Dear reviewer,

Thank you so much for your insightful feedback on our manuscript. We value your suggestions and have made changes as described below.

1. Reviewer #1 raises an excellent point that the data is confined to the pre-COVID era. This does indeed represent a major limitation. The authors have recently begun a related prospective study at the same site, but it does not currently have sufficient data to compare the pre-COVID vs post-COVID eras. We nevertheless suggest that the large sample size and manual chart review as opposed to use of aggregate billing data represent major strengths that outweigh this limitation.
2. Reviewer #1 asks whether patients with failed screening were diagnosed at a later stage. We have added information about these findings to the results section of the manuscript. Despite our large sample size, only four patients in our cohort were diagnosed with HCC during the study period. All patients diagnose with HCC experienced delays in screening. One was diagnosed at stage IVb and passed away due to hepatocellular carcinoma. One was lost to follow-up following discovery of a 3.1 cm nodule on MR liver mass. Two were underwent Y-90 transarterial radioembolization and partial surgical hepatectomy. One of these patients ultimately elected to transition to hospice and passed away due to worsening hepatic decompensation; the other is still alive.
3. Reviewer #1 asks whether any screening failures could be attributed to specific physicians. There were no major differences between physicians.
4. Reviewer #1 asks where the radiology studies were performed. All of those who received their care exclusively within the public university medical system were referred to the radiology department within the institution. 35 patients who followed with community-based gastroenterologists and came to the institution for periodic subspecialty consultation elected to undergo HCC screening with local private radiologists.
5. Reviewer #2 suggest that the authors conduct an “in-depth analysis of the data.” The reviewer may be referring to the lack of statistical analysis, specifically hypothesis-testing, available in the results section. The methodology of this retrospective review was not designed to detect individual or demographic risk factors for screening failure, but instead to identify root causes of screening failure. The authors reiterate that the large sample size and manual chart review as opposed to use of aggregate billing data represent major strengths that outweigh this limitation.
6. The authors clarified the imaging methodology, as suggested by Reviewer #3.
7. Reviewer #3 raises an excellent point, that the authors are practicing in a high-resource setting, and the AASLD guidelines would not apply in a setting that is not equipped to treat HCC. We added a sentence in the discussion section explaining that the World Gastroenterology Organization offers different guidelines to low-resource settings in which treatment for HCC is not available.
8. Reviewer #3 raises suggests that alternative screening strategies would dramatically improve screening intervals, eliminating radiology scheduling delays as the most

common cause for screening failure. We added a sentence in the discussion section highlighting ongoing research into biomarkers.