state that household income exceeds Medicaid's limit or otherwise provide a standardized "Designated Reason" generated from one of DCF's reason codes. Some income-based termination notices, however, did not contain a Designated Reason identifying income as the basis for DCF's decision.

The challenged notices here also did not state the SFU size, countable income, or income limit DCF used in making the determination. Nor did they identify the Medicaid eligibility category under which DCF evaluated the recipient or the other categories DCF considered.

After receiving a notice, recipients can seek more information from several sources about their benefits or a termination decision. DCF operates a call center whose agents can consult FLORIDA, case notes, applications, third-party income records, and policy materials. DCF also maintains Family Resource Centers, the MyACCESS online portal, and public Medicaid materials.

And a recipient can request a hearing to contest a termination decision. *See* Fla. Admin. Code rr. 65-2.044, 65-2.045. After a hearing request, DCF generally conducts a supervisory review in which a supervisor can examine the underlying eligibility determination, explain it to the recipient, and correct any error before the hearing.

B. The Challenged Notices

The named plaintiffs all received income-based termination notices during the Medicaid "unwinding." Their notices were different in length and in the number and order of Medicaid and Medically Needy sections, but each illustrates the problems with the notices at issue in this case.

For example, DCF sent Chianne D. an eleven-page notice containing eight separate health-benefit sections. One Medicaid section listed every household member, including her newborn son S.D., as ineligible. The notice stated that the listed recipients were ineligible because "your household's income is too high," but it did not disclose the SFU, income figure, or income level used in determining eligibility. Several pages later, however, another section stated that S.D. remained eligible for Medicaid as a newborn. That latter section reflected DCF's actual decision; S.D.'s coverage never ended. Chianne D.'s own coverage, however, was terminated after DCF incorrectly ended her continuous postpartum coverage and evaluated her under a different eligibility category. DCF later restored her Medicaid retroactively.

Kimber Taylor and her newborn son K.H. received a nine-page notice stating that their Medicaid would end but that her newborn was eligible for the Medically Needy program. The notice did not disclose the SFU, income figure, or income level that DCF had used to determine Taylor and her newborn's ineligibility for full Medicaid. DCF later determined that both terminations were erroneous: Taylor remained entitled to continuous postpartum coverage, and K.H. remained entitled to continuous coverage as an infant born to a mother receiving Medicaid. DCF restored their coverage retroactively.

A.V.'s eight-page notice contained seven Medically Needy sections before the Medicaid termination section. The notice did not disclose the SFU, income figure, or income limit DCF had used in determining A.V.'s eligibility. The record shows that DCF used an SFU of six instead of eight, which reduced the applicable monthly income limit from $6,110 to $4,868, and also attributed $6,456.99 in monthly income to the family even though the family had reported $4,727.10. DCF later corrected the calculation and restored A.V.'s Medicaid.

C. Proceedings Below

Plaintiffs brought this action against the Secretaries of AHCA and DCF, alleging that Florida's Medicaid termination notices violated the Due Process Clause and the Medicaid Act. They sought declaratory and injunctive relief. The district court certified the following class, pursuant to Federal Rule of Civil Procedure Rule 23(b)(2):

> All Florida Medicaid enrollees who on or after March 31, 2023, have been or will be found ineligible for Medicaid coverage based on a finding that the individual or household has income that exceeds the threshold for Medicaid eligibility, and were issued a written notice that does not identify the individualized income used in the eligibility determination or the income standard applied.

The district court also certified a subclass consisting of class members "whose written notice does not provide a Designated Reason or includes only Designated Reasons that do not identify income as the factor on which the State relied in finding the individual to be ineligible for Medicaid."

After a six-day bench trial, Plaintiffs dismissed their Medicaid Act claim, leaving only the due-process claim. The district court later entered findings of fact and conclusions of law in Plaintiffs' favor.

The district court first addressed the notices themselves. It found that they did not "unambiguously communicate the State's decision to terminate benefits, the reason for that decision, or to whom it applies." As the district court found, the notices were "exceedingly confusing and contradictory in their language and construction." Further, the district court found that the notices did not provide enough case-specific information for recipients to understand how DCF had reached a termination decision, making it "difficult, if not impossible, for the recipient to understand the State's intended action as to each enrollee or the reasons for that action."

The district court then considered whether Florida's other sources of information cured those problems. It found that they did not. It determined that the call center did not provide accurate explanations of eligibility decisions. Further, MyACCESS and DCF's public materials did not provide the missing case-specific information. And although employees at Family Resource Centers could access case information, DCF did not direct recipients there to help them understand a termination decision.

DCF's supervisory review process offered a fuller explanation for those seeking clarity for a termination decision. But that review began only after a recipient requested a hearing. The district court found that this review process "comes too late in the process to provide the enrollee with the information she needs to decide whether to appeal" the termination decision in the first place. (emphasis omitted). Based on these findings, the district court concluded that Florida's methods of notice were insufficient "to meet the requirements of due process under the circumstances."

The district court entered a permanent injunction barring Florida from terminating a class member's Medicaid for financial ineligibility unless the written notice (i) unambiguously states that Medicaid coverage will end; (ii) identifies each person whose coverage will end; and (iii) explains the reason for the decision as to that person. For an income-based termination, the order requires the notice to include, "at a minimum," the enrollee's "household size (SFU) and countable income" as determined by the State, to

identify "the eligibility category in which the enrollee had been receiving benefits" and explain any change, and to provide enough information for the recipient to "ascertain the eligibility categories in which the enrollee was tested and the income limits the State applied."

Florida timely appealed.

II. STANDARD OF REVIEW

"After a bench trial, we review the district court's conclusions of law de novo and the district court's factual findings for clear error." *Proudfoot Consulting Co. v. Gordon*, 576 F.3d 1223, 1230 (11th Cir. 2009) (citing *Renteria–Marin v. Ag–Mart Produce, Inc.*, 537 F.3d 1321, 1324 (11th Cir. 2008)).

III. ANALYSIS

Florida raises several arguments on appeal, but they reduce to two central issues. The first is whether Florida's income-based Medicaid termination notices, considered together with the other sources of information available to recipients, satisfy due process. The second is whether the district court violated Rule 23 by resolving the adequacy of those notices on a classwide basis and entering the resulting injunction. We address each in turn.

A. Whether Florida's Notice System Satisfies Due Process

1. Governing Principles

The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law."

U.S. Const. amend. XIV, § 1. When the government proposes to deprive someone of a protected interest, the Supreme Court has explained that notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane v. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306, 314 (1950) (citations omitted).[2] Further, a notice "must be of such nature as reasonably to *convey the required information*, and it must afford a reasonable time for those interested to make their appearance." *Id.* (emphasis added) (citations omitted).

The Supreme Court has clarified that, in the context of termination of public benefits, due process requires that a recipient must "have timely and adequate notice *detailing the reasons* for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally." *Goldberg v. Kelly*, 397 U.S. 254, 267–68 (1970) (emphasis added). Those explanations matter where a recipient wants to challenge termination decisions "as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases." *Id.* at 268.

Taken together, *Mullane* and *Goldberg* frame the question the district court confronted: considering "all the circumstances," were

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[2] We have repeatedly confirmed that *Mullane*, not the later three-factor balancing test of *Mathews v. Eldridge*, 424 U.S. 319 (1976), governs the adequacy of notice. *See Grayden v. Rhodes*, 345 F.3d 1225, 1242 (11th Cir. 2003); *Arrington v. Helms*, 438 F.3d 1336, 1349 (11th Cir. 2006).

Florida's notices and the other means available to recipients "reasonably calculated" to provide "timely and adequate notice detailing the reasons" DCF was terminating their Medicaid benefits? *Mullane*, 339 U.S. at 314–15; *Goldberg*, 397 U.S. at 267–68. After a six-day bench trial, the district court found that the notices did not "unambiguously communicate the State's decision to terminate benefits, the reason for that decision, or to whom it applies," and that the other available sources did not cure those deficiencies. We agree.

2. *The Notices of Case Action*

The deficiency is apparent from Chianne D.'s notice. Her April 24, 2023, notice spans eleven pages and contains eight separate sections concerning health benefits. The first Medicaid section lists every member of the household, including her newborn son S.D., as ineligible for Medicaid because the "income is too high." Several pages later, another section contradicts the earlier statement and states S.D. *is* eligible for Medicaid as a newborn. That second statement reflected DCF's actual decision; S.D.'s Medicaid was never terminated. But nothing in the notice explained the conflicting information.

When Chianne D. called DCF for help, a Tier 3 agent read the same notice and told her that S.D.'s Medicaid was ending because the household's income was too high. The district court found that the agent "misunderstood the notice due to its multiple sections and gave Chianne D. the wrong answer," even though the agent had earlier recognized that S.D.'s Medicaid remained open.

When a trained DCF employee could read the notice and come away with the wrong answer about whose coverage was ending, the district court did not err in finding that the notice did not reasonably convey DCF's decision to its intended recipient.

Even when a recipient located the termination section and understood that income was involved, another problem remained. A notice stating "your household income is too high" gives the recipient DCF's conclusion. But financial eligibility for Medicaid turns on several factors including: (1) the countable income that DCF attributes to the recipient's SFU; (2) the size of that SFU; (3) the eligibility category under which DCF evaluated the recipient; and (4) the income limit corresponding to that category and SFU. The challenged notices did not disclose enough of those inputs for recipients to check DCF's determination against their own records.

Thus, for A.V.'s eligibility determination, DCF used an SFU of six when the correct SFU was eight. That mistake caused DCF to apply an income limit of $4,868 instead of $6,110. DCF also calculated the family's earned income as $6,456.99, even though the family had reported $4,727.10. Yet A.V.'s notice did not tell her mother the SFU or income standard DCF had used. William Roberts, who works in DCF's Medicaid Policy Unit and who testified at the bench trial, could not determine why A.V. had been found financially ineligible by looking at the notice, the family's MyACCESS account, or DCF's website. Roberts needed DCF's internal Budget screen, which Medicaid recipients cannot access. Thus, the

information needed to understand what DCF had done was available inside the agency but not to the person whose coverage DCF terminated.

These gaps in crucial information are precisely the concern that *Goldberg* addresses. When an agency's decision may rest on an "incorrect or misleading factual premise[]" or a mistaken application of its rules to a particular person, due process requires notice "detailing the reasons" for the termination. 397 U.S. at 267–68. A recipient who is informed only that his "income is too high" cannot tell whether DCF has based its determination on the wrong income, counted the wrong people in the recipient's SFU, evaluated the recipient under the wrong Medicaid category, or applied the wrong income limit. And without knowing which premise DCF used, the recipient does not know what objection to make.

Florida argues that our decisions in *Jordan v. Benefits Review Board*, 876 F.2d 1455 (11th Cir. 1989), and *Arrington v. Helms*, 438 F.3d 1336 (11th Cir. 2006), do not require the State to disclose individualized findings or calculations, and that the district court erred by requiring "individualized" termination decisions as to each recipient. True, neither case required an agency to reproduce their arithmetic. But the notices we approved in those cases at least gave their recipients something Florida's notices clearly do not: enough concrete information to understand the basis of the decision and to test it against information already available to them.

In *Jordan*, the agency denied black lung benefits because the claimant there had failed to meet one of three eligibility requirements. The termination notice listed all three requirements and identified the one the claimant had failed to prove. 876 F.2d at 1458–59. The notice also defined the relevant requirement and referred the claimant to a guide explaining the evidence that could satisfy it. *Id.* Under those circumstances, we held that the notice provided "sufficient detail to pass the notice requirement of due process." *Id.* at 1459. The claimant in *Jordan* did not receive every step of the agency's reasoning, but he knew what part of his claim had failed and what evidence was relevant.

The notice in *Arrington* provided recipients a similar ability to check the government's work. Alabama's monthly child support notice identified the relevant court order and gave the amounts paid toward current support, arrears, and the family. 438 F.3d at 1350. A parent could compare the amount shown in the notice with the parent's child support order, then compare the amount Alabama said it paid to the family with the parent's payment check stub. *Id.* If questions remained after that comparison, the check stub directed the parent to a 24-hour hotline, and customer-service representatives were available by telephone, fax, mail, email, or in person. *Id.* at 1350–51. The notice and those additional resources together gave parents "ample information with which to determine" whether they had received the correct payment. *Id.*

Florida's notices provide no comparable starting point. They do not identify the individualized income used or the applicable standard against which DCF measured it. Unlike the recipients in *Jordan* and *Arrington*, then, a class member cannot use the notice and information already in their possession to identify the disputed premise or check the agency's work.

Based on the evidence before it, the district court did not err in concluding that Florida's notices fail to meet due process requirements because they are too vague and confusing to reasonably inform recipients what action the State intends to take, to whom that action applies, or why the State is taking it.

3. Other sources of information

But that deficiency alone does not end our inquiry. Due process asks whether Florida's notice system, considered as a whole, was "reasonably calculated, under all the circumstances," to convey the information recipients needed to understand and challenge the termination. *Mullane*, 339 U.S. at 314; *Jordan*, 876 F.2d at 1459. We therefore turn to the other sources of information that Florida says supplement its otherwise deficient written notices.

The record gave the district court good reason to find those sources unreliable for that purpose. Start with the call center. In April 2024, DCF blocked 744,000 calls before they could enter a queue for a live agent, representing 53.9 percent of the calls requesting an agent. Of the calls that entered a queue, another 31.3 percent ended before an agent answered. Those figures count calls rather than unique recipients and therefore do not establish how

many individual Medicaid recipients ultimately failed to reach DCF. But they support the district court's finding that the call center received "far more calls with requests for live agents than it is equipped to handle."

Reaching an agent did not necessarily answer the question for several class members who tried to ascertain the reason for the termination of their benefits. When the FLORIDA system moves a recipient from "Medicaid" to "Medically Needy," it deletes the Budget screen containing the Medicaid termination determination. An agent who attempts to explain the basis for a termination may therefore have to reconstruct that determination from scratch using information elsewhere in DCF's system. This often resulted in long delays and incorrect information being provided to recipients who did reach an agent.

Florida's reliance on the call center assumes that a recipient who cannot understand the notice can simply ask DCF what the agency actually decided. But there is a fundamental problem that goes unaddressed by Florida: what is the recipient to do when DCF's answer conflicts with the notice? That happened here. One agent told Chianne D. that she and C.D. were "good" and remained covered through May 2024, when DCF was in fact terminating her full Medicaid coverage. A Tier 3 agent later read the notice and incorrectly told Chianne D. that S.D.'s Medicaid was ending because the household's income was too high, even though another section of the same notice said that S.D. remained eligible.

Faced with competing answers from the agency itself, a recipient has no reliable basis for knowing which one to trust. Requiring a recipient to independently determine which account is correct brings us back to the task that the notices are supposed to perform in the first place.

The problem is compounded because a recipient must then decide whether to request a hearing and challenge the termination decision. If the recipient relies on the agent and the agent is wrong, the recipient may forgo a hearing that the recipient needed. If instead the recipient relies on a confusing or contradictory notice, the recipient still may not know what factual premise or eligibility determination to contest. Either way, Florida has not given the recipient a reliable basis for making the choice *Mullane* says belongs to the recipient: whether to "acquiesce or contest." 339 U.S. at 314.

The remaining sources of information did not fill the gap left behind by the inadequate notices. For example, MyACCESS did not provide the case-specific information that was omitted from the notices. DCF's Policy Manual and Appendix A-7 describe Medicaid rules generally, but they do not tell a recipient what income, SFU, eligibility category, or income limit DCF actually used in the recipient's case. And although employees at Family Resource Centers could access specific case information, neither the notices nor DCF's website told recipients to visit those centers to help understand a termination decision.

The timing of DCF's supervisory review also shows why these gaps in information leave a recipient with little understanding

about what is happening and why. Once a recipient requests a hearing, a supervisor independently reviews the eligibility determination. As part of that process, the supervisor reviews the application, the notice, DCF's Budget and other internal screens, the governing policies, the income tables, and third-party income records. The supervisor then contacts the recipient and explains "how the decision was made, the reason for the decision, and the facts used to make the decision," including the income and policies DCF applied.

That is essentially the explanation the recipient needed before deciding whether to challenge the termination. But DCF provides it only *after* the recipient has requested a hearing. As the district court found, "the review occurs only after an individual has made the decision to appeal. Thus, it comes too late in the process to provide the enrollee with the information she needs to decide whether to appeal." (emphasis omitted).

Mullane speaks directly to Florida's backwards sequence. "This right to be heard has little reality or worth unless one is informed that the matter is pending and can choose for himself whether to appear or default, acquiesce or contest." 339 U.S. at 314. *Goldberg* followed the same logic. There, a caseworker with doubts about continued eligibility had to "first discuss them with the recipient" before recommending termination. 397 U.S. at 258. If the caseworker still believed the recipient was ineligible, the agency sent a letter stating the reasons for the proposed termination and

explaining how to seek further review. *Id.* at 258–59. Before deciding whether to contest the termination, the recipient thus knew "the precise questions raised about his continued eligibility" and "the legal and factual bases for the Department's doubts." *Id.* at 268. Florida's process runs in the opposite direction with the fuller explanation coming only *after* the recipient decides to object.

Contrary to Florida's arguments, the district court did not impose a rule requiring every agency to reproduce every internal calculation in every notice. Rather, it applied *Mullane* and *Goldberg* to the notice system proved at trial. Here, DCF's eligibility determination turns on the recipient's SFU and countable income, the eligibility category DCF used, and the corresponding income limit. Those were also among the premises on which the record revealed actual errors. On this record, Florida did not provide that information through its notices or through another method reasonably calculated to convey it before recipients had to decide whether to object.

We therefore find no error with the district court's determination that Florida's notice system did not satisfy due process.

B. The Classwide Ruling and Injunction

Florida next argues that the district court went beyond the class claim it certified. According to Florida, the court only certified a challenge to the information omitted from the notices but later decided a different "structural claim" about how the notices communicated the State's decision. Because that supposed claim

was never certified, Florida argues, the district court could not decide it for the class. We disagree.

Rule 23(c)(1)(B) requires a certification order to "define the class and the class claims, issues, or defenses." Fed. R. Civ. P. 23(c)(1)(B). The district court did that here. It limited the class to Medicaid enrollees whom Florida found financially ineligible and who received a notice that (1) did not identify the income used in the eligibility determination or (2) the income standard applied. It also certified a subclass whose notices contained no Designated Reason or only Designated Reasons that did not identify income as the basis for the decision.

The certification order also identified what the court would decide at trial. It described "[t]he central question" as "what information and degree of detail must be included in a Medicaid termination notice to satisfy the Due Process Clause." And, recognizing that the notices were not identical, the court said it would "consider the adequacy of the notice in its entirety and under the totality of the circumstances." The question, it explained, was whether Florida's notices were "reasonably calculated to apprise intended recipients, as a whole, of their rights."

The district court's inquiry thus necessarily included *how* the notices communicated the information they contained, not simply *what* they said. *Mullane* requires that a notice "reasonably" convey the required information. *339* U.S. at *314*. So, if multiple sections, conflicting statements, or the way household members are grouped together make it unclear what DCF decided or to whom

the decision applies, those facts are directly relevant to the due process claim certified for classwide consideration. Contrary to Florida's argument, they do not create a second constitutional claim called "structure."

The class certification order itself anticipated that inquiry, recognizing that "the content of each termination notice varies." Even so, after limiting the class to income-based terminations, the district court found common omissions across the notices and concluded that they were "sufficiently similar as to allow review of their adequacy across the class." Indeed, when Florida argued that other language in particular notices had to be considered, the court agreed: the notices would be reviewed "in their entirety."

In the end, the district court certified a narrow class. It excluded Medicaid terminations based on reasons other than income because different reasons might require different explanations. The class therefore includes only recipients whose Medicaid was terminated because DCF found their income too high and whose notices omitted either the income DCF used or the income limit. The common question was whether those notices gave recipients adequate notice of an income-based termination.

That common question does not turn on whether every notice looked the same. *Jordan* asks whether the notice was "reasonably calculated to apprise intended recipients, as a whole, of their rights," not whether a particular recipient understood it. 876 F.2d

at 1459. Some notices had more sections than others. But the district court could still answer the same question for the class: did Florida adequately tell these recipients what it was doing and why?

The final injunction that was entered reflects that same narrow ruling. It does not tell Florida how to design its notices or how to change the "structure." Instead, it requires notices to clearly say that Medicaid will end, identify whose benefits will end, and explain why. The explanation must give the recipient enough case-specific information to check DCF's decision and decide whether to request a fair hearing.

For an income-based termination, the notice must include, "at a minimum," the enrollee's "household size (SFU) and countable income" and identify "the eligibility category in which the enrollee had been receiving benefits," including the reason for any change. It must also allow the recipient to "ascertain the eligibility categories in which the enrollee was tested and the income limits the State applied."

These requirements track the standards set forth in *Mullane* and *Goldberg*, 339 U.S. at 314–15; 397 U.S. at 267–68, governing the information that Florida must give recipients before ending benefits because of income. And Rule 23 permitted the district court to answer that question for the class and to enter an injunction requiring that notice. We find no error in the district court's injunction.

IV. CONCLUSION

Because Florida's notice system did not provide constitutionally adequate notice, and because the district court properly resolved that claim on a classwide basis and tailored its injunction to that violation, we affirm.

AFFIRMED.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
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November 04, 2026

MEMORANDUM TO COUNSEL OR PARTIES

Appeal Number: 26-10419-GG
Case Style: Chianne D., et al v. Secretary, Florida Agency for Health Care Administ, et al
District Court Docket No: 3:23-cv-00985-MMH-LLL

Opinion Issued
Enclosed is a copy of the Court's decision issued today in this case. Judgment has been entered today pursuant to FRAP 36. The Court's mandate will issue at a later date pursuant to FRAP 41(b).

Petitions for Rehearing
The time for filing a petition for panel rehearing or rehearing en banc is governed by 11th Cir. R. 40-2. Please see FRAP 40 and the accompanying circuit rules for information concerning petitions for rehearing. The Court has proposed amending 11th Cir. R. 40-1 (Number of Copies) to no longer require paper copies of a petition for panel rehearing or a petition for rehearing en banc. Based on the proposed amendment, other than an original petition filed in paper by a non-electronic filer, **parties are asked not to submit any paper copies** of a petition for panel rehearing or a petition for rehearing en banc.

Costs
Costs are taxed against Appellant(s) / Petitioner(s).

Bill of Costs
If costs are taxed, please use the most recent version of the Bill of Costs form available on the Court's website at www.ca11.uscourts.gov. For more information regarding costs, see FRAP 39 and 11th Cir. R. 39-1.

Attorney's Fees
The time to file and required documentation for an application for attorney's fees and any objection to the application are governed by 11th Cir. R. 39-2 and 39-3.

Appointed Counsel
Counsel appointed under the Criminal Justice Act (CJA) must submit a voucher claiming compensation via the eVoucher system no later than 45 days after issuance of the mandate or the filing of a petition for writ of certiorari. Please contact the CJA Team at (404) 335-6167 or

cja_evoucher@ca11.uscourts.gov for questions regarding CJA vouchers or the eVoucher system.

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OPIN-1 Ntc of Issuance of Opinion